OKLAHOMA HEALTH CARE AUTHORITY
AMENDED BOARD MEETING
March 22, 2023, at 2:00 P.M.
Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
Oklahoma City, OK. 73105

A G E N D A

Public access via Zoom:
https://www.zoomgov.com/webinar/register/WN_VntF8PKzS62LQMXIbSohDA
Telephone: 1-669-216-1590 Webinar ID: 161 147 8788

*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. Discussion and Vote on the January 18, 2023, OHCA Board Meeting Minutes…….……Marc Nuttle, Chair

3. Chief Executive Officer's Report……..Kevin Corbett, Chief Executive Officer

    a) Member Moment……Verna Foust, Chief Executive Officer, Red Rock Behavioral Health System

4. Chief of Staff Report……..……..Ellen Buettner, Chief of Staff

5. State Medicaid Director's Report ……..Traylor Rains, State Medicaid Director

6. Continuous Coverage Unwinding Update (Attachment "A")……Brandon Keppner, Chief Operating Officer

7. Discussion of Report from the Pharmacy Advisory Committee and Possible Action Regarding Drug Utilization Review Board Recommendation:……Corey Finch, M.D. Chair, Pharmacy Advisory Committee

    a) Discussion and Possible Vote 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 "B"):

Drug Name:	Used For:
Relyvrio™	**Amyotrophic Lateral Sclerosis (ALS),** also known as Lou Gehrig's disease, is a progressive and fatal disease attacking neurons that control voluntary movement.
Vyvgart®	**Myastenia Gravis** is an autoimmune neuromuscular disorder primarily characterized by muscle weakness and muscle fatigue.
Vabysmo™	**Neovascular Wet Age-Related Macular Degeneration (Wet AMD)** is a serious type o late AMD. It happens when vascular endothelial protein growth factor makes abnormal blood vessels grow in the wrong place in the back of your eye.
Kimmtrak® Opdualag™	**Metastatic Melanoma** is a serious type of skin cancer which has spread to another area of the body.
Lytgobi®	**Cholangiocarcinoma i**s also known as bile duct cancer and is a rare form of cancer affecting 8,000 people in the US each year.
Pedmark® Vijoice®	**Prevent ototoxicity associated with cisplatin therapy** Ototoxicity is the pharmacological adverse reaction affecting the inner ear or auditory nerve. **PIK3CA-Related Overgrowth Spectrum (PROS)** includes a group of rare genetic disorders that leads to overgrowth of various body parts due to mutations in the gene

Hyftor™	**Facial Angiofibromas Associated with Tuberous Sclerosis Complex (TSC)** Facial angiofibroma is the most predominant cutaneous manifestation of TSC, a rare autosomal dominant genetic disorder.

8. Discussion of Report from the Compliance Advisory Committee and Possible Action ……Phil Kennedy Chair, Compliance Advisory Committee

    a) Discussion and Possible 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. (Attachment "C")

        i. Third Partly Liability (TPL) Systems

9. Discussion of Report of Strategic Planning & Operational Advisory Committee ……Marc Nuttle Chair, Strategic Planning & Operational Advisory Committee

10. Discussion of Report of Administrative Rules Advisory Committee and Possible Action (Attachment "D") ……..…Tanya Case Administrative Rules Advisory Committee Member

<u>The following EMERGENCY rules HAVE NOT previously been approved by the Board:</u>

a) APA WF # 23-01 State Plan Personal Care Services for Expansion Adults, TEFRA Eligible Children and Certain MAGI Populations
b) APA WF # 23-05 Notification of Date of Service (NODOS) Timeframe Change
c) APA WF # 23-06A&B Transition to SoonerSelect

<u>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.</u>

d) APA WF # 22-01 Non-Emergency Transportation NEMT) Driver Compliance
e) APA WF # 22-02 Independent Clinical Psychologist Services for Adults
f) APA WF # 22-03 Clinical Trials Services and Dental Out-of-State Services
g) APA WF # 22-05 Ambulance Service Provider Access Payment Program
h) APA WF # 22-07 Tribal Residential Substance Use Disorder (SUD) Policy Updates
i) APA WF # 22-08 Hospice Benefit for Expanded Population
j) APA WF # 22-10 Long-Term Care Facility (LTC) Pay-for-Performance (PFP) Program
k) APA WF # 22-11 Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Visit and Sick Visit on the Same Day
l) APA WF # 22-12 Staff Ratios and Staff Licensing Requirements for Out-of-State Psychiatric Providers
m) APA WF # 22-13 Allowing Advanced Practice Registered Nurses (APRNs) and Physician Assistants (PAs) to Render Physician-Required Psychiatric Services
n) APA WF # 22-14 Coverage for Donor Human Breast Milk
o) APA WF # 22-15 Removing Provider Panel Limits in the Patient Centered Medical Home (PCMH)
p) APA WF # 22-17 Covering Former Foster Care Youth from Another State
q) APA WF # 22-18 Mobile Dental Services
r) APA WF # 22-21A&B Increase Income Standard for Pregnant Women and Extend Postpartum Coverage
s) APA WF # 22-22 Ukrainian Humanitarian Parolees

<u>The following PERMANENT rule HAS previously been approved by the Board and the Governor under EMERGENCY rulemaking. This rule HAS been revised for PERMANENT rulemaking.</u>

t) APA WF # 22-16 Statewide HIE

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

u) APA WF # 22-23A&B ADvantage Waiver Rule Changes
v) APA WF # 22-24A&B Developmental Disabilities Services (DDS) Policy Changes
w) APA WF # 22-25 Behavioral Health Rules Cleanup
x) APA WF # 22-26 Crisis Intervention Rule Revisions
y) APA WF # 22-27 Physician Assistant Rule Revisions
z) APA WF # 22-28 Opioid Treatment Program (OTP) Rule Changes
aa) APA WF # 22-29 Laboratory Services Policy Cleanup
bb) APA WF # 22-30 Outdated/Obsolete Policy Language Cleanup
cc) APA WF # 22-31 Eliminate Certificate of Medical Necessity (CMN) Form Requirement for Most Medical Supplies, Equipment, and Appliances

11. Discussion and Possible Action……Marc Nuttle, Chair
Possible Executive Session as Recommended by the General Counsel and Authorized by the Open Meeting Act, 25 O.S. § 307(B)(4) , To Discuss Confidential Legal Matters Concerning Pending Litigation.

12. Adjournment.....……..Marc Nuttle, Chair

NEXT BOARD MEETING
May 17, 2023, at 2:00PM
Oklahoma Health Care Authority
4345 N. Lincoln Blvd
Oklahoma City, OK 73105

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MINUTES OF AN AMENDED BOARD MEETING
OF THE HEALTH CARE AUTHORITY BOARD
January 18, 2023
Samis Education Center
1200 Children's Avenue
Oklahoma City, Oklahoma

Manner and Time of Notice of Meeting: A statutorily required public meeting notice was placed on the front door of the Samis Education Center on January 17, 2023 at 2:00 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 January 13, 2023 at 4:06 p.m.

Pursuant to a roll call of the members, a quorum was declared to be present, and Chairman Nuttle called the meeting to order at 2:00 p.m.

BOARD MEMBERS PRESENT: Chairman Nuttle, Member Case, Member Christ, Member Cruzan, Member Kennedy, Member Sharpe

BOARD MEMBERS ABSENT: Vice-Chairman Yaffe, Member Finch

ITEM 2 / DISCUSSION AND POSSIBLE VOTE ON THE NOVEMBER 16, 2022, OHCA BOARD MEETING MINUTES
Chairman Nuttle, OHCA Board Chairman

MOTION: Member Christ moved for approval of item 2, as published. The motion was seconded by Member Kennedy.

BOARD MEMBERS PRESENT: Chairman Nuttle, Member Case, Member Christ, Member Cruzan, Member Kennedy, Member Sharpe

BOARD MEMBERS ABSENT: Vice-Chairman Yaffe, Member Finch

ITEM 3 / CHIEF EXECUTIVE OFFICER'S REPORT
Kevin Corbett, Chief Executive Officer

CEO Corbett thanked Member Susan Dell'Osso and Member Tom Sharpe, both of which have and will have resigned. CEO Corbett introduced Dr. Richard Lofgren, OU Health CEO, who provided an overview of OU Health.

Supplemental Payments: OHCA was able to provide a one-time supplemental to hospital participants.

Public Health Emergency Update: The PHE is still in place. It was extended and running on a 60-day clock, after which we will find out if it will be terminated. Should the PHE not be extended, the unwinding plan will begin in April. The Omnibus Bill that was passed by the President decoupled the PHE and continuous coverage. So, by virtue of the Omnibus Bill being passed, the continuous coverage had a sunset date, which is the end of March or first part of April. OHCA teams are now actively moving and mobilizing with regards to OHCA's unwinding plan, which will be presented later during the meeting. The unwinding period is estimated to be nine to twelve months. The Omnibus Bill allows OHCA to continue to receive enhanced FMAP, which will help cover the state's cost.

SoonerSelect Update: OHCA will announce the Dental entities soon. The medical side is proceeding with requests for proposals.

Budget Hearings: OHCA presented its budget to the Senate on January 11th and will present to the House on January 25th.

CEO Corbett thanked Member Case and Member Christ for agreeing to serve on a newly constituted Strategic Planning and Operational Committee. This new Committee will be a working committee, much like the other board committees.

AG Opinion: The Board should have received the recent AG's Opinion. The OHCA team is working through that to be able to provide an overview. The Opinion specifically states that the Board is not an advisory board, so there is much to be said about that.

Litigation: The Department of Justice investigation that's taking place over mental health is underway. OHCA is a party to that, along with the Department of Mental Health, Oklahoma City, and Oklahoma County. A recently filed suit regarding the SoonerSelect program is also being reviewed by OHCA team.

ITEM 4 / CHIEF OF STAFF REPORT
Ellen Buettner, Chief of Staff

Ms. Buettner provided a legislative and budget hearing update.

Legislative Update: OHCA has requested four bills, three of which are related to Managed Care, specifically about the dental benefit licensure, the second would create the single provider credentialing process, and the third would amend the ambulance supplemental provider payment program. The fourth bill would allow OHCA to maximize the recovery of Third-Party Liability cases. OHCA is tracking several bills related to managed care, nursing facilities, rural health, and gender affirming care. OHCA will continue to track the bills and will provide updates to the Board.

Budget Hearings: The House and Senate Budget Hearings have been scheduled this month, the House hearing is scheduled on January 25, 2023; and the Senate Hearing was scheduled January 11, 2023.

ITEM 5 / STATE MEDICAID DIRECTOR'S REPORT
Traylor Rains, State Medicaid Director

Mr. Rains provided an update on the 2023 consolidation appropriations bills and their impact on SoonerCare, new and upcoming program changes, and a SoonerSelect update on important milestones.

For more detailed information, see attachment A in the board packet.

ITEM 6 / CONTINUOUS COVERAGE UNWINDING PRESENTATION
Brandon Keppner, Chief of Operations

Mr. Keppner provided and overview of the Public Health Emergency Unwinding, which included information on the PHE and the Families First Coronavirus Response Act, Consolidated Appropriations Act, OHCA Communications Phases, Unwinding Preparations, OHCA's Commitment, Unwinding Requirements, Normal Operations, Protecting Vulnerable Members, Transition Process, and Resources.

For more detailed information, see Attachment B in the board packet.

ITEM 7i-viii / DISCUSSION OF REPORT FROM THE PHARMACY ADVISORY COMMITTEE AND POSSIBLE ACTION REGARDING DRUG UTILIZATION BOARD RECOMMENDATIONS
Terry Cothran, Director of Pharmacy Services

Action Item – a) Discussion and Possible 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 "C")

	Drug Name:	Used For:
i	Enjaymo	**Cold agglutinin disease** is a rare type of autoimmune hemolytic anemia in which the body's immune system mistakenly attacks and destroys its own red blood cells.
	Pyrukynd	**Pyruvate kinase deficiency** is a genetic blood disorder characterized by low levels of an enzyme called pyruvate kinase, which is used by red blood cells
	Zynteglo	**Transfusion dependent beta thalassemia**: Beta thalassemia is a blood disorder that reduces the production of hemoglobin.
ii	Spevigo	**Pustular psoriasis** is an uncommon form of psoriasis consisting of widespread pustules on an erythematous background.
	Tavneos	**Anti-neutrophil cytoplasmic autoantibody (ANCA)-associated vasculitis** is a group of rare diseases involving inflammation of your small to medium-sized blood vessels.
iii	Besremi	**Polycythemia vera** is a rare, chronic disorder involving the overproduction of blood cells in the bone marrow.
	Vonjo	**Myelofibrosis** is an uncommon type of bone marrow cancer that disrupts your body's normal production of blood cells.
iv	Xenpozyme	**Acid sphingomyelinase deficiency (ASMD)** is a rare progressive genetic disorder that

		results from a deficiency of the enzyme acid sphingomyelinase, which is required to break down (metabolize) a fatty substance (lipid) called sphingomyelin.
v	Carvykti & Tecvavli	**Multiple myeloma** is a cancer that begins in plasma cells, a type of white blood cell.
vi	Tezspire	**Asthma** is a chronic (long-term) lung disease.
vii	Adbry & Cibingo	**Atopic dermatitis (AD)** is a chronic skin condition characterized by patches of dry, inflamed, and itchy skin.
viii	Skysona	**Cerebral adrenoleukodystrophy (cerebral ALD, or CALD)** is a genetic disorder. It is the childhood-onset form of ALD. ALD leads to the accumulation of very-long-chain fatty acids in the brain and adrenal glands.

MOTION: Member Sharpe moved for approval of item 7i-viii, as published. The motion was seconded by Chairman Nuttle.

BOARD MEMBERS PRESENT: Chairman Nuttle, Member Case, Member Christ, Member Cruzan, Member Kennedy, Member Sharpe

BOARD MEMBERS ABSENT: Vice-Chairman Yaffe, Member Finch

ITEM 8 / DISCUSSION OF REPORT FROM THE COMPLIANCE ADVISORY COMMITTEE
Phil Kennedy, Chair, Compliance Advisory Committee

Member Kennedy provided an update on December and January Compliance Committee meetings.

Financials: The revenues for OHCA through November were $3.3 billion or 5.2% over budget. The expenditures were $3.1 billion or 6.6 over budget, primarily from Nursing Facility supplemental payments and impacts from the PHE and continuous coverage. The state budget variance is negative $31 million, which is a decrease from October. OHCA recently submitted a budget revision in January, increasing the budget from $635 million. This includes Nursing Facility supplemental payment, additional SHOPP distribution, and a 12-month impact of the PHE and Continuous Coverage. OHCA does not expect increase to be reoccurring. OHCA will utilize cash reserves to fund the increases.

Program Integrity: OHCA completed the 2022 Payment Error Rate Measurement (PERM), which is reviewed by CMS. The PERM rate for Oklahoma was 1.95%, which is the second lowest rate in the nation and is significantly below the national average of 15.62%. There are two elements to this, the accuracy and payment of claims and eligibility. The actual accuracy for claims showed zero errors. That is the best it's ever been in the agency M

a) Discussion and Possible Vote regarding the Authorities 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. (Attachment "D")

    i. SoonerSelect Medical
    ii. SoonerSelect Dental
    iii. SoonerSelect Children's Specialty
    iv. Social Determinants of Health
    v. Electronic Visit Verification

MOTION: Member Kennedy moved for approval of item 8a.i-iii, as published. The motion was seconded by Member Sharpe.

BOARD MEMBERS PRESENT: Chairman Nuttle, Member Case, Member Christ, Member Cruzan, Member Kennedy, Member Sharpe

BOARD MEMBERS ABSENT: Vice-Chairman Yaffe, Member Finch

MOTION: Member Kennedy moved for approval of item 8a.iv, as published. The motion was seconded by Member Sharpe.

BOARD MEMBERS PRESENT: Chairman Nuttle, Member Case, Member Christ, Member Cruzan, Member Kennedy, Member Sharpe

BOARD MEMBERS ABSENT: Vice-Chairman Yaffe, Member Finch

MOTION: Member Kennedy moved for approval of item 8a.v, as published. The motion was seconded by Member Sharpe.

BOARD MEMBERS PRESENT: Chairman Nuttle, Member Case, Member Christ, Member Cruzan, Member Kennedy, Member Sharpe

BOARD MEMBERS ABSENT: Vice-Chairman Yaffe, Member Finch

ITEM 9 / DISCUSSION OF REPORT FROM THE ADMINISTRATIVE RULES ADVISORY COMMITTEE AND POSSIBLE ACTION REGARDING AGENCY RULEMAKING

Tanya Case, Interim Administrative Rules Advisory Committee Chairwoman

a) Discussion and Possible Vote on 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 "E"):

   i. APA WF # 22-11 Early and Periodic Screening, Diagnostic and treatment (EPSDT) Visit and Sick Visit on the Same Day
   j. APA WF # 22-21A Increase Income Standard for Pregnant Women and Extend Postpartum Coverage
   k. APA WF # 22-21B Increase Income Standard for Pregnant Women and Extend Postpartum Coverage
   l. APA WF # 22-22 Ukrainian Humanitarian Parolees

MOTION: Member Sharpe moved to approve that there was significant evidence of the above rules being presented as emergency rules. The motion was seconded by Member Christ.

BOARD MEMBERS PRESENT: Chairman Nuttle, Member Case, Member Christ, Member Cruzan, Member Kennedy, Member Sharpe

BOARD MEMBERS ABSENT: Vice-Chairman Yaffe, Member Finch

MOTION: chairman Nuttle moved to approve the rules listed in item 9 as published. The motion was seconded by Member Christ.

BOARD MEMBERS PRESENT: Chairman Nuttle, Member Case, Member Christ, Member Cruzan, Member Kennedy, Member Sharpe

BOARD MEMBERS ABSENT: Vice-Chairman Yaffe, Member Finch

ITEM 10 / PROPOSED EXECUTIVE SESSION AS RECOMMENDED BY THE CHIEF OF LEGAL SERVICES AND AUTHORIZED BY THE OPEN MEETINGS ACT, 25 OKLAHOMA STATUTES §307(B) (4).

Marc Nuttle, OHCA Board Chairman

MOTION: Member Kennedy moved to go into Executive Session. The motion was seconded by Member Cruzan.

BOARD MEMBERS PRESENT: Chairman Nuttle, Member Case, Member Christ, Member Cruzan, Member Kennedy, Member Sharpe

BOARD MEMBERS ABSENT: Vice-Chairman Yaffe, Member Finch

MOTION: Member Case moved to leave Executive Session. The motion was seconded by Member Kennedy.

BOARD MEMBERS PRESENT: Chairman Nuttle, Member Case, Member Christ, Member Cruzan, Member Kennedy, Member Sharpe

BOARD MEMBERS ABSENT: Vice-Chairman Yaffe, Member Finch

ITEM 10 / ADJOURNMENT
Marc Nuttle, OHCA Board Chairman

MOTION: Member Kennedy moved to adjourn. The motion was seconded by Member Christ.

BOARD MEMBERS PRESENT: Chairman Nuttle, Member Case, Member Christ, Member Cruzan, Member Kennedy, Member Sharpe

BOARD MEMBERS ABSENT: Vice-Chairman Yaffe, Member Finch

Meeting adjourned at 4:03 p.m., 1/18/2023

NEXT BOARD MEETING
March 22, 2023
Oklahoma Health Care Authority
4345 N. Lincoln Blvd
Oklahoma City, OK 73105

Martina Ordonez
Board Secretary

Minutes Approved: _____

Initials: _____

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Attachment B

Oklahoma Health Care Authority Board Meeting – Drug Summary

Drug Utilization Review Board Meeting – February 8, 2023

Recommendation/ Vote	Drug	Used for	Cost*	Notes
1	Relyvrio™	• Amyotrophic Lateral Sclerosis (ALS)	• $162,555.12 per year	• ALS, also known as Lou Gehrig's disease, is a progressive and fatal disease, attacking neurons that control voluntary movement. The result is the gradual loss of muscle movement, speech, swallowing, and eventually, breathing. ALS is most common in whites, males, and people over the age of 60. It is estimated there are 5-10 per 100,000 persons with ALS.
2	Vyvgart®	• Myastenia Gravis	• $333,200 per year	• Myasthenia gravis is an auto-immune neuromuscular disorder primarily characterized by muscle weakness and muscle fatigue. Although the disorder usually becomes apparent during adulthood, symptom onset may occur at any age. The prevalence is estimated between 14-20 per 100,000 in the US.
3	Vabysmo™	• Neovascular Wet Age-Related Macular	• $28,470 per year	• Wet AMD is a serious type of late AMD. It happens when a protein called vascular endothelial growth factor

		Degeneration (Wet AMD)		(VEGF) makes abnormal blood vessels grow in the wrong place in the back of your eye which can cause vision impairment to vision loss. Most common in those over 65 years old. • Other treatments options available
4	Kimmtrak® Opdualag™	• Metastatic Melanoma	• $994,280 per year • $356,049 per year	• Metastatic melanoma is a serious type of skin cancer which has spread to another area of the body. The rate of new cases is approximately 21.5 per 100,000 people US with the median age at diagnosis being 65 years.
5	Lytgobi®	• Cholangiocarcinoma	• $31,258 per month	• Cholangiocarcinoma is also known as bile duct cancer and is a rare form of cancer affecting 8,000 people in the US each year.
6	Pedmark® Vijoice®	• Prevent ototoxicity associated with cisplatin therapy • PIK3CA-Related Overgrowth Spectrum (PROS)	• $11,417 per treatment • $34,821 per month	• Ototoxicity is the pharmacological adverse reaction affecting the inner ear or auditory nerve, causing hearing or balance loss • (PROS) includes a group of rare genetic disorders that leads to overgrowth of various body parts due to mutations in the gene PIK3CA. This gene is involved

				in making a protein that helps regulate cell growth, division and survival. Certain areas of the body are overgrown, ranging from isolated digits to whole limbs, trunk, or brain. Different tissues may be involved individually or in combination such as fat, muscle, bone, nerve, brain and blood vessels. Prevalence is unknown due to rarity.
7	Hyftor™	• Facial angiofibromas associated with tuberous sclerosis complex (TSC)	• $42,000 per year	• Facial angiofibroma is the most predominant cutaneous manifestation of TSC, a rare autosomal dominant genetic disorder. Facial angiofibroma can bleed spontaneously, impair eyesight, and cause aesthetic disfiguration causing psychological and social stress. TSC affects 1 in 6,000 newborns with approximately 40,000-80,000 people in the US having TSC.

*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.

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Recommendation 1: Vote to Prior Authorize Relyvrio™

The Drug Utilization Review Board recommends the prior authorization of Relyvrio™ (Sodium Phenylbutyrate/Taurursodiol)with the following criteria:

Relyvrio™ (Sodium Phenylbutyrate/Taurursodiol) Approval Criteria:

1. An FDA approved diagnosis of amyotrophic lateral sclerosis (ALS); and
2. Member must be 18 years of age or older; and
3. Disease duration of 18 months or less (for initial approval); or
    a. A prior authorization request with patient-specific information may be submitted for consideration of Relyvrio™ for members with disease duration >18 months, including but not limited to disease progression, specific symptoms related to the disease, activities of daily living currently affected by the disease, or prognosis; and
4. Must be prescribed by a neurologist or other specialist with expertise in the treatment of ALS (or an advanced care practitioner with a supervising physician who is a neurologist or other specialist with expertise in the treatment of ALS); and
5. Approvals will be for the duration of 6 months. For each subsequent approval, the prescriber must document the member is responding to the medication, as indicated by a slower progression in symptoms and/or slower decline in quality of life compared to the typical ALS disease progression; and
6. A quantity limit of 56 packets per 28 days will apply.

Recommendation 2: Vote to Prior Authorize Vyvgart®

The Drug Utilization Review Board recommends the prior authorization of Vyvgart® (Efgartigimod Alfa-fcab) with the following criteria:

Vyvgart® (Efgartigimod Alfa-fcab) Approval Criteria:

1. An FDA approved diagnosis of generalized myasthenia gravis (gMG); and
2. Member must be 18 years of age or older; and
3. Member must have a positive serologic test for anti-acetylcholine receptor (anti-AChR) antibodies; and
4. Member must have a Myasthenia Gravis Foundation of America (MGFA) Clinical Classification class II to IV; and
5. Member must have a MG-Activities of Daily Living (MG-ADL) total score ≥5; and
6. Member must be on a stable dose of either an acetylcholinesterase (AChE) inhibitor or immunosuppressive therapy (IST); and

7. Vyvgart® must be prescribed by, or in consultation with, a neurologist or a specialist with expertise in the treatment of gMG; and
8. Initial approvals will be for the duration of 6 months, at which time an updated MG-ADL score must be provided. Continued authorization requires improvement in the MG-ADL score from baseline. Subsequent approvals will be for the duration of 1 year.

Recommendation 3: Vote to Prior Authorize Vabysmo™

The Drug Utilization Review Board recommends the prior authorization of Vabysmo™ (Faricimab-svoa) with the following criteria:

Vabysmo™ (Faricimab-svoa Intravitreal Injection) Approval Criteria:

1. An FDA approved diagnosis of 1 of the following:
    a. Neovascular (wet) age-related macular degeneration (AMD); or
    b. Diabetic macular edema (DME); and
2. Member must be 18 years of age or older; and
3. Member must not have ocular or periocular infections or active intraocular inflammation; and
4. Vabysmo™ must be prescribed and administered by an ophthalmologist or a physician experienced in vitreoretinal injections; and
5. Prescriber must verify the member will be monitored for endophthalmitis, retinal detachment, increase in intraocular pressure, and arterial thromboembolic events, and
6. Female members of reproductive potential must have a negative pregnancy test prior to initiation of therapy and must agree to use effective contraception during treatment and for 3 months after the final dose of Vabysmo™; and
7. A patient-specific, clinically significant reason why the member cannot use vascular endothelial growth factor (VEGF) inhibitor injection products (appropriate to the disease state) available without prior authorization [i.e., Beovu® (brolucizumab-dbll), Byooviz™ (ranibizumab-nuna), Cimerli™ (ranibizumab-eqrn), Eylea® (aflibercept)] must be provided; and
8. A quantity limit of 0.05mL per 28 days will apply

Recommendation 4: Vote to Prior Authorize Kimmtrak® and Opdualag™

The Drug Utilization Review Board recommends the prior authorization of e Kimmtrak® (Tebentafusp-tebn) and Opdualag™ (Nivolumab/Relatlimab-rmbw)) with the following criteria:

Kimmtrak® (Tebentafusp-tebn) Approval Criteria [Uveal Melanoma Diagnosis]:

1. Diagnosis of unresectable or metastatic uveal melanoma; and
2. Positive expression of HLA-A*02:01 genotype.

Opdualag™ (Nivolumab/Relatlimab-rmbw) Approval Criteria [Unresectable or Metastatic Melanoma Diagnosis]:

1. Diagnosis of unresectable or metastatic melanoma; and
2. Member must be 12 years of age or older; and
3. As first-line therapy; and
4. Member has not previously failed programmed death 1 (PD-1) inhibitors [e.g., Keytruda® (pembrolizumab), Opdivo® (nivolumab)].

Recommendation 5: Vote to Prior Authorize Lytgobi®

The Drug Utilization Review Board recommends the prior authorization of Lytgobi® (Futibatinib) with the following criteria:

Lytgobi® (Futibatinib) Approval Criteria [Intrahepatic Cholangiocarcinoma Diagnosis]:

1. Diagnosis of unresectable, locally advanced, or metastatic intrahepatic cholangiocarcinoma; and
2. Member was previously treated with at least 1 prior therapy; and
3. Tumor is positive for fibroblast growth factor receptor 2 (FGFR2) gene fusion or rearrangement.

Recommendation 6: Vote to Prior Authorize Pedmark® and Vijoice®

The Drug Utilization Review Board recommends the prior authorization of Pedmark® (Sodium Thiosulfate) and Vijoice® (Alpelisib) with the following criteria:

Pedmark® (Sodium Thiosulfate) Approval Criteria [Reduction in Ototoxicity Risk Associated with Cisplatin for Solid Tumor Diagnosis]:

1. Pediatric members 1 month to 18 years of age with a diagnosis of localized, non-metastatic solid tumor; and
2. An FDA approved indication to reduce the risk of ototoxicity associated with cisplatin; and
    a. Member's cisplatin regimen must be provided (i.e., frequency of chemotherapy cycles, number of treatment days per cycle, number of chemotherapy cycles remaining); and
3. Pedmark® will be administered as follows:
    a. Starting 6 hours after completion of cisplatin infusion; or

   b. For multi-day cisplatin regimens, Pedmark® will be administered 6 hours after each cisplatin infusion but at least 10 hours before the next cisplatin infusion; and
4. Member has a baseline serum sodium <145mmol/L.

Vijoice® (Alpelisib) Approval Criteria [PIK3CA-Related Overgrowth Spectrum (PROS) Diagnosis]:

1. Adult and pediatric members 2 years of age and older; and
2. Documented PIK3CA gene mutation; and
3. Severe or life-threatening clinical manifestations of PROS.

Recommendation7 : Vote to Prior Authorize Hyftor™

The Drug Utilization Review Board recommends the prior authorization of Hyftor™ (Sirolimus Topical Gel) with the following criteria:

Hyftor™ (Sirolimus Topical Gel) Approval Criteria [Facial Angiofibromas Associated with Tuberous Sclerosis Complex (TSC) Diagnosis]:

1. Documented diagnosis of TSC; and
2. Member has facial angiofibromas that are at least 2mm in diameter with redness in each; and
3. Member must be 6 to 20 years of age; or
   a. For members older than 20 years of age, a clinical exception may apply for medical issues caused by facial angiofibromas (specific documentation of clinically significant medical issues must be provided; Hyftor™ is not covered for cosmetic use); and
5. Initial approvals will be for a duration of 12 weeks, as the need for continuing Hyftor™ should be reevaluated if symptoms do not improve within 12 weeks of treatment. Reauthorization may be granted if the prescriber documents the member is responding well to treatment and documents the anticipated duration of treatment.

Attachment C

SUBMITTED TO THE C.E.O. AND BOARD ON MARCH 22, 2023
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

BACKGROUND

Services	Third Party Liability (TPL) Systems
Purpose and Scope	Oklahoma Health Care Authority is seeking to extend the current Health Management Systems (HMS) contract for 90 days to ensure continuity of Medicaid Third Party Liability revenue collection services in accordance with 42 CRF 433.135 while the competitively bid contracts that will replace the current agreement finalize award. TPL services are revenue generating for OHCA. HMS service scope includes: • Identify third party liability through data match • Continuously analyze data to identify coverage changes • Implement audits and reviews • Maximize recoveries of billed claims • Denial analysis • Lockbox services
Mandate	Federal law and regulations require that Medicaid pays for services only after liable third parties have met their obligation to pay.
Procurement Method	Competitive Bid
External Approvals	N/A
Contract Term	Extended through June 30, 2023

BUDGET

Amount requested for approval	$2,000,000.00
Federal Match Percentage(s) within the Total Contract Not-to-Exceed	50%

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 extend the Health Management Services agreement as described above for up to 90 days for a total not to exceed extension cost of $2,000,000.00

Additional Information

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.)
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 $1,000,000.00 or more, the contract increase shall require additional Board approval.)
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.)

March Board
Proposed Rules Amendment Summaries

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

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

The Agency is requesting the effective date to be immediately upon receiving gubernatorial approval. The Governor will have until May 8, 2023, to approve or disapprove each rule, upon the Agency's submission for gubernatorial review.

A. **APA WF # 23-01 State Plan Personal Care Services for Expansion Adults, TEFRA Eligible Children and Certain MAGI Populations —** The proposed revisions add policy to delineate eligibility requirements, definitions, medical eligibility criteria for personal care, and the process for medical eligibility determinations. Additionally, rules add the current business practice for approving the TEFRA population and any EPSDT members who meet medical necessity criteria to receive personal care services.

   Budget Impact: The estimated budget impact for SFY2023 will be an increase in the total amount of $91,173; with $25,200 in state share. The estimated budget impact for SFY2024 will be an increase in the total amount of $273,520; with $88,921 in state share.

B. **APA WF # 23-05 Notification of Date of Service (NODOS) Timeframe Change —** The proposed revisions update rules on filing a Notification of Date of Service (NODOS) application. The current five-day requirement for the hospital to file the electronic NODOS will remain in effect; however, after the electronic NODOS is filed, the applicant, or someone acting on behalf of the applicant, will have forty (40) days to submit a completed SoonerCare application instead of the current fifteen (15) days.

   Budget Impact: The estimated budget impact for SFY 2024 will be an increase in the total amount of $420,861; with $136,822 in state share. The estimated budget impact for SFY 2025 will be an increase in the total amount of $561,147; with $182,429 in state share).

C. **APA WF # 23-06A&B Transition to SoonerSelect —** These changes comply with Oklahoma Senate Bill 1337 (SB1337) and Oklahoma Senate Bill 1396 (SB 1396), which directs the Oklahoma Health Care Authority to transition to a new health care system, called SoonerSelect. Policy will define terms, processes, and regulations from SB1337 and the published Request for Proposals (RFP) and/or Model Contract. The proposed rule additions/revisions outline and address state-sanctions and complementary non-compliance remedies required of the medical and dental contracted entities (CEs). Other rule additions include, but are not limited to, managed care mandatory and voluntary populations (American Indian/Alaskan Native (AI/AN) members), processes for network adequacy, provider requirements, termination of contracts, transition of care policies, medical necessity, required notices, and grievances and appeals.

   Budget Impact: The OHCA Board approved expenditure authority for the SoonerSelect RFP at the January 18, 2023 meeting. The goal of the SoonerSelect delivery model over the term of the contracts (first year, plus 5 renewal years) is budget neutrality.

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.

All of the proposed ***PERMANENT*** rules were presented at Tribal Consultation and the Medical Advisory Committee. These changes were subject to a 30-day public review period from **February 1 through March 3, 2023**.

The Agency is requesting the effective date to be **Sept. 2023**, contingent upon receiving legislature and gubernatorial approval.

D. 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.

E. 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 previously approved budget impact for the emergency rule is as follows: 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).

F. APA WF # 22-03 Clinical Trials Services and Dental Out-of-State Services — The proposed rule revisions will strike outdated language and add new language to the formerly named "Clinical Trials" policy OAC 317:30-3-57.1. To comply with new federal guidelines this policy will be renamed "Coverage of routine services in relation to clinical trials" and restructured to address qualifying clinical trials criteria, clinical trials determination standards, routine patient costs, and excluded items. Importantly, new language will be added that states that the Oklahoma Health Care Authority will provide a coverage determination decision for requested and medically necessary routine services within 72-hours for a member participating in a qualifying clinical trial. Revisions to the out-of-state services policy, at OAC 317:30-3-90, will also add language to assure that clinical trials will be provided in accordance with federal requirements and that clinical trials do not follow all of the out-of-state policy requirements. Furthermore, language will be added to allow for the override of prior authorizations that are related to lodging and meals services when they are provided in accordance with an approved clinical trial. Finally, revisions will add language that allows for a SoonerCare member to travel up to one hundred miles (100) from the Oklahoma border to receive dental services.

Budget Impact: Budget neutral.

G. APA WF # 22-05 Ambulance Service Provider Access Payment Program — The proposed policy establishes rules consistent with the Oklahoma State Plan, which outlines the

Ambulance Service Provider Access Payment Program (ASPAPP). The ASPAPP is a program designed to help assure access to quality emergency transports for SoonerCare members by assessing a fee to privately owned ambulance service providers and then issuing quarterly supplemental payments to those providers.

Budget Impact: The previously approved budget impact for the emergency rule is as follows: The estimated total cost for SFY 2023 is $5,802,463 ($4,392,464 in federal share and $1,409,999 in state share). The estimated total cost for SFY 2024 is $5,802,463 ($3,908,539 in federal share and $1,893,924 in state share). Both SFY 2023 and SFY 2024 will include a $200,000 administrative cost collection from a provider tax.

H. **APA WF # 22-07 Tribal Residential Substance Use Disorder (SUD) Policy Updates —** The proposed revisions will update policy at Oklahoma Administrative Code 317:30-5-1094 to reflect that I/T/U providers will be reimbursed the outpatient OMB rate for rendered residential SUD services. This policy change aligns with the authority in the Oklahoma Medicaid State Plan and with current business practices.

Budget Impact: Budget neutral.

I. **APA WF # 22-08 Hospice Benefit for Expanded Population —** The proposed rule will add hospice services as a covered benefit for members eligible as expansion adults, described in the Code of Federal Regulations (C.F.R.) Title 42 Section 435.119. The proposed rule will outline hospice coverage, eligibility, reimbursement, provider qualifications/requirements, and prior authorization requirements.

Budget Impact: The previously approved budget impact for the emergency rule is as follows: The estimated budget impact for SFY 2022 is $584,135; with $58,414 in state share. The estimated budget impact for SFY 2023 is $778,847; with $77,885 in state share.

J. **APA WF # 22-10 Long-Term Care Facility (LTC) Pay-for-Performance (PFP) Program —** The proposed rule revisions will remove outdated language and add new language to the LTC PFP program payment criteria section. These policy revisions will align with the proposed Oklahoma Medicaid State Plan. The overall purpose of the proposed rule revisions will be to maintain compliance with federal requirements and continuity of processes.

Budget Impact: Budget neutral.

K. **APA WF # 22-11 Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Visit and Sick Visit on the Same Day —** The proposed rules revise policy to allow reimbursement for an EPSDT visit and a sick visit that occur on the same date of service, when it is deemed medically appropriate. The revisions will outline the requirements that must be met including, but not limited to, separate documentation/note to justify additional condition(s), information on the appropriate use of Modifier 25, a provider's ability to only claim the additional time required above and beyond the completion of the EPSDT screening, and clarification that any health problem that is encountered in the EPSDT screening and does not require significant additional work will be included in the EPSDT visit and should not be billed separately.

Budget Impact: The previously approved budget impact for the emergency rule is as follows: The estimated budget impact, for SFY2023, will be an increase in the total amount of $418,468; with $115,665 in state share. The estimated budget

impact, for SFY2024 will be an increase in the total amount of $1,255,404; with $409,513 in state share.

L. **APA WF # 22-12 Staff Ratios and Staff Licensing Requirements for Out-of-State Psychiatric Providers —** The proposed rule changes allow out-of-state inpatient psychiatric providers to utilize the staffing ratios and staff licensing requirements of the state in which the facility/provider is located.

Budget Impact: Budget neutral.

M. **APA WF # 22-13 Allowing Advanced Practice Registered Nurses (APRNs) and Physician Assistants (PAs) to Render Physician-Required Psychiatric Services —** The proposed rules allow APRNs with psychiatric certifications and PAs to provide psychiatric services. Presently, psychiatric service provision is only allowed by psychiatrists to members in inpatient settings. The psychiatric services provided by APRNs and PAs will now also include psychiatric evaluations and weekly individual treatment hours. The proposed rule aims to address physician shortages and extend the reach of behavioral health treatments such as psychiatric evaluations and weekly individual treatment hours by allowing inpatient psychiatric providers to utilize APRNs with psychiatric certifications and PAs.

Budget Impact: Budget neutral.

N. **APA WF # 22-14 Coverage for Donor Human Breast Milk —** The Agency proposes to add this benefit as a new service covered under the Medical Suppliers section of policy. Proposed rules outline medical necessity, provider qualifications, coverage, and reimbursement for donor human breast milk. Further proposed revisions to the Enteral Nutrition section of policy removes human breast milk as a non-covered item.

Budget Impact: The previously approved budget impact for the emergency rule is as follows: The estimated total cost for SFY 2023 is $229,211 ($169,410 in federal share and $59,801 in state share). The estimated total cost for SFY 2024 is $343,816 total ($231,663 in federal share and $112,153 in state share).

O. **APA WF # 22-15 Removing Provider Panel Limits in the Patient Centered Medical Home (PCMH) —** The proposed revisions remove member cap limits from Agency policy for Physicians, Advanced Practice Registered Nurses (APRN), and Physician Assistants (PA) participating in SoonerCare Choice as a Patient Centered Medical Home (PCMH) provider. Current policy allows 2,500 members for each physician, 1,250 members for each APRN, and 1,250 members for each PA. The proposed revisions make access to care easier for members and aligns policy with the current redesign of the PCMH model.

Budget Impact: Budget neutral.

P. **APA WF # 22-17 Covering Former Foster Care Youth from Another State —** The proposed revisions implement changes in federal law requiring SoonerCare to grant eligibility to individuals in the former foster care youth category who were enrolled in Medicaid when they aged out of foster care in another state on January 1, 2023, or later, and who now reside in Oklahoma. Prior to the federal law changes, the requirement for SoonerCare was to grant eligibility to former foster care youth who were enrolled in Medicaid when they aged out of foster care in Oklahoma.

Budget Impact: The previously approved budget impact for the emergency rule is as follows: The estimated total cost for SFY 2023 is $187,650 ($135,784 in federal share and $51,866 in state share). The estimated total cost for SFY 2024 is $375,300 total ($252,802 in federal share and $122,498 in state share).

Q. **APA WF # 22-18 Mobile Dental Services —** The proposed policy will allow mobile dental providers to render more services that SoonerCare currently covers for dental providers and authorizes mobile dental services for both children and adults. These changes aim to help SoonerCare members access dental care where there are shortage areas in the State.

Budget Impact: The previously approved budget impact for the emergency rule is as follows: The proposed rule changes regarding mobile dental services are budget neutral. This change is only allowing more dental providers through mobile units to render services currently covered by SoonerCare; no new services will be added.

R. **APA WF # 22-21A&B Increase Income Standard for Pregnant Women and Extend Postpartum Coverage —** The proposed policy revisions will expand Medicaid eligibility for pregnant women by increasing the federal poverty level (FPL) percentage income standard from 133% to 185%, or 210% FPL once converted to MAGI and applying the applicable MAGI disregards. Additionally, the proposed revisions will extend Medicaid postpartum coverage from sixty (60) days to twelve (12) months. This new coverage option afforded through the American Rescue Plan Act was made permanent with the passing of the 2023 Consolidated Appropriations Act.

Budget Impact: The previously approved budget impact for the emergency rule is as follows: The estimated budget impact, for SFY 2023, will be an increase in the total amount of $6,150,000; with $1,509,210 in state share. The estimated budget impact, for SFY 2024, will be an increase in the total amount of $12,300,000; with $4,054,326 in state share.

S. **APA WF # 22-22 Ukrainian Humanitarian Parolees —** Policy will be updated to comply with Public Law 117-128, which entitles certain Ukrainian nationals who enter the United States, during a designated period of time, to receive SoonerCare services provided all other eligibility factors are met. Ukrainian humanitarian parolees are eligible for the same benefits available to refugees admitted under Section 207 of the Immigration and Nationality Act, except for the program of initial resettlement.

Budget Impact: The previously approved budget impact for the emergency rule is as follows: The estimated budget impact, for SFY 2023, will be an increase in the total amount of $323,915; with $62,517 in state share. The estimated budget impact, for SFY 2024, will be an increase in the total amount of $680,220, with $211,419 in state share.

T. **APA WF # 22-16 Statewide Health Information Exchange (HIE) —** The proposed revisions will update policy to comply with OK Senate Bill 1369 which changed the statewide HIE. The revisions include repealing all previously approved language; updating definitions; adding the Office of the State Coordinator for HIE; designating that the Office of the State Coordinator for HIE will oversee the state-designated entity for HIE; and revising the definition of "health information exchange organization" to indicate that it is an organization governed by its stakeholders. Additional revisions will state that beginning July 1, 2023, all qualified health care providers, as defined by OHCA rules and who are licensed by and located in Oklahoma,

shall be actively engaged with the HIE in the onboarding process of connecting to the HIE. This ensures that the legislative requirement of data reporting capabilities and utilizing the state-designated entity for HIE are met. **The aforementioned changes were approved during promulgation of the emergency rule. The following are proposed changes not previously reviewed:** The proposed changes add language that states that exemptions, including broad-based exemptions, may be granted on the basis of type of health care provider, financial hardship, size, or technological capability of a health care provider/organization.

Budget Impact: The previously approved budget impact for the emergency rule is as follows: The proposed rules are budget neutral for the agency; however, there will be a cost for providers to connect to the statewide HIE. The cost varies depending on the type and size of the organization.

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

U. APA WF # 22-23A&B ADvantage Waiver Rule Changes — The proposed revisions align policy with the recently approved waiver amendment which added Assistive Technology and Remote Support services. Revisions also outline and define the purpose and scope of remote support services, service description, provider requirements, guidelines, limitations, and service discontinuation. Additional revisions outline the assistive technology services and devices that are covered/non-covered. Further revisions correct formatting and grammatical errors.

Budget Impact: The estimated budget impact, to add assistive technology services, for SFY 2023 will be an increase in the total amount of $3,750,000; with $958,875 in state share. The estimated budget impact for SFY 2024 will be an increase in the total amount of $6,250,000; with $2,025,000 in state share.

The estimated budget impact, to add remote support services, for SFY 2023 will be an increase in the total amount of $13,634,400; with $3,486,316 in state share. The estimated budget impact for SFY 2024 will be an increase in the total amount of $22,724,000; with $7,362,576 in state share.

The state share will be paid by the Oklahoma Department of Human Services (OHS).

V. APA WF # 22-24A&B OHS Developmental Disabilities Services Policy Changes — The proposed revisions update coverage limits for individual family training and group family training from $5,500 to $6,500 and remove outdated documentation requirements for family support services. The revisions also add new criteria and standards for specialized foster care and criteria for providers of respite care and homemaker, remote, and agency companion services. Further policy changes add optometry benefits, to include routine eye examination and purchase of corrective lenses, add language to support the increase of the public transportation limit, correct formatting/grammatical errors, and align policy with current business practices.

Budget Impact: The estimated budget impact, to increase the limit on family training, for Federal Fiscal Year (FFY) 2023 and 2024 will be an increase in the total amount of $1,634,000; with $533,338 in state share.

The estimated budget impact, to add therapeutic leave to specialized family care, for FFY 2023 and 2024, will be an increase in the total amount of $106,142; with $34,645 in state share.

The estimated budget impact, to add eyeglasses and vision exams, for FFY 2023 and 2024, will be an increase in the total amount of $50,000; with $16,320 in state share.

The estimated budget impact, to expand adapted transportation and increase coverage limitations for public transportation, for FFY 2023 and 2024, is $300,000; with $97,920 in state share.

The state share will be paid by the OHS.

W. APA WF # 22-25 Behavioral Health Rules Cleanup — The proposed revisions clarify timely completion of the placement tool for a substance use disorder (SUD) admission or extension requests and update service plan, documentation, and signature requirements. Furthermore, the proposed revisions require providers to report to OHS instances of child abuse/neglect in residential settings in accordance with state law. Revisions also include grammatical and formatting changes as needed.

Budget Impact: Budget neutral.

X. APA WF # 22-26 Crisis Intervention Rule Revisions — The proposed revisions clarify crisis intervention services (CIS) as the provision of these services is expanding in the State. Rule changes will define mobile versus on-site CIS and include other grammatical and formatting changes as needed.

Budget Impact: Budget neutral.

Y. APA WF # 22-27 Physician Assistant Rule Revisions — The proposed revisions ensure that policy is aligned with Oklahoma Statutes. Rule changes include: updating the term "supervising" physician to "delegating" physician; removing the application to practice requirements and replace it with the practice agreement requirements; and a new timeframe of 10 business days for providers to submit any updated copy of the practice agreement due to changes. Other revisions will involve limited rewriting aimed at improving readability and overall flow of policy language.

Budget Impact: Budget neutral.

Z. APA WF # 22-28 Opioid Treatment Program (OTP) Rule Changes — The proposed revisions revise OTP rules to align with federal regulations with updates to the phase requirements. Further revisions update service plan signatures to clarify requirements according to the member's age.

Budget Impact: Budget neutral.

AA. APA WF # 22-29 Laboratory Services Policy Cleanup — The proposed revisions combine the existing laboratory policies into one centralized location. This will allow for better access to the policies and an easier understanding of services covered under the laboratory benefit. Language will be placed into policy to clarify coverage of reference (outside) laboratories when an independent or hospital laboratory refers a service to another laboratory.

Budget Impact: Budget neutral.

BB. APA WF # 22-30 Outdated/Obsolete Policy Language Cleanup — The proposed revisions remove obsolete references and combines sections of policy to remove the overabundant 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.

CC. APA WF # 22-31 Eliminate Certificate of Medical Necessity (CMN) Form Requirement for Most Medical Supplies, Equipment, and Appliances — The proposed revisions eliminate the requirement to include a CMN form when requesting the prior authorization (PA) for most medical supplies, equipment, and appliances. Rules will state that the CMN form continues to be required for enteral and parenteral nutrition.

Budget Impact: Budget neutral.

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

SUBCHAPTER 16. STATE PLAN PERSONAL CARE SERVICES FOR EXPANSION ADULTS, TEFRA ELIGIBLE CHILDREN AND CERTAIN MAGI POPULATIONS

317:35-16-1. State Plan Personal Care Services (SPPC)

(a) The State Plan Personal Care services described in this subchapter are available to the following:

(1) Expansion adults;

(2) TEFRA children; and

(3) Certain MAGI populations (children) who qualify under the EPSDT program.

(b) SPPC services assist a member in carrying out Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs) directly related to the member's personal care needs. SPPC services prevent or minimize physical health regression or deterioration. SPPC services require a skilled nursing assessment to:

(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.

(c) 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.

(d) SPPC members may receive services in limited types of living arrangements as per (1) through (5) of this subsection.

(1) SPPC members are not eligible to receive services while residing in an institutional setting including, but not limited to:

(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) home, except with approval of the OHCA supervisor overseeing SPPC. For approval, a clinical evaluation of the household composition must be conducted and reviewed. The clinical evaluation shall include, but is not limited to, the following:

(A) Informal supports available;

(B) All legal obligations of the household member, including the individual who is a legally responsible family member such as a spouse, legal guardian, or parent of a minor child as defined per OAC 317:35-16-7(3);

(C) Urgency of the services; and

(D) Any other factors that may arise warranting approval as determined by the OHCA Supervisor.

(3) Members may receive 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 and preparation amenities in addition to bedroom and living space.

(4) For SPPC members who are full-time students, a dormitory room qualifies as an allowable living arrangement to receive SPPC services.

(5) With prior approval from an OHCA supervisor overseeing 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) SPPC services eligibility is contingent on a member requiring one (1) or more of the services offered at least monthly including personal care, meal preparation, housekeeping, laundry, shopping or errands, or specified special tasks to meet ADL or IADL assessed needs.

317:35-16-2. Determination of medical eligibility for State Plan Personal Care (SPPC) services for Expansion Adults, TEFRA, and certain MAGI populations

(a) **Eligibility.** The OHCA Clinical Review team (OHCA nurse) determines medical eligibility for 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 assistance. SPPC services are initiated to support the regular care provided in the member's home. SPPC services are not intended to take the place of regular care, general maintenance tasks, or meal preparation provided by natural supports, such as spouses or other adults who live in the same household. Additionally, SPPC services are not furnished when they principally benefit the family unit. To be eligible for SPPC services, the applicant:

(1) Has adequate informal supports. 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 remain in his or her home without risk to his or her health, safety, and well-being, the applicant:

(A) Must have 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) His or her decision-making ability, lacks the physical capacity to respond appropriately to situations that jeopardize health and safety, and an OHCA nurse has informed his/her of potential risks and consequences of remaining in the home.

(2) Requires a care plan for planning and administering services delivered under a professional personnel's supervision;

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

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

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

(6) 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 that reflect the applicant's or member's ability to perform self-care tasks essential for sustaining health and safety, such as:

(A) Bathing;

(B) Eating;

(C) Dressing;

(D) Grooming;

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

(F) Mobility;

(G) Toileting; and

(H) 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) **"Applicant or Member support very low"** means the applicant's or member's UCAT Part III Support score is zero (0), 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 in most functional areas.

(4) **"Applicant or Member support low"** means the member's UCAT Part III Support score is five (5), 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 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) **"Applicant or Member support moderate"** means the UCAT Part III applicant or member score is fifteen (15), 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. Informal caregiver support is considered questionable or unreliable due to one (1) or more criteria in (A) through (D) of this paragraph:

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

(6) **"Applicant or Member support high"** means the applicant or member score is twenty-five (25) 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 the applicant's or member's high degree of need.

(7) **"Community 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 aa registry established by the OKDHS per Section (§) 1025.1 of Title 56 of the Oklahoma Statutes (O.S.) to list community services workers who have a final investigative finding of abuse, neglect, or exploitation, per 43A O.S. § 10-103, involving a frail elderly, disabled person(s), or person(s) with developmental disabilities was made by 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)"** 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;
(B) Cooking;
(C) Cleaning;
(D) Managing money;
(E) Using a phone;
(F) Doing laundry;
(G) Taking medication; and
(H) 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.

(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 a total weighted UCAT Part III Nutrition score is eight (8) or greater that indicates poor appetite or weight loss combined with special diet requirements, medications, or difficulties in eating.

(15) **"Social Resource score is eight (8) or more"** means the applicant or member lives alone, 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 SPPC.** The medical eligibility minimum criteria

for SPPC services are the minimum UCAT score criteria that an applicant or member meets for medical eligibility 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) Applicant or Member Support score is fifteen (15) or more; or Applicant or Member Support score is five (5) and the Social Resources score is eight (8) or greater.

(d) **Medical eligibility determination.** Medical eligibility for personal care is determined by the OHCA. The medical decision for personal care is made by the OHCA supervisor, overseeing SPPC services, utilizing the UCAT Part III. The member will be notified prior to UCAT III assessment that the result could indicate a need for disability review.

(1) Referrals will be made to the OKDHS if the applicant requires a disability review based on information obtained in referral and/or UCAT Part III.

(2) Upon receipt of the referral the OHCA nurse is responsible for completing the UCAT Part III assessment visit within ten (10) business days of the personal care application for the applicant who is SoonerCare eligible at the time of the request. The OHCA nurse completes the assessment visit within twenty (20) business days of the referral for the applicant not determined SoonerCare eligible at the time of the request. When the 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, to prevent an emergency situation, or to avoid institutional placement, the UCAT Part III assessment visit has top-scheduling priority.

(3) During the assessment visit, the OHCA nurse completes the UCAT III and reviews rights to privacy, fair hearing, provider choice, and the pre-service acknowledgement agreement with the member. The OHCA nurse informs the applicant of medical eligibility criteria and provides information about OHCA long-term care service options. The OHCA nurse 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 OHCA nurse determines if the member may be at risk for health and safety, an immediate referral is made to Adult Protective Services or Child Protective Services, as applicable. The referral is documented on the UCAT Part III.

(A) When the applicant's needs cannot be met by personal care services alone, the OHCA nurse provides information about other community long-term care service options. The OHCA nurse assists in accessing service options the applicant or member selects in addition to, or in place of, SPPC services.

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

(C) The OHCA nurse provides the applicant 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 agency choice. When the applicant or family declines to choose a primary personal care service agency, the round-robin rotation system is used for agency selection. The OHCA nurse documents the selected personal care provider agency's name.

(4) The OHCA nurse completes the UCAT Part III and sends it to an alternate OHCA nurse for medical eligibility determination. SPPC services 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 from the initial assessment to the date of service eligibility determination exceeds ninety (90) calendar days, a new UCAT Part III assessment is required.

(B) The OHCA nurse 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 is for twelve (12) months and is provided by the OHCA nurse.

(5) Upon establishing SPPC certification, the OHCA nurse 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 (1) business day of provider agency acceptance, the OHCA nurse submits the information via electronic system to the provider agency for plan development. Refer to OAC 317:35-15-8(a).

(6) Following the provider agency's SPPC plan development, and within three (3) business days of receipt from the provider agency, the OHCA nurse reviews the documentation to ensure agreement with the plan. Once agreement is established, the plan is submitted to OHCA Personal Care Supervisor for review and then the plan is authorized.

(7) Within one (1) business day of knowledge of the authorization, the OHCA nurse submits the plan authorization to the provider agency via electronic system.

317:35-16-3. General financial eligibility requirements for State Plan Personal Care

Financial eligibility for SPPC is determined using the rules on income and resources according to the eligibility group the member is related to

317:35-16-4. Determining financial eligibility of categorically needy individuals

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

(1) **Financial eligibility for Modified Adjusted Gross Income (MAGI) eligibility groups.** See MAGI eligibility rules in Subchapter 6 of this Chapter to determine financial eligibility.

(2) **Determining financial eligibility for State Plan Personal Care (SPPC).** For individuals determined categorically needy for SPPC, the member will not pay a vendor payment for SPPC services.

317:35-16-5. Certification for State Plan Personal Care

(a) **State Plan Personal Care (SPPC) certification period.** The first month of the SPPC certification period is the first month the member is determined financially and medically eligible for SPPC. When eligibility or ineligibility for SPPC is established, OHCA updates the computer-generated notice and the appropriate notice is mailed to the member.

(b) **Financial certification period.** The financial certification period for SPPC services is twelve (12) months. 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 a member who is approved for SPPC. The certification period for SPPC services is based on the Uniform Comprehensive Assessment Tool evaluation and clinical judgment of the OHCA nurse.

317:35-16-6. Agency State Plan Personal Care (SPPC) service authorization and monitoring

(a) Within ten (10) business days of referral receipt for SPPC services, the personal care provider

agency nurse completes an assessment of the member's personal care service needs and completes and submits a person-centered plan based on the member's needs to the OHCA nurse. The plan includes the:

(1) Adv/SPPC-Nurse Evaluation;

(2) SPPC-Service Planning; and

(3) SPPC Member Service Agreement.

(b) When more than one (1) person in the household is referred to receive SPPC or ADvantage services, all household members' 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 authorized for each individual is distributed between all eligible family members. 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 SPPC member is referred to or 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 the OHCA nurse for authorization to begin services. The agency provides a copy of the plan to the member upon initiating services.

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

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

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

(2) The provider agency nurse makes a 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 care plan for adequacy of goals and authorized units. Whenever a monitoring visit is made, the provider agency nurse documents findings in the electronic system. The provider agency submits monitoring documentation to OHCA nurse for review within five (5) business days of the visit. A registered nurse (RN) conducts the monitoring visit when the PCA is performing hands-on personal care. A licensed practical nurse may only conduct the monitoring visit when the PCA is not performing hands-on personal care. An RN also co-signs the progress notes.

(3) The provider agency nurse's requests to change the number of authorized units in the SPPC plan are submitted via the electronic system to the OHCA nurse to approve or deny prior to changed number of authorized units implementation.

(4) Annually, or more frequently when the member's needs change, the provider agency nurse re-assesses the member's needs and develops a new plan to meet the member's needs. The provider agency nurse completes and submits the annual reassessment documents to the OHCA nurse no sooner than sixty (60) calendar days before the existing service plan end-date, and no later than 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. 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 thirty (30) days, the provider agency notifies the OHCA nurse. The OHCA nurse contacts the member and when the member chooses, initiates a member transfer to another provider agency that can provide staff.

317:35-16-7. Agency State Plan Personal Care services; billing, and problem resolution

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

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

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

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

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

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

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

(2) **Issue resolution.**

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

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

counsels the PCA regarding problems with his or her performance.

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

317:35-16-8. Financial eligibility redetermination for State Plan Personal Care

The OHCA nurse reviews the electronic system to confirm member eligibility before the end of the certification period. A notice is generated only if there is a change affecting the member's financial eligibility.

317:35-16-9. Medical eligibility redetermination for State Plan Personal Care (SPPC) services

(a) **Medical eligibility redetermination.** The OHCA nurse completes a medical redetermination before the end of the SPPC certification period.

(b) **Recertification.** The OHCA nurse re-assesses the 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) at least every thirty-six (36) months. Members younger than eighteen (18) years of age, are re-evaluated by the OHCA nurse using the UCAT on a twelve (12) month basis or sooner when needed. During this re-certification assessment, the OHCA nurse informs the member of the state's other SoonerCare (Medicaid) long-term care options. The OHCA nurse submits the re-assessment to the OHCA nurse for recertification. Documentation is sent to the OHCA nurse no later than the tenth (10^{th}) calendar day of the month certification expires. When the OHCA nurse determines medical eligibility for SPPC services, a recertification review date is entered on the system.

(c) **Change in amount of units or tasks.** When the SPPC provider agency determines a need for a change in the amount of units or tasks in the service, a care plan is completed and submitted to the OHCA nurse within five (5) business days of identifying the assessed need. The OHCA nurse approves or denies the change prior to implementation.

(d) **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 is sent a Voluntary Withdrawal Request for confirmation and signature, and the request is entered into the electronic system upon receipt. A closure notification is submitted to the provider agency.

(e) **Resuming personal care services.** When a SPPC member approved for SPPC services is without services for less than ninety (90) calendar days, but the member has current medical and SoonerCare (Medicaid) financial eligibility approval, SPPC services may be resumed using the member's previously approved care 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 completes an assessment visit and submits a SPPC services skilled nursing need re-assessment within ten (10) business days of the resumed plan start date. When the member's needs dictate, the personal care provider agency may submit a request for a change in authorized SPPC service units. When no changes occur, the OHCA agency nurse documents the contact in the electronic system for the OHCA ten (10) business days of the resumed plan start date.

(f) **Financial ineligibility.** When the OHCA nurse determines the member has lost SoonerCare eligibility, they notify the member of the determination and his or her right to appeal the decision in writing. A closure notification is also submitted to the provider agency.

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

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

(2) Who are hospitalized or in an extended medical care facility, the existing medical eligibility certification is extended for thirty (30) calendar days from the date of discharge from the facility or for sixty (60) calendar days from the date of previous medical eligibility expiration date, whichever is longer;

(3) Whose medical eligibility redetermination is not made by applicable extended deadline, the member is determined to be medically ineligible; or

(4) Who no longer meet medical eligibility or cannot be located to complete the redetermination assessment, the OHCA nurse notifies the OHCA personal care supervisor. The OHCA personal care supervisor updates the system's medical eligibility end date and notifies the OHCA nurse of effective end date. A closure notification is submitted to the provider agency.

(h) **State Plan Personal Care services termination.**

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

(A) Professional documentation supports the member poses a threat to self or others;

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

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

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

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

(F) 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. This eliminates the need for SoonerCare SPPC services;

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

(H) The member refuses to select or accept a provider agency or Personal Care Assistant (PCA) service for ninety (90) consecutive days as professional or credible documentation

supports.

(2) For members receiving SPPC services, the provider agency submits documentation with the recommendation to discontinue services to the OHCA. The OHCA nurse reviews the documentation and submits it to the OHCA personal care supervisor for determination. The personal care provider agency or PCA 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.

317:35-16-10. Case changes

(a) Any time there are changes affecting the State Plan Personal Care case eligibility, computer generated notices are issued.

(b) A member has the right to withdraw their request for SPPC services at any time during the process, but if the member is determined to meet eligibility under another aid category based on information available to the agency during this time (as referenced under 317:35-6-60.1), we are required to take action on this regardless of the withdrawal of the request for SPPC services.

317:35-16-11. Billing procedures for State Plan personal care

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

317:35-16-12. Social services referral

In many situations, members receiving medical services through SoonerCare (Medicaid) need social services. If a member, who is eligible for State Plan Personal Care Services through this Subchapter, has a need for social services, the OHCA will process those necessary referrals.

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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 3. APPLICATION PROCEDURES

317:35-6-15. SoonerCare application for pregnant women, families with children, and expansion adults; forms

(a) **Application**. An application for pregnant women, 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. Individuals who wish to use a paper application form to apply for coverage under a ~~MAGI~~Modified Adjusted Gross Income (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, Oklahoma Department of Health, in the individual's county Oklahoma Department of Human Services (OKDHS) office, or online. A face-to-face interview is not required. Applications are mailed to the ~~OHCA~~Oklahoma Health Care Authority (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. 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 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)~~forty (40) days from the date the NODOS form was received by OHCA to submit a completed SoonerCare application. Filing a NODOS does not guarantee coverage and if a completed application is not submitted within ~~fifteen (15)~~forty (40) 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 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 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.

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~~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~~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~~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 ~~representive~~representative, must appear at the hearing, either in person or telephonically. 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.

(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~~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. 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;

(H) Appeals which relate to a requested step therapy protocol exception as provided by 63 O.S. § 7310; and

(I) Requests for ~~State~~state fair hearing arising from a member's appeal of a ~~managed care~~CE or DBM 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.~~

317:2-1-2.6. Continuation of benefits or services pending appeal

(a) In accordance with Section 431.230 of Title 42 of the Code of Federal Regulations, if an ~~Appellant~~appellant submits a written request for a hearing within ~~ten (10)~~sixty (60) days of the notice of the adverse ~~agency~~Agency action, the ~~Appellant~~appellant may also request that existing benefits or services (hereinafter, collectively referred to as "services") be continued or reinstated until the earlier of dismissal of the appeal, ~~Appellant's~~appellant's withdrawal of the appeal, or an initial hearing decision adverse to the ~~Appellant~~appellant.

(b) If the ~~Appellant~~appellant fails to indicate a preference as to continuation or reinstatement of services in a written request for hearing made within ~~ten (10)~~sixty (60) days of the notice of the adverse ~~agency~~Agency action, services shall be continued or reinstated. Provided, however, that a SoonerCare member shall not be entitled to continuation or reinstatement of services pending an appeal related to the following:

(1) When a service is denied because the member has exceeded the limit applicable to that service;

(2) When a request for a prior authorization is denied for a prescription drug. However:

(A) The Oklahoma Health Care Authority (OHCA) may authorize a single seventy-two (72) hour emergency supply of the drug, in accordance with Oklahoma Administrative Code (OAC) 317:30-5-77.2;

(B) A SoonerCare provider may initiate a step therapy exception request on behalf of a member, in accordance with OAC 317:30-5-77.4;

(3) When coverage of a prescription drug or service is denied because the requested drug or service is not a category or class of drugs or services covered by OHCA;

(4) When coverage for a prescription drug is denied because the ~~enrollee~~Enrollee has been locked into one (1) pharmacy and the member seeks to fill a prescription at another pharmacy; or

(5) When a physician or other licensed health care practitioner has failed to prescribe or order

the service or level of service for which continuation or reinstatement is requested.
(c) If services are continued or reinstated during the appeals process and the hearing is not decided in the ~~Appellant's~~appellant's favor, OHCA may seek to recover reimbursement of all services received pending the hearing decision.

SUBCHAPTER 3. MEMBER GRIEVANCES AND APPEALS, PROVIDER COMPLAINTS, AND STATE FAIR HEARINGS IN ~~MANAGED CARE~~SOONERSELECT

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~~CE or DBM or according to managed care law, regulations, and contracts.

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

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

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

"**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~~contracted entity employee or contracted provider, or failure to respect the ~~member's~~Enrollee's rights regardless of whether remedial action is requested. A grievance includes a ~~member's~~Enrollee's right to dispute an extension of time to make an authorization decision when proposed by the ~~managed care entity~~Contractor.

"**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~~Enrollees on a prepaid basis, except for copayments or deductibles for which ~~enrollee~~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~~state to provide services to ~~enrollees~~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~~CE or DBM. "Member" is synonymous with "~~health plan enrollee~~Enrollee".

"OAC" means the Oklahoma Administrative Code.

"OHCA" means the Oklahoma Health Care Authority.

"O.S." means the Oklahoma Statutes.

"**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)~~" or **"PA"** means a requirement that a member, through a provider, obtain the ~~managed care entity's~~CE or DBM 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.)~~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 ~~M~~CE receives request.

(c) A request for reconsideration or appeal a provider sends via mail is deemed filed on the date the ~~M~~CE receives the request.

(d) A request for ~~State~~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.)~~O.S. § 7310 and 42 ~~Code of Federal Regulations (C.F.R.)~~C.F.R. §§ 438.210, 431.213-14, 438.402, 438.404, 438.408, and 438.410, each ~~M~~CE and DBM 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~~a CE or DBM**. Except as described in this ~~section~~Section, when the member is enrolled in a managed care program, the member initially files a grievance with the ~~managed care entity~~CE or DBM in which the member is enrolled.

(2) **Exception: Filing with OHCA.** When the member is enrolled in a ~~managed care~~SoonerSelect 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)~~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~~resolution 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.)~~C.F.R. § 438.408, the standard resolution of a grievance will occur within ninety (90) calendar days after the ~~managed care entity~~CE or DBM receives the grievance. The OHCA may choose to adopt a shorter timeframe for the grievance resolution. The CE and DBM must adhere to such timeframes that are described within the Contract.

~~(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)~~(2) The ~~M~~CE and DBM may extend the timeframe ~~in (f)(2)~~ up to fourteen (14) days if:

(A) The member requests the extension; or

(B) The ~~M~~CE and DBM 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)~~(3) If the ~~M~~CE and DBM 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~~Enrollee of the right to file a grievance if he or she disagrees with that decision; and

~~(5)~~(4) The ~~M~~CE and DBM 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~~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~~a CE or DBM.** 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~~CE or DBM in which the member is enrolled.

(2) **Exception: Filing with OHCA.** When the member is enrolled in a ~~managed care~~SoonerSelect program, the member initially files administrative appeals with OHCA and follows the appeals rules set forth at ~~Oklahoma Administrative Code (OAC)~~OAC 317:2-1-2 et seq. whenever the appeal concerns a decision the ~~Oklahoma Health Care Authority (OHCA)~~OHCA made regarding:

(A) Eligibility for Oklahoma Medicaid;

(B) Eligibility for a ~~managed care~~SoonerSelect program;

(C) Enrollment into Oklahoma Medicaid;

(D) Enrollment, including use of an auto-assignment algorithm, into a ~~managed care entity~~CE or DBM;

(E) Disenrollment from a ~~managed care entity~~CE or DBM; 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.~~

(1) Per OAC 317:2-3-4(b), a member may file a grievance at any time. If the grievance decision is adverse to the member, the member may file an appeal. The member has sixty (60) days from the adverse decision notice to file an appeal.

(2) 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~~CE or DBM will use only one (1) level of ~~appeals~~appeal, in accordance with 42 ~~Code of Federal Regulations (C.F.R.)~~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)~~ (1) Per 42 C.F.R. § 438.408, the 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~~CE or DBM receives the appeal;

(B) ~~Expedited resolution of an appeal will occur within seventy-two (72) clock-hours after the MCE receives the appeal;~~The CE and DBM will be responsible for expedited resolutions.

(i) An expedited appeal resolution should occur if the standard resolution timeframe could jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function.

(ii) Per 42 C.F.R. § 438.408(b)(2), if the CE or DBM denies a request for expedited appeal resolution, the CE or DBM must transfer the appeal to the standard appeal resolution timeframe.

(C) In exigent circumstances, resolution of a step therapy request appeal will occur within twenty-four (24) clock-hours after the ~~M~~CE 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 ~~M~~CE receives the appeal.

(3) The ~~M~~CE and DBM may extend the timeframes in (g)~~(2)~~(1)(A) or (B) up to fourteen (14) days if:

(A) The member requests the extension; or

(B) The ~~M~~CE and DBM 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 ~~M~~CE and DBM 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~~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 ~~M~~CE and DBM 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~~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~~state fair hearing.

317:2-3-5.1. Continuation of benefits pending appeal and state fair hearing

(a) Per OAC 317:2-1-2.6 and 42 C.F.R. § 438.420, the CE or DBM shall continue a member's benefits under the plan when all of the following occur:

(1) The member files the request for an appeal within sixty (60) calendar days following the date on the adverse benefit determination notice in accordance with 42 C.F.R. § 438.402(c)(1)(ii) and (c)(2)(ii):

(2) The appeal involves the termination, suspension, or reduction of previously authorized services;

(3) The services were ordered by an authorized provider;

(4) The period covered by the original authorization has not expired; and

(5) The member timely files for continuation of benefits, meaning on or before the later of the following:

(A) Within ten (10) calendar days of the CE or DBM sending the notice of adverse benefit determination; or

(B) The intended effective date of the CE or DBM's proposed adverse benefit determination.

(b) If the member fails to indicate a preference as to continuation or reinstatement of services in a written request for hearing made within sixty (60) calendar days of the adverse benefit determination, services shall be continued or reinstated. Notwithstanding the foregoing, continuation or reinstatement of benefits shall not occur under the following circumstances:

(1) The member has exceeded the limit applicable to the services; or

(2) When a provider has failed to prescribe or order the service or level of service for which continuation or reinstatement is requested.

(c) The CE or DBM shall continue or reinstate benefits if the member:

(1) Files a request for a state fair hearing within one hundred twenty (120) days of the adverse resolution notice; and

(2) Files a request for continuation of benefits within thirty (30) calendar days of the adverse resolution notice.

(d) If the CE or DBM continues or reinstates the member's benefits at the member's request while the appeal or state fair hearing is pending, the benefits must be continued until one (1) of the following occurs:

(1) The member withdraws the appeal or request for state fair hearing;

(2) The member fails to request a state fair hearing and continuation of benefits within ten (10) calendar days after the CE or DBM sends the notice of an adverse resolution to the member's appeal under 42 C.F.R. §§ 438.420 (c)(2) and 438.408 (d)(2); or

(3) A state fair hearing officer issues a hearing decision adverse to the member.

317:2-3-6. External medical review and clinical expertise

(a) **~~No external~~External medical review.** The ~~Oklahoma Health Care Authority (OHCA)~~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 ~~M~~CE and DBM will be licensed or credentialed health care clinicians with relevant clinical training and/or experience.

(2) All ~~M~~CE and DBM 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.)~~C.F.R. § 438.420(d), the ~~M~~CE and DBM may recover from the member the costs of services provided to the member while an appeal or ~~State~~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~~state fair hearing upholds the ~~M~~CE or DBM's adverse benefit determination.

(b) If OHCA or the ~~M~~CE or DBM reverses a decision to deny, limit, or delay services and these services were not furnished while the appeal or ~~State~~state fair hearing was pending, the ~~M~~CE or DBM will authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires.

(c) If OHCA or the ~~M~~CE or DBM reverses a decision to deny, limit, or delay services and the member received the disputed services while the appeal or ~~State~~state fair hearing was pending, the ~~M~~CE or DBM will pay for these services.

317:2-3-8. Grievances and appeals notice

(a) The ~~M~~CE or DBM 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.)~~C.F.R. § 438.10 related to information provided from an ~~M~~CE or DBM to a member.

(c) At minimum, each notice will:

(1) Be written in a manner and format, as outlined in the Contract, 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~~Enrollee Handbook related to the ~~contract~~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 ~~M~~CE or DBM 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 ~~M~~CE or DBM by ~~contract~~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 ~~M~~CE or DBM by contract or 42 C.F.R. § 438.404;

(C) Any appeal resolution notice required to be sent by the ~~M~~CE or DBM by contract or 42 C.F.R. § 438.404 or 438.408; or

(D) Any other notice required to be sent by the ~~M~~CE or DBM by ~~contract~~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~~CE or DBM under ~~any managed care contract~~Contract for professional services unless and until this ~~section~~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~~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~~or

(E) The ~~M~~CE or DBM 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~~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~~state fair hearing.

317:2-3-9. Exhaustion of ~~managed care entity~~CE or DBM appeals

(a) **Deemed exhaustion of ~~M~~CE or DBM appeals.** If the ~~M~~CE or DBM 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 ~~M~~CE's or DBM's appeal process, and the member or the member's authorized representative may request a ~~State~~state fair hearing.
(b) **Actual exhaustion of ~~M~~CE or DBM appeals.** Except as allowed in (a), a member or the member's authorized representative may request a ~~State~~state fair hearing only after receiving notice from the ~~M~~CE or DBM 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 ~~M~~CE or DBM appeals, determination.** OHCA has sole authority to decide whether ~~M~~CE or DBM appeals have been exhausted for any member. Documentation, as submitted to OHCA by the ~~M~~CE or DBM within fifteen (15) calendar days of the request for ~~State~~state fair hearing, will serve as evidence to deemed exhaustion, actual exhaustion, or no exhaustion of the ~~M~~CE or DBM appeals process.

317:2-3-10. Provider complaint system and appeal requests
(a) A participating provider or nonparticipating provider may file a complaint whenever:
(1) The provider is not satisfied with the ~~M~~CE or DBM's policies and procedures; or
(2) The provider is not satisfied with a decision made by the ~~M~~CE or DBM that does not impact the provision of services to members.
(b) The ~~M~~CE or DBM 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 ~~M~~CE or DBM will operate a reconsideration process whereby providers may request the ~~M~~CE or DBM reconsider a decision the ~~M~~CE or DBM 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 ~~M~~CE or DBM 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 ~~M~~CE or DBM 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 ~~M~~CE or DBM permits for reconsideration requests.
(3) **Desk review.** The ~~M~~CE or DBM will conduct the reconsideration through a desk review of the request and all related and available documents.
(4) **Reconsideration resolution.** The ~~M~~CE or DBM will resolve all requests for reconsideration within ~~twenty (20) calendar days of the date the MCE receives the request for reconsideration~~the timeframes established by the OHCA. The ~~M~~CE or DBM will send a

reconsideration resolution notice to the provider within ~~three (3) days of the MCE finalizing the resolution~~five (5) calendar days of resolution of the consideration.

(5) **Notice of ~~Reconsideration Resolution~~reconsideration resolution**. The ~~M~~CE or DBM will send a reconsideration resolution notice that contains, at a minimum:

(A) The date of the notice;

(B) The action the ~~M~~CE 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 ~~M~~CE or DBM 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~~CE's or DBM'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~~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~~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 ~~M~~CE or DBM 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~~CE or DBM's provider audit findings~~,~~ or for-cause or immediate termination of the provider agreement~~, or a denied claim~~.

(1) **Request for appeal.** The ~~M~~CE or DBM 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 ~~M~~CE or DBM 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 ~~M~~CE or DBM.

(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 or dental review staff of the ~~M~~CE or DBM will be licensed or credentialed health care clinicians with relevant clinical training or experience; and

(ii) All ~~M~~CEs or DBMs will use medical or dental 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 ~~M~~CE or DBM will resolve all appeals within ~~forty-five (45)~~

~~calendar days of the date the MCE receives the request for appeal~~the timeframes established by the OHCA. The ~~M~~CE or DBM will send an appeal resolution notice to the provider within ~~three (3) business~~five (5) calendar days of the ~~M~~CE or DBM finalizing the resolution.

(4) **Notice of ~~Appeal Resolution~~appeal resolution.** The ~~M~~CE or DBM 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.~~

(i) An explanation of the provider's ability to request and OHCA administrative appeal within thirty (30) calendar days of the date recorded on the notice;

(ii) How to request an OHCA administrative appeal, including the OHCA address and contact information for submitting a request;

(iii) Details on the right to be represented by counsel at the OHCA administrative appeal.

(D) Any other information required by state or federal statute or regulation, by Contract, or by Contract-related manual.

(5) **Documentation.** The ~~M~~CE or DBM will furnish to OHCA documentation including all information specified ~~at OAC 317:2-3-13(c)(2)~~within the Contract within fifteen (15) calendar days of a provider's request for ~~a State fair hearing~~an OHCA administrative appeal.

(6) **State fair hearing for providers.** There are no state fair hearings provided for providers under a CE or DBM, per OAC 317:2-3-13.

317:2-3-11. Recordkeeping

In compliance with 42 C.F.R. § 438.3(h) and (u), the ~~M~~CE or DBM 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 ~~M~~CE or DBM 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~~SoonerSelect 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~~state fair hearing.** With regard to grievances or appeals first filed with the ~~M~~CE or DBM, a member may request a ~~State~~state fair hearing under 42 C.F.R. 431 Subpart E only after receiving notice from the ~~M~~CE or DBM 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~~state fair hearing. Refer to 42 C.F.R. §§ 438.402(c)(1)(i) and 438.408(f)(1).

(b) **~~M~~CE or DBM policies and procedures.** The ~~M~~CE or DBM will implement established policies and procedures that allow a member described in (a) to initiate a ~~State~~state fair hearing process after having exhausted the ~~MCE's~~CE or DBM's appeals process or after the member is deemed to have exhausted the process due to the ~~MCE's~~CE or DBM's failure to adhere to notice and timing

requirements.

(c) **Member's request for a ~~State~~state fair hearing.** The ~~M~~CE or DBM will allow the member to request a ~~State~~state fair hearing either through an established ~~M~~CE or DBM process or through an established OHCA process. Any ~~M~~CE or DBM process will ensure that notice of the request for ~~State~~state fair hearing is communicated in writing to the OHCA contracting officer within twenty-four (24) clock-hours of receiving the request.

(d) **~~M~~CE or DBM documentation obligation.** The ~~M~~CE or DBM will provide documentation to the member, the member's authorized representative, OHCA, and the Office of Administrative Hearings.

(1) **Timing.** The ~~M~~CE or DBM will provide the ~~documentation~~support documentation (summary) described in this subsection~~:~~ within fifteen (15) calendar days after notification of the request for state fair hearing.

~~(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~~Support documentation (summary) 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~~state fair hearing;

(C) A brief chronological summary of the ~~MCE's~~CE or DBM's action in relationship to the matter underlying the member's request for ~~State~~state fair hearing;

(D) The member's appeal request, along with any supporting documentation, if received by the ~~M~~CE or DBM;

(E) Any applicable correspondence between the ~~M~~CE or DBM and the member, including system notes entered by one (1) or more ~~M~~CE or DBM employees based on one (1) or more telephone conversations with the member;

(F) All exhibits offered at any hearing held with the ~~M~~CE or DBM;

(G) All documents the ~~M~~CE or DBM used to reach its decision;

(H) A statement of the legal basis for the ~~MCE's~~CE or DBM's decision;

(I) A citation of the applicable policies and/or legal authorities relied upon by the ~~M~~CE or DBM 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 ~~M~~CE or DBM employees who will serve as witnesses at the ~~State~~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~~state fair hearing or any matter giving rise to the ~~State~~state fair hearing.

(e) **~~M~~CE or DBM staffing.** The ~~M~~CE or DBM will maintain a sufficient level of staffing to competently perform the functions, requirements, roles, and duties involved in ~~State~~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~~state fair hearing requests that are resolved upholding the ~~MCE's~~CE or DBM's original determination when and as OHCA deems necessary or appropriate.

(g) **Post-transition obligations**. After termination or expiration of the ~~managed care contract~~Contract, the ~~M~~CE or DBM will remain responsible for ~~State~~state fair hearings related to dates of service prior to the ~~contract~~Contract termination or expiration, including but not limited to the provision of records and representation at ~~State~~state fair hearings.
(h) **Cost of services.** If the ~~State~~state fair hearing officer reverses the ~~MCE's~~CE or DBM's decision to deny authorization of services and the member received the disputed services while the ~~State~~state fair hearing was pending, the ~~M~~CE or DBM 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.~~

(a) There are no state fair hearings provided for providers under a CE or DBM. The CE or DBM shall provide the following:

(1) A provider complaint system;

(2) A provider reconsideration system whereby providers may request the CE or DBM to reconsider the decision the CE or DBM has made or intends to make that is adverse to the

provider. This shall include, at minimum, reconsiderations for Program Integrity provider audit findings and provider agreement termination.

(3) Provider appeal to the CE or DBM:

(A) The CE or DBM shall implement and operate a system for provider appeals of the CE or DBM's audit findings related to Program Integrity efforts and for cause and immediate provider agreement termination.

(B) The CE or DBM shall operate a process whereby providers may appeal a decision the CE or DBM has made or intends to make that is adverse to the provider.

(b) For decisions not wholly in the provider's favor an OHCA administrative appeal will be provided, per OAC 317:2-3-10 (d)(4)(C).

317:2-3-14. Administrative Law Judge (ALJ) jurisdiction

The ALJ has jurisdiction of the following matters:

(1) **Member ~~State~~state fair hearing.** The ALJ has jurisdiction to hear any ~~State~~state fair hearing arising from a member's ~~MCE~~CE or DBM 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.~~ **Provider OHCA administrative appeal.** The ALJ has jurisdiction to hear any OHCA administrative appeal arising from a decision that was not wholly in the provider's favor.

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~~contracted entities 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 [REVOKE]

~~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.~~

The following words and terms, when used in this Chapter, shall 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 (1) or more requirements of Title XIX of the Social Security Act (Act) are waived based on the waiver authority of Section 1115 of the Act.

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

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

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

"Accrediting entity" means an entity recognized by CMS under 45 C.F.R. § 156.275. Current CMS-recognized accrediting entities include Accreditation Association for Ambulatory Health Care (AAAHC), National Committee for Quality Assurance (NCQA) and Utilization Review Accreditation Commission (URAC). To the extent CMS recognizes additional accrediting entities,

OHCA will also permit the CE or DBM to achieve accreditation from such entity to meet the requirements.

"Act" means the Social Security Act.

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

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

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

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

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

"Applicant" means an individual who seeks SoonerCare coverage.

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

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

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

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

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

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

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

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

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

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

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

"CDT" means current dental terminology (dental procedure codes).

"CEO" means Chief Executive Officer.

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

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

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

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

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

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

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

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

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

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

"**Clinical practice guidelines"** means systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances. The CE or DBM shall adopt clinical practice guidelines in accordance with 42 C.F.R. § 438.236, ensuring they are based on valid and reliable clinical evidence or a consensus of providers in the particular field; consider the needs of Enrollees; are adopted in consultation with participating providers; and are reviewed and updated periodically as appropriate.

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

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

applicable state and federal laws and regulations.

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

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

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

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

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

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

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

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

"Credibility adjustment" means an adjustment to the medical loss ratio (MLR) for a partially credible CE or DBM to account for a difference between the actual and target MLRs that may be due to random statistical variation.

"Crisis intervention services" means face-to-face services for the purpose of responding to acute behavioral or emotional dysfunction as evidenced by psychotic, suicidal, homicidal severe psychiatric distress and/or danger of alcohol or drug relapse.

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

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

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

"Dental related emergency services" means services provided to a SoonerSelect Dental Enrollee that are necessary for the treatment of any condition requiring immediate attention for the relief of pain, hemorrhage, acute infections, or traumatic injury to the teeth, supporting structures

(periodontal membrane, gingival, alveolar bone), jaws, and tissue of the oral cavity.

"DIR" means direct and indirect remuneration.

"Disclosing entity" means a Medicaid provider (other than an individual practitioner or group of practitioners) or a fiscal agent pursuant to 42 C.F.R. § 455.101.

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

"**DSH**" means disproportionate share hospital.

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

"Early and Periodic Screening, Diagnostic and Treatment (EPSDT)" means screening and diagnostic services to determine physical or mental defects in Eligibles or Health Plan Enrollees under age twenty-one (21) and health care, treatment, and other measures to correct or ameliorate any existing defects and/or chronic conditions discovered.

"Electronic Visit Verification (EVV) system" means an electronic system that documents the time that providers begin and end the delivery of services to Health Plan Enrollees and the location of services. The EVV system shall comply with Section 12006 of the 21st Century Cures Act and associated CMS requirements.

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

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

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

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

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

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

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

"EOB" means explanation of benefits.

"**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 CE must provide access, including but not limited to neonatal, perinatal, pediatric, trauma and burn services.

"Excluded benefits" means Medicaid-covered services that are not the responsibility of the CE.

"**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.

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

"Exploitation" means an unjust or improper use of the resources of a vulnerable Enrollee for the profit or advantage, pecuniary or otherwise, of a person other than the vulnerable Enrollee through the use of undue influence, coercion, harassment, duress, deception, false representation or false pretense.

"External Quality Review (EQR)" means the analysis and evaluation by an External Quality Review Organization (EQRO), of aggregated information on quality, timeliness and access to the health care services that the CE or DBM furnishes to Enrollees.

"Family planning services and supplies" means services and supplies described in § 1905(a)(4)(C) of the Act, including contraceptives and pharmaceuticals for which OHCA claims or could claim federal match at the enhanced rate under § 1905(a)(5) of the Act.

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

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

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

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

"FPL" means federal poverty level.

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

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

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

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

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

"Health risk screening" means a screening tool developed by the contracted entity, and

approved by the OHCA, to obtain basic health and demographic information, identify any immediate needs a Health Plan Enrollee may have and assist the contracted entity to assign a risk level for the Health Plan Enrollee to determine the level of care management needed.

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

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

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

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

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

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

"Local Oklahoma provider organization" means any state provider association, accountable care organization, Certified Community Behavioral Health Clinic, Federally Qualified Health Center, Native American tribe or tribal, association, hospital or health system, academic medical institution, currently practicing licensed provider, or other local Oklahoma provider organization as approved by the Authority.

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

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

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

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

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

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

"OAC" means Oklahoma Administrative Code.

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

"OHCA" means the Oklahoma Health Care Authority.

"OJA" means the Office of Juvenile Affairs.

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

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

"O.S." means Oklahoma Statutes.

"OSDE" means the Oklahoma State Department of Education.

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

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

"Patient-centered medical home" or **"PCMH"** means, in this Chapter, the care coordinated delivery system as defined within the contract between OHCA and a CE.

"Pharmacy Benefit Manager" means a third-party responsible for operating and administering the CE's pharmacy program**.**

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

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

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

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

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

(C) Does not have a comprehensive risk contract.

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

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

"**Presumptive eligibility**" means a period of temporary SoonerCare eligibility for individuals who are categorically related to certain eligibility groups listed in OAC 317:35-6-38(a)(1)(A)(i) through (vi) and are also determined by a qualified entity, on the basis of applicant self-attested income information, to meet the eligibility requirements for a Modified Adjusted Gross Income (MAGI) eligibility group.

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

community.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) Have experience serving Medicaid members and:

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

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

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

(ii) Represent the providers or facilities including, but not limited to, individuals who are employed by a statewide provider association; or

(iii) Are nonclinical administrators of clinical practices serving Medicaid members.

"Quality Assessment and Performance Improvement" or **"QAPI"** means a process designed

to address and continuously improve CE and DBM quality metrics.

"Quality Improvement Committee" or **"QIC"** means a committee within the CE or DBM's organizational structure that oversees all QAPI functions.

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

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

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

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

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

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

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

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

"Telehealth" means the practice of health care delivery, diagnosis, consultation, evaluation and treatment, transfer of medical data or exchange of medical education information by means of a two-way, real-time interactive communication, not to exclude store and forward technologies, between a patient and a health care provider with access to and reviewing the patient's relevant clinical information prior to the telemedicine visit. In accordance with Oklahoma law, including OAC 317:30-3-27 and 59 O.S. § 478, telehealth shall not include consultations provided by telephone audio-only communication, electronic mail, text message, instant messaging conversation, website questionnaire, nonsecure videoconference, or facsimile transmission.

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

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

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

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

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

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

317:55-1-4. Eligible entities

(a) **Eligible entities.** The OHCA shall enter into a capitated contract for the delivery of statewide Medicaid services. Eligible entities include an accountable care organization, a provider-led entity, a commercial plan, or any other entity as determined by OHCA. The CE or DBM shall meet the following requirements:

(1) **Licensure and certificate of authority.**

(A) The CE must be licensed as a Health Maintenance Organization (HMO) pursuant to 36 O.S. § 6901 et seq.
(B) The CE must furnish OHCA with a certificate of authority, to operate as an HMO, prior to contract implementation.
(C) The DBM must be licensed and authorized, as prepaid dental health plan, and able to transact dental business in the State of Oklahoma in accordance with 36 O.S. § 6141 et seq.
(D) The DBM must furnish OHCA with a certificate of authority for accident and health insurance or pre-paid dental prior to contract implementation in accordance with 36 O.S. § 703.
(E) Any changes to the certificate of authority, for CE and DBM, must be reported immediately to the OHCA.

(2) **Accreditation.** The CE or DBM shall seek accreditation from a private independent accrediting entity, as well as, earn a National Committee for Quality Assurance (NCQA) Health Equity Accreditation in the State of Oklahoma, within eighteen (18) months of initial enrollment implementation. When undergoing accreditation, the CE or DBM shall submit reports documenting the status of the accreditation process as required in the Contract and reporting manual.

(A) **Accreditation review.** The CE or DBM shall authorize the accrediting entity to provide the OHCA a copy of the CE's or DBM's most recent accreditation review including:

(i) Accreditation status, survey type, and level (as applicable);
(ii) Accreditation results, including recommended actions or improvements, corrective action plans, and summaries of findings; and
(iii) Expiration date of the accreditation.

(B) **Reaccreditation.** The CE and DBM shall undergo reaccreditation in accordance with the timeframes required by the accrediting entity and federal regulations.
(C) **Failure to achieve or maintain accreditation for a CE.** Failure to achieve or maintain accreditation shall be considered a breach of the CE Contract and may result in intermediate sanctions/penalties or termination in accordance with OAC 317:55-5-10(e)
(D) **Failure to achieve or maintain accreditation for a DBM.** Failure to achieve or maintain accreditation shall be considered a breach of the DBM Contract and may result in administrative remedies, including liquidated damages or termination, in accordance with OAC 317:50-5-11 and 317:55-5-12.

317:55-1-5. Program administration requirements

(a) **Compliance**. The CE or DBM shall comply with all applicable state and federal laws and regulations, including, but not limited to, 42 C.F.R. Part 438, and HIPAA privacy and security law, as defined in Section 3009 of the Public Health Service Act.
(b) **Subcontracting.** The CE or DBM shall seek approval from the OHCA prior to the effective date of any subcontract for performance of certain Contract responsibilities.

(1) The CE or DBM shall maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its Contract with OHCA, notwithstanding any relationship(s) with any subcontractors. The CE or DBM shall actively monitor subcontractors to ensure their compliance with the Contract and verify the quality of their services.
(2) The CE or DBM is prohibited from entering into any subcontract for the performance of any duty under the Contract in which such services are to be transmitted or performed outside of the United States.

(c) **Staffing.** The CE or DBM shall have sufficient staff to operate efficiently and meet all Contract obligations and standards. Additionally, the CE or DBM shall ensure staff and subcontractor staff receive detailed training on the requirements, policies, and procedures of the SoonerSelect program. All CE or DBM staff, including subcontractor staff, shall receive initial and ongoing training and education necessary to fulfill their job responsibilities under the Contract.

(d) **Policies and procedures.** The CE or DBM and any subcontractor shall:

(1) Develop and maintain written policies and procedures describing in detail how the CE or DBM and any subcontractor will fulfill the responsibilities outlined in the Contract.

(2) Submit all policies and procedures for OHCA's review and approval prior to adoption and implementation.

(3) Submit an annual certification in which the CE or DBM attests to the creation of updated policies and procedure.

(e) **Readiness review.**

(1) In accordance with 42 C.F.R. § 438.66(d)(1), the CE or DBM is required to participate, submit documentation, and satisfactorily pass the readiness review process in the following situations:

(A) Prior to initial implementation;

(B) When the specific CE or DBM has not previously contracted with the state; or

(C) When the CE or DBM, which is currently contracted with the state, will begin to provide, or arrange for covered benefits to new eligibility groups.

(2) All readiness review activities shall be completed to the satisfaction of OHCA and CMS pursuant to the Contract and/or any other policy guidelines/memorandum before being eligible to receive enrollment of Eligibles.

(3) Additionally, the state will conduct a desk review / optional on-site review of new subcontracts executed during the Contract term, or when the subcontract undertakes new eligibility groups or services. CEs, DBMs, and their subcontractors must adhere to all the contractual obligations found at 42 C.F.R. Part 438.

(f) **Marketing**. The CE or DBM must provide each Enrollee with an Enrollee handbook within ten (10) days and identification card within seven days (7) days after receiving notice of the Enrollee's enrollment or within ten (10) days of the Enrollee's request for the Enrollee handbook. The CE or DBM shall not falsify or misrepresent information that furnishes to an Enrollee, Eligible or provider. All marketing activities and materials shall comply with applicable laws and regulations regarding marketing by the Contractor and Contract terms. The OHCA shall approve all marketing materials, which must comply with federal funding requirements, including 42 C.F.R. § 438.10 and 42 C.F.R. § 438.104.

(g) **Accessibility**. The CE or DBM shall ensure Enrollees and providers have continuous access to information as determined by OHCA and that complies with the requirements at Section 508 of the Rehabilitation Act of 1973, Pub. L. No. 93-112, and the Oklahoma Electronic and Information Technology Accessibility law, 2004 HB 2197. To ensure ongoing accessibility standards are met, the CE or DBM shall:

(1) Provide its URL to the OHCA and any changes to the URL shall be approved by the OHCA.

(2) Assign and maintain a point of contact to assist the OHCA with interfacing/exchanging data in the CE's or DBM's system.

(h) **Disaster preparation and data recovery**. The CE and DBM shall submit to the OHCA and maintain a written disaster plan for information resources that will ensure service continuity as required by the Contract.

(i) **System performance.** The CE and DBM shall meet performance requirements pursuant to the Contract.

(j) **Call center standards.** The CE and DBM shall provide assistance to Enrollees and providers through a toll-free call-in system that meets the performance standards and requirements outlined in the Contract.
(k) **Failure to comply.** If the CE or DBM fails to comply with OAC 317:55-1-5, the OHCA may impose any or all the CE intermediate sanctions, found at OAC 317:55-5-10 and the CE Contract, or DBM administrative remedies, found at OAC 317:55-5-11 and the DBM Contract.

SUBCHAPTER 3. GENERAL PROGRAM INFORMATION

PART 1. ELIGIBILITY, ENROLLMENT AND CONTINUITY OF CARE

317:55-3-1. ~~**Mandatory populations**~~**Mandatory, voluntary, and excluded 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.~~
(a) **Mandatory populations.** The following SoonerCare Eligibles will be mandatorily enrolled with a CE and DBM under the SoonerSelect Dental and Medical program:
(1) Expansion adults;
(2) Parents and caretaker relatives;
(3) Pregnant women;

(4) Deemed newborns;
(5) Former foster children;
(6) Juvenile justice involved children;
(7) Foster care children;
(8) Children receiving adoption assistance; and
(9) Children.

(b) **Voluntary populations.** SoonerCare Eligible individuals may voluntarily choose to enroll in the SoonerSelect Dental and Medical program through an opt-in process if they are American Indians and/or Alaskan Natives. AI/AN populations will have the option to:

(1) Voluntarily enroll in the DBM and/or CE through an opt-in process;
(2) Enroll in a DBM and/or CE at each open enrollment period, regardless of initial selection or past disenrollment from the DBM and/or CE;
(3) When enrolled, AI/AN populations shall:
(A) Receive services from an IHCP;
(B) Choose the IHCP as the Enrollee's provider, if the provider has the capacity to provide such services;
(C) Obtain services covered under the Contract from out-of-network IHCPs when the Enrollee is otherwise Eligible to receive the IHCP's services;
(D) Self-refer for services provided by IHCPs to AI/AN Enrollees;
(E) 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
(F) Disenroll from any DBM and/or CE at any time without cause.

(c) **Excluded populations.** The following individuals are excluded from enrollment in the SoonerSelect program:

(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 ICF-IID level of care, except for Enrollees with a pending level of care determination;
(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 Medicaid 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.

(d) **Additional eligibility criteria.** For additional eligibility criteria, refer to Chapter 35 Medical Assistance for Adults and Children Eligibility Manual, Subchapter 5 Eligibility and Countable Income.

317:55-3-2. ~~Excluded populations~~Enrollment and disenrollment process

(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.~~

(a) **Enrollment process.** The OHCA beneficiary support system will provide choice counseling to all potential Enrollees at the time of initial enrollment, during the annual open enrollment period and for Enrollees who disenroll from a CE or DBM for good cause as described in the Contract and in this Section. The OHCA, or its designee, will provide information about individual CE or DBM benefit structures, services, and network providers, as well as information about other Medicaid programs as requested by the Eligible to assist the Eligible in making an informed selection.

(1) **Selection/auto assignment.** During the application process, at OHCA's discretion, an Applicant may have up to sixty (60) days to select a contracted CE and DBM of their choice. Applicants who are Eligible to choose a CE and DBM and fail to make an election on the SoonerCare application, within the allotted timeframe, will be assigned to the CE and DBM that is due next to receive an auto assignment.

(2) **Exemptions to auto-assignments**

(A) The OHCA will not make auto-assignments to the CE if:

(i) The CE's maximum enrollment has been capped and actual enrollment has reached ninety-five percent (95%) of the cap;

(ii) The CE has been excluded from receiving new enrollment due to the application of non-compliance remedies; or

(iii) The CE has failed to meet readiness review requirements.

(B) The OHCA will not make auto-assignments to the DMB if:

(i) The DBM's maximum enrollment has been capped and actual enrollment has reached ninety-five percent (95%) of the cap;

(ii) The DBM has been excluded from receiving new enrollment due to the imposition of administrative remedies; or

(iii) The DBM has failed to meet readiness review requirements.

(3) **Enrollment effective date**

(A) Eligibles, with the exception of deemed newborns, who select or are assigned to a CE and/or DBM from the first day of the month through the fifteenth day of the month shall be enrolled effective on the first day of the following month.

(B) Eligibles who select or are assigned to a CE and/or DBM on the sixteenth (16^{th}) day of the month through the last day of the month will be enrolled effective on the first day of the second following month.

(C) Prior to these enrollment dates, most Eligibles will be covered by a fee-for-service payment structure administered by OHCA.

(D) Deemed newborns eligible for the CE and/or DBM shall be enrolled effective as of the date of birth, if the newborn's mother also is enrolled in the SoonerSelect program.

(E) Notwithstanding the foregoing, the effective date of enrollment with the CE or DBM shall be the date recorded on the outbound ANSI ASC X 12 834 electronic transaction sent by OHCA.

(4) **Enrollment lock-in period.** An Enrollee may, within the first ninety (90) days of initial enrollment, request to change enrollment without cause from the CE and/or DBM, or during the ninety (90) days following the date OHCA sends the Enrollee notice of initial enrollment, whichever is later. Enrollees will also be permitted to change CEs and/or DBMs, without cause, at least once every twelve (12) months during the open enrollment period. After the disenrollment period from the CE or DBM has lapsed, the Enrollee will remain enrolled with the CE or DBM until the next annual open enrollment period, unless:

(A) The SoonerSelect Medical Enrollee:

(i) Is disenrolled due to loss of SoonerCare eligibility;
(ii) Becomes a foster child under custody of the state;
(iii) Becomes juvenile justice involved under the custody of the state;
(iv) Is a former foster care or child receiving adoption assistance and opts to enroll in the SoonerSelect Children's Specialty program;
(v) Demonstrates good cause under the following conditions:
(I) The Enrollee moves out of the service area;
(II) The Enrollee requires specialized care for a chronic condition and the Enrollee or Enrollee's representative, the CE, OHCA and receiving CE agree that assignment to the receiving CE is in the Enrollee's best interest;
(III) The plan does not cover the service the Enrollee seeks, because of moral or religious objections;
(IV) The Enrollee needs related services to be performed at the same time; not all related services are available within the CE's network; and the Enrollee's primary care provider or another provider determines that receiving the services separately would subject the Enrollee to unnecessary risk;
(V) For other reasons, including a filed and prevailed grievance related to poor quality of care, lack of access to services covered under the Contract, or lack of access to providers experienced in dealing with the Enrollee's oral health care needs or other matters deemed sufficient to warrant disenrollment; and
(VI) The Enrollee has been enrolled in error, as determined by the OHCA.
(vi) Experiences a temporary loss of eligibility or enrollment which caused the Enrollee to miss the annual disenrollment period, then the Enrollee may disenroll without cause upon reenrollment; or
(vii) The OHCA has imposed intermediate sanctions on the CE and allows Enrollees to disenroll without cause.
(B) The SoonerSelect Dental Enrollee:
(i) Is disenrolled due to loss of SoonerCare eligibility;
(ii) Demonstrates good cause under the following conditions:
(I) The Enrollee moves out of the service area;
(II) The plan does not cover the service the Enrollee seeks, because of moral or religious objections;
(III) The Enrollee needs related services to be performed at the same time; not all related services are available within the DBM's network; and the Enrollee's primary care dental provider or another provider determines that receiving the services separately would subject the Enrollee to unnecessary risk;
(IV) For other reasons, including a filed and prevailed grievance related to poor quality of care, lack of access to services covered under the Contract, or lack of access to providers experienced in dealing with the Enrollee's oral health care needs or other matters deemed sufficient to warrant disenrollment; and
(V) The Enrollee has been enrolled in error, as determined by the OHCA.
(iii) Experiences a temporary loss of eligibility or enrollment which caused the Enrollee to miss the annual disenrollment period, then the Enrollee may disenroll without cause upon reenrollment; or
(iv) The DBM is terminated.
(5) **Annual and special enrollment periods.** Sixty (60) days prior to the start of the Enrollee's annual open enrollment period, the Enrollee shall be notified of the option to maintain enrollment with the current CE and/or DBM or to enroll with a different CE and/or DBM.

OHCA, at its sole discretion, may schedule a special open enrollment period, under the following circumstances:

(A) In the event of the early termination of a CE or DBM under the process described in the Contract; or

(B) The loss of a major participating provider(s) places the CE or DBM at risk of failing to meet service accessibility standards and the CE or DBM does not have an acceptable plan for mitigating the loss or finding of non-compliance.

(6) **Enrollment caps.** OHCA, at its sole discretion, may impose a cap on the CE or DBM's enrollment, in response to a request by the CE or DBM or as part of a corrective action in accordance to the respective Contract.

(b) **Disenrollment**. The OHCA shall have sole authority to grant or deny a disenrollment request from the Enrollee, and/or CE or DBM.

(1) **CE or DBM-requested disenrollment**. Pursuant to 42 C.F.R. § 438.56(b)(2), the CE or DBM cannot request a disenrollment based on adverse change in the member's health status or utilization of medically necessary services, diminished mental capacity, or uncooperative or disruptive behavior resulting from their special needs, except when their continued Enrollment with the Contractor seriously impairs the Contractor's ability to furnish services to either this particular Enrollee or other Enrollees.

(A) The CE may only request disenrollment of the Enrollee only for good cause. The following actions, if found by OHCA, comprise good cause:

(i) The Enrollee requires specialized care for a chronic condition and the Enrollee or Enrollee's representative, the CE, OHCA and receiving CE agree that assignment to the receiving CE is in the Enrollee's best interest;

(ii) The Enrollee has been enrolled in error, as determined by OHCA;

(iii) The Enrollee has exhibited disruptive behaviors to the extent the CE cannot effectively manage their care, and the CE has made all reasonable efforts to accommodate the Enrollee; or

(iv) The Enrollee has committed fraud, including but not limited to, loaning an identification (ID) card for use by another person.

(B) The DBM may only request disenrollment of the Enrollee only for good cause. The following actions, if found by OHCA, comprise good cause:

(i) The Enrollee has been enrolled in error, as determined by OHCA;

(ii) The Enrollee has exhibited disruptive behaviors to the extent the DBM cannot effectively manage their care, and the DBM has made all reasonable efforts to accommodate the Enrollee; or

(iii) The Enrollee has committed fraud, including but not limited to, loaning an ID card for use by another person.

(2) **Enrollee-requested disenrollment.** Enrollees shall seek redress through the CE's or DBM's grievance process before OHCA will make a determination on an Enrollee's request for disenrollment. The CE or DBM shall accept Enrollee requests for disenrollment orally or in writing. The CE or DBM shall complete a review of the request within ten (10) days of the Enrollee filing the grievance. If the Enrollee remains dissatisfied with the result of the grievance process, the CE or DBM shall refer the disenrollment request to OHCA. The Contractor shall send records gathered during the grievance process to OHCA to facilitate OHCA's decision-making process. Disenrollment requests will be adjudicated by OHCA and, if approved, will become effective on a date established by OHCA.

(A) The Enrollee may request disenrollment from the CE or DBM as allowed by 42 C.F.R. § 438.56(c).

(B) An Enrollee may request disenrollment from the CE or DBM at any time based on any cause listed at 42 C.F.R. § 438.56(d)(2).

(C) An Enrollee may request disenrollment at any time in accordance with (a)(4)(A)(v)(I)-(VI) and (B)(ii)(I)-(V) of this Section and the applicable Contract.

(3) **Disenrollment by OHCA.** The CE or DBM shall report to OHCA, within five (5) business days of learning of any change in an Enrollee's status affecting the Enrollee's eligibility.

(A) The OHCA will initiate disenrollment of SoonerSelect Medical Enrollees under the following circumstances:

(i) Loss of eligibility for Medicaid;

(ii) Transition to a SoonerCare eligibility group excluded from the SoonerSelect Medical program;

(iii) Enrollee becomes enrolled in Medicare;

(iv) Death;

(v) Enrollee becomes a foster child under the custody of the state;

(vi) Enrollee becomes juvenile justice involved under the custody of the state;

(vii) The Enrollee becomes an inmate of a public institution;

(viii) The Enrollee commits fraud or provides fraudulent information; or

(ix) Disenrollment is ordered by a hearing officer or court of law.

(B) The OHCA will initiate disenrollment of SoonerSelect Dental Enrollees under the following circumstances:

(i) Loss of eligibility for Medicaid;

(ii) Transition to a SoonerCare eligibility group excluded from the SoonerSelect Dental program;

(iii) Enrollee becomes enrolled in Medicare;

(iv) Death;

(v) The Enrollee becomes an inmate of a public institution;

(vi) The Enrollee commits fraud or provides fraudulent information; or

(vii) Disenrollment is ordered by a hearing officer or court of law.

(4) **Disenrollment effective date**. Consistent with 42 C.F.R. § 438.56(e), except as provided for below, and unless OHCA determines that a delay would have an adverse effect on an Enrollee's health, it is OHCA's intent that a disenrollment shall be effective on the first day of the second following month.

(A) Grievance resolution for poor quality of care, lack of access to services covered under the Contract or lack of access to providers experienced in dealing with the Enrollee's health care needs or other matters deemed sufficient to warrant disenrollment under (b)(2) of this Section must be completed within this timeframe. If the CE fails to complete the grievance process in time to permit disenrollment by OHCA, the disenrollment shall be considered approved for the effective date that would have been established had the CE complied with this timeframe. Disenrollment for any of the following reasons shall be effective as of the date that the Enrollee's SoonerSelect Medical program eligibility status changes:

(i) Loss of eligibility for Medicaid;

(ii) Transition to a SoonerCare eligibility group excluded from the SoonerSelect program;

(iii) Enrollee becomes a foster child under the custody of the state;

(iv) Enrollee becomes JJ Involved under the custody of the state;

(v) Enrollee becomes eligible for Medicare;

(vi) Death;

(vii) Enrollee becomes an inmate of a public institution;

(viii) Enrollee commits fraud or provides fraudulent information;
(ix) Disenrollment is ordered by a hearing officer or court of law; or
(x) Enrollee requiring long-term care.
(I) Enrollees requiring long-term care in a nursing facility or ICF-IID shall be disenrolled from the CE when the level of care determination is finalized.
(II) For additional information regarding nursing facility and ICF-IID stays, refer to the Contract.

(B) Grievance resolution for poor quality of care, lack of access to services covered under the Contract or lack of access to providers experienced in dealing with the SoonerSelect Dental Enrollee's oral health care needs, or other matters deemed sufficient to warrant disenrollment under (b)(2) of this Section must be completed within this timeframe. If the Contractor fails to complete the grievance process in time to permit disenrollment by OHCA, the disenrollment shall be considered approved for the effective date that would have been established had the Contractor complied with this timeframe. Disenrollment for any of the following reasons shall be effective as of the date that the SoonerSelect Dental Enrollee's SoonerSelect Dental program eligibility status changes:
(i) Loss of eligibility for Medicaid;
(ii) Transition to a SoonerCare eligibility group excluded from the SoonerSelect Dental program;
(iii) SoonerSelect Dental Enrollee becomes eligible for Medicare;
(iv) Death;
(v) SoonerSelect Dental Enrollee becomes an inmate of a public institution;
(vi) SoonerSelect Dental Enrollee commits Fraud or provides fraudulent information;
(vii) Disenrollment is ordered by a hearing officer or court of law; or
(viii) SoonerSelect Dental Enrollees requiring long-term care in a nursing facility or ICF-IID shall be disenrolled from the Contractor when the level of care determination being done by the SoonerSelect or SoonerSelect Children's Specialty CEs is complete.

(C) Notwithstanding the foregoing, the effective date of disenrollment from the Contractor shall be the date recorded on the outbound ANSI ASC X 12 834 electronic transaction sent by OHCA.

(c) **Retroactive dual eligibility.** Dual eligibles are excluded from the SoonerSelect program. SoonerSelect Enrollees who become dual eligible individuals will be disenrolled as of their Medicare eligibility effective date.
(1) In the event a SoonerSelect Enrollee becomes retroactively Medicare eligible, the CE or DBM shall recover claims payments made to providers during the months of retroactive Medicare eligibility.
(2) The CE or DBM shall also notify the provider of the requirement to submit the claim to Medicare for reimbursement.
(3) OHCA will recoup the capitation payments paid for months of retroactive Medicare eligibility.

(d) **Re-enrollment following loss of eligibility.** Enrollees who lose and regain eligibility for SoonerSelect Medical or Dental program within a period of sixty (60) days or less will be re-enrolled automatically with their prior CE and/or DBM unless the CE and/or DBM is otherwise suspended or excluded from receiving new Enrollees. Re-enrolled Enrollees will have the right to change CE/DBM in accordance with this Section and the Contract.

(e) **Eligibles voluntarily opting out of SoonerSelect Children's Specialty program.** FFC and children receiving adoption assistance shall be enrolled in the SoonerSelect Children's Specialty program. These Eligibles may opt-out of enrollment in the Children's Specialty program; however,

the legal guardian of the Eligible will be required to enroll the Eligible with a CE.
(f) **Non-discrimination**. The CE or DBM may not refuse an assignment or seek to disenroll an Enrollee or otherwise discriminate against Eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity, health status, need for medical services, or disability and may not use any policy or practice that has the effect of discriminating on the basis of race, color or national origin, sex, sexual orientation, gender identity, or disability. The Contractor also may not discriminate against an Enrollee on the basis of expectations that the Enrollee will require frequent or high-cost care, or on the basis of health status or need for health care services or due to an adverse change in the Enrollee's health in enrollment, disenrollment, or re-enrollment. If the CE or DBM fails to comply with OAC 317:55-3-2, the OHCA may impose any or all the CE intermediate sanctions, found at OAC 317:55-5-10 and the CE Contract, or DBM administrative remedies, found at OAC 317:55-5-11 and the DBM Contract.

317:55-3-3. ~~Voluntary enrollment and disenrollment~~Enrollee rights

~~(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.~~
(a) In accordance with 42 C.F.R. § 438.100, state and federal regulations, and all contractual requirements, the CE and DBM shall allow the Enrollee the right to:
(1) Receive information on the SoonerSelect program and the CE or DBM;
(2) Receive information on all available treatment options and alternatives;
(3) Participate in decisions regarding their healthcare;
(4) Free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation; and
(5) Request and receive a copy of their medical records in accordance with all HIPAA rules.
(b) Each Enrollee is free to exercise their rights without the CE or DBM treating them adversely.
(c) The CE or DBM may not otherwise discriminate against Enrollees on the basis of race, color, national origin, sex, sexual orientation, gender identity, health status, need for medical services, or disability and may not use any policy or practice that has the effect of discriminating on the basis of race, color or national origin, sex, sexual orientation, gender identity, or disability. If the CE or DBM fails to comply with OAC 317:55-3-3, the OHCA may impose any or all the CE intermediate sanctions, found at OAC 317:55-5-10 and the CE Contract, or DBM administrative remedies, found at OAC 317:55-5-11 and the DBM Contract.

PART 3. ~~SCOPE AND ADMINISTRATION~~ACCESS TO COVERED SERVICES AND PROVIDER NETWORK STANDARDS

317:55-3-10. ~~Grievances and appeals~~Covered services

~~(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.~~

(a) **Amount, duration, and scope of services.** The CE or DBM must ensure members have timely access to all medically necessary services, as applicable, covered by SoonerCare under the Medicaid State Plan, the Alternative Benefit Plan (ABP), and the 1115 IMD Waiver. The CE or DBM must ensure:

(1) Services are sufficient in amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are provided;

(2) The amount, duration, and scope of a required service is not arbitrarily denied or reduced solely because of the diagnosis, type of illness, or condition;

(3) PA is available for services on which the CE or DBM has placed a pre-identified limitation to ensure the limitation may be exceeded when medically necessary.

(A) The CE or DBM may propose to impose alternative PA requirements, subject to OHCA's review and approval, except for those benefits identified as exempt from PA. The CE or DBM may be less restrictive on the requirements of a PA than OHCA but may not impose greater restrictions.

(B) PA shall be processed in accordance with timeliness requirements specified in the Contract.

(4) Coverage decisions are based on the coverage and medical necessity criteria published in Title 317 of the Oklahoma Administrative Code and practice guidelines/manual; and

(5) If a member is unable to obtain medically necessary services offered by SoonerCare from a CE or DBM network provider, the CE or DBM must adequately and timely cover the services out of network, until the CE or DBM is able to provide the services from a network provider.

(b) **Emergency services**. The CE or DBM shall provide emergency services to Enrollees in accordance with the respective CE or DBM Contract.

(c) **Post-stabilization services.** In accordance with the provisions set forth at 42 C.F.R. § 422.113(c), the CE shall provide post-stabilization care services are:

(1) Obtained within or outside the CE network that are:

(A) Pre-approved by a CE or representative; or

(B) Not pre-approved by a CE or representative but administered to maintain the Enrollee's stabilized condition within one (1) hour of a request to the CE for pre-approval of further post-stabilization care services.

(2) Administered to maintain, improve, or resolve the Enrollee's stabilized condition without preauthorization, and regardless of whether the Enrollee obtains the services within the CE network when the CE:

(A) Did not respond to a request for pre-approval within one (1) hour;

(B) Could not be contacted; or

(C) Representative and the treating physician could not reach agreement concerning the Enrollee's care and a CE physician was not available for consultation.

(3) In accordance with 42 C.F.R. §§ 438.114(e) and 422.113(c)(2)(iv), the CE shall limit charges to Enrollees for post-stabilization care services to an amount no greater than what the CE would charge the Enrollee if they obtained the services through the CE. Additionally, the CE's financial responsibility for post-stabilization care services if not pre-approved ends when:

(A) A CE physician with privileges at the treating hospital assumes responsibility for the Enrollee's care;

(B) A CE physician assumes responsibility for the Enrollee's care through transfer;

(C) A CE representative and the treating physician reach an agreement concerning the Enrollee's care; or

(D) The Enrollee is discharged.

(d) **Continued services to Enrollees.** The CE and DBM shall take all the necessary steps to ensure continuity of care when Enrollees transition to the CE or DBM from another CE/DBM or SoonerCare program. The CE and DBM shall ensure that established Enrollee and provider relationships, current services and existing PAs and care plans will remain in place during the continuity of care period in accordance with the requirements outlined in this Section.

(1) Transition to the CE/DBM shall be as seamless as possible for Enrollees and their providers.

(2) The CE shall take special care to provide continuity of care for newly enrolled Enrollees who have physical health conditions, behavioral health conditions and/or functional needs and are under the care of existing treatment providers and whose health could be placed in jeopardy, or who could be placed at risk of hospitalization or institutionalization, if covered services are disrupted or interrupted.

(3) The DBM shall take special care to provide continuity of care for newly enrolled SoonerSelect Dental Enrollees who have oral health care needs and are under the care of existing treatment providers and whose health could be placed in jeopardy, or who could be placed at risk of hospitalization, if covered services are disrupted or interrupted.

(4) The DBM shall work with SoonerSelect and SoonerSelect Children's Specialty CEs to transition and coordinate care after a dental related emergency service pursuant to the Contract.

(5) The CE/DBM shall make transition of care policies available to Enrollees and provide instructions to Enrollees on how to access continued services during the continuity of care period.

(6) The CE/DBM shall ensure that all Enrollees are held harmless by providers for payment for any existing covered services, other than required cost sharing, during the continuity of care period.

(e) **Non discrimination.** The CE or DBM shall not discriminate an Enrollee on the basis of the Enrollee's health or need for medical services.

(f) **Failure to comply.** If the CE or DBM fails to comply with OAC 317:55-3-10, the OHCA may impose any or all the CE intermediate sanctions, found at OAC 317:55-5-10 and the CE Contract, or DBM administrative remedies, found at OAC 317:55-5-11 and the DBM Contract.

317:55-3-11. ~~Intermediate sanctions~~Cost sharing

~~(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).~~

The CE or DBM shall ensure that all Enrollees are held harmless by providers for payment for any existing covered services, other than required cost sharing, during the continuity of care period. The CE or DBM shall not impose premiums or charges on Enrollees that are in excess of those permitted in the SoonerCare program in accordance with OAC 317:30-3-5 and the Oklahoma Medicaid State Plan. If the CE or DBM fails to comply with OAC 317:55-3-11, the OHCA may impose any or all the CE intermediate sanctions, found at OAC 317:55-5-10 and the CE Contract, or DBM administrative remedies, found at OAC 317:55-5-11 and the DBM Contract.

317:55-3-12. ~~Non-compliance damages and remedies~~Provider contracting and network requirements

~~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.~~

(a) **Provider contracts**. A CE or DBM must provide or arrange for the delivery of covered health care services described in OAC 317:55-3-5 through a provider agreement with SoonerCare-contracted providers. All provider agreements must be in writing and in accordance with the Contract and 42 C.F.R. §§ 434.6 and 438.6. The CE's or DBM's execution of a provider agreement does not terminate the CE's or DBM's legal responsibility to the OHCA to ensure all the CE's and DBM's activities and obligations are performed in accordance with Okla. Admin. Code § 317, as applicable, the CE's or DBM's Contract with the OHCA, and all applicable federal, state, and local regulations. The CE or DBM shall maintain, and have available, written policies and procedures on:

(1) Participating provider selection;
(2) Retention and termination of a provider's participation with the CE or DBM;
(3) Responding to changes in the CE'S or DBM'S network of participating providers that affect access and ability to deliver services in a timely manner; and
(4) Access standards.

(b) **Provider network.**

(1) The CE and DBM must maintain, in accordance with 42 C.F.R. § 438.206(b)(1), a network of appropriate participating providers that is supported by a signed provider agreement and is sufficient to provide adequate access and availability to all services covered under the Contract with the OHCA, including those with limited English proficiency or physical or mental disabilities.
(2) The CE and DBM must ensure that all requirements found at 42 C.F.R. § 438.3(q)(1) and (q)(3) are met.
(3) The CE and DBM must meet and require its participating providers to meet state standards for timely access to care and services, in accordance with 42 C.F.R. § 438.206(c) and all contractual requirements.
(4) The OHCA shall monitor and review the CE's and DBM's compliance with all standards as part of all ongoing oversight activities.

(c) **Credentialing and recredentialing.**

(1) All CE and DBM must utilize the same single Credential Verification Organization (CVO) that is certified by a CMS-approved accrediting organization and approved by OHCA as part of its provider credentialing and recredentialing process. The CE and DBM credentialing and re-credentialing processes shall comply with relevant state and federal regulations, including, but not limited to, 42 C.F.R. §§ 438.12, 438.206(b)(6), and 438.214, and all applicable contractual requirements.

(2) The CE and DBM must ensure that providers have been properly credentialed to ensure provider facilities, organizations, and staff meet all qualifications and requirements for participation in the Oklahoma Medicaid program. All applications must be credentialed and the CE's or DBM's claim systems must be able to recognize the provider as a SoonerSelect program network provider, within all applicable timeframes as outlined within the Contract with the OHCA.

(3) The recredentialing process must take into consideration provider performance data including Enrollee grievance and appeal, quality of care, and utilization management.

(4) The CE and DBM must review and approve the credentials of all applicable licensed and unlicensed participating and contracted providers who participate in the CE's or DBM's provider network at least once every three (3) years.

(5) If the CE or DBM fails to comply with the credentialing and recredentialing standards per OAC 317:55-5-12(c), the OHCA may impose any or all the CE intermediate sanctions, found at OAC 317:55-5-10 and the CE Contract, or DBM administrative remedies, found at OAC 317:55-5-11 and the DBM Contract.

(d) **Non-discrimination against providers.**

(1) The CE's and DBM's written policies and procedures shall not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatment, per 42 C.F.R. §§ 438.12(a)(2) and 438.214(a).

(2) In accordance with 56 O.S. § 4002.4(B), shall not exclude essential community providers, providers who receive directed payments in accordance with 42 C.F.R. Part 438, and such other providers, as directed by OHCA from execution of provider agreements.

317:55-3-13. ~~Termination of managed care contract~~Time, distance, and access standards

(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).~~

(a) The CE and DBM must meet all time and distance standards as established by the OHCA in accordance with 42 C.F.R. § 438.68. The time and distance standards will apply to all geographic areas in which the CE or DBM operates, with standards varying for urban and rural areas, which will include, at a minimum:

(1) Anticipated enrollment;

(2) Expected utilization of services;

(3) Characteristics and health care needs of all covered populations;

(4) Provider-to-Enrollee ratios;

(5) Travel time or distance to providers;

(6) Percentage of contracted providers that are accepting new patients;

(7) Ability to communicate with limited English proficiency Enrollees;

(8) Ability to ensure physical access, reasonable accommodations, and accessible equipment for Enrollees with physical or mental disabilities;

(9) Maximum wait times; and

(10) Hours of operations.

(b) The standards listed in (a)(1) – (10) of this Section apply to the following medical provider types, in accordance with 42 C.F.R. § 438.68(b) and specified in the Medical and Children's Specialty Contract:

(1) Adult and pediatric PCPs;

(2) Obstetrics and Gynecology (OB/GYN) providers;

(3) Adult and pediatric mental health providers;

(4) Adult and pediatric substance use disorder (SUD) providers;

(5) Adult and pediatric specialists;

(6) Hospitals;

(7) Pharmacies; and

(8) Essential community providers.

(c) The standards listed in (a)(1) – (10) of this Section apply to the following dental provider types, in accordance with 42 C.F.R § 438.68(b) and specified in the DBM Contract:

(1) General dentistry providers;

(2) Pediatric specialty dental providers;

(3) Specialty dental providers; and

(4) Essential community providers.

(d) If the CE or DBM fails to comply with the standards as set forth in this Section, the OHCA may impose any or all the CE intermediate sanctions, found at OAC 317:55-5-10 and the CE Contract, or DBM administrative remedies, found at OAC 317:55-5-11 and the DBM Contract.

317:55-3-14. ~~Record retention~~Primary care requirements

~~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.~~

(a) **Primary care spending/expenses.** No later than the end of the fourth (4^{th}) year of the initial contracting period, each CE shall be currently spending not less than eleven percent (11%) of its total health care expenses on primary care services.

(b) **Primary care expenditure reporting requirements.**

(1) The CEs must submit a primary care implementation plan which describes the CEs strategies for increasing the percentage of total medical expenditures allocated to primary care over the initial four (4) year contract period.

(2) The plan shall include target annual percentage increases over the previous year baseline data that demonstrate the CEs ability to achieve eleven percent (11%) by the end of year four (4).

(c) **Primary care expenditure calculations.**

(1) CEs shall submit data on an annual basis for primary care and total medical expenditures made through paid claims amounts and non-claims payments to the OHCA, in the manner and timeline prescribed in the SoonerSelect Contract.

(2) The OHCA will consider non-claims-based investments into primary care including but not limited to investments in electronic health record (EHR) systems, health information exchange (HIE) costs, care coordination activities and systems, and recruitment/retention incentives for primary care providers in rural and medically underserved areas.

(3) Other non-claims-based investments may be reviewed and approved by the OHCA.

(4) The OHCA may impose a cap on the amount of non-claims-based investment considered in the primary care expenditure calculation.

317:55-3-15. Provider agreement/contract termination

(a) The CE and DBM and all participating providers have the right to terminate the Contract entered into with each other via a provider agreement.

(b) The CE and DBM and all participating providers may terminate the provider agreement for cause with thirty (30) days advance written notice and without cause with sixty (60) days advance written notice to the other party.

(c) The CE and DBM shall terminate its provider agreement with a participating provider immediately if any of the following circumstances occur:

(1) In order to protect the health and safety of all Enrollees;

(2) If a credible allegation of fraud results in a conviction of credible allegation on the participating provider;

(3) When the participating provider's licenses, certifications and/or accreditations are modified, revoked or in any other way making it unlawful for the provider to provide services under the Contract; or

(4) If requested by the OHCA.

(d) The OHCA reserves the right to terminate a provider from SoonerCare participation. The OHCA will notify the CE or DBM regarding any termination. The CE and DBM shall be responsible for monitoring all state registries to review any participating providers that are terminated by OHCA and excluded from participation in the CE's or DBM's participating provider network.

317:55-3-16. Non-licensed providers

(a) The CE and DBM must ensure that all non-licensed providers are educated, trained, and qualified to perform all job responsibilities.

(b) Background checks and database screening in accordance with state and federal laws must be completed to ensure the non-licensed provider has not been excluded or debarred from participation in Medicare, Medicaid, or any federal health care program.

(c) All applicable state and federal regulations and contractual requirements must be followed when employing non-licensed providers.

PART 5. ~~REQUIRED FEDERAL AUTHORIZATIONS~~GRIEVANCE, APPEAL AND PROVIDER COMPLAINT SYSTEM

317:55-3-20. ~~Authorizations~~SoonerSelect enrollee grievance and appeal system

~~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.~~

(a) The CE or DBM shall have written grievance and appeal policies and procedures for an Enrollee, or an Enrollee's authorized representative, to appeal a CE's or DBM's action and/or file a grievance. The policies must address contractual requirements, including performance standards, and federal funding requirements, including 42 C.F.R. § 438 Subpart F and OAC 317:2-3-3.

(1) Timeframes, pursuant to OAC 317:2-3-2;

(2) Grievances, pursuant to OAC 317:2-3-4;

(3) Appeals, pursuant to OAC 317:2-3-5;

(4) Grievance and appeal notices, pursuant to OAC 317:2-3-8;

(5) State fair hearings, pursuant to OAC 317:2-3-12;

(6) Recordkeeping, pursuant to OAC 317:2-3-11; and

(7) Continuation of benefits, pursuant to OAC 317:2-1-2.6 and 317:2-3-5.1.

(b) If the CE or DBM fails to meet performance standards, the OHCA may impose any or all the CE intermediate sanctions, found at OAC 317:55-5-10 and the CE Contract, or DBM administrative remedies, found at OAC 317:55-5-11 and the DBM Contract.

317:55-3-21. ~~Timing~~ Provider complaint system

~~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.~~

The CE or DBM shall have written provider complaint policies and procedures for an Enrollee, or an Enrollee's authorized representative, to appeal a CE's or DBM's action and/or file a grievance. The policies must address contractual requirements, including performance standards, and federal funding requirements, including 42 C.F.R. Part 438 Subpart F and OAC 317:2-3-10.

(1) Timeframes, pursuant to OAC 317:2-3-2;

(2) Notices, pursuant to OAC 317:2-3-8; and

(3) Recordkeeping, pursuant to OAC 317:2-3-11.

SUBCHAPTER 5. REQUIREMENTS FOR ~~MANAGED CARE ORGANIZATIONS~~ CONTRACTED ENTITIES AND DENTAL BENEFITS MANAGERS

PART 1. ~~ACCREDITATION AND READINESS~~MONITORING, PROGRAM INTEGRITY, DATA, AND REPORTING

317:55-5-1. ~~MCO or DBM accreditation~~Monitoring system for all SoonerSelect programs

~~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.~~

(a) In accordance with 42 C.F.R. § 438.66, the OHCA will monitor each CE or DBM 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.

(b) The CE or DBM shall have a reporting monitoring process for ensuring compliance with all Contract requirements, implementation deadlines for mandates and/or laws as directed by CMS, CDC, or other federal or state government entity. The CE or DBM shall report monthly on its compliance monitoring activities as required by the reporting manual.

317:55-5-2. ~~MCO or DBM readiness~~Program integrity; data and reporting

~~(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.~~

(a) **Program integrity standards.** The CE and DBM shall comply with all state and federal laws, regulations, and mandates including but not limited to 42 C.F.R. § 438.608. The CE and DBM shall have and implement written policies and procedures that are designed to detect and prevent fraud, waste, and abuse pursuant to the Contract and federal regulations. The CE and DBM shall:

(1) Provide a monthly report (by close of the last calendar day of each month), of all open Program Integrity related audits and investigations related to fraud, waste, and abuse activities for identifying and collecting potential overpayments, utilization review, and provider compliance.

(2) Refer credible allegations of fraud to OHCA's Legal Division in writing within three (3) business days of discovery.

(3) Suspend all payments to the provider when a credible allegation of fraud exists.

(4) Participate in good faith at monthly Program Integrity meetings held jointly with MFCU and OHCA.

(5) Participate in good faith at monthly meetings with OHCA Program Integrity and Accountability Unit.

(6) Disclose any change in ownership and control information to OHCA within thirty-five (35) calendar days.

(7) Submit to OHCA or HHS, within thirty-five (35) days of request, full and complete information about:

(A) The ownership of any subcontractor with whom the CE/DBM has had business transactions totaling more than twenty-five thousand dollars ($25,000) during the twelve (12-month) period ending on the date of the request; and

(B) Any significant business transactions between the CE/DBM and any wholly owned supplier, or between the provider and any subcontractor, during the five (5-year) period ending on the date of request.

(b) **Data and reporting standards.**

(1) The CE and DBM shall:

(A) Provide information responsive to specific requests made by OHCA, MFCU, or other authorized state and federal authorities (including, but not limited to, requests for records of Health Plan Enrollee and provider interviews), within three (3) business days of said request, unless otherwise agreed upon by OHCA.

(B) Submit weekly encounter data by the deadline established by OHCA and in accordance with OHCA accuracy standards.

(C) Submit a required report timely and/or accurately.

(2) The CE or DBM shall not falsify or misrepresent information that it furnishes to CMS or OHCA.

(c) **Request for information.** The CE or DBM shall provide and prioritize requests for information made by OHCA, MFCU, or other authorized state and federal authorities. The CE or DBM shall respond to urgent requests from OHCA within twenty-four hours (24-hours) and according to guidance and timelines provided by OHCA.

(d) **Record retention.** The CE or DBM shall retain records for a period of ten (10) years as well as comply with all state and federal regulations and contractual requirements.

(e) **Non-compliance actions**. If the CE or DBM fails to submit any OHCA-requested materials, as specified in this Section, without cause as determined by OHCA, on or before the due date, OHCA may impose any or all the CE sanctions, found at OAC 317:55-5-10 and the CE Contract, or DBM administrative penalties, found at OAC 317:55-5-11 and the DBM Contract.

317:55-5-3. Critical incident reporting system

(a) The CE shall ensure that any serious incident that harms or potentially harms the Enrollee's health, safety, or well-being, including incidents of seclusion and restraint, are immediately identified, reported, reviewed, investigated, and corrected, in compliance with state and federal law.
(b) When the Enrollee is in the care of a behavioral health inpatient, PRTF, or crisis stabilization unit, critical incidents shall include, but are not limited to the following:

(1) Suicide death;
(2) Non-suicide death;
(3) Death-cause unknown;
(4) Homicide;
(5) Homicide attempt with significant medical intervention;
(6) Suicide attempt with significant medical intervention;
(7) Allegation of physical, sexual, or verbal abuse or neglect;
(8) Accidental injury with significant medical intervention;
(9) Use of restraints/seclusion (isolation);
(10) AWOL or absence from a mental health facility without permission; or
(11) Treatment complications (medication errors and adverse medication reaction) requiring significant medical intervention.

(c) The CE shall develop and implement a critical incident reporting and tracking system for behavioral health adverse or critical incidents and shall require participating providers to report adverse or critical incidents to the CE, OHS, and the Enrollee's parent or legal guardian.
(d) Participating providers shall contact the CE by phone no later than 5:00pm Central time on the business day following a serious occurrence and disclose, at a minimum:

(1) The name of the Enrollee involved in the serious incident;
(2) A description of the occurrence; and
(3) The name, street address, and telephone number of the facility.

(e) The participating provider must, within three (3) days of the serious occurrence, submit a written facility critical incident report to the CE.

(1) The facility critical incident report must include specific information regarding the incident including the following:

(A) All information listed in OAC 317:55-5-3 (d)(1) through (3);
(B) Available follow-up information regarding the Enrollee's condition;
(B) Debriefings; and
(C) Any programmatic changes that were implemented.

(2) A copy of this report must be maintained in the Enrollee's record, along with the names of the persons at the CE and OHS to whom the occurrence was reported.
(3) A copy of the report must also be maintained in the incident and accident report logs kept by the facility.
(4) The CE shall review the participating provider's report and follow up with the participating provider as necessary to ensure that an appropriate investigation was conducted, and corrective actions were implemented within applicable timeframes.

(f) The CE shall provide appropriate training and take corrective action as needed to ensure its staff and participating providers, as applicable, comply with all critical incident requirements, in the manner and format outlined in the reporting manual.

PART 3. ~~PROVIDER REQUIREMENTS~~NON-COMPLIANCE OF A CE AND/OR DBM AND NOTIFICATIONS

317:55-5-10. ~~Provider contracts and credentialing standards~~Non-compliance of contracted entities

~~(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.~~

(a) **Failure to comply**. If the CE fails to fulfill its duties and obligations or meet performance standards under 42 C.F.R. Part 438, 42 U.S.C. § 1396b(m), 42 U.S.C. § 1396u-2, Title 317 of the Oklahoma Administrative Code, or the CE Contract, OHCA will notify the CE of unmet performance expectations, violations or deficiencies, and may impose corrective actions or any sanctions in addition to or instead of any actions or sanctions specified in the Contract.

(b) **Non-material compliance deficiencies.**

(1) If OHCA determines that unmet performance expectations, violations, or deficiencies do not result in a material deficiency or delay in the implementation or operation of services, the CE will have five (5) business days (or the date specified by OHCA) of receipt of notice to provide the OHCA with a written response that:

(A) Explains the reasons for the deficiency;

(B) The CE's plan to address or cure the deficiency; and

(C) The date and time by which the deficiency will be cured.

(D) If the CE disagrees with OHCA's findings, the CE shall provide its reasons for disagreeing with OHCA's findings.

(2) The CE's proposed cure of a non-material deficiency is subject to the approval of OHCA.

(3) The CE's repeated commission of non-material deficiencies or repeated failure to resolve any such deficiencies may be regarded by OHCA as a material deficiency and entitle OHCA to pursue any other remedy provided in the Contract or any other appropriate remedy OHCA may have at law or equity.

(c) **Material compliance deficiencies.**

(1) An item of material non compliance means a specific action of the CE that:

(A) Violates a substantive term of the Contract;

(B) Fails to meet an agreed upon measure of performance; or

(C) Represents a failure of the CE to be reasonably responsive to a reasonable request of OHCA relating to the Services for information, assistance, or support within the timeframe specified by OHCA.

(2) If OHCA determines that unmet performance expectations, violations, or deficiencies result in a material deficiency, The CE may be required to submit a written CAP under the signature of the CE's CEO to correct or resolve a material breach of the Contract.

(A) The CAP must:

(i) Be submitted by the deadline set forth in the OHCA's request for a CAP.

(ii) Be reviewed and approved by the OHCA.

(B) Following the approval of the CAP, the OHCA may:

(i) Condition such approval on completion of tasks in the order or priority that the OHCA prescribes;

(ii) Disapprove portions of the CE's proposed CAP; or

(iii) Require additional or different corrective action(s) or timelines/time limits.

(C) The CE remains responsible for achieving the established performance criteria.

(3) OHCA may apply one (1) or more of the following non-compliance remedies for each item of material non-compliance listed in (2) of this Section.

(A) Conduct accelerated monitoring of the CE;

(B) Require additional, more detailed, financial and/or programmatic reports to be submitted by the CE;

(C) Decline to renew or extend the Contract;

(D) Require forfeiture of all or part of the CE's performance bond or other substitute; or

(E) Terminate the Contract in accordance with OAC 317:55-5-14.

(4) In addition to the non-compliance remedies, the OHCA may impose tailored remedies, including liquidated damages pursuant to (e) of this Section.

(d) **Imposition of intermediate sanctions.** In accordance with 42 C.F.R. § 438.702, if OHCA determines the CE is non-compliant and 42 C.F.R. § 438.700(b) is the basis for the Agency's determination, OHCA may impose the following intermediate sanctions:

(1) Imposition of civil money penalties in the amounts specified in 42 C.F.R. § 438.704;

(2) Grant Enrollee(s) the right to terminate enrollment without cause and notifying the affected Enrollees of their right to disenroll;

(3) Suspend all new enrollment of Enrollee(s), including default enrollment, after the date OHCA notifies the CE of a determination of a violation of any requirement under § 1903(m) or § 1932 of The Act;

(4) Suspend or recoup capitation payments to the CE for Enrollees enrolled after the effective date of the sanction and until OHCA is satisfied that the reason for imposition of the sanction no longer exist and is not likely to recur;

(5) Impose additional sanctions provided for under state statutes or regulations to address noncompliance in accordance with 42 C.F.R. § 438.702(b); and

(6) Appoint temporary management in accordance with 42 C.F.R. § 438.706. The CE shall comply with the contractual requirements found in Section 1.26.3.5 "Intermediate Sanctions" of the Contract.

(7) The CE shall be responsible for all reasonable expenses related to the direct operation of the SoonerSelect program, including but not limited to attorney fees, cost of preliminary or other audits of the CE and expenses related to the management of any office or other assets of the CE.

(e) **Liquidated damages.** OHCA may impose actual, consequential, and liquidated damages in accordance with Tit. 23 O.S. § 21, resulting from the CE's failure to comply with any of the terms of the Contract, Ch. 55, or any applicable state or federal regulations. Consequential and liquidated damages will be assessed if OHCA determines such failure is the fault of the CE, including the CE's subcontractors and/or consultants, and is not materially caused or contributed to by OHCA or its agents.

(f) **Other provisions.** The CE shall be responsible for all reasonable expenses related to the direct operation of the SoonerSelect Medical program, including but not limited to attorney fees, cost of preliminary or other audits of the CE and expenses related to the management of any office or other assets of the CE.

317:55-5-11. ~~Network adequacy standards~~Non-compliance of dental benefit managers

~~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.~~

(a) **Failure to comply**. If the DBM fails to fulfill its duties and obligations or meet performance standards under 42 C.F.R. Part 438, 42 U.S.C. § 1396b(m), 42 U.S.C. § 1396u-2, Title 317 of the Oklahoma Administrative Code, or the DBM Contract, OHCA will notify the DBM of unmet performance expectations, violations, or deficiencies, and may impose corrective actions or any sanctions in addition to or instead of any actions or sanctions specified in the Contract.

(b) **Non-material compliance deficiencies.**

(1) If OHCA determines that unmet performance expectations, violations, or deficiencies do not result in a material deficiency or delay in the implementation or operation of services, the DBM will have five (5) business days (or the date specified by OHCA) of receipt of notice to provide the OHCA with a written response that:

(A) Explains the reasons for the deficiency;

(B) The DBM's plan to address or cure the deficiency; and

(C) The date and time by which the deficiency will be cured; or

(D) If the DBM disagrees with OHCA's findings, the DBM shall provide its reasons for disagreeing with OHCA's findings.

(2) The DBM's proposed cure of a non-material deficiency is subject to the approval of OHCA.

(3) The DBM's repeated commission of non-material deficiencies or repeated failure to resolve any such deficiencies may be regarded by OHCA as a material deficiency and entitle OHCA to pursue any other remedy provided in the Contract or any other appropriate remedy OHCA may have at law or equity.

(c) **Material compliance deficiencies.**

(1) An item of material non compliance means a specific action of the DBM that:

(A) Violates a substantive term of the Contract;

(B) Fails to meet an agreed upon measure of performance; or

(C) Represents a failure of the DBM to be reasonably responsive to a reasonable request of OHCA relating to the services for information, assistance, or support within the timeframe specified by OHCA.

(2) If OHCA determines that unmet performance expectations, violations, or deficiencies result in a material deficiency, the DBM may be required to submit a written CAP under the signature of the DBM's CEO to correct or resolve a material breach of the Contract.

(A) The CAP must:

(i) Be submitted by the deadline set forth in OHCA's request for a CAP.

(ii) Be reviewed and approved by OHCA.

(B) Following the approval of the CAP, the OHCA may:

(i) Condition such approval on completion of tasks in the order or priority that the OHCA prescribes;

(ii) Disapprove portions of the DBM's proposed CAP; or

(iii) Require additional or different corrective action(s) or timelines/time limits.

(C) The DBM remains responsible for achieving the established performance criteria.

(3) OHCA may apply one (1) or more of the administrative remedies found in (f) of this Section for each item of material non-compliance listed in (c)(2) of this Section.

(d) **Liquidated damages.** OHCA may impose actual, consequential, and liquidated damages in accordance with 23 O.S. § 21, resulting from the DBM's failure to comply with any of the terms of the Contract, Ch. 55, or any applicable state or federal regulations. Consequential and liquidated damages will be assessed if OHCA determines such failure is the fault of the DBM, including the CE's subcontractors and/or consultants, and is not materially caused or contributed to by OHCA or its agents.

(e) **Administrative remedies**. OHCA may impose the following remedies:

(1) Conduct accelerated monitoring of the DBM;

(2) Require additional, more detailed, financial and/or programmatic reports to be submitted by the DBM;

(3) Decline to renew or extend the Contract;

(4) Require forfeiture of all or part of the DBM's performance bond or other substitute; or

(5) Terminate the Contract in accordance with OAC 317:55-5-14.

(6) Grant Enrollee(s) the right to terminate enrollment without cause and notifying the affected Enrollees of their right to disenroll;

(7) Suspend all new enrollment of Enrollee(s), including default enrollment, after the date OHCA notifies the CE or DBM of a determination of a violation of any requirement;

(8) Suspend or recoup capitation payments to the DBM for Enrollees enrolled after the effective date of the sanction and until OHCA is satisfied that the reason for imposition of the sanction no longer exist and is not likely to recur; and

(9) Appoint temporary management in accordance with 42 C.F.R. § 438.706. The DBM shall comply with the contractual requirements found in the Contract at Section 1.26.3.5 "Imposition of Liquidated Damages".

(f) **Other provisions.** The DBM shall be responsible for all reasonable expenses related to the direct operation of the SoonerSelect Dental program, including but not limited to attorney fees, cost of preliminary or other audits of the DBM and expenses related to the management of any office or other assets of the DBM.

317:55-5-12. ~~Prior authorization requirements, generally~~Termination of contract

~~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.~~

(a) The Contract may be terminated prior to its scheduled expiration date only for the reasons specified in this Section.

(1) **Termination for mutual consent.** OHCA and the CE or DBM may terminate the contract by mutual written agreement.

(2) **Termination for convenience.** The OHCA may terminate the contract, in whole or in part, for convenience if it is determined that termination is in the state's best interest.

(3) **Termination for default.** OHCA may, at its election, assign Enrollees to another DBM/CE or provide benefits through other State Plan authority if the DBM/CE has breached this contract and is unable or unwilling to cure such breach within the period of time as specified in writing by OHCA.

(4) **Termination for unavailability of funds.** If state, federal, or other funding is not sufficiently appropriated, or is withdrawn, reduced, or limited in any way after the effective date

of the contract, OHCA may terminate this contract immediately, effective on the close of business on the day specified. OHCA shall be the final authority as to the availability of funds.

(5) **Termination for lack of authority.** If any necessary federal or state approval or authority to operate the SoonerSelect Medical or Dental program is not granted, or the Oklahoma Legislature prohibits OHCA from contracting with a CE or DBM for the provision of health care for Eligibles or Enrollees, OHCA may terminate this contract immediately, effective on the close of business on the day specified.

(6) **Termination for financial instability.** If the OHCA deems, in its sole discretion, that the CE or DBM is financially unstable to the point of threatening the ability of OHCA to obtain the services provided for under this contract, ceases 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 this Contract effective on the close of business on the date specified.

(7) **Termination for debarment.** The CE or DBM will not knowingly have a relationship with an individual or affiliate, as defined in 42 C.F.R. § 438.610.

(b) **Transition period requirements.** A transition period begins upon notification by the OHCA of intent to terminate the contract, notice by the CE or DBM or OHCA of intent not to extend the contract for a subsequent extension period, or if the CE or DBM has no remaining extension periods.

317:55-5-13. Notification of material change

~~An MCO~~A CE 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~~plan.

317:55-5-14. Patient data

~~An MCO~~A CE or DBM will provide patient data to a provider upon request to the extent allowed under federal or ~~State~~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~~Financial standards and third-party liability

~~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.~~

(a) **Financial standards.** The CE or DBM shall comply with Oklahoma Insurance Department requirements for minimum net worth and risk- based capital in accordance with applicable Oklahoma Statutes found in Title 36 Insurance.

(b) **Insolvency protection.** In accordance with the requirements found at 42 C.F.R. §§ 438.106, 438.116, 36 O.S. § 6901, et seq., and all contractual requirements, the CE and DBM will provide satisfactory assurances to the OHCA to ensure that neither Enrollees nor the OHCA is held liable or responsible for any of the following:

(1) Any debts obtained by the CE or DBM;

(2) Covered services that are provided to the Enrollee for which the OHCA does not pay the CE or DBM; or

(3) Payment for covered services that are in excess of the amount that the Enrollee would owe the CE or DBM if those services were covered directly.

(c) **Medical loss ratio.** A CE or DBM will have a medical loss ratio that, at minimum, meets the standards provided by 42 C.F.R. §§ 438.8, 438.74, and applicable Contract. OHCA will monitor

compliance with this requirement. If CE or DBM are not compliant with submission of MLR reporting, OHCA will evaluate the CE's or DBM's status for penalties or termination. Monitoring procedures to ensure compliance with MLR reporting include review of timeliness and completeness of reporting requirement and audit of date contained within the report.

(d) **Third-party liability**. Medicaid should be the payer of last resort for all covered services pursuant to federal regulations including but not limited to 42 C.F.R. 433 Subpart D and 42 C.F.R. § 447.20. The OHCA will notify the CE and DBM for any known third-party resources identified or made available to OHCA at the time of an Applicant's or Eligible's eligibility determination or re-determination. The CE or DBM shall make every reasonable effort to:

(1) Determine the liability of third parties to pay for services rendered to Enrollees;

(2) Avoid costs which may be the responsibility of third parties;

(3) Reduce payments based on payments by a third-party for any part of a service;

(4) Recover any liability from responsible third-party sources, except for estate recovery and third-party subrogation which will remain OHCA's responsibility;

(5) Treat funds recovered from third parties as reductions to claims payments as required in the Contract; and

(6) Report all third-party liability collections as specified by the OHCA, the Contract, and reporting manual.

317:55-5-21. ~~Medical loss ratio~~Payment to CEs and DBMs

~~An MCO or DBM will have a medical loss ratio that, at minimum, meets the standards provided by 42 C.F.R. § 438.8.~~

(a) **Capitation rates.** In consideration for all services rendered by a CE or DBM under a contract with the OHCA, the CE and DBM will receive a monthly capitation payment for each Enrollee pursuant to 42 C.F.R. §§ 438.3(c), 438.4 and any other applicable state and/or federal regulation.

(b) **Capitation reconciliation.** The CE and DBM shall perform monthly reconciliation of enrollment roster data against capitation payments and notify discrepancies to the OHCA on schedule and as defined by the OHCA.

(c) **Denial of payment.** Capitation payments to the CE or DBM will be denied for new Enrollees when, and for so long as, payment for those Enrollees is denied by CMS under 42 C.F.R. § 438.730(e). CMS may deny payment to OHCA for new Enrollees if its determination is not contested timely by the CE. OHCA will define in writing to the CE the conditions for lifting the payment denials.

(d) **Recoupment for Medicare eligible Enrollees.** In the event an Enrollee becomes retroactively Medicare eligible, the CE or DBM shall recover claims payments made to providers during the months of retroactive Medicare eligibility. The CE or DBM shall also notify the provider of the requirement to submit the claim to Medicare for reimbursement. OHCA will recoup the capitation payments paid for months of retroactive Medicare eligibility.

317:55-5-22. ~~Value-based purchasing~~Payment to providers

~~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.~~

(a) **Provider payment.**

(1) The CE and DBM shall establish rates for participating providers are reasonable to cover access to services.

(2) The CE and DBM shall abide by state and federal requirements related to payment of specific provider types as described in the Contract.

(3) Pursuant to 56 O.S. § 4002.12, the OHCA shall establish minimum rates of reimbursement from CEs to providers who elect not to enter into a value-based payment arrangement or other alternative payment arrangements for health care services rendered to Enrollees.

(4) Applicable exceptions to OAC 317:55-5-22(3) can be found at 56 O.S. § 4002.12(I).

(b) **Non-participating provider payment.** If the CE or DBM is unable to provide covered services to an Enrollee within its network of participating providers, the CE or DBM must adequately and timely arrange for the provision and payment of these services by non-participating providers. Except as otherwise provided by law and/or specified for IHCPs, FQHCs, RHCs, and CCBHs, the CE or DBM will reimburse non-participating providers for covered services provided to Enrollees at a minimum of ninety percent (90%) of the current Medicaid fee schedule, unless the CE or DBM and the non-participating provider has agreed to a different reimbursement amount.

(c) **Value-based payments.** The CE and DBM shall implement value-based payment strategies and quality improvement initiatives to promote better care, better health outcomes, and lower spending for publicly funded health care services. OHCA will follow the withhold payment schedule and perform annual assessments to ensure CEs and DBMs are adhering to the VBP target requirements in accordance with the Contract. Pursuant to 42 C.F.R. § 438.10(f)(3), if the CE uses physician financial incentive plans, the Contractor must make available information about the incentive program. The CE shall also provide information about any physician incentive plans to OHCA prior to its initial use and prior to any subsequent revisions, and report information to OHCA as specified in the reporting manual. Any such incentive plans must comply with all applicable laws, including, without limitation 42 U.S.C. § 1395mm(i)(8) and 42 C.F.R § 417.479.

317:55-5-23. ~~Special contract provisions related to payment~~Timely claims filing and processing

~~(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.~~

(a) **Timely claims filing.** The CE or DBM shall adjudicate provider claims in accordance with timely filing limits specified in OAC 317:30-3-11.

(b) **Timely payment.** The CE or DBM shall meet timely claims payment standards specified in the Contract and 42 C.F.R § 447.45.

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~~CEs. The program will be fully described in the ~~managed care contract~~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~~CE 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~~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~~CE or DBM will process a clean claim within the time frame outlined in 36 O.S. § 1219.

(1) The ~~MCO~~CE 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~~CE 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~~CE 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~~CE or DBM will comply with the post payment audit process established by OHCA.

(2) The ~~MCO~~CE 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~~A CE 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~~Contract.

317:55-5-26. Prohibited payments

(a) **Overpayment.** The CE or DBM shall report overpayments to OHCA and promptly recover identified overpayments.

(b) **Suspension of payments.** The CE or DBM shall suspend payments to providers for which the state determines there is a credible allegation of fraud in accordance with the Contract and 42 C.F.R. § 455.23.

(c) **Providers ineligible for payment.** The CE or DBM shall ensure that no Medicaid funds are reimbursed to a provider whose payments are suspended or that has been terminated by the OHCA.
(d) **Provider-preventable conditions.** In accordance with 42 C.F.R. §§ 438.3(g), 434.6(a)(12)(i) and 447.26(b), the CE or DBM shall not make any payment to a provider for provider-preventable conditions as defined at 42 C.F.R. § 447.26(b). A list of provider-preventable conditions including health care-acquired conditions (HCACs) and other provider-preventable conditions (OPPCs) for which payment shall not be made can be found at OAC 317:30-3-62 and 30-3-63.

PART 7. THE ~~MANAGED CARE~~SOONERSELECT QUALITY ADVISORY COMMITTEE

317:55-5-30. ~~Managed care~~SoonerSelect quality advisory committee

(a) The Chief Executive Officer (CEO) of OHCA will establish and appoint members to the ~~MC~~Medicaid Delivery System 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~~recommendations 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~~plan, OHCA will create a quality scorecard, in accordance with 56 O.S. § 4002.11, that compares ~~MCOs~~CEs to one another and DBMs to one another.
(b) OHCA will provide the most recent quarterly scorecard for ~~initial enrollees~~first time Enrollees during choice counseling.
(c) OHCA will provide the most recent quarterly scorecard to all ~~enrollees~~Enrollees at the beginning of each open enrollment period.
(d) OHCA will publish each quarterly scorecard on its website.

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.~~

~~(c)~~(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 ~~35~~thirty five (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 3. GENERAL PROVIDER POLICIES

PART 3. GENERAL MEDICAL PROGRAM INFORMATION

317:30-3-57.1. ~~Clinical trials~~Coverage of routine services in relation to clinical trials

~~(a) **Definition.** A clinical trial is a federally funded study that is either being conducted under an Investigational New Drug (IND) application or is exempt from having an IND application and helps to prevent, detect, or treat cancer or a life-threatening illness, injury, or disease.~~

~~(b) **Medical necessity.** Clinical trials must be determined to be medically necessary for the individual affected member. Documentation in the member's plan of care should support the medical necessity of the clinical trial for the affected individual member and that the clinical trial is for the medical purposes only. Requests for clinical trials 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) 317:30-3-1(f) for policy on medical necessity.~~

~~(c) **Documentation/requirements.** 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). An OHCA approved clinical trial must include the following:~~

~~(1) The clinical trial does one (1) of the following for the treatment of cancer or a life-threatening illness, injury, or disease:~~

~~(A) Tests how to administer a health care service;~~

~~(B) Tests responses to a health care service;~~

~~(C) Compares effectiveness of a health care service; or~~

~~(D) Studies new uses of a health care service.~~

~~(2) The clinical trial is approved and funded by one (1) of the following:~~

~~(A) Research facilities that have an established peer review program that has been approved by the National Institutes of Health Center (NIH);~~

~~(B) The Centers for Disease Control and Prevention;~~

~~(C) The Agency for Health Care Research and Quality (AHRQ);~~

~~(D) The Centers for Medicare and Medicaid Services (CMS);~~

~~(E) The United State Department of Veterans Affairs (VA);~~

~~(F) The United States Department of Defense (DOD);~~

~~(G) The Food and Drug Administration;~~

~~(H) The United States Department of Energy; or~~

~~(I) Research entities that meet the eligibility criteria for a support grant from a NIH center.~~

~~(3) Is conducted in a facility where the personnel have training and expertise needed to provide the type of care required and there is written protocol for the approved clinical trial;~~

~~(4) Complies with appropriate federal regulations regarding the protection of human subjects; and~~

~~(5) For full guidelines, please refer to www.okhca.org/mau.~~

~~(d) **Routine care costs.**~~

~~(1) The following are included in routine care costs for approved clinical trials and by a SoonerCare contracted provider:~~

~~(A) Costs that are required for the administration of the investigational item or service and are not a covered benefit of the clinical trial;~~

~~(B) Costs regarding the appropriate monitoring of the effects from the item or service; and~~

~~(C) Costs that are necessary for the prevention, diagnosis or treatment of medical complications for a non-covered item or service that was provided in the clinical trial.~~

~~(2) The following are excluded from routine care costs in approved clinical trials:~~

~~(A) The investigational item or service;~~

~~(B) Items or services that the study gives for free;~~

~~(C) Items or services that are only utilized when determining if the individual is eligible for the clinical trial;~~

~~(D) Items or services that are used only for data collection or analysis;~~

~~(E) Evaluations that are designed to only test toxicity or disease pathology;~~

~~(F) Experimental, investigational, and unproven treatments or procedures and all related services provided outside of an approved clinical trial; and~~

~~(G) Any non-FDA approved drugs that were provided or made available to the member during the approved clinical trial will not be covered after the trial ends.~~

~~(3) Applicable plan limitations for coverage for out-of-network and out-of-state providers will apply to routine care costs in an approved clinical trial.~~

~~(4) Applicable utilization management guidelines will apply to routine care costs in an approval clinical trial.~~

~~(e) **Experimental and investigational.** SoonerCare does not cover for medical, surgical, or other health care procedures, which are considered experimental or investigational in nature.~~

(a) **Coverage.** The Oklahoma Health Care Authority (OHCA) will cover routine patient costs provided under a qualifying clinical trial to an eligible member. The OHCA does not:

(1) Determine eligibility for participation in any research study; or

(2) Reimburse for any costs associated in the research study, other than for routine patient costs for clinical studies, as defined in this Section and in the Oklahoma Medicaid State Plan.

(b) **Qualifying clinical trials criteria.**

(1) Clinical trial, as adopted from the National Institute of Health (NIH) definition, means a research study in which one (1) or more human subjects are prospectively assigned to one (1) or more interventions, which may include placebo or other control, to evaluate the effects of those interventions on health-related biomedical or behavioral outcomes.

(2) Pursuant to Section 1905(a)(30) and 1905(gg) of the Act, as amended and added by Division CC, Title II, Section 210 of the Consolidated Appropriations Act, 2021 (Public Law 116-260, Section 210), qualifying clinical trial means a clinical trial, in any clinical phase of development, that is conducted in relation to the prevention, detection, or treatment of any serious or life-threatening disease or condition and is described in any of the following clauses:

(A) The clinical trial is approved, conducted, or supported (which may include funding through in-kind contributions) by one (1) or more of the following:

(i) The National Institutes of Health (NIH);

(ii) The Centers for Disease Control and Prevention (CDC);

(iii) The Agency for Healthcare Research and Quality (AHRC);

(iv) The Centers for Medicare and Medicaid Services (CMS);

(v) A cooperative group or center of any of the entities described above or of the Department of Defense or the Department of Veteran Affairs;

(vi) A qualified non-governmental research entity identified in guidelines issued by the National Institutes of Health for center support grants, including guidelines issued after the date of these rules; or

(vii) Any of the following if the clinical trial has been reviewed and approved through a system of peer review that the Secretary determines to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health and assures unbiased review of the highest scientific standards by qualified individuals with no interest in the outcome of the review:

(I) The Department of Veterans Affairs;

(II) The Department of Defense; or

(III) The Department of Energy.

(B) The clinical trial is conducted pursuant to an investigational new drug exemption under section 505(i) of the Federal Food, Drug, and Cosmetic Act or an exemption for a biological product undergoing investigation under section 351(a)(3) of the Public Health Service Act.

(C) The clinical trial is a drug trial that is exempt from being required to have an investigational new drug exemption or an exemption for a biological product undergoing investigation.

(3) Serious disease or condition, as adopted from 21 C.F.R. § 312.300, means a disease or condition associated with morbidity that has substantial impact on day-to-day functioning. Short-lived and self-limiting morbidity will usually not be sufficient, but the morbidity need not be irreversible, provided it is persistent or recurrent. Whether a disease or condition is serious is a matter of clinical judgment, based on its impact on such factors as survival, day-to-day functioning, or the likelihood that the disease, if left untreated, will progress from a less severe condition to a more serious one.

(4) Life-threatening disease or condition, as adopted from 21 C.F.R. § 312.300, means a stage of disease in which there is reasonable likelihood that death will occur within a matter of months or in which premature death is likely without early treatment.

(c) **Clinical trials determination standards.** Pursuant to Section 1905(a)(30) and 1905(gg) of the Act, as amended and added by Division CC, Title II, Section 210 of the Consolidated Appropriations Act, 2021 (Public Law 116-260, Section 210, the OHCA will expedite and complete a coverage determination for routine services under this Section within seventy-two (72) hours of receiving the required attestation as described below. The OHCA will maintain the following standards in any coverage determination under this section:

(1) **Attestation.** The health care provider and principal investigator for the qualifying clinical trial must submit a standardized form attestation to the OHCA regarding the appropriateness of the qualifying clinical trial for the individual member.

(2) **Expedited determination.** Upon receiving the completed required attestation, the OHCA will expedite and complete a coverage determination under this Section within seventy-two (72) hours. All documentation submitted to request services must demonstrate, through adequate objective medical records, evidence sufficient to meet at least one (1) definition in subsection (b)(3)-(4) above for the terms "serious disease or condition" or "life-threatening disease or condition".

(3) **Geographic and network allowance.** The OHCA will determine coverage under this Section without limitation on the geographic location or network affiliation of the health care provider treating the individual member or the principal investigator of the qualifying clinical trial.

(4) **Protocols and proprietary documentation.** The OHCA will determine coverage under this Section without requiring the submission of the protocols of the qualifying clinical trial or any other documentation that may be proprietary or determined by the Secretary to be burdensome to provide.

(5) **Documentation of serious or life-threatening disease or condition.** In determining coverage under this Section, the OHCA will consider existing or newly offered documentation that the individual member has been diagnosed with or is suffering from one (1) or more serious or life-threatening diseases or conditions that are the subject of the qualifying clinical trial as shown in the attestation.

(d) **Routine patient costs.**

(1) **Included items and services.** Routine patient costs include any item or service provided to Medicaid-eligible members under the qualifying clinical trial, including:

(A) Any item or service provided to prevent, diagnose, monitor, or treat complications resulting from participation in the qualifying clinical trial, to the extent that the provision of such items or services to the member would otherwise be covered outside the course of participation in the qualifying clinical trial under the Oklahoma Medicaid State Plan or waiver, including a demonstration project under section 1115 of the Act; and

(B) Any item or service required solely for the provision of the investigational item or services that is the subject of the qualifying clinical trial, including the administration of the investigational item or service.

(2) **Excluded items and services.** The following items and services are excluded from routine patient costs in qualifying clinical trials:

(A) Any investigational item or service that is:

(i) The subject of the qualifying clinical trial; and

(ii) Not otherwise covered outside of the clinical trial under the Oklahoma Medicaid State Plan or waiver, including a demonstration project under section 1115 of the Act; and

(B) Any item or service that is:

(i) Provided to the member solely to satisfy data collection and analysis for the qualifying clinical trial and is not used in the direct clinical management of the member; and

(ii) Not otherwise covered under the Oklahoma Medicaid State Plan or waiver, including a demonstration project under section 1115 of the Act.

PART 6. OUT-OF-STATE SERVICES

317:30-3-90. Out-of-state services

(a) Consistent with Section 431.52 of Title 42 of the Code of Federal Regulations (C.F.R.), an eligible SoonerCare member who is a resident of Oklahoma but who is temporarily out of state, may receive services from an out-of-state provider to the same extent that he or she would receive such services in Oklahoma, if:

(1) Medical services are needed for a medical emergency, as determined by the attending physician or other provider (M.D., D.O., P.A., or A.P.R.N), or a dentist [Doctor of Dental Surgery (DDS), or Doctor of Medicine in Dentistry (DMD)]. For any provider, who is not contracted at the time the services are provided, documentation as requested from the Oklahoma Health Care Authority (OHCA) of the emergency must be submitted, including, but not limited to, emergency room reports, medical histories, discharge summaries, and all other relevant medical reports.

(2) Medical services are needed and the member's health would be endangered if he or she were required to return to Oklahoma for medical care and treatment, as determined by the attending physician or other provider (M.D., D.O., P.A., or A.P.R.N), or a dentist [Doctor of Dental Surgery (DDS), or Doctor of Medicine in Dentistry (DMD)]. For any provider, who is not contracted at the time the services are provided, documentation of the nature and possible extent of the endangerment must be submitted as requested from the OHCA.

(3) The Oklahoma Health Care Authority's (OHCA) Chief Medical Officer (CMO), or his or her designee, determines, on the basis of medical advice, that the needed medical services, or necessary supplemental resources, are more readily available in the state where the member is located at the time of needing medical treatment. Prior authorization must be obtained from the OHCA's CMO, or his or her designee, before the services are rendered~~; or~~.

~~(4) The customary or general practice for members residing in a particular locality within Oklahoma is to use medical resources in another state, and the member is using a provider that is contracted with the OHCA.~~

(b) Per 42 C.F.R. § 431.52, if it is the customary or general practice for SoonerCare members who are residing in a particular locality within Oklahoma to use medical or dental resources in another state, reimbursement is available for services furnished in another State to the same extent that reimbursement for services is furnished within Oklahoma boundaries. The services being rendered must be provided by a provider who is contracted with the OHCA and must be appropriately licensed and in good standing with the state in which they practice.

~~(A)~~(1) Except for out-of-state inpatient psychiatric services, no prior authorization is necessary for services provided in accordance with paragraph ~~(a)~~(4)(b), above, if the member obtains them from an out-of-state provider that is:

~~(i)~~(A) Located in a border state (Arkansas, Colorado, Kansas, Missouri, New Mexico, or Texas) within fifty (50) miles of the Oklahoma border, with exceptions for dental services. The OHCA will allow the member to travel up to one hundred (100) miles of the Oklahoma border to receive dental services; and

~~(ii) Contracted with the OHCA;~~

~~(iii)~~(B) Provided, however, that nothing in this paragraph shall be interpreted to eliminate or otherwise affect a prior authorization requirement established by any other OHCA rule, including, but not limited to, Oklahoma Administrative Code (OAC) 317:30-3-31, that would have to be met if the health care-related good and/or service were provided in Oklahoma.

~~(B)~~(2) In all other instances, prior authorization must be obtained from the OHCA's CMO, or his or her designee, before the services are rendered.

(c) Clinical trials, either in-state or out-of-state, will need to adhere to any federal regulations which provides for certain exceptions to OHCA's out-of-state policy. For the full clinical trials policy, please refer to OAC 317:30-3-57.1.

~~(b)~~(d) Except as provided in subsections (a)(1),(a)(2) ~~and (a)(4)(A),~~(b)(1) and (c), above, SoonerCare will not pay for any services furnished by an out-of-state provider unless prior authorization has been obtained from the OHCA's CMO, or his or her designee, before the services are rendered. Prior authorization for out of state services must be obtained in all instances in which the member is located in Oklahoma at the time the services are determined to be medically necessary.

(1) As part of this authorization process, the following documents must be submitted to the OHCA's CMO, or his or her designee:

(A) Documents sufficient to establish the "medical necessity" of the services requested, as that term is defined by OAC 317:30-3-1(f). See also OAC 317:30-3-31, Prior authorization for health care-related goods and services. Examples of such documents may include, but are not limited to, Histories of Present Illnesses (HPIs), physical exams, laboratory reports, imaging reports, progress notes, hospital charts, and/or other relevant medical records; and

(B) Documents sufficient to establish that the health care needs of the member cannot be met in Oklahoma. Such documents shall include, but not be limited to, a letter from the referring provider that contains:

(i) A clear presentation of the member's medical condition and diagnosis for which out-of-state treatment is requested, including a summary of treatment to date that is supported by the documents in paragraph ~~(b)~~(c)(1)(A), above;

(ii) Names of physicians and/or facilities in Oklahoma that the member has previously been referred to for diagnosis and/or treatment;

(iii) Physicians consulted by the attending physician relative to diagnosis and/or availability of recommended treatment in Oklahoma;

(iv) Recommended treatment or further diagnostic work; and

(v) Reasons why medical care cannot be provided in Oklahoma or the next closest location outside Oklahoma.

(C) Except for emergency medical, behavioral health cases, and as provided in subsections (a)(1),(a)(2) and (b)(1), above, prior authorization requests for out-of-state services must be made in writing with all the necessary documents that show medical necessity and details of the services provided, including but not limited to, relevant medical history, description of services and procedures to be performed, Histories of Present Illnesses (HPIs), physical exams, laboratory reports, imaging reports, and received by the OHCA at least ten (10) calendar days prior to the date services are to be provided in another state or at the discretion of the CMO or his/her designee.

(i) Emergency medical, ~~or~~ behavioral health, and dental cases must be identified as such by the physician or provider in the prior authorization request.

(ii) Any telephone request for prior authorization of out-of-state services will only be accepted in emergency situations, and must be promptly followed by a written request.

(2) Prior authorization requirements for medically necessary lodging, transportation, and/or meals assistance associated with out-of-state services are established in other OHCA rules, including, but not limited to, OAC 317:30-3-92 and 317:30-5-327.1. In accordance with federal regulations, exceptions to prior authorization requirements will be made for members who are participating in a clinical trial that require out-of-state medically necessary services. For the full clinical trials policy, please refer to OAC 317:30-3-57.1.

~~(c)~~(e) The ~~restrictions~~limitations established in subsections (a) through ~~(b)~~(c), above, shall not apply to children who reside outside of Oklahoma and for whom the Oklahoma ~~Department of~~ Human Services (OKDHS) makes Title IV-E adoption assistance payments or Title IV-E foster care maintenance payments.

~~(d)~~(f) Denials of requests for prior authorization may be appealed in accordance with OAC 317:2-1-2(d)(1)(C).

~~(e)~~(g) Out-of-state providers shall, upon request by authorized OHCA representatives, make available fiscal and medical records as required by applicable federal regulations, OHCA rules, and the Provider Agreement. Such records shall be made available for review by authorized OHCA representatives at the OHCA's address in Oklahoma City, Oklahoma.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 33. TRANSPORTATION BY AMBULANCE

317:30-5-345. Ambulance Service Provider Access Payment Program (ASPAPP)

(a) **Purpose.** The Ambulance Service Provider Access Payment Program (ASPAPP) is an ambulance service provider (ASP) assessment fee that is eligible for federal matching funds when used to reimburse SoonerCare services in accordance with Section 3242.1 through 3242.6 of Title 63 of the Oklahoma Statutes (O.S.).

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

(1) **"Air ambulance"** means ambulance services provided by fixed or rotor wing ambulance services.

(2) **"Alliance"** means the Oklahoma Ambulance Alliance or its successor association.

(3) **"Ambulance"** means a motor vehicle that is primarily used or designated as available to provide transportation and basic life support or advanced life support.

(4) **"Ambulance service"** or **"ambulance service provider (ASP)"** means any private firm or governmental agency licensed by the Oklahoma State Department of Health (OSDH) to provide levels of medical care based on certification rules or standards promulgated by the state Commissioner of Health.

(5) **"Emergency"** or **"emergent"** means a serious situation or occurrence that happens unexpectedly and demands immediate action, such as a medical condition 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.

(6) **"Emergency transport"** means the movement of an acutely ill or injured patient from the scene to a health care facility or the movement of an acutely ill or injured patient from one health care facility to another health care facility.

(7) **"Medicaid"** means the medical assistance program established in Title XIX of the Social Security Act and administered in Oklahoma by the Oklahoma Health Care Authority (OHCA).

(8) **"Net operating revenue"** means the gross revenues earned for providing emergency transports in Oklahoma excluding revenues earned for providing air ambulance services, non-emergency transports, and amounts refunded to or recouped, offset, or otherwise deducted by a patient or payer for ground medical transportation.

(9) **"Non-emergency transport"** as defined in Oklahoma Administrative Code (OAC) 317:30-5-335.1, means the movement of any patient in an ambulance other than an emergency transport.

(10) **"Upper payment limit"** means the lesser of the customary charges of the ASP or the prevailing charges in the locality of the ASP for comparable services under comparable circumstances, calculated according to methodology in an approved state plan amendment for the state Medicaid program.

(11) **"Upper payment limit gap"** means the difference between the upper payment limit of the ASP and the Medicaid payments not financed using the ASP assessments made to all ASPs, provided that the upper payment limit gap shall not include air ambulance services.

(c) **ASPAPP exemptions.**

(1) Pursuant to 63 O.S. §§ 3242.1 through 3242.6 the OHCA is mandated to assess ASPs licensed in Oklahoma, unless exempted under (c) (2) of this Section, an ASP access payment program fee.

(2) The following ASPs are exempt from the ASPAPP fee:

(A) Owned or operated by the state or a state agency, the federal government, a federally recognized Indian tribe, or the Indian Health Service.

(B) Eligible for Supplemental Hospital Offset Payment Program (SHOPP) Medicaid reimbursement;

(C) Provides air ambulance services only; or

(D) Provides non-emergency transports only.

(d) **The ASPAPP assessment.**

(1) The ASPAPP assessment is imposed on each ambulance service provider, except those exempted under (c)(2) of this Section, for each calendar year in an amount calculated as a percentage of each ambulance service provider's net operating revenue.

(2) The assessment rate shall be determined annually based upon the percentage of net operating revenue needed to generate an amount up to the non-federal portion of the upper payment limit gap, plus the annual fee paid to OHCA for administrative expenses incurred in performing the activities, not to exceed $200,000 each year, plus the state share of ASP access payments for ASPs that participate in the assessment. At no time will the assessment rate exceed the maximum rate allowed by federal law or regulation.

(3) OHCA will review and determine the amount of annual assessment in December of each year in consultation with the Oklahoma Ambulance Alliance.

(4) The annual assessment is due and payable quarterly. However, a payment of the assessment will not be due and payable until:

(A) OHCA issues written notice stating that the payment methodologies to the ASPs under 63 O.S. §§ 3242.1 through 3242.6 have been approved by the Centers for Medicare and Medicaid Services (CMS) and the waiver under 42. C.F.R. § 433.68 for the assessment, if necessary, has been granted by CMS.

(B) OHCA has made all quarterly installments of the ASP access payments that were otherwise due, consistent with the effective date of the approved state plan.

(5) The method of collection of net operating revenue is as follows:

(A) Annually, no later than January 31, OHCA will send all licensed ASPs the net operating revenue form. ASPs shall complete the forms and deliver them to OHCA or its contractor no later than March 31 of that year. ASPs that fail to return the net operating revenue form will have their assessment calculated based on the state per capita average assessment for that year. OHCA will send a notice of assessment to each ASP informing the provider of the assessment rate and the estimated annual amount owed by the ASP for the applicable calendar year.

(B) The first notice of assessment will be sent within forty-five (45) days of receipt by OHCA of notice from the Centers for Medicare and Medicaid Services that the payments under 63 O.S. §§ 3242.1 through 3242.6, and if necessary, the waiver granted under 42 C.F.R. § 433.68 have been approved.

(C) Annual notices of assessment will be sent at least forty-five (45) days before the due date for the first quarterly assessment payment of each calendar year. The ASP shall have thirty (30) days from the date of its receipt of a notice of assessment to review and verify the assessment rate and the estimated assessment amount.

(D) If an ASP operates, conducts, or maintains more than one (1) ASP in the state, the

ASP will pay the assessment for each ASP separately. However, if the ASP operates more than one (1) ASP under one (1) Medicaid provider number, the ASP provider may pay the assessment for all such ASPs in the aggregate.

(6) The method of collection of the assessment fee is as follows:

(A) After the initial installment has been paid, each subsequent quarterly payment of an assessment will be due and payable by the 15th day on the first month of the applicable quarter (i.e., January 15th, April 15th, etc.).

(B) Failure to pay the amount by the 15th or failure to have the payment mailing postmarked by the 13th will result in a debt to the State of Oklahoma and is subject to penalties of five percent (5%) of the amount and interest of one and one-quarter percent (1.25%) per month.

(e) **Penalties and adjustments**

(1) If an ASP fails to timely pay the full amount of a quarterly assessment, OHCA will add to the assessment:

(A) A penalty equal to five percent (5%) of the quarterly amount not paid on or before the due date, and

(B) An additional five percent (5%) penalty on any unpaid quarterly and unpaid penalty amounts on the last day of each quarter after the due date until the assessed amount and the penalty imposed under subpart (A) of this paragraph are paid in full.

(2) The quarterly assessment including applicable penalties and interest must be paid regardless of any appeals action requested by the facility. If an ASP fails to pay the OHCA the assessment within the timeframes noted on the invoice to the provider, the assessment, applicable penalty, and interest will be deducted from the ASP's payment.

(3) Any change in payment amount resulting from an appeals decision will be adjusted in future payments.

(4) If Medicaid reimbursement rates are adjusted, ASP rates may not be adjusted less favorably than the average percentage-rate reduction or increase applicable to the majority of other provider groups.

(f) **Closure, merger, and new Ambulance Service Providers (ASPs).**

(1) If an ASP ceases to operate as an ASP for any reason or 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 ASP is subject to the assessment and the denominator of which is three hundred sixty-five (365). Within thirty (30) days of ceasing to operate as an ASP, or otherwise ceasing to be subject to the assessment, the ASP will pay the assessment for the year as so adjusted, to the extent not previously paid.

(2) The ASP also shall receive payments under 63 O.S. §§ 3242.1 through 3242.6, for the calendar year in which the cessation occurs, which will be adjusted by the same fraction as its annual assessment.

(3) For new ASPs, the OHCA will calculate revenue to be assessed based on the population of the county for which the ASP is licensed. The per capita amount will be assigned and calculated based on the average net operating revenue per capita for all other ASPs in the state that are currently being assessed. Average revenue per capita will be used in this way through the end of the second calendar year.

(4) Any assessment paid by a provider on revenue subject to another health care related tax as defined in 42 CFR § 433.68 shall be a credit against any assessment due under these rules.

(g) **Disbursement of payment to ASPs.**

(1) To preserve and improve access to ambulance services, for ambulance services rendered

on or after the approval of the ASPAPP by CMS, OHCA shall make ASP payments as set forth in this section. These payments are considered supplemental payments and do not replace any currently authorized Medicaid payments for ambulance services.

(2) OHCA shall pay all quarterly ASP access payments within ten (10) calendar days of the due date for the quarterly assessment payments established in subsection (d) of this section.

(3) OHCA shall calculate the ASP access payment amount as the balance of the ASPAPP Fund plus any federal matching funds earned on the balance up to but not to exceed the upper payment limit gap for all ASPs.

(4) All ASPs shall be eligible for ASP access payments each year as set forth in this subsection except ambulance services excluded or exempted in subsection (c)(2) of this section.

(5) Access payments shall be made on a quarterly basis.

(6) ASPs eligible to receive ASP access payments are those providers:

(A) Subject to this assessment; and

(B) That apply to receive the ASP access payment as provided in Section 317:30-5-345.

(7) An application by the ASP shall be submitted to OHCA to be eligible to receive payments.

(A) Not less than one-hundred eighty (180) days prior to the beginning of each state fiscal year, OHCA will send all qualified licensed ASPs an application for ASP access payments.

(B) The application will:

(i) Allow the ASP to submit all information needed to calculate that ASP's average commercial rate;

(ii) Provide that the application must be received by OHCA on a date which will be no less than one- hundred twenty (120) days prior to the beginning of the calendar year;

(iii) Explain that unless exempt from payment by law, the ASP will be required to pay the ASP assessment even if the provider fails to apply for the ASP access payments;

(iv) Explain that if the ASP fails to supply the Net Operating Revenue Survey, the assessment will be calculated based on the state per capita average assessment for that year; and

(v) Explain that the ASP will not be eligible to receive ASP access payments in the next calendar year if the application is not timely filed but will still be assessed based on the average assessment.

(C) An ASP that has previously received ASP access payments is required to make an application for such payments and provide the revenue survey no less than every three (3) years.

(8) The Average Commercial Rate will be calculated as follows:

(A) The ASP access payment shall be determined in a manner to bring the payments for these services up to the average commercial rate level as described in Section 317:30-5-345. The average commercial rate level is defined as the average amount payable by the commercial payers for the same service.

(B) OHCA shall align the paid Medicaid claims with the Medicare fees for each healthcare common procedure coding system (HCPCS) or current procedure terminology (CPT) code for the ASP and calculate the Medicare payment for those claims.

(C) OHCA shall calculate an overall Medicare to commercial conversion factor for each qualifying ASP that submits an ASP access payment application by dividing the total amount of the average commercial payments for the claims by the total Medicare payments for the claims.

(D) The commercial to Medicare ratio for each provider will be redetermined every three (3) years.

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TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
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SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

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

317:30-5-1094. Behavioral health services provided at I/T/Us

(a) **Inpatient behavioral health.** Services are covered when provided in accordance with a documented individualized service plan developed to treat the identified behavioral health needs. ~~Inpatient psychiatric service providers must meet the requirements and applicable limitations, restrictions, or prior authorization requirements set forth in Oklahoma Administrative Code (OAC) 317:30-5-95 through 317:30-5-97.~~

~~(1) The provision of inpatient psychiatric services by Indian Health Services (IHS) facilities are reimbursed at the OMB inpatient encounter rate. Inpatient psychiatric services provided by non-IHS facilities are reimbursed at the established per diem or DRG rate.~~

~~(2) For the provision of residential substance use disorder (SUD) treatment services, I/T/U facilities must be contracted as residential SUD service providers and meet the requirements found at OAC 317:30-5-95.43 through 317:30-5-95.49. Residential SUD treatment services will be reimbursed at the OMB outpatient encounter rate.~~

(1) Inpatient psychiatric service providers must meet the requirements and applicable limitations, restrictions, or prior authorization requirements set forth in Oklahoma Administrative Code (OAC) 317:30-5-95 through 317:30-5-97.

(2) The provision of inpatient psychiatric services by Indian Health Services (IHS) facilities are reimbursed at the OMB inpatient encounter rate. Inpatient psychiatric services provided by non-IHS facilities are reimbursed at the established per diem or DRG rate.

(b) **Outpatient behavioral health**. Services are covered when provided in accordance with a documented individualized service plan developed to treat the identified mental health needs and/or SUD. Outpatient behavioral health services are reimbursed at the I/T/U outpatient encounter rate unless otherwise noted in the section.

(1) A full description of services may be found at OAC 317:30-5-241 and 317:30-5-241.5(d), 317:30-5-241.7. Services may include, but are not limited to:

(A) Mental health and/or substance use assessment/evaluation and testing;
(B) Service plan development;
(C) Crisis intervention services;
(D) Medication training and support;
(F) Individual/interactive psychotherapy;
(G) Group psychotherapy;
(H) Family psychotherapy;
(I) Medication-assisted treatment (MAT) services and/or medication; and
(J) Peer recovery support specialist (PRSS) services.

(2) In order to support access to behavioral health services, these services may be provided in settings outside of the I/T/U. Offsite services must take place in a confidential setting.

(3) For the provision of behavioral health related case management services, I/T/U facilities must be fully contracted with the Oklahoma Health Care Authority (OHCA) as an outpatient behavioral health agency. The provision of these services is considered to be outside of the

I/T/U encounter and will be paid at the current FFS rate. Contracted behavioral health case management providers must comply with the requirements found at OAC 317:30-5-241.6 and are responsible for obtaining all necessary prior authorizations, if needed.

(4) For the provision of psychosocial rehabilitation services, I/T/U facilities must be fully contracted with the OHCA as an outpatient behavioral health agency. The provision of these services is considered to be outside of the I/T/U encounter and will be paid at the current FFS rate. Contracted psychosocial rehabilitation service providers must comply with the requirements found at OAC 317:30-5-241.3 and are responsible for obtaining all necessary prior authorizations, if needed.

(5) Services provided by behavioral health practitioners, such as, licensed clinical social workers (LCSW), licensed marital and family therapists (LMFT), licensed professional counselors (LPC), licensed behavioral health practitioners (LBHP), licensed alcohol and drug counselors (LADC), and licensure candidates are not eligible for direct reimbursement as practitioners. Services provided by the aforementioned practitioners are compensable only when billed by their OHCA-contracted employer and when provided in those clinical settings in which they are currently approved to render services. Licensure candidates must meet the requirements contained in OAC 317:30-5-240.3.

(6) Behavioral health services must be billed on an appropriate claim form using the appropriate procedure code and guidelines. The time indicated on the claim form must be the time actually spent with the member.

(c) **Residential substance use disorder (SUD).** For the provision of residential SUD treatment services, I/T/U facilities must be contracted as SoonerCare providers and meet the requirements found at OAC 317:30-5-95.43 through 317:30-5-95.49. Residential SUD treatment services will be reimbursed at the OMB outpatient encounter rate.

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CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 58. ~~NON-HOSPITAL BASED~~ HOSPICE

317:30-5-530. Eligible providers

~~Non-Hospital Affiliated Hospice entities must be appropriately licensed and have a contract with the Oklahoma Health Care Authority to provide Hospice services.~~

(a) Providers of hospice services will meet applicable state and federal licensing requirements and meet Medicare certification requirements to provide hospice services.

(b) Providers of hospice services will enter into a contractual agreement with the State Medicaid Agency, Oklahoma Health Care Authority (OHCA).

317:30-5-531. Coverage for adults

~~There is no coverage for hospice services provided Medicaid eligible adults except for the hospice provision provided through the ADvantage Waiver.~~

(a) **Definition.** Hospice care is a comprehensive, holistic program of palliative and/or comfort care and support provided to the member and his/her family when a physician certifies that the member has a terminal illness and has a life expectancy of six (6) months or less.

(1) 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.

(2) Hospice care is performed under the direction of a physician as per the member's plan of care in an approved hospital hospice facility, in-home hospice program, or nursing facility.

(b) **Eligibility.** Coverage for hospice services is provided to Medicaid eligible expansion adults only.

(1) Expansion adults defined by 42 Code of Federal Regulations § 435.119 who are age nineteen (19) or older and under sixty-five (65), at or below one hundred thirty-three percent (133%) of the federal poverty level (FPL), and who are not categorically related to the aged, blind, or disabled eligibility group are eligible for hospice services.

(2) Hospice care eligibility requires physician certification that the member is terminally ill and includes a medical prognosis with a life expectancy of six (6) months or less if the illness runs its normal course. The terminal prognosis also must be supported by clinical documentation in the medical record.

(3) For information regarding hospice provision provided through waivers, refer to Oklahoma Administrative Code (OAC) 317:30-5-763, 317:30-5-1200, and 317:30-5-1202.

(c) **Covered services.** Hospice care services can include but are not limited to:

(1) Nursing care;

(2) Physician services (e.g., physicians employed or working under arrangements made with the hospice);

(3) Medical equipment and supplies;

(4) Drugs for symptom control and pain relief;

(5) Home health aide services;

(6) Personal care services;

(7) Physical, occupational and/or speech therapy;

(8) Medical social services;

(9) Dietary counseling; and

(10) Grief and bereavement counseling to the member and/or family are required but are not reimbursable.

(d) **Prior authorization.** All services must be prior authorized, and a written plan of care must be established before services are rendered. For medical review purposes, all hospice services will be authenticated in accordance with OAC 317:30-3-30.

(e) **Service election.**

(1) The member or member's legal guardian or authorized representative must sign an election statement, choosing hospice care instead of routine medical care with the objective to treat and cure the member's terminal illness, and by doing so waives his or her right to other Medicaid benefits, except for care not related to the terminal illness and care provided by the attending physician.

(2) Once the member, legal guardian, or member's authorized representative has elected hospice care, the hospice medical team assumes responsibility for the member's medical care for the terminal illness.

(f) **Service revocation.**

(1) Hospice care services may be revoked by the member, legal guardian, or authorized representative at any time.

(2) Upon revoking the election of Medicaid coverage of hospice care for a particular election period, the member resumes Medicaid coverage of the benefits waived when hospice care was elected.

(3) The member may at any time elect to receive hospice coverage for any other hospice election periods for which he or she is eligible.

(g) **Service frequency.** Hospice care services:

(1) Are available for an initial two (2) ninety-day (90-day) certification periods. After the two (2) initial ninety-day (90-day) periods, a member is allowed an unlimited number of sixty-day (60-day) certification periods during the remainder of the member's lifetime. Each certification period requires a new prior authorization.

(2) Require a hospice physician or nurse practitioner to have a face-to-face encounter with the member to determine if the member's terminal illness necessitates continuing hospice care services. The encounter should take place prior to the one hundred eightieth (180^{th}) day recertification and each subsequent recertification thereafter; and attest that such visit took place.

(h) **Documentation.** Initial documentation requirements for requesting services, documentation requirements for continuation of services, and the full hospice guidelines can be found at OHCA's website, https://oklahoma.gov/ohca.

(i) **Reimbursement.**

(1) SoonerCare shall provide hospice care reimbursement:

(A) For each day that an individual is under the care of a hospice, the hospice will be reimbursed an amount applicable to the level, type and intensity of the services furnished to the individual for that day in accordance with the Oklahoma Medicaid State Plan.

(B) For independent physician direct services in accordance with the Oklahoma Medicaid State Plan.

(2) Through the Oklahoma Medicaid State Plan, the OHCA established payment amounts for the following categories:

(A) **Routine hospice care.** Member is at home and not receiving hospice continuous care.

(B) **Continuous home care.** Member is not in an inpatient facility and receives hospice on a continuous basis at home; primarily consisting of nursing care to achieve palliation and

management of acute medical symptoms during a brief period of crisis only as necessary to maintain the terminally ill patient at home. If less skilled care is needed on a continuous basis to enable the person to remain at home, this is covered as routine hospice care.

(C) **Inpatient respite care.** Member receives care in an approved inpatient facility on a short-term basis for respite.

(D) **General inpatient care.** Member receives general inpatient care in an inpatient facility for pain control or acute or chronic symptom management that cannot be managed at home.

(E) **Nursing facility (NF)/intermediate care facilities for individuals with intellectual disabilities (ICF/IID) care**. Member receives hospice care in a NF or ICF/IID. Hospice nursing facility or ICF/IID room and board per diem rates are reimbursed to the in-home hospice provider at a rate equal to 95% of the skilled nursing facility rate. The hospice provider is responsible for passing the room and board payment through to the NF or ICF/IID. If Medicare is the primary payer of hospice benefits, OHCA will only reimburse the hospice provider for coinsurance and deductible amounts per the Oklahoma Medicaid State Plan and will continue to pay the room and board to the nursing facility.

(F) **Service intensity add-on**. Member receives care by a registered nurse (RN) or social worker when provided in the last seven (7) days of his/her life.

(G) **Other general reimbursement items.**

(i) **Date of discharge**. For the day of discharge from an inpatient unit, the appropriate home care rate is to be paid unless the patient dies as an inpatient. When the patient is discharged as deceased, the inpatient rate, either general or respite, is to be paid for the discharge date.

(ii) **Inpatient day cap**. Payments to a hospice for inpatient care must be limited according to the number of days of inpatient care furnished to Medicaid patients. During the twelve-month (12-month) period beginning October 1 of each year and ending September 30, the aggregate number of inpatient days (both for general inpatient care and inpatient respite care) may not exceed twenty percent (20%) of the aggregate total number of days of hospice care provided to all Medicaid recipients during that same period. This limitation is applied once each year, at the end of the hospices' cap period.

(iii) **Obligation of continuing care**. After the member's Medicare hospice benefit expires, the patient's Medicaid hospice benefits do not expire. The hospice must continue to provide the recipient's care until the patient expires or until the member revokes the election of hospice care.

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

317:30-5-1096. Off-site services

I/T/U covered services provided off-site or outside of the I/T/U setting, including but not limited to hospice services, mobile clinics, or places of residence, are compensable at the OMB rate when billed by an I/T/U that has been designated as a Federally Qualified Health Center. The I/T/U must meet provider participation requirements listed in OAC 317:30-5-1088. I/T/U off-site services may be covered if the services rendered were within the provider's scope of practice and are of the same integrity of services rendered at the I/T/U facility.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 9. LONG-TERM CARE FACILITIES

317:30-5-136.1. Pay-for-Performance (PFP) program

(a) **Purpose.** The PFP program was established through Oklahoma State Statute, Title 56, Section 56-1011.5 as amended. PFP's mission is to enhance the quality of life for target citizens by delivering effective programs and facilitating partnerships with providers and the community they serve. The program has a full commitment to the very best in quality, service and value which will lead to measurably improved quality outcomes, healthier lifestyles, greater satisfaction and confidence for our members.

(b) **Eligible providers.** Any Oklahoma long-term care nursing facility that is licensed and certified by the Oklahoma State Department of Health (OSDH) as defined in Oklahoma Administrative Code (OAC) 317:30-5-120.

(c) **Quality measure care criteria.** To maintain status in the PFP program, each nursing facility shall submit documentation as it relates to program metrics quarterly or upon the request of the Oklahoma Health Care Authority (OHCA). The program metrics can be found on the OHCA's PFP website or on PFP/Quality of Care (QOC) data collection portal. If any quality metric, listed below, is substituted or removed by Centers of Medicare and Medicaid Services (CMS), an alternative quality metric may be chosen with the support of participating partners. For the period beginning October 1, 2019 and until changed by amendment, qualifying facilities participating in the PFP program have the potential to earn an average of the five dollars ($5.00) quality incentive per Medicaid patient per day. Facility(s) baseline is calculated annually and will remain the same for the twelve (12) month period. Facility(s) will meet or exceed five-percent (5%) relative improvement or the CMS' national average each quarter for the following metrics:

(1) Decrease percent of high risk/unstageable pressure ulcers for long-stay residents.
(2) Decrease percent of unnecessary weight loss for long-stay residents.
(3) Decrease percent of use of anti-psychotic medications for long-stay residents.
(4) Decrease percent of urinary tract infection for long-stay residents.

(d) **Payment.** Payment to long-term care facilities for meeting the metrics will be awarded quarterly. A facility may earn a minimum of one dollar and twenty-five cents ($1.25) per Medicaid patient per day for each qualifying metric. A facility receiving a scope and severity tag deficiency of "I" or greater ~~related to a targeted quality measure in the program is disqualified from receiving an award related to that measure for that quarter.~~from the Oklahoma State Department of Health will forfeit the PFP incentive for the quarter out of compliance.

(1) **Distribution of payment.** OHCA will notify the PFP facility of the quality reimbursement amount on a quarterly basis.

(2) **Penalties.** Facilities shall have performance review(s) and provide documentation upon request from OHCA to maintain program compliance. Program payments will be withheld from facilities that fail to submit the requested documentation within fifteen (15) business days of the request.

(3) **Timeframe.** To qualify for program reimbursement by meeting a specific quality measure, facilities are required to provide metric documentation within thirty (30) days after the end of

each quarter to the OHCA.

(e) **Appeals.** Facilities can file an appeal with the Quality Review Committee and in accordance, with the grievance procedures found at OAC 317:2-1-2(c) and 317:2-1-17.

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SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 4. EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) PROGRAM/CHILD-HEALTH SERVICES

317:30-3-65. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program/Child-health Services

Payment is made to eligible providers for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services on behalf of eligible individuals under the age of twenty-one (21).

(1) The EPSDT program is a comprehensive child-health program, designed to ensure the availability of, and access to, required health care resources and help parents and guardians of Medicaid-eligible children and adolescents use these resources. An effective EPSDT program assures that health problems are diagnosed and treated early before they become more complex and their treatment more costly. The physician plays a significant role in educating parents and guardians about all services available through the EPSDT program. The receipt of an identified EPSDT screening makes the member eligible for all necessary follow-up care that is within the scope of the SoonerCare program. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) covers services, supplies, or equipment that are determined to be medically necessary for a child or adolescent, and which are included within the categories of mandatory and optional services in Section 1905(a) of Title XIX, regardless of whether such services, supplies, or equipment are listed as covered in Oklahoma's Medicaid State Plan.

(2) Federal regulations also require that the State set standards and protocols for each component of EPSDT services. The standards must provide for services at intervals which meet reasonable standards of medical and dental practice. The standards must also provide for EPSDT services at other intervals as medically necessary to determine the existence of certain physical or behavioral health illnesses or conditions.

(3) SoonerCare providers who perform EPSDT screenings must assure that the screenings they provide meet the minimum standards established by the Oklahoma Health Care Authority in order to be reimbursed at the level established for EPSDT services.

(4) An EPSDT screening is considered a comprehensive examination. ~~A provider billing SoonerCare for an EPSDT screen may not bill any other Evaluation and Management Current Procedure Terminology (CPT) code for that patient on that same day. It is expected that the screening provider will perform necessary treatment as part of the screening charge. However, there may be other additional diagnostic procedures or treatments not normally considered part of a comprehensive examination, including diagnostic tests and administration of immunizations, required at the time of screening. Additional diagnostic procedures or treatments may be billed independently from the screening. Some services as set out in this section may require prior authorization.~~

(A) If a member is receiving an EPSDT screening and an additional focused complaint arises that requires evaluation and management to address the complaint, the provider may deliver all medically necessary care and submit a claim for both the EPSDT screening and the appropriate level of focused service if the following requirements are met:

(i) The medical issue is significant enough to require additional work to address the issue;

(ii) The visit is documented on a separate note;

(iii) Appropriate documentation that clearly lists the condition being managed at the time of the encounter and supports the billing of both services; and

(iv) Modifier 25 is added to the appropriate code that indicates that a separate evaluation and management service was provided by the same physician on the same day as the EPSDT screening. All claims submitted with Modifier 25 will be reviewed prior to payment, per Oklahoma Administrative Code (OAC) 317:30-3-33. The following items will be reviewed prior to any payment:

(I) Medical necessity;

(II) Appropriate utilization of Modifier 25; and

(III) All documentation to support both the EPSDT screening and the additional evaluation and management for a focused complaint must be submitted for review.

(v) All claims are subject to a post payment review by the OHCA's Program Integrity Unit.

(B) When providing evaluation and management of a focused complaint, during an EPSDT screening, the provider may claim only the additional time that is required above and beyond the completion of the EPSDT screening.

(C) An insignificant or trivial problem that is encountered in the process of performing the preventive evaluation and management service and does not require additional work is included in the EPSDT visit and should not be billed/reported.

(5) There may be other additional diagnostic procedures or treatments not normally considered part of a comprehensive examination, including diagnostic tests and administration of immunizations, required at the time of screening. Additional diagnostic procedures or treatments may be billed independently from the screening. Some services as set out in this section may require prior authorization.

~~(5)~~(6) For an EPSDT screening to be considered a completed reimbursable service, providers must perform, and document, all required components of the screening examination. Documentation of screening services performed must be retained for future review.

~~(6)~~(7) All comprehensive screenings provided to individuals under age twenty-one (21) must be filed on HCFA-1500 using the appropriate preventive medicine procedure code or an appropriate Evaluation and Management code from the Current Procedural Terminology Manual (CPT) accompanied by the appropriate ~~"V"~~well-child exam diagnosis code.

~~(7)~~(8) For EPSDT services in a school-based setting that are provided pursuant to an IEP, please refer to Part 103, Qualified Schools As Providers Of Health-Related Services, in ~~Oklahoma Administrative Code~~OAC 317:30-5-1020 through 317:30-5-1028.

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. General provisions and eligible providers

(a) **Eligible settings for inpatient psychiatric services.** The following individuals may receive SoonerCare-reimbursable inpatient psychiatric services in the following eligible settings:

(1) Individuals under twenty-one (21) years of age, in accordance with OAC 317:30-5-95.23, may receive SoonerCare-reimbursable inpatient psychiatric services in a psychiatric unit of a general hospital, a psychiatric hospital, or a PRTF; and may receive chemical dependency detoxification/withdrawal management services in a psychiatric unit of a general hospital or in a psychiatric hospital.

(2) Individuals ages twenty-one (21) and older may receive SoonerCare-reimbursable inpatient psychiatric and/or chemical dependency detoxification/withdrawal management services in a psychiatric unit of a general hospital or in a psychiatric hospital.

(b) **Psychiatric hospitals and psychiatric units of general hospitals.** To be eligible for payment under this Part, inpatient psychiatric programs must be provided to eligible SoonerCare members in a hospital that:

(1) Is a psychiatric hospital that:

(A) Successfully underwent a State survey to determine whether the hospital meets the requirements for participation in Medicare as a psychiatric hospital per 42 C.F.R. § 482.60; or

(B) Is accredited by a national organization whose psychiatric accrediting program has been approved by CMS; or

(2) Is a general hospital with a psychiatric unit that:

(A) Successfully underwent a State survey to determine whether the hospital meets the requirements for participation in Medicare as a hospital as specified in 42 C.F.R. Part 482; or

(B) Is accredited by a national accrediting organization whose accrediting program has been approved by CMS; and

(3) Meets all applicable federal regulations, including, but not limited to:

(A) Medicare Conditions of Participation for Hospitals (42 C.F.R. Part 482), including special provisions applying to psychiatric hospitals (42 C.F.R. § 482.60-.62);

(B) Medicaid for Individuals Age 65 or over in Institutions for Mental Diseases (42 C.F.R. Part 441, Subpart C);

(C) Inpatient Psychiatric Services for Individuals under Age 21 in Psychiatric Facilities or Programs (42 C.F.R. Part 441, Subpart D); and/or

(D) Utilization Control [42 C.F.R. Part 456, Subpart C (Utilization Control: Hospitals) or Subpart D (Utilization Control: Mental Hospitals)]; and

(4) Is contracted with the OHCA; and

(5) If located within Oklahoma and serving members under eighteen (18) years of age, is appropriately licensed by the Oklahoma Department of Human Services (OKDHS) as a

residential child care facility (10 O.S. §§ 401 to 402) that is providing services as a residential treatment facility in accordance with OAC 340:110-3-168.

(6) If located out of state, services must be provided within the licensure for each facility and scope of practice for each provider and supervising or rendering practitioner for the state in which the facility/provider is located. Services must be in compliance with the state-specific statutes, rules and regulations of the applicable practice act.

(c) **PRTF.** Every PRTF must:

(1) Be individually contracted with OHCA as a PRTF;

(2) Meet all of the state and federal participation requirements for SoonerCare reimbursement, including, but not limited to, 42 C.F.R. § 483.354, as well as all requirements in 42 C.F.R. 483 Subpart G governing the use of restraint and seclusion;

~~(3) Be appropriately licensed by OKDHS as a residential child care facility (10 O.S. § 401 to 402) that is providing services as a residential treatment facility in accordance with OAC 340:110-3-168;~~

(3) Be appropriately licensed and/or certified:

(A) If an in-state facility, by OKDHS as a residential child care facility (10 O.S. § 401 to 402) that is providing services as a residential treatment facility in accordance with OAC 340:110-3-168; or

(B) If an out-of-state facility, by the licensing or certifying authority of the state in which the facility does business and must provide an attestation to OHCA that the PRTF is in compliance with the condition of participation for restraint and seclusion, as is required by federal law.

(4) Be appropriately certified by the State Survey Agency, the Oklahoma State Department of Health (OSDH) as meeting Medicare Conditions of Participation; and

(5) Be accredited by TJC, the Council on Accreditation of Rehabilitation Facilities (CARF), or the Council on Accreditation (COA).

~~(d) **Out-of-state PRTF.** Any out-of-state PRTF must be appropriately licensed and/or certified in the state in which it does business, and must provide an attestation to OHCA that the PRTF is in compliance with the condition of participation for restraint and seclusion, as is required by federal law. Any out-of-state PRTF must also be accredited in conformance with OAC 317:30-5-95(c)(5).~~

~~(e)~~(d) **Required documents.** The required documents for enrollment for each participating provider can be downloaded from the OHCA's website.

317:30-5-95.24. Prior authorization of inpatient psychiatric services for individuals under twenty-one (21)

(a) All inpatient psychiatric services for members under twenty-one (21) years of age must be prior authorized by the OHCA or its designated agent. All inpatient Acute, Acute II, and PRTF services will be prior authorized for an approved length of stay. Admission requirements for services must be provided in accordance with 42 C.F.R. Part 441 and 456. Additional information will be required for SoonerCare-compensable approval on enhanced treatment units or in special population programs.

(b) Unit staffing ratios shall always meet the requirements in OAC 317:30-5-95.24 (c), (d), (h) and (i). Out-of-state facilities may adhere to the staffing requirements of the state in which the services are provided if the staff ratio is sufficient to ensure patient safety and that patients have reasonable and prompt access to services. The facility cannot use staff that is also on duty in other units of the

facility in order to meet the unit staffing ratios. Patients shall be grouped for accommodation by gender, age, and treatment needs. At a minimum, children, adolescent, and adult treatment programs shall be separate with distinct units for each population. A unit is determined by separate and distinct sleeping, living, and treatment areas often separated by walls and/or doors. A unit that does not allow clear line of sight due to the presence of walls or doors is considered a separate unit. Each individual unit shall have assigned staff to allow for appropriate and safe monitoring of patients and to provide active treatment.

(c) In Acute and Acute II settings, at least one (1) registered nurse (RN) must be on duty per unit at all times, with additional RNs to meet program needs. RNs must adhere to Oklahoma State Department of Health (OSDH) policy at OAC 310:667-15-3 and 310:667-33-2(a)(3).

(d) Acute, non-specialty Acute II, and non-specialty PRTF programs require a staffing ratio of one (1) staff: six (6) patients during routine waking hours and one (1) staff: eight (8) patients during time residents are asleep with twenty-four (24) hour nursing care supervised by an RN for management of behaviors and medical complications. For PRTF programs, at a minimum, a supervising RN must be available by phone and on-site within one (1) hour. If the supervising RN is off-site, then an RN or licensed practical nurse (LPN) must be on-site to adhere to a twenty-four (24) hour nursing care coverage ratio of one (1) staff: thirty (30) patients during routine waking hours and one (1) staff: forty (40) patients during time residents are asleep.

(e) Specialty treatment at Acute II or PRTF is a longer-term treatment that requires a higher staff-to-member ratio because of the need for constant, intense, and immediate reinforcement of new behaviors to develop an understanding of the behaviors. The environment of specialized residential treatment centers requires special structure and configuration (e.g., sensory centers for autistic members) and specialized training for the staff in the area of the identified specialty. The physician, Advanced Practice Registered Nurse (APRN) with psychiatric certification or Physician Assistant (PA) will see the child at least one (1) time a week.

(f) An Acute II or PRTF will not be considered a specialty treatment program for SoonerCare without prior approval of the OHCA behavioral health unit.

(g) A treatment program that has been approved as a specialized treatment program must maintain medical records that document the degree and intensity of the psychiatric care delivered to the members and must meet active treatment requirements found at OAC 317:30-5-95.34.

(h) Criteria for classification as a specialty Acute II will require a staffing ratio of one (1) staff: four (4) patients at a minimum during routine waking hours and one (1) staff: six (6) patients during time residents are asleep with twenty-four (24) hour nursing care supervised by a RN for management of behaviors and medical complications. The specialty Acute II will be a secure unit, due to the complexity of needs and safety considerations. Admissions and authorization for continued stay for a specialty Acute II will be restricted to members who meet the medical necessity criteria at OAC 317:30-5-95.29 and OAC 317:30-5-95.30 for the respective level of care and meet the additional criteria found in the Behavioral Health Services Medical Necessity Criteria Manual, available on OHCA's website, ~~www.okhca.org.~~www.oklahoma.gov/ohca.

(i) Criteria for classification as a specialty PRTF will require a staffing ratio of one (1) staff: four (4) patients at a minimum during routine waking hours and one (1) staff: six (6) patients during time residents are asleep with twenty-four (24) hour nursing care supervised by a RN for management of behaviors and medical complications. The specialty PRTF will be a secure unit, due to the complexity of needs and safety considerations. Admissions and authorization for continued stay in a specialty PRTF will be restricted to members who meet the medical necessity

criteria at OAC 317:30-5-95.29 and OAC 317:30-5-95.30 for the respective level of care and meet the additional criteria found in the Behavioral Health Services Medical Necessity Criteria Manual, available on OHCA's website, ~~www.okhca.org.~~www.oklahoma.gov/ohca.
(j) Non-authorized inpatient psychiatric services will not be SoonerCare compensable.
(k) For out-of-state placement policy, refer to OAC 317:30-3-89 through 317:30-3-92. A prime consideration for placements will be proximity to the family or guardian in order to involve the family or guardian in active treatment, including discharge and reintegration planning. Out-of-state facilities are responsible for insuring appropriate medical care, as needed under SoonerCare provisions, as part of the per-diem rate.
(l) Reimbursement for inpatient psychiatric services in all psychiatric units of general hospitals, psychiatric hospitals, and PRTFs are limited to the approved length of stay. OHCA, or its designated agent, will approve lengths of stay using the current OHCA Behavioral Health medical necessity criteria as described in OAC 317:30-5-95.25 through OAC 317:30-5-95.30. The approved length of stay applies to both facility and physician services.

317:30-5-95.40. Other required standards

The provider is required to maintain all programs and services according to applicable C.F.R. requirements, the Joint Commission' (TJC) and American Osteopathic Association' (AOA) standards for behavioral health care, Oklahoma State Department of Health's (OSDH) hospital standards for psychiatric care, and Oklahoma Department of Human Services' (OKDHS) licensing standards for residential treatment facilities. PRTFs may substitute the Commission on Accreditation of Rehabilitation Facilities (CARF) accreditation in lieu of TJC or AOA accreditation. In addition to federal requirements, out-of-state inpatient psychiatric facilities must adhere to OAC 317:30-5-95 and 317:30-5-95.24.

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

317:30-5-95.6. Medical, psychiatric, and social evaluations for adults aged twenty-one (21) to sixty-four (64)

The record for an adult member aged twenty-one (21) to sixty-four (64) must contain complete medical, psychiatric, and social evaluations.

(1) The evaluations must be completed as follows:

(A) History and ~~Physical~~physical must be completed within twenty-four (24) hours of admission by a licensed independent practitioner [~~MD, DO~~Allopathic Doctor, Osteopathic Doctor, Advanced Practice ~~Register~~Registered Nurse (APRN), or Physician Assistant (PA)].

(B) Psychiatric ~~Evaluation~~evaluation must be completed within sixty (60) hours of admission by an Allopathic ~~Or~~or Osteopathic Physician with a current license and a board certification/eligible in psychiatry, an APRN with a psychiatric certification or a PA.

(C) Psychosocial ~~Evaluation~~evaluation must be completed within seventy-two (72) hours of admission by a licensed independent practitioner (~~MD, DO,~~Allopathic Doctor, Osteopathic Doctor, APRN, or PA), ~~a licensed behavioral health professional~~an LBHP, or a licensure candidate as defined in OAC 317:30-5-240.3.

(2) The evaluations must be clearly identified as such and must be signed and dated by the evaluator.

317:30-5-95.16. Medical psychiatric and social evaluations for persons sixty-five (65) years of age or older receiving inpatient acute psychiatric services

The record of a member sixty-five (65) years of age or older receiving inpatient acute psychiatric services must contain complete medical, psychiatric, and social evaluations.

(1) The evaluations must be completed as follows:

(A) History and ~~Physical~~physical must be completed within twenty-four (24) hours of admission by a licensed independent practitioner [~~MD, DO~~Allopathic Doctor, Osteopathic Doctor, Advanced Practice ~~Register~~Registered Nurse (APRN), or Physician Assistant (PA)].

(B) Psychiatric ~~Evaluation~~evaluation must be completed within sixty (60) hours of admission by an ~~allopathic~~Allopathic or ~~osteopathic~~Osteopathic physician with a current license and a board certification/eligible in psychiatry, an APRN with a psychiatric certification or a PA.

(C) Psychosocial ~~Evaluation~~evaluation must be completed within seventy-two (72) hours of admission by a licensed independent practitioner (Allopathic Doctor, Osteopathic Doctor, APRN, or PA), ~~a licensed behavioral health professional (LBHP)~~an LBHP, or licensure candidate as defined in OAC 317:30-5-240.3.

(2) The evaluations must be clearly identified as such and must be signed and dated by the evaluator.

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 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. 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, Advanced Practice Registered Nurse (APRN), or Physician Assistant (PA).** Individual treatment provided by the physician, APRN with psychiatric certification or PA 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, APRN with psychiatric certification or PA 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. Individual treatment provided by the physician, APRN with psychiatric certification or PA 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 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 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, APRN or PA.**

(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, one (1) visit during the admission week is required, then once a week thereafter. Individual treatment provided by the physician, APRN with psychiatric certification or PA 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. 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, APRN with psychiatric certification or PA. If the member is admitted on the last day of the admission week, then the member must be seen by a physician, APRN with psychiatric certification or PA 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.)~~ [Allopathic Doctor, Osteopathic Doctor, Advanced Practice Registered Nurse (APRN), or Physician Assistant (PA)] in Acute, Acute II, and PRTFs.

(B) Psychiatric evaluation must be completed within sixty (60) hours of admission by an ~~allopathic~~Allopathic or ~~osteopathic~~Osteopathic physician with a current license and a board certification/eligible in psychiatry. APRN with a psychiatric certification or PA in Acute, Acute II, and PRTFs.

(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 by a licensed independent practitioner ~~(M.D., D.O., A.P.N., or P.A.)~~(Allopathic Doctor, Osteopathic Doctor, APRN, or PA), 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.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

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 laws. All suppliers of medical supplies, equipment, and appliances must be accredited by a Medicare deemed accreditation organization for quality standards for 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 DME providers must meet the following criteria:

(1) 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 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 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) DME providers are required to comply with Medicare DME Supplier Standards for medical supplies, equipment, and appliances provided to SoonerCare members, except the requirement to meet surety bond requirements, as specified in 42 Code of Federal Regulations (C.F.R.) 424.57(c).

(3) Complex rehabilitation technology (CRT) suppliers are considered 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.

(4) For additional requirements regarding DME providers of donor human breast milk, please refer to OAC 317:30-5-211.29.

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.

317:30-5-211.29. Donor human breast milk

(a) **Donor human breast milk.** Donor human breast milk is pasteurized donor human milk which has been donated to a Human Milk Banking Association of North America (HMBANA) milk bank. Upon donation, it is screened, pooled, and tested so that it can be dispensed. All donor mothers require screening and approval by a HMBANA milk bank, and additionally, all donor milk is logged, pasteurized, and monitored.

(b) **Provider qualifications.** Donor human breast milk must be obtained from a milk bank accredited by, and in good standing with, the HMBANA and be contracted with the Oklahoma Health Care Authority (OHCA) as a Durable Medical Equipment (DME) provider.

(c) **Medical necessity criteria.** To qualify to receive donor human breast milk the infant must

meet medically necessary criteria, which can include but not limited to the following conditions:

(1) Other feeding options have been exhausted or are contraindicated; and

(2) Baby's biological mother's milk is contraindicated, unavailable due to medical or psychosocial condition, or mother's milk is available but is insufficient in quantity or quality to meet the infant's dietary needs, as reflected in medical records or by a physician (MD or DO), physician's assistant, or advanced practice nurse; and

(3) Donor human breast milk must be procured through a HMBANA entity and delivered through a contracted provider, facility, or the supplier (HMBANA-accredited milk bank); and

(A) Requests for coverage over thirty-five (35) ounces per day, per infant, shall require review and approval by an OHCA Medical Director; and

(B) Coverage shall be extended for as long as medically necessary, but not to exceed an infant's twelve (12) months of age; and

(C) A new prior authorization will be required every ninety (90) days.

(4) The infant has one (1) or more of the following conditions:

(A) Infant born at Very Low Birth Weight (VLBW) (less than 1,500 grams) or lower; or

(B) Gastrointestinal anomaly, metabolic/digestive disorder, or recovery from intestinal surgery where digestive needs require additional support; or

(C) Diagnosed failure to thrive; or

(D) Formula intolerance with either documented feeding difficulty or weight loss; or

(E) Infant hypoglycemia; or

(F) Congenital heart disease; or

(G) Pre or post organ transplant; or

(H) Other serious health conditions where the use of donor human breast milk has been deemed medically necessary and will support the treatment and recovery of the infant as reflected in the medical records or by a physician (MD or DO), physician's assistant, or advanced practice nurse.

(5) For full guidelines, including the medically necessary criteria, please refer to www.okhca.org/mau.

(d) **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 317:30-5-211.20(c). Documentation must include:

(1) A prescription from a contracted provider [a physician (MD or DO), physician's assistant, or advanced practice nurse]. The prescription must include but not limited to:

(A) Name of infant, address and diagnoses;

(B) Parent name and phone number or email;

(C) Donor human breast milk request form;

(D) Number of ounces per day, week, or month needed; and

(E) Prescriptions must be written on a prescription notepad and signed off by an authorized provider.

(F) For full guidelines, please refer to www.okhca.org/mau.

(2) Donor human breast milk is excluded from requiring a CMN.

(e) **Reimbursement.** Donor human breast milk is reimbursed as follows:

(1) When donor human breast milk is provided in the inpatient setting, it will be reimbursed within the prospective Diagnosis Related Group (DRG) payment methodology for hospitals as authorized under the Oklahoma Medicaid State Plan.

(2) When donor human breast milk is provided in an outpatient setting as a medical supply benefit, it will be reimbursed as a durable medical equipment, supplies, and appliances (DME) item in accordance the OHCA fee schedule.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 25. SOONERCARE CHOICE

SUBCHAPTER 7. SOONERCARE

PART 1. GENERAL PROVISIONS

317:25-7-5. Primary care providers (PCPs)

For provision of health care services, the OHCA contracts with qualified PCPs. All providers serving as PCPs must have a valid SoonerCare Fee-for-Service contract as well as an exercised SoonerCare Choice addendum. Additionally, all PCPs, excluding provider or physician groups must agree to accept a minimum capacity of fifty (50) patients; provided, however, this does not guarantee PCPs a minimum patient volume. PCPs are limited to:

(1) **Physicians.** Any physician licensed to practice medicine in the state in which he or she practices who is engaged in a general practice or in family medicine, general internal medicine or general pediatrics may serve as a PCP. Out-of-state PCPs are required to comply with all access standards imposed on Oklahoma physicians, as well as Oklahoma Administrative Code (OAC) 317:30-3-89 through 317:30-3-92.

~~(A) For physicians serving as SoonerCare Choice PCPs, the State caps the number of members per physician at two thousand, five hundred (2,500). If a physician practices at multiple sites, the capacity at each site is determined based on the number of hours per week the physician holds office hours, not to exceed one (1) FTE. Thus, the physician cannot exceed a maximum total capacity of two thousand, five hundred (2,500) members.~~
~~(B) In areas of the state where cross-state utilization patterns have developed because of limited provider capacity in the state the OHCA may authorize contracts with out-of-state providers for PCP services. Out-of-state PCPs are required to comply with all access standards imposed on Oklahoma physicians, as well as Oklahoma Administrative Code (OAC) 317:30-3-89 through 317:30-3-92.~~

(2) **Advanced Practice Registered Nurses (APRNs).** APRNs who have prescriptive authority may serve as PCPs for the Primary Care Case Management delivery system if licensed to practice in the state in which he or she practices. ~~APRNs who have prescriptive authority may serve as PCPs for a maximum number of one thousand, two hundred and fifty (1,250) members.~~

(3) **Physician Assistants (PAs).** PAs may serve as PCPs if licensed to practice in the state in which he or she practices. ~~PAs may serve as PCPs for a maximum number of one thousand, two hundred and fifty (1,250) members.~~

(4) **Indian Health Service (IHS) Facilities and Federally Qualified Health Center (FQHC) provider groups and Rural Health Clinics (RHC).**

(A) IHS facilities whose professional staff meet the general requirements in paragraphs (1) through (3) of this Section and the provider participation requirements at OAC 317:30-5-1088 may serve as PCPs.

(B) FQHCs whose professional staff meet the general requirements in paragraphs (1) through (3) of this Section and the provider participation requirements in OAC 317:30- 5-660.2 may serve as PCPs.

(C) RHCs whose professional staff meet the general requirements in paragraphs (1) through (3) of this Section and the provider participation requirements in OAC 317:30- 5-355 may serve as PCPs.

(5) **Provider or physician group capacity and enrollment**.

(A) Provider or physician groups must agree to accept a minimum enrollment capacity ~~and~~

~~may not exceed two thousand, five hundred (2,500) members per physician~~ ~~participating in the provider group~~ of fifty (50) members.

~~(B) If licensed PAs or APRNs are members of a group, the capacity may be increased by one thousand, two hundred and fifty (1,250) members if the provider is available full- time.~~

~~(C)~~(B) Provider or physician groups must designate a medical director to serve as the primary contact with OHCA.

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 RELATIONSHIP

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 SSA/SSI recipient in current payment status (including presumptive eligibility), a 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. 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 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 services is established in accordance with OAC 317:35-5-25. Categorical relationship for the Breast and Cervical Cancer (BCC) treatment program is established in accordance with Subchapter 21 of this Chapter. Categorical relationship for the SoonerPlan 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 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) Parents and caretaker relatives;~~

~~(7) Refugee;~~
~~(8) BCC treatment program;~~
~~(9) SoonerPlan 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 whom a public agency is assuming full or partial financial responsibility who are in custody as reported by OKDHS and in foster homes, private institutions or public facilities; or~~

~~(B) In adoptions subsidized in full or in part by a public agency; or~~

~~(C) Individuals under age twenty-one (21) receiving active treatment as inpatients in public psychiatric facilities or programs if inpatient psychiatric services for individuals under age 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 (21) if they are in custody as reported by OKDHS on their eighteenth (18th) birthday and living in an out-of-home placement.~~

(a) In order to be eligible for SoonerCare, an individual must first meet the description of a member eligibility group.

(1) 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.

(2) If the individual is a SSA/SSI recipient in current payment status (including presumptive eligibility), a 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.

(3) For individuals related to expansion adults the categorical relationship is established and defined by 42 Code of Federal Regulations (C.F.R.) § 435.119.

(4) Categorical relationship to the pregnancy group is established when the determination is made by medical evidence that the individual is or has been pregnant. 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.

(5) 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.

(6) For an individual to be related to the former foster care children group, the individual must have been receiving Medicaid benefits as a foster care child in Oklahoma or another state when he/she attained the age of eighteen (18), or aged out of foster care, until he/she reaches the age of twenty-six (26). If the individual aged out of foster care in a state other than

Oklahoma, the date of ageing out had to occur on January 1, 2023, or later, and the individual must now be residing in Oklahoma. There is no income or resource test for the former foster care children group.

(7) Categorical relationship to refugee services is established in accordance with OAC 317:35-5-25.

(8) Categorical relationship for the Breast and Cervical Cancer (BCC) treatment program is established in accordance with Subchapter 21 of this Chapter.

(9) Categorical relationship for the SoonerPlan family planning program is established in accordance with OAC 317:35-5-8.

(10) Categorical relationship for pregnancy related benefits covered under Title XXI is established in accordance with 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.

(b) 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) Parents and caretaker relatives;

(7) Refugee;

(8) BCC treatment program;

(9) SoonerPlan family planning program;

(10) Benefits for pregnancies covered under Title XXI;

(11)Former foster care children; or

(12) Expansion adults.

(c) 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 whom a public agency is assuming full or partial financial responsibility who are in custody as reported by Oklahoma Human Services (OKDHS) and in foster homes, private institutions or public facilities; or

(B) In adoptions subsidized in full or in part by a public agency; or

(C) Individuals under age twenty-one (21) receiving active treatment as inpatients in public psychiatric facilities or programs if inpatient psychiatric services for individuals under age 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 (21) if they are in custody as reported by OKDHS on their eighteenth (18^{th}) birthday and living in an out-of-home placement.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 80. ~~MOBILE AND/OR PORTAL DENTAL TREATMENT FACILITIES~~MOBILE AND PORTABLE DENTAL SERVICES

317:30-5-706. ~~Definitions~~Mobile Dental Units

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

~~"**Individual provider**" means a dentist, dental hygienist, or dental assistant who provides dental services at a mobile and/or portable dental treatment facility.~~

~~"**Mobile and/or portable dental treatment facilities**" means the following, limited places of treatment, as authorized by the Oklahoma State Dental Act: group homes for juveniles; public and private schools; and mobile dental clinics. The rules in this Part expressly shall not apply to SoonerCare reimbursement of dental services provided at any other authorized place of service, including, but not limited to: "dental offices," as defined by 59 O.S. ' 328.3; federal, tribal, state, or local public health facilities; federally qualified health centers; and hospitals or dental ambulatory surgery centers.~~

(a) **Definition.** Mobile dental unit means a motor vehicle or trailer that contains dental equipment and is used to provide dental services to eligible SoonerCare members on-site in accordance with Title 59 of Oklahoma Statutes (O.S.), Section 328.3 (59 O.S. §328.3).

(b) **Eligible providers.** For dental services provided at a mobile dental unit to be eligible for SoonerCare reimbursement, a dental group shall meet all applicable requirements set forth in the Oklahoma Board of Dentistry rules, the Oklahoma State Dental Act (59 O.S., Ch. 7), and the requirements in this Section, including but not limited to, all licensing and permitting requirements.

(1) All dentists working at a mobile dental unit shall be currently licensed in good standing with the Oklahoma Board of Dentistry. All other contracted providers of the dental group, working at a mobile dental unit, shall meet all credentialing/certification requirements, as per their specialty. In addition, all members of the dental group working at a mobile dental unit shall comply with the requirements at Oklahoma Administrative Code (OAC) 317:30-5-695.

(2) The license, certification, accreditation, and/or permit (or a photocopy of these documents) of every individual provider in the dental group shall be prominently displayed at the mobile dental unit, pursuant to 59 O.S., Section (§) 328.21.

(3) For services provided in a mobile dental unit, the permit to operate the mobile dental unit shall be prominently displayed in the mobile dental unit vehicle, pursuant to 59 O.S. §328.40a.

(4) In accordance with OAC 317:30-5-695.1, every dental group providing services at a mobile dental unit must be fully contracted with the Oklahoma Health Care Authority (OHCA) as a dental group provider and must also be fully contracted with OHCA as a mobile dental unit.

(5) Every individual dentist practicing at a mobile dental unit must be fully contracted with the OHCA as a dentist.

(6) Dental groups and individual providers providing dental services at a mobile dental unit shall comply with all applicable state and federal Medicaid laws, including, but not limited to,

OHCA administrative rules, the Code of Federal Regulations, and the Oklahoma State Medicaid Plan.

(c) **Coverage.** Refer to OAC 317:30-5-696 for dental coverage descriptions for children and adults.

(d) **Description of services.** Mobile dental units must treat both children and adults and provide urgent, preventive, and restorative dental services that are appropriate to provide in this setting.

(1) All current dental rules at OAC 317, Part 79, still apply to all mobile dental services including, but not limited to, prior authorizations, medically necessity criteria, documentation, and limitations.

(2) Endodontics, orthodontics, prosthodontics, periodontics, and permanent crowns will not be covered in mobile clinic.

(3) Mobile dental units will be required to refer a member to a SoonerCare contracted dental provider for any follow-up care when needed or to access services that cannot be provided in the mobile unit.

(e) **Limited provider service area.** Mobile dental units should serve members in SoonerCare dental provider shortage areas. Dental provider shortage areas mean Oklahoma counties that have less than ten (10) Medicaid general dental providers.

(f) **Billing and reimbursement.** Billing and reimbursement policies in accordance with OAC 317:30-5-704 through 317:30-5-705 apply to mobile dental services.

(g) **Post Care.** Each member receiving dental care at a mobile dental unit must receive an information sheet at the end of the visit. The information sheet must contain:

(1) The name of the dentist, dental hygienist, and/or dental assistant who provided the dental services at the mobile dental unit;

(2) Valid contact information which can include a business telephone number, email address and/or other emergency contact number for the dental group and/or dentist that provided the dental services at the mobile dental unit;

(3) A listing of the treatment rendered, including, when applicable, billing codes, fees, and tooth numbers;

(4) A description of any follow-up treatment that is needed or recommended; and

(5) Referrals to specialists or other dentists if the mobile dental unit providers were unable to provide the necessary treatment and/or additional care is needed.

(6) All dental records including radiographs from that visit should be provided to the member and/or forwarded to the dental provider providing follow-up care. Electronic and/or printed forms of records are acceptable.

317:30-5-707. ~~Eligible providers~~Portable Dental Units

~~(a) In order for dental services provided at a mobile and/or portable dental treatment facility to be eligible for SoonerCare reimbursement, a dental group shall meet all applicable requirements set forth in the Oklahoma Board of Dentistry rules and the Oklahoma State Dental Act, including, but not limited to, all licensing and permitting requirements.~~

~~(1) All dentists and dental hygienists working at a mobile and/or portable dental treatment facility shall be currently licensed in good standing with the Oklahoma Board of Dentistry. All dental assistants working at a mobile and/or portable dental treatment facility shall be currently permitted by the Oklahoma Board of Dentistry.~~

~~(2) The license or permit (or a photocopy of the license or permit) of every individual provider shall be prominently displayed at the mobile and/or portable dental treatment facility, pursuant to 59 O.S. ' 328.21.~~

~~(3) For services provided in a mobile dental clinic, the permit to operate the mobile dental clinic shall be prominently displayed in the mobile dental clinic vehicle, pursuant to 59 O.S. ' 328.40a.~~

~~(b) In accordance with OAC 317:30-5-695.1, every dental group providing services at a mobile and/or portable dental treatment facility must be fully contracted with the OHCA as a dental group provider and must be fully contracted with OHCA as a mobile and/or portable dental treatment facility.~~

~~(c) Every individual dentist practicing at a mobile and/or portable dental treatment facility must be fully contracted with the OHCA as a dentist.~~

~~(d) Dental groups and individual providers providing dental services at a mobile and/or portable dental treatment facility shall comply with all state and federal Medicaid law, including, but not limited to, OHCA administrative rules, the Code of Federal Regulations, and the Oklahoma State Medicaid Plan.~~

(a) **Definition.** Portable dental unit means a non-facility in which dental equipment used in the practice of dentistry is transported to and used on a temporary basis at an out-of-office location at either group homes for juveniles or public and private schools.

(b) **Eligible providers.** For dental services provided at a portable dental unit to be eligible for SoonerCare reimbursement, a dental group shall meet all applicable requirements set forth in the Oklahoma Board of Dentistry rules, the Oklahoma State Dental Act (59 O.S., Ch. 7), and the requirements in this Section, including but not limited to, all licensing and permitting requirements.

(1) All dentists working at a portable dental unit shall be currently licensed in good standing with the Oklahoma Board of Dentistry. All other contracted providers of the dental group, working at a portable dental unit, shall meet all credentialing/certification requirements, as per their specialty. In addition, all members of the dental group working at a portable dental unit shall comply with the requirements at Oklahoma Administrative Code (OAC) 317:30-5-695.

(2) The license or permit (or a photocopy of the license or permit) of every individual provider shall be prominently displayed at the portable dental unit site, pursuant to Title of 59 O.S. § 328.21.

(3) In accordance with OAC 317:30-5-695.1, every dental group providing services at a portable dental unit must be fully contracted with the OHCA as a dental group provider.

(4) Every individual dentist practicing at a portable dental unit must be fully contracted with the OHCA as a dentist.

(5) Dental groups and individual providers providing dental services at a portable dental unit shall comply with all state and federal Medicaid laws, including, but not limited to, OHCA administrative rules, the Code of Federal Regulations, and the Oklahoma State Medicaid Plan.

(c) **Coverage.** Portable dental unit services are only available for SoonerCare-eligible individuals under the age of twenty-one (21) and limited to the services noted in (1) through (3) of this Subsection. All portable dental units must have a SoonerCare-contracted, Oklahoma-licensed dentist onsite to supervise all other portable dental unit staff. Coverage for dental services provided to children/adolescents at a portable dental unit is limited to:

(1) One (1) fluoride application per member per twelve (12) months;

(2) One (1) dental screening annually that is performed by a SoonerCare-contracted, Oklahoma-licensed dentist; and

(3) Dental sealants on tooth numbers 2, 3, 14, 15, 18, 19, 30, and 31. The OHCA will not reimburse the application of dental sealants for a given OHCA member more than once every thirty-six (36) months, regardless of whether the services are provided at a portable dental unit, or at some other authorized place of service.

(d) **Post Care.** Each member receiving dental care at a portable dental unit must receive an information sheet at the end of the visit. The information sheet must contain:

(1) The name of the dentist, dental hygienist, and/or dental assistant who provided the dental services at the portable dental unit;

(2) A valid business telephone number and/or other emergency contact number for the dental group and/or dentist that provided the dental services at the portable dental unit;

(3) A listing of the treatment rendered, including, when applicable, billing codes, fees, and tooth numbers;

(4) A description of any follow-up treatment that is needed or recommended; and

(5) Referrals to specialists or other dentists if the portable dental unit providers were unable to provide the necessary treatment and/or additional care is needed.

(e) **Billing.** Refer to OAC 317:30-5-704 through 317:30-5-705 for billing instructions and guidelines. Please note that for any dental service provided through a portable dental unit that is billed to SoonerCare, the appropriate place of service must be identified on the claim to receive reimbursement.

317:30-5-708. Parental consent requirements

Individual providers at a ~~mobile and/or portable dental treatment facility~~mobile or portable dental unit shall not perform any service on a minor without having obtained, prior to the provision of services, a signed, written consent from the minor's parent or legal guardian, that includes, at a minimum, the:

(1) Name of the dental group and/or dentist providing the dental services at the mobile and/or portable dental ~~treatment facility~~unit;

(2) Permanent business mailing address of the dental group and/or dentist providing the dental services at the mobile and/or portable dental ~~treatment facility~~unit;

(3) Business telephone number of the dental group and/or dentist providing the dental services at the mobile and/or portable dental ~~treatment facility~~unit. This telephone number must be available for emergency calls;

(4) Full printed name of the child to receive services;

(5) Child's SoonerCare Member ID number; and

(6) An inquiry of whether the child has had dental care in the past twelve (12) months and if the child has a dental appointment scheduled with his/her regular dentist. If applicable, parent should list the name and address of the dentist and/or dental office where the care is provided.

317:30-5-709. Coverage [REVOKED]

~~Payment is made only to contracted dental groups for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services provided to SoonerCare-eligible individuals under the age of twenty-one (21). All mobile and/or portable dental treatment facilities must have a SoonerCare-contracted, Oklahoma-licensed dentist onsite to supervise staff and provide certain services.~~

~~Coverage for dental services provided to children/adolescents at a mobile and/or portable dental treatment facility is limited to:~~

~~(1) One (1) fluoride application per member per twelve (12) months;~~

~~(2) One (1) dental assessment annually that is performed by a SoonerCare-contracted, Oklahoma-licensed dentist; and~~

~~(3) Dental sealants on tooth numbers 2, 3, 14, 15, 18, 19, 30, and 31. The Oklahoma Health Care Authority (OHCA) will not reimburse the application of dental sealants for a given OHCA member more than once every thirty-six (36) months, regardless of whether the services are provided at a mobile and/or portable dental treatment facility, or at some other authorized place of service.~~

317:30-5-710. Post-care [REVOKED]

~~Each member receiving dental care at a mobile and/or portable dental treatment facility must receive an information sheet at the end of the visit. The information sheet must contain:~~

~~(1) The name of the dentist, dental hygienist, and/or dental assistant who provided the dental services at the mobile and/or portable dental treatment facility;~~

~~(2) A valid business telephone number and/or other emergency contact number for the dental group and/or dentist that provided the dental services at the mobile and/or portable dental treatment facility;~~

~~(3) A listing of the treatment rendered, including, when applicable, billing codes, fees, and tooth numbers;~~

~~(4) A description of any follow-up treatment that is needed or recommended; and~~

~~(5) Referrals to specialists or other dentists if the individual providers were unable to provide the necessary treatment, and additional care is needed.~~

317:30-5-711. Billing [REVOKED]

~~Refer to Oklahoma Administrative Code (OAC) 317:30-5-704 through 317:30-5-705 for billing instructions and guidelines. Please note that for any dental service provided at a mobile and/or portable dental treatment facility that is billed to SoonerCare, the appropriate place of service must be identified on the claim.~~

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 3. GENERAL MEDICAL PROGRAM INFORMATION

317:30-3-57. General SoonerCare coverage - categorically needy

The following are general SoonerCare coverage guidelines for the categorically needy:

(1) Inpatient hospital services.

(A) Adult coverage for inpatient hospital stays as described at Oklahoma 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 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 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 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 Medical Authorization Unit.

(11) Medically necessary screening mammography. Additional follow-up mammograms are covered when medically necessary.

(12) Long-term care facility services (other than services in an institution for tuberculosis or mental diseases).

(13) Early and Periodic Screening, 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 services are outlined in OAC 317:30-3-65.2 through 317:30-3-65.12.

(A) 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 317:30-5-94 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, 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 long-term care facility, 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;
(E) Certified nurse midwives;
(F) Advanced practice registered nurses; and
(G) Anesthesiologist assistants.

(17) 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 medically necessary monthly prescriptions for:
(i) Members under the age of twenty-one (21) years; and
(ii) Residents of long-term care facilities or ICF/IID.
(B) 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 (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 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.

(24) Standard medical supplies.

(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.

(26) Blood and blood fractions for members when administered on an outpatient basis.

(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.

(28) Long-term care facility services, limited to members preauthorized and approved by OHCA for such care.

(29) Inpatient psychiatric facility admissions for members are limited to an approved length of stay with provision for requests for extensions.

(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.

(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~~twelve (12) months after the pregnancy ends regardless of the reason, beginning on the last date of pregnancy.

(32) Long-term care facility services for members under twenty-one (21) years of age.

(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 (RN).

(34) Medicare Part A, Part B, and Part C deductibles, coinsurance, and copays.

(35) HCBS for the intellectually disabled.
(36) Home health services can be provided without a PA for the first thirty-six (36) visits. A PA will be required beyond the 36th visit. The visits are limited to any combination of RN and nurse aide visits.
(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) 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.

(38) HCBS for intellectually disabled members who were determined to be inappropriately placed in a long-term care facility (Alternative Disposition Plan - ADP).
(39) Case management services for the chronically and/or seriously mentally ill.
(40) Emergency medical services, including emergency labor and delivery for undocumented or ineligible aliens.
(41) Services delivered in Federally Qualified Health Centers (FQHCs). Payment is made on an encounter basis.
(42) Early intervention services for children ages zero (0) to three (3).
(43) Residential behavior management in therapeutic foster care setting.
(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 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).

PART 16. MATERNAL AND INFANT HEALTH LICENSED CLINICAL SOCIAL WORKERS

317:30-5-208. Reimbursement

(a) Maternal and infant health social work services must be billed using appropriate CPT codes

and guidelines.
(b) SoonerCare does not allow more than ~~32~~thirty-two (32) units ~~(15 minutes = 1 unit)~~[fifteen (15) minutes = one (1) unit] during the pregnancy which includes ~~60 days~~twelve (12) months postpartum.
(c) LCSWs that are employed by or remunerated by another provider may not bill the SoonerCare program directly for services if that billing would result in duplicate payment for the same service.
(d) Only the LCSW directly performing the care or a county health department may bill the SoonerCare Program.
(e) The time indicated on the claim form must be the time actually spent with the member.

PART 18. GENETIC COUNSELORS

317:30-5-221. Coverage
(a) Genetic counseling services are covered for SoonerCare members who meet the criteria for receiving medically necessary genetic testing as set forth in 317:30-5-2 (a)(1)(FF) and for pregnant/postpartum SoonerCare members as set forth in this section. Services for pregnant/postpartum SoonerCare members must be referred by a provider involved in the provision of obstetric or pediatric care. Members are eligible for genetic counseling during pregnancy which includes ~~sixty (60) days~~twelve (12) months postpartum. Reasons for genetic counseling include but are not limited to the following:

(1) Advanced maternal age;
(2) Abnormal maternal serum first or second screening;
(3) Previous child or current fetus/infant with an abnormality;
(4) Consanguinity/incest;
(5) Parent is a known carrier or has a family history of a genetic condition;
(6) Parent was exposed to a known or suspected reproductive hazard;
(7) Previous fetal demise, stillbirth, or neonatal death involving known/suspected abnormalities;
(8) History of recurrent pregnancy loss; or
(9) Parent(s) are in an ethnic or racial group associated with an increased risk for specific genetic conditions.

(b) These services may be provided in an office or outpatient setting.

317:30-5-222. Reimbursement
(a) Counseling services must be billed using appropriate CPT codes and guidelines and must be medically necessary. SoonerCare does not allow more than six units ~~(30 minutes = 1 unit)~~[thirty (30) minutes = one (1) unit] per pregnancy including ~~60 days~~twelve (12) months postpartum care.
(b) Genetic Counselors who are employed by or remunerated by another provider may not bill the SoonerCare program directly for services if that billing would result in duplicate payment for the same service.

PART 20. LACTATION CONSULTANTS

317:30-5-232. Coverage
Lactation Consultant services are covered for pregnant women and women up to ~~60 days~~twelve (12) months postpartum. SoonerCare members may self-refer or be referred by any

provider. Reasons for lactation services include but are not limited to the following:

(1) ~~prenatal~~Prenatal education/training for ~~first time~~first-time mothers;

(2) ~~women~~Women who have not previously breastfed, have a history of breastfeeding difficulty, have identified risk factors for breastfeeding difficulty or lactation insufficiency (e.g., history of breast surgery, infertility, hormonal imbalance, diabetes, obesity);

(3) ~~women~~Women expecting an infant with risk factors for ineffective breastfeeding (e.g., preterm, multiples, congenital birth defects);

(4) ~~latch on~~Latch-on difficulties;

(5) ~~low~~Low milk supply;

(6) ~~breastfeeding~~Breastfeeding a premature baby (~~36~~thirty-six (36) weeks or less gestation);

(7) ~~breastfeeding~~Breastfeeding multiples; and

(8) ~~a~~A baby with special needs (e.g., Down Syndrome, cleft lip/or palate).

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

317:35-5-6. Determining categorical relationship to pregnancy-related services

(a) For applications made prior to January 1, 2014, categorical relationship to pregnancy-related services can be established by determining through medical evidence that the individual is currently or has been pregnant. Pregnancy must be verified by providing medical proof of pregnancy within ~~30~~thirty (30) days of application submission. OKDHS form 08MA005E, Notification of Needed Medical Services, is not required but will be accepted as medical verification. If proof of pregnancy is not provided within ~~30~~thirty (30) days of application submission, SoonerCare benefits will be closed for the pregnant woman at the end of the thirty (30) day period. The expected date of delivery must be established either by information from the applicant's physician or certified nurse midwife or the member's statement.

(b) Effective January 1, 2014, women who are pregnant, including ~~60 days~~twelve (12) months postpartum, are related to the pregnant women group. Pregnancy does not have to be verified unless the declaration that an applicant or member is pregnant is not reasonably compatible with other information available to the agency. The individual must also provide the expected date of delivery.

SUBCHAPTER 6. SOONERCARE FOR PREGNANT WOMEN AND FAMILIES WITH CHILDREN

PART 7. CERTIFICATION, REDETERMINATION AND NOTIFICATION

317:35-6-60. Certification for SoonerCare for pregnant women and families with children

(a) **General rules of certification.**

(1) An individual determined eligible for SoonerCare may be certified for a prospective period of coverage on or after the date of certification.

(2) In accordance with 42 Code of Federal Regulations (C.F.R.) § 435.915 and Oklahoma Administrative Code (OAC) 317:35-6-60.2, an individual may also be determined eligible and certified for a retroactive period of coverage during the three (3) month period directly prior to the date of application. This only applies if the individual received covered medical services at any time during that period~~,~~ and would have been eligible for SoonerCare at the time he or she received the services, regardless of whether the individual is alive when application for Medicaid is made. An individual may be eligible for the retroactive period even though ineligible for the prospective period.

(3) The individual who is categorically needy and related to pregnancy-related services retains eligibility for the period covering prenatal, delivery, and postpartum periods without regard to eligibility for other household members in the case. Eligibility during the postpartum period does not apply to women receiving pregnancy-related coverage under Title XXI.

(b) **Certification as a TANF (cash assistance) recipient.** A categorically needy individual who is determined eligible for TANF is certified effective the first day of the month of TANF eligibility.

(c) **Certification of non-cash assistance individuals related to the children and parent and caretaker relative groups.** The certification period for the individual related to the children or parent and caretaker relative groups is twelve (12) months. The certification period can be less than twelve (12) months if the individual:

(1) Is certified as eligible in a money payment case during the twelve-month (12-month) period;

(2) Is certified for long-term care during the twelve-month (12-month) period;

(3) Becomes ineligible for SoonerCare after the initial month; or

(4) Becomes financially ineligible.

(A) If an income change after certification causes the case to exceed the income standard, the case is closed.

(B) Individuals, however, who are determined pregnant and financially eligible continue to be eligible for pregnancy-related services through the prenatal, delivery and postpartum period, regardless of income changes. A pregnant individual included in a TANF case which closes continues to be eligible for pregnancy-related services through the postpartum period.

(d) **Certification of individuals related to pregnancy-related services.** The certification period for the individual related to pregnancy-related services will cover the prenatal, delivery and postpartum periods. The postpartum period is defined as the ~~two (2)~~twelve (12) months following the month the pregnancy ends. Financial eligibility is based on the income received in the first month of the certification period. No consideration is given to changes in income after certification.

(e) **Certification of newborn child deemed eligible.**

(1) Every newborn child is deemed eligible on the date of birth for SoonerCare when the child is born to a woman who is eligible for and enrolled in pregnancy-related services as categorically needy. The newborn child is deemed eligible through the last day of the month the newborn child attains the age of one (1) year. The newborn child's eligibility is not dependent on the mother's continued eligibility. The mother's coverage may expire at the end of the postpartum period; however, the newborn child is deemed eligible until age one (1). The newborn child's eligibility is based on the original eligibility determination of the mother for pregnancy-related services, and consideration is not given to any income or resource changes that occur during the deemed eligibility period.

(2) The newborn child is deemed eligible for SoonerCare as long as he/she continues to live in Oklahoma. In accordance with 42 C.F.R. § 435.117, no other conditions of eligibility are applicable, including social security number enumeration, child support referral, and citizenship and identity verification. However, it is recommended that social security number enumeration be completed as soon as possible after the newborn child's birth. It is also recommended that a child support referral be completed, if needed, as soon as possible and sent to the Oklahoma Child Support Services (OCSS) division at DHS. The referral enables child support services to be initiated.

(3) When a categorically needy newborn child is deemed eligible for SoonerCare, he/she remains eligible through the end of the month that the newborn child reaches age one (1). If the child's eligibility is moved from the case where initial eligibility was established, it is required that the newborn receive the full deeming period. The certification period is shortened only in the event the child:

(A) ~~loses~~Loses Oklahoma residence; or

(B) ~~expires~~Expires.

(4) A newborn child cannot be deemed eligible when the mother's only coverage was presumptive eligibility, and continued eligibility was not established.

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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 3. NON-MEDICAL ELIGIBILITY REQUIREMENTS

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

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

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

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

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

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

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

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

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

(A) Most reliable forms of citizenship verification are:

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

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

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

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

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

(B) Other less reliable forms of citizenship verification are:

(i) An extract of a hospital record on hospital letterhead established at the time of the person's birth that was created five (5) years before the initial application date and that indicates a U.S. place of birth. For children under sixteen (16) the evidence must have been created near the time of birth or five (5) years before the date of application;
(ii) Life, health, or other insurance record showing a U.S. place of birth that was created at least five (5) years before the initial application date and that indicates a U.S. place of birth;
(iii) Federal or state census record showing U.S. citizenship or a U.S. place of birth (generally for persons born 1900 through 1950). The census record must also show the applicant's/member's age; or
(iv) One (1) of the following items that show a U.S. place of birth and was created at least five (5) years before the application for SoonerCare. This evidence must be one (1) of the following and show a U.S. place of birth:

(I) Seneca Indian tribal census record;
(II) Bureau of Indian Affairs tribal census records of the Navajo Indians;
(III) U.S. State Vital Statistics official notification of birth registration;
(IV) An amended U.S. public birth record that is amended more than five (5) years after the person's birth; or
(V) Statement signed by the physician or midwife who was in attendance at the time of birth.

(3) Acceptable evidence of identity that must accompany citizenship evidence listed in (A) and (B) of paragraph (2) of this subsection includes:

(A) A driver's license issued by a U.S. state or territory with either a photograph of the individual or other identifying information such as name, age, sex, race, height, weight, or eye color;
(B) A school identification card with a photograph of the individual;
(C) An identification card issued by federal, state, or local government with the same information included on driver's licenses;
(D) A U.S. military card or draft record;
(E) A U.S. military dependent's identification card;

(F) A Native American Tribal document including Certificate of Degree of Indian Blood, or other U.S. American Indian/Alaska Native Tribal document with a photograph of the individual or other personal identifying information;

(G) A U.S. Coast Guard Merchant Mariner card;

(H) A state court order placing a child in custody as reported by the OKDHS;

(I) For children under sixteen (16), school records may include nursery or daycare records;

(J) If none of the verification items on the list are available, an affidavit may be used for children under sixteen (16). An affidavit is only acceptable if it is signed under penalty of perjury by a parent or guardian stating the date and place of the birth of the child and cannot be used if an affidavit for citizenship was provided.

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

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

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

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

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

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

(i) There must be at least two (2) affidavits by two (2) individuals who have personal knowledge of the event(s) establishing the 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) **Noncitizen eligibility.** SoonerCare services are provided as described to the defined groups as indicated in this subsection if they meet all other factors of eligibility, including but not limited to residency requirements, and if the relevant noncitizen status is verifiable by federally approved means.

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

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

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

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

(i) A noncitizen who is lawfully admitted for permanent residence under the Immigration and Nationality Act [INA], per 8 U.S.C. 1101 et seq.;

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

(iii) A noncitizen who is admitted to the U.S. under INA section 207 refugee, per 8 U.S.C. 1157;

(iv) A noncitizen who is paroled into the U.S. under INA section 212(d)(5), per 8 U.S.C. 1182(d)(5), for a period of at least one (1) year;

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

(vi) A noncitizen who is granted conditional entry before 1980 pursuant to INA section 203(a)(7), per 8 U.S.C. 1153(a)(7), as in effect prior to April 1, 1980;

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

(viii) A noncitizen who, or whose parent or child, has been battered or subjected to extreme cruelty in the U.S. by a U.S. citizen or lawful permanent resident spouse or parent or by a member of the spouse's or parent's family residing in the same household, except during any period in which the individual responsible for such battery or cruelty resides in the same household or family eligibility unit as the individual subjected to such battery or cruelty and only when the alien meets all of the following requirements:

(I) The noncitizen, if not the individual subjected to battery or extreme cruelty, had no active participation in the battery or cruelty;

(II) The noncitizen is a credible victim; and

(III) The noncitizen is able to show a substantial connection between the need for benefits sought and the batter or extreme cruelty; and

(IV) The noncitizen has been approved or has a petition pending which sets forth a prima facie case for one of the following: status as a spouse or child of a U.S. citizen under INA 204(a)(1)(A); classification under INA 204(a)(1)(B)(ii) or (iii); suspension of deportation under INA 244(a)(3); status as a spouse or child of a U.S. citizen under INA 204(a)(1)(A); or classification under INA 204(a)(1)(B); or cancellation of removal under INA 240A(b)(2).

(ix) A noncitizen who is or has been a victim of a severe form of trafficking in persons and who has been granted nonimmigrant status under INA 101(a)(15)(T) or who has a pending application that sets forth a prima facie case for eligibility for such immigration status; or

(x) Beginning December 27, 2020, a noncitizen who lawfully resides in the state in accordance with the Compacts of Free Association between the Government of the United States and the Governments of the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau.

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

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

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

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

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

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

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

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

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

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

(ii) The noncitizen has either:

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

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

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

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

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

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

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

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

(E) **Five-year wait exception for COFA migrants.** Per 8 U.S.C. 1613(b)(3) and as of December 27, 2020, any noncitizen who lawfully resides in the state in accordance with the Compacts of Free Association between the Government of the United States and the Governments of the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau is, with regard to the Medicaid program, are not subject to the five-year waiting period unless and until the individual=s status is adjusted to lawful permanent resident (LPR), at which time the five year waiting period must be calculated, unless the individual meets a separate exception to the five-year waiting period:

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

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

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

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

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

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

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

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

(B) **Certain Iraqi nationals.**

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

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

(III) The child of a principal noncitizen.

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

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

(C) **Certain Afghan nationals.**

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

(I) Principal noncitizens who have provided relevant service to the U.S. government or the International Security Assistance Force, while employed by or on behalf of the U.S. government in Afghan, for not less than one (1) year

beginning on or after October 7, 2001, and who have experienced or are experiencing an ongoing serious threat as a consequence of that employment;

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

(III) The child of a principal noncitizen.

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

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

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

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

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

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

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

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

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

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

(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.

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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)~~Statewide Health Information Exchange

(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.~~The Office of the State Coordinator for HIE is the office within the Oklahoma Health Care Authority (OHCA) that holds the power and duty to oversee the state-designated entity for health information exchange, as described under 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.~~

(1) **"Health care facility"** means any public or private organization, corporation, authority, partnership, sole proprietorship, association, agency, network, joint venture, or other entity that is established and appropriately licensed in this state to administer or provide health care services. Health care facility includes but is not limited to hospitals, medical centers, ambulatory surgery centers, physicians' offices, clinics, pharmacies, laboratories, nursing homes, rehabilitation centers, home care agencies, hospices, and long-term care agencies.

(2) **"Health care provider"** means a health care facility or person who is licensed, certified, or otherwise authorized by the laws of this state to administer health care in the ordinary course of business or practice of a profession.

(3) **"Health care services"** means any service provided by a health care provider, or by any individual working under the supervision of a health care provider, that relate to:

(A) The diagnosis, prevention, or treatment of any human disease or impairment; or

(B) The assessment or care of the health of human beings.

(4) **"Report data to"** means that health care providers shall establish a direct, secure connection to the state designated entity for HIE and submit data in the form and format as defined on the Office of the State Coordinator for HIE website.

(5) **"State designated entity (SDE)"** means the health information exchange organization designated by the State of Oklahoma under 63 O.S. § 1-133. The name and contact information for the state designated entity for HIE is found on the Office of the State Coordinator for HIE website.

(6) **"Utilize"** means to actively use the HIE services to securely access records during and/or in support of patient treatment or health care operations.

~~(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.~~

(d) **Required participation.**

(1) By July 1, 2023, all health care providers as defined above and who are licensed by and located in the state of Oklahoma shall report data to and utilize the SDE.

(2) The state acknowledges that establishing the connection to the HIE can take substantial time to complete. A health care provider will be considered to have met the requirement to report data to the SDE as long as the provider is actively engaged with the HIE in the onboarding process of connecting to the HIE, and as reported by the SDE.

(3) In order to meet the requirement to utilize the SDE, each health care provider shall secure access to HIE services by the following:

(A) Completing and maintaining an active participation agreement with the SDE for HIE;

(B) Executing annually an order form electing at a minimum the set of core services relevant to the provider practice or organization; and

(C) Maintaining good standing as a participating organization in the SDE for HIE by remaining compliant with the terms and conditions, network policies and procedures, and paying all fees associated with the services elected on the order form.

(4) The SDE will provide a utilization report for providers and organizations to the Office of the State Coordinator for HIE on an annual basis. Utilization metrics and benchmarks will be determined annually by the Office of the State Coordinator for HIE in consultation with the SDE and will be published three (3) months prior to the commencement of each State Fiscal Year.

(e) **Exemptions.**

(1) The Office of the State Coordinator for HIE, at its discretion, may allow exemptions from the requirement to report data to and/or utilize the SDE beginning July 1, 2023. Exemptions may be granted on the basis of type of health care provider, financial hardship, size, or technological capability of a health care provider or organization, or such other bases as may be provided by rules promulgated by OHCA.

(2) Exemptions granted will be consistent with the requirements of the policies herein and current state and federal laws and regulations. The exemption criteria as specified by the Office of the State Coordinator for HIE as well as broad-based exemptions granted can be found on the HIE website.

(3) Any health care provider as defined above that believes they meet the criteria to be exempt from reporting data to and/or utilizing the SDE must submit a request for exemption as specified on the Office of the State Coordinator for HIE website. Health care providers that are included within a broad-based exemption as identified on the HIE website are not required to request an exemption on an individual basis.

(4) The authorization of an exemption is not permanent and must be renewed annually with the Office of the State Coordinator for HIE unless otherwise specified.

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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

317:30-5-763. Description of services

Services included in the ADvantage program are:

(1) **Case management.**

(A) Case management services, regardless of payment source, assist a member to gain access to medical, social, educational, or other services that may benefit him or her to maintain health and safety. Case managers:

(i) Initiate and oversee necessary assessments and reassessments to establish or reestablish waiver program eligibility;

(ii) Develop the member's comprehensive person-centered service plan, listing only the services necessary to prevent institutionalization of the member, as determined through the assessments;

(iii) Initiate the addition of necessary services or deletion of unnecessary services, as dictated by the member's condition and available support; and

(iv) Monitor the member's condition to ensure delivery and appropriateness of services and initiate person-centered service plan reviews. Case managers submit an individualized ~~Form 02CB014,~~ Services Backup Plan, on all initial service plans, annually at reassessment, and on updates as appropriate throughout the year, reflecting risk factors and measures in place to minimize risks. When a member requires hospital or nursing facility (NF) services, the case manager:

(I) Assists the member in accessing institutional care and, as appropriate, periodically monitors the member's progress during the institutional stay;

(II) Helps the member transition from institution to home by updating the person-centered service plan;

(III) Prepares services to start on the date the member is discharged from the institution; and

(IV) Must meet ADvantage program minimum requirements for qualification and training prior to providing services to ADvantage members.

(B) Providers of ADvantage services for the member or for those who have an interest in or are employed by an ADvantage provider for the member must not provide case management or develop the person-centered service plan, except when the ADvantage Administration (AA) demonstrates the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area, also provides other ADvantage services. Prior to providing services to members receiving ~~Consumer Directed~~Consumer Directed Personal Assistance Services and Supports (CD-PASS), case manager supervisors, and case managers are required to receive training and demonstrate knowledge regarding the CD-PASS service delivery model, "Independent Living Philosophy," and demonstrate competency in person-centered planning.

(C) Providers may only claim time for billable case management activities, described as:

(i) Any task or function, per Oklahoma Administrative Code (OAC) 317:30-5-763(1)(A) that only an ADvantage case manager ~~can perform on behalf of the member~~, because of skill, training, or authority, can perform on behalf of a member; and

(ii) Ancillary activities, such as clerical tasks, including, but not limited to, mailing, copying, filing, faxing, driving time, or supervisory and administrative activities are not billable case management activities. The administrative cost of these activities and other normal and customary business overhead costs are included in the reimbursement rate for billable activities.

(D) Case management services are prior authorized and billed per fifteen (15) minute unit of service using the rate associated with the location of residence of the member served.

(i) Case management services are billed using a standard rate for reimbursement for billable service activities provided to a member who resides in a county with a population density greater than twenty-five (25) persons per square mile.

(ii) Case management services are billed using a very rural/outside providers' service area rate for billable service activities provided to a member who resides in a county with a population density equal to, or less than twenty-five (25) persons per square mile. Exceptions are services to members who reside in Oklahoma ~~Department of~~ Human Services (OKDHS) Community Living, Aging and Protective Services identified zip codes in Osage County adjacent to the metropolitan areas of Tulsa and Washington counties. Services to these members are prior authorized and billed using the standard rate.

(iii) The latest United States Census, Oklahoma counties population data is the source for determination of whether a member resides in a county with a population density equal to, or less than twenty-five (25) persons per square mile~~,~~ or resides in a county with a population density greater than twenty-five (25) persons per square mile.

(2) **Respite.**

(A) Respite services are provided to members who are unable to care for themselves. Services are provided on a short-term basis due to the primary caregiver's absence or need for relief. Payment for respite care does not include room and board costs unless more than seven (7) hours are provided in a NF. Respite care is only utilized when other sources of care and support are exhausted. Respite care is only listed on the service plan when it is necessary to prevent institutionalization of the member. Units of services are limited to the number of units approved on the service plan.

(B) In-home respite services are billed per fifteen (15) minute unit of service. Within any one (1) day period, a minimum of eight (8) units [two (2) hours] must be provided with a maximum of twenty-eight (28) units [seven (7) hours] provided. The service is provided in the member's home.

(C) Facility-based extended respite is filed for a per diem rate when provided in a NF. Extended respite must be at least eight (8) hours in duration.

(D) In-home extended respite is filed for a per diem rate. A minimum of eight (8) hours must be provided in the member's home.

(3) **Adult day health (ADH) care.**

(A) ADH is furnished on a ~~regularly-scheduled~~regularly scheduled basis for one (1) or more days per week in an outpatient setting. It provides both health and social services

necessary to ensure the member's optimal functioning. Most assistance with activities of daily living (ADLs), such as eating, mobility, toileting, and nail care are integral ~~services~~ to the ADH care service and are covered by the ADH care basic reimbursement rate.

(B) ADH care is a fifteen (15) minute unit of service. No more than eight (8) hours, [thirty-two (32) units] are authorized per day. The number of units of service a member may receive is limited to the number of units approved on the member's approved service plan.

(C) Physical, occupational, and speech therapies are only provided as an enhancement to the basic ADH care service when authorized by the service plan and are billed as a separate procedure. ADH care therapy enhancement is a maximum of one (1) session unit per day of service.

(D) Meals provided as part of this service do not constitute a full nutritional regimen. One (1) meal, that contains at least one-third (1/3) of the current daily dietary recommended intake (DRI), as established by the Food and Nutrition Board of the National Academies of Sciences, Engineering, and Medicine, is provided to those participants who are in the center for four (4) or more hours per day~~,~~ and does not constitute a full nutritional regimen. Member's access to food at any time must also be available in addition to the required meal and is consistent with an individual not receiving Medicaid-funded services and supports.

(E) ~~Personal care~~Personal care service enhancement in ADH is assistance in bathing, hair care, or laundry service, authorized by the person-centered service plan and billed as separate procedures. This service is authorized when an ADvantage waiver member who uses ADH requires assistance with bathing, hair care, or laundry to maintain health and safety. Assistance with bathing, hair care, or laundry ~~service~~ is not a usual and customary ADH care service. ADH personal care enhancement is a maximum of one (1) unit per day of bathing, hair care, or laundry service.

(F) OKDHS Home and Community-Based Services (HCBS) waiver settings have qualities defined in Home and Community-Based Services: Waiver Requirements, 42 Code of Federal Regulations, Section (§) 441.301 (c)(4) based on the individual's needs, defined in the member's authorized service plan.

(i) The ADH center is integrated and supports full access of ADvantage members to the greater community, including opportunities to:

(I) Seek employment and work in competitive integrated ADH Center, not a requirement for persons that are retirement age;

(II) Engage in community life;

(III) Control personal resources; and

(IV) Receive services in the community, to the same degree as individuals not receiving ADvantage Program or other Medicaid HBCS waiver services.

(ii) The ADH is selected by the member from all available service options and given the opportunity to visit and understand the options.

(iii) The ADH ensures the member's rights of privacy, dignity, respect, and freedom from coercion and restraint.

(iv) The ADH optimizes the member's initiative, autonomy, and independence in making life choices including, but not limited to:

(I) Daily activities;

(II) The physical environment; and

(III) Social interactions.

(v) The ADH facilitates the member's choice regarding services and supports including the provider.

(vi) Each member has the freedom and support to control his or her own schedules, activities, and access to food at any time.

(vii) Each member may have visitors whenever he or she chooses.

(viii) The ADH center is physically accessible to the member.

(G) ADH centers that are presumed not to be HCBS settings per 42 C.F.R. § 441.301(c)(5)(v) include, ADH centers:

(i) ~~in~~In a publicly- or privately-owned facility providing inpatient treatment;

(ii) ~~on~~On the grounds of or adjacent to a public institution; and

(iii) ~~with~~With the effect of isolating individuals from the broader community of individuals not receiving ADvantage program or another Medicaid HCBS;

(H) When the ADH is presumed not HCBS, according to 42 C.F.R. § 441.301(c)(5)(v), it may be subject to heightened scrutiny by AA, the Oklahoma Health Care Authority (OHCA), and the Centers for Medicare and Medicaid Services (CMS). The ADH must provide evidence that the ADH portion of the facility has clear administrative, financial, programmatic, and environmental distinctions from the institution and comply with additional monitoring by the AA.

(4) **Environmental modifications**.

(A) Environmental modifications are physical adaptations to the home, required by the member's person-centered service plan that are necessary to ensure the member's health, welfare, and safety or enable the member to function with greater independence in the home, and that without such, the member would require institutionalization. Adaptations or improvements to the home ~~but~~ not of direct medical or remedial benefit to the waiver member are excluded.

(B) All services require prior authorization.

(5) **Specialized medical equipment and supplies.**

(A) Specialized medical equipment and supplies are devices, controls, or appliances specified in the person-centered service plan that enable members to increase their abilities to perform ADLs, or to perceive, control, or communicate with the environment in which they live. Necessary items for life support, ancillary supplies, and equipment necessary for the proper functioning of such items, and durable and non-durable medical equipment not available under the Oklahoma Medicaid State Plan are also included. This service excludes any equipment ~~and/or~~or supply items not of direct medical or remedial benefit to the waiver member and necessary to prevent institutionalization.

(B) Specialized medical equipment and supplies are billed using the appropriate HealthCare Common Procedure Code (HCPC). Reoccurring supplies shipped and delivered to the member are compensable only when the member remains eligible for waiver services, continues to reside in the home, and is not institutionalized in a hospital, skilled nursing facility, or nursing home. It is the provider's responsibility to verify the member's status prior to shipping and delivering these items. Payment for medical supplies is limited to the SoonerCare (Medicaid) rate when established, to the Medicare rate, or to actual acquisition cost, plus thirty percent (30%). All services must have prior authorization.

(6) **Advanced supportive/restorative assistance**.

(A) Advanced supportive/restorative assistance services are maintenance services used to assist a member who has a chronic, yet stable condition. These services assist with ADLs that require devices and procedures related to altered body functions. These services are for maintenance only and are not utilized as treatment services.

(B) Advanced supportive/restorative assistance service is billed per fifteen (15) minute unit of service. The number of units of service a member may receive is limited to the number of units approved on the person-centered service plan.

(7) **Nursing.**

(A) Nursing services are services listed in the person-centered service plan that are within the scope of the state's Nurse Practice Act. These services are provided by a registered nurse (RN), a licensed practical nurse (LPN), or a licensed vocational nurse (LVN) under the supervision of an RN licensed to practice and in good standing in the state in which services are provided. Nursing services may be provided on an intermittent or part-time basis or may be comprised of continuous care. The provision of the nursing service works to prevent or postpone the institutionalization of the member.

(B) Nursing services are services of a maintenance or preventative nature provided to members with stable, chronic conditions. These services are not intended to treat an acute health condition and may not include services reimbursable under either the Medicaid or Medicare home health program. This service primarily provides nurse supervision to the personal care assistant or to the advanced supportive/restorative assistance aide and assesses the member's health and prescribed medical services to ensure they meet the member's needs as specified in the person-centered service plan. A nursing assessment/evaluation, on-site visit is made to each member, with additional visits for members with advanced supportive/restorative assistance services authorized to evaluate the condition of the member and medical appropriateness of services. An assessment/evaluation report is forwarded to the ADvantage program case manager and the skilled nurse in accordance with review schedule determined between the case manager and the skilled nurse and outlined in the member's person-centered service plan, to report the member's condition or other significant information concerning each ADvantage member.

(i) The ADvantage program case manager may recommend authorization of nursing services as part of the interdisciplinary team planning for the member's person-centered service plan and/or assessment/evaluation of the:

(I) Member's general health, functional ability, and needs; and/or

(II) Adequacy of personal care and/or advanced supportive/restorative assistance services to meet the member's needs, including providing on-the-job training and competency testing for personal care or advanced supportive/restorative care aides per rules and regulations for the delegation of nursing tasks established by the ~~board of nursing~~Board of Nursing in the state in which services are provided.

(ii) In addition to assessment/evaluation, the ADvantage program case manager may recommend authorization of nursing services to:

(I) Prepare a one (1) week supply of insulin syringes for a person who is blind and has diabetes and can safely self-inject the medication but cannot fill his or her own syringe. This service includes monitoring the member's continued ability to self-administer the insulin;

(II) Prepare oral medications in divided daily compartments for a member who self-administers prescribed medications but needs assistance and monitoring due to a minimal level of disorientation or confusion;

(III) Monitor a member's skin condition when a member is at risk for skin breakdown due to immobility or incontinence or the member has a chronic stage II decubitus ulcer requiring maintenance care and monitoring;

(IV) Provide nail care for ~~the~~a member with diabetes or ~~member~~ who has circulatory or neurological compromise; and

(V) Provide consultation and education to the member, member's family, or other informal caregivers identified in the person-centered service plan, regarding the nature of the member's chronic condition. Skills training, including return skills demonstration to establish competency, to the member, family, or other informal caregivers as specified in the person-centered service plan for preventive and rehabilitative care procedures are also provided.

(C) Nursing service includes interdisciplinary team planning and recommendations for the member's person-centered service plan development and/or assessment/evaluation or for other services within the scope of the nurse's license, including private duty nursing. Nursing services are billed per fifteen (15) minute unit of service. A specific procedure code is used to bill for interdisciplinary team planning and recommendations for the member's person-centered service plan, but other procedure codes may be used to bill for all other authorized nursing services. A maximum of eight (8) units [two (2) hours], per day of nursing for service plan development and assessment evaluation are allowed. An agreement by a provider to perform a nurse evaluation is also an agreement to provide the Medicaid in-home care services for which the provider is certified and contracted. Reimbursement for a nurse evaluation is denied when the provider that produced the nurse evaluation fails to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted.

(8) **Skilled nursing services.**

(A) Skilled nursing services are listed in the person-centered service plan, ~~that are~~ within the state's Nurse Practice Act scope, ~~of the state's Nurse Practice Act~~ and are ordered by a licensed physician, osteopathic physician, physician assistant, or ~~an~~ advanced practice nurse, and are provided by ~~an~~a RN, LPN, or LVN under the supervision of ~~an~~a RN, licensed to practice and in good standing in the state ~~in which~~where services are provided. Skilled nursing services provided in the member's home or other community setting are services requiring the specialized skills of a licensed nurse. The scope and nature of these services are intended for treatment of a disease or a medical condition and are beyond the scope of ADvantage nursing services. These intermittent nursing services are targeted toward a prescribed treatment or procedure that must be performed at a specific time or other predictable rate of occurrence. The RN contacts the member's physician to obtain necessary information or orders pertaining to the member's care. When the member has an ongoing need for service activities requiring more or less units than authorized, the RN must recommend, in writing, that the service plan be revised.

(B) Skilled nursing services are provided on an intermittent or part-time basis, and billed per fifteen (15) minute unit of service. Skilled nursing services are provided when nursing services are not available through Medicare or other sources or when SoonerCare plan

nursing services limits are exhausted. Amount, frequency, and duration of services are prior-authorized in accordance with the member's person-centered service plan.

(9) **Home-delivered meals.**

(A) Home-delivered meals provide one (1) meal per day. A home-delivered meal is a meal prepared in advance and brought to the member's home. Each meal must have a nutritional content equal to at least one-third (1/3) of the dietary reference intakes as established by the Food and Nutrition Board of the National Academies of Sciences, Engineering and Medicine. Home-delivered meals are only provided to members who are unable to prepare meals and lack an informal provider to do meal preparation.

(B) Home-delivered meals are billed per meal, with one (1) meal equaling one (1) unit of service. The limit of the number of units a member is allowed to receive is in accordance with the member's person-centered service plan. The provider must obtain a signature from the member or the member's representative at the time the meal is delivered. In the event the member is temporarily unavailable, such as at a doctor's appointment, and the meal is left at the member's home, the provider must document the reason a signature was not obtained. The signature logs must be available for review.

(10) **Occupational therapy services.**

(A) Occupational therapy services are services that increase functional independence by enhancing the development of adaptive skills and performance capacities of members with physical disabilities and related psychological and cognitive impairments. Services are provided in the member's home and are intended to help the member achieve greater independence, enabling him or her to reside and participate in the community. Treatment involves the therapeutic use of self-care, work, and play activities, and may include modification of the tasks or environment to enable the member to achieve maximum independence, prevent further disability, and maintain health. Under a physician's order, a licensed occupational therapist evaluates the member's rehabilitation potential and develops an appropriate written, therapeutic regimen. The regimen utilizes paraprofessional, occupational therapy assistant services, within the limitations of his or her practice, working under the supervision of a licensed occupational therapist. The regimen includes education and training for informal caregivers to assist with ~~and/or~~or maintain services when appropriate. The occupational therapist ensures monitoring and documentation of the member's rehabilitative progress and reports to the member's case manager and physician to coordinate the necessary addition or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Occupational therapy services are billed per fifteen (15) minute unit of service. Payment is not allowed solely for written reports or record documentation.

(11) **Physical therapy services.**

(A) Physical therapy services are those services that maintain or improve physical disability through the evaluation and rehabilitation of members disabled by pain, disease, or injury. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Treatment involves the use of physical therapeutic means, such as massage, manipulation, therapeutic exercise, cold and/or heat therapy, hydrotherapy, electrical stimulation, and light therapy. Under a physician's order, a licensed physical therapist evaluates the member's rehabilitation potential and develops an appropriate, written, therapeutic regimen. Under the Oklahoma Physical Therapy Practice Act, a physical therapist may

evaluate a member's rehabilitation potential and develop and implement an appropriate, written, therapeutic regimen without a referral from a licensed health care practitioner for a period not to exceed thirty (30) calendar days. Any treatment required after the thirty (30) calendar day period requires a prescription from a physician or the physician's assistant of the licensee. The regimen utilizes paraprofessional physical therapy assistant services, within the limitations of his or her practice, working under the licensed physical therapist's supervision ~~of the licensed physical therapist~~. The regimen includes education and training for informal caregivers to assist with and/or maintain services when appropriate. The licensed physical therapist ensures monitoring and documentation of the member's rehabilitative progress and reports to the member's case manager and physician to coordinate the necessary addition or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Physical therapy services ~~are~~ may be authorized as ADH care therapy enhancement and are a maximum of one (1) session unit per day of service. Payment is not allowed solely for written reports or record documentation.

(12) **Speech and language therapy services.**

(A) Speech and language therapy services are those that maintain or improve speech and language communication and swallowing disorders/disability through the evaluation and rehabilitation of members disabled by pain, disease, or injury. Services are provided in ~~the member's home~~an ADH service setting and are intended to help the member achieve greater independence to reside and participate in the community. Services involve the use of therapeutic means, such as evaluation, specialized treatment, or development and oversight of a therapeutic maintenance program. Under a physician's order, a licensed speech and language pathologist evaluates the member's rehabilitation potential and develops an appropriate, written, therapeutic regimen. The regimen utilizes speech language pathology assistant services within the limitations of his or her practice, working under the supervision of the licensed speech and language pathologist. The regimen includes education and training for informal caregivers to assist with~~,~~ and/or maintain services when appropriate. The speech and language pathologist ensures monitoring and documentation of the member's rehabilitative progress and reports to the member's case manager and physician to coordinate the necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Speech and language therapy services are authorized as ADH care-therapy enhancement and are a maximum of one (1) session unit per day of service. Payment is not allowed solely for written reports or record documentation.

(13) **Hospice services.**

(A) Hospice services are palliative and comfort care provided to the member and his or her family when a physician certifies the member has a terminal illness, with a life expectancy of six (6) months or less, and orders hospice care. ADvantage hospice care is authorized for a six (6) month period and requires physician certification of a terminal illness and orders of hospice care. When the member requires more than six (6) months of hospice care, a physician or nurse practitioner must have a face-to-face visit with the member thirty (30) calendar days prior to the initial hospice authorization end-date, and re-certify that the member has a terminal illness, has six (6) months or less to live, and orders additional hospice care. After the initial authorization period, additional periods of ADvantage hospice may be authorized for a maximum of sixty (60) calendar day

increments with physician certification that the member has a terminal illness and six (6) months or less to live. A member's person-centered service plan that includes hospice care must comply with Waiver requirements to be within total person-centered service plan cost limits.

(B) A hospice program offers palliative and supportive care to meet the special needs arising out of the physical, emotional, and spiritual stresses experienced during the final stages of illness, through the end of life, and bereavement. The member signs a statement choosing hospice care instead of routine medical care with the objective to treat and cure the member's illness. Once the member has elected hospice care, the hospice medical team assumes responsibility for the member's medical care for the illness in the home environment. Hospice care services include nursing care, physician services, medical equipment and supplies, drugs for symptom and pain relief, home health aide and personal care services, physical, occupational and speech therapies, medical social services, dietary counseling, and grief and bereavement counseling to the member and/or the member's family.

(C) A hospice person-centered service plan must be developed by the hospice team in conjunction with the member's ADvantage case manager before hospice services are provided. The hospice services must be related to the palliation or management of the member's terminal illness, symptom control, or to enable the member to maintain ADL and basic functional skills. A member who is eligible for Medicare hospice provided as a Medicare Part A benefit, is not eligible to receive ADvantage hospice services.

(D) Hospice services are billed per diem of service for days covered by a hospice person-centered service plan and while the hospice provider is responsible for providing hospice services as needed by the member or member's family. The maximum total annual reimbursement for a member's hospice care within a twelve (12) month period is limited to an amount equivalent to eighty-five percent (85%) of the Medicare hospice cap payment, and must be authorized on the member's person-centered service plan.

(14) **ADvantage personal care.**

(A) ADvantage personal care is assistance to a member in carrying out ADLs, such as bathing, grooming, and toileting or in carrying out instrumental activities of daily living (IADLs), such as preparing meals and laundry service, to ensure the member's personal health and safety, or to prevent or minimize physical health regression or deterioration. Personal care services do not include service provision of a technical nature, such as tracheal suctioning, bladder catheterization, colostomy irrigation, or the operation and maintenance of equipment of a technical nature.

(B) ADvantage home care agency skilled nursing staff working in coordination with an ADvantage case manager is responsible for the development and monitoring of the member's personal care services.

(C) ADvantage personal care services are prior-authorized and billed per fifteen (15) minute unit of service, with units of service limited to the number of units on the ADvantage approved person-centered service plan.

(15) **Personal emergency response system (PERS).**

(A) PERS is an electronic device that enables members at high risk of institutionalization, to secure help in an emergency. Members may also wear a portable "help" button to allow for mobility. PERS is connected to the person's phone and programmed to signal, per member preference, a friend, relative, or a response center, once the "help" button is

activated. For an ADvantage member to be eligible for PERS service, the member must meet all ~~of the~~ service criteria in (i) through (vi). The member:

(i) Has a recent history of falls as a result of an existing medical condition that prevents the member from getting up unassisted from a fall;

(ii) Lives alone and without a regular caregiver, paid or unpaid, and therefore is left alone for long periods of time;

(iii) Demonstrates the capability to comprehend the purpose of and activate the PERS;

(iv) Has a health and safety plan detailing the interventions beyond the PERS to ensure the member's health and safety in his or her home;

(v) Has ~~has~~ a disease management plan to implement medical and health interventions that reduce the possibility of falls by managing the member's underlying medical condition causing the falls; and

(vi) Will likely avoid premature or unnecessary institutionalization as a result of PERS.

(B) PERS services are billed using the appropriate HCPC procedure code for installation, monthly service, or PERS purchase. All services are prior authorized per the ADvantage approved service plan.

(16) **CD-PASS.**

(A) CD-PASS are personal services assistance (PSA) and advanced personal services assistance (APSA) that enables a member in need of assistance to reside in his or her home and community of choice, rather than in an institution; and to carry out functions of daily living, self-care, and mobility. CD-PASS services are delivered as authorized on the person-centered service plan. The member becomes the employer of record and employs the PSA and the APSA. The member is responsible, with assistance from ADvantage program administrative Financial Management Services (FMS), for ensuring the employment complies with state and federal labor law requirements. The member/employer may designate an adult family member or friend, who is not a PSA or APSA to the member, as an "authorized representative" to assist in executing the employer functions. The member/employer:

(i) Recruits, hires, and, as necessary, discharges the PSA or APSA;

(ii) Ensures ~~that~~ the PSA or APSA has received sufficient instruction and training. If needed, the member/employer will work with the consumer-directed agent/case manager (CDA) to obtain training assistance from ADvantage skilled nurses. Prior to performing an APSA task for the first time, the APSA must demonstrate competency in the tasks in an on-the-job training session conducted by the member, and the member must document the attendant's competency in performing each task in the APSA's personnel file;

(iii) Determines where and how the PSA or APSA works, hours of work, what is to be accomplished and, within individual budget allocation limits, wages to be paid for the work;

(iv) Supervises and documents employee work time; and

(v) Provides tools and materials for work to be accomplished.

(B) The services the PSA may provide include:

(i) Assistance with mobility and transferring in and out of bed, wheelchair, or motor vehicle, or all;

(ii) Assistance with routine bodily functions, such as:

(I) Bathing and personal hygiene;

(II) Dressing and grooming; and

(III) Eating, including meal preparation and cleanup;

(iii) Assistance with home services, such as shopping, laundry, cleaning, and seasonal chores;

(iv) Companion assistance, such as letter writing, reading mail, and providing escort or transportation to participate in approved activities or events. "Approved activities or events," means community, civic participation guaranteed to all citizens including, but not limited to, exercise of religion, voting or participation in daily life activities in which exercise of choice and decision making is important to the member, and may include shopping for food, clothing, or other necessities, or for participation in other activities or events specifically approved on the person-centered service plan.

(C) An APSA provides assistance with ADLs to a member with a stable, chronic condition, when such assistance requires devices and procedures related to altered body function if such activities, in the opinion of the attending physician or licensed nurse, may be performed if the member were physically capable, and the procedure may be safely performed in the home. Services provided by the APSA are maintenance services and are never used as therapeutic treatment. Members who develop medical complications requiring skilled nursing services while receiving APSA services are referred to his or her attending physician, who may order home health services, as appropriate. APSA includes assistance with health maintenance activities that may include:

(i) Routine personal care for persons with ostomies, including tracheotomies, gastrostomies, and colostomies with well-healed stoma, external, indwelling, and suprapubic catheters that include changing bags and soap and water hygiene around the ostomy or catheter site;

(ii) Removing external catheters, inspecting skin, and reapplication of same;

(iii) Administering prescribed bowel program, including use of suppositories and sphincter stimulation, and enemas pre-packaged only without contraindicating rectal or intestinal conditions;

(iv) Applying medicated prescription lotions or ointments and dry, non-sterile dressings to unbroken skin;

(v) Using a lift for transfers;

(vi) Manually assisting with oral medications;

(vii) Providing passive range of motion (non-resistive flexion of joint) therapy, delivered in accordance with the person-centered service plan unless contraindicated by underlying joint pathology;

(viii) Applying non-sterile dressings to superficial skin breaks or abrasions; and

(ix) Using universal precautions as defined by the Centers for Disease Control and Prevention.

(D) FMS are program administrative services provided to participating CD-PASS members/employers by AA. FMS are employer-related assistance that provides Internal Revenue Service (IRS) fiscal reporting agent and other financial management tasks and functions, including, but not limited to:

(i) Processing employer payroll, after the member/employer has verified and approved the employee timesheet, at a minimum of semi-monthly, and associated

withholding for taxes, or for other payroll withholdings performed on behalf of the member as employer of the PSA or APSA;

(ii) Other employer-related payment disbursements as agreed to with the member/employer and in accordance with the member/employer's individual budget allocation;

(iii) Responsibility for obtaining criminal and abuse registry background checks on prospective hires for PSA or APSA on the member/employer's behalf;

(iv) Providing orientation and training regarding employer responsibilities, as well as employer information and management guidelines, materials, tools, and staff consultant expertise to support and assist the member to successfully perform employer-related functions; and

(v) Making Hepatitis B vaccine and vaccination series available to PSA and APSA employees in compliance with Occupational Safety and Health Administration (OSHA) standards.

(E) The PSA service is billed per fifteen (15) minute unit of service. The number of units of PSA a member may receive is limited to the number of units approved on the person-centered service plan.

(F) The APSA service is billed per fifteen (15) minute unit of service. The number of units of APSA a member may receive is limited to the number of units approved on the person-centered service plan.

(17) **~~Institutional~~Institution transition services.**

(A) ~~Institutional~~Institution transition services are those services necessary to enable a member to leave the institution and receive necessary support through ADvantage waiver services in his or her home and community.

(B) Transitional case management services are services per OAC 317:30-5-763(1) required by the member and included on the member's person-centered service plan that are necessary to ensure the member's health, welfare, and safety, or to enable the member to function with greater independence in the home, and without which, the member would continue to require institutionalization. ADvantage transitional case management services assist institutionalized members who are eligible to receive ADvantage services in gaining access to needed waiver and other State Plan services, as well as needed medical, social, educational, and other services to assist in the transition, regardless of the funding source for the services to which access is gained. Transitional case management services may be authorized for periodic monitoring of an ADvantage member's progress during an institutional stay and for assisting the member to transition from institution to home by updating the person-centered service plan, including necessary ~~institutional~~ institution transition services to prepare services and supports to be in place or to start on the date the member is discharged from the institution. Transitional case management services may be authorized to assist individuals that have not previously received ADvantage services, but were referred by ~~OKDHS AS~~CAP to the case management provider for assistance in transitioning from the institution to the community with ADvantage services support.

(i) ~~Institutional~~Institution transition case management services are prior authorized and billed per fifteen (15) minute unit of service using the appropriate HCPC procedure code and modifier associated with the location of residence of the member served, per OAC 317:30-5-763(1)~~(C).~~(D).

(ii) A unique modifier code is used to distinguish institution transitional case management services from regular case management services.

(C) ~~Institutional~~Institution transition services may be authorized and reimbursed, per the conditions in (i) through (iv).

(i) The service is necessary to enable the member to move from the institution to his or her home.

(ii) The member is eligible to receive ADvantage services outside of the institutional setting.

(iii) ~~Institutional~~Institution transition services are provided to the member within one-hundred and eighty (180) calendar-days of discharge from the institution.

(iv) Services provided while the member is in the institution are claimed as delivered on the day of discharge from the institution.

(D) When the member receives ~~institutional~~institution transition services but fails to enter the waiver, any ~~institutional~~institution transition services provided are not reimbursable.

(18) **Assisted living services (ALS).**

(A) ALS are personal care and supportive services furnished to waiver members who reside in a homelike, non-institutional setting that includes twenty-four (24) hour on-site response capability to meet scheduled or unpredictable member needs and to provide supervision, safety, and security. Services also include social and recreational programming and medication assistance, to the extent permitted under State law. The ALS provider is responsible for coordinating services provided by third parties to ADvantage members in the assisted living center (ALC). Nursing services are incidental rather than integral to the provision of ALS. ADvantage reimbursement for ALS includes services of personal care, housekeeping, laundry, meal preparation, periodic nursing evaluations, nursing supervision during nursing intervention, intermittent or unscheduled nursing care, medication administration, assistance with cognitive orientation, assistance with transfer and ambulation, planned programs for socialization, activities, and exercise, and for arranging or coordinating transportation to and from medical appointments. Services, except for planned programs for socialization, activities, and exercise, are to meet the member's specific needs as determined through the individualized assessment and documented on the member's person-centered service plan.

(B) The ADvantage ALS philosophy of service delivery promotes member choice, and to the greatest extent possible, member control. A member has control over his or her living space and his or her choice of personal amenities, furnishings, and activities in the residence. The ADvantage member must have the freedom to control his or her schedule and activities. The ALS provider's documented operating philosophy, including policies and procedures, must reflect and support the principles and values associated with the ADvantage assisted living philosophy and approach to service delivery emphasizing member dignity, privacy, individuality, and independence.

(C) ADvantage ALS required policies for admission and termination of services and definitions.

(i) ADvantage-certified assisted living centers (ALC) are required to accept all eligible ADvantage members who choose to receive services through the ALC, subject only to issues relating to, one (1) or more of the following:

(I) Rental unit availability;

(II) The member's compatibility with other residents;

(III) The center's ability to accommodate residents who have behavior problems, wander, or have needs that exceed the services the center provides; or

(IV) Restrictions initiated by statutory limitations.

(ii) The ALC may specify the number of units the provider is making available to service ADvantage members. At minimum, the ALC must designate ten (10) residential units for ADvantage members. Residential units designated for ADvantage may be used for other residents at the ALC when there are no pending ADvantage members for those units. Exceptions may be requested in writing subject to the approval of AA.

(iii) Mild or moderate cognitive impairment of the applicant is not a justifiable reason to deny ALC admission. Centers are required to specify whether they are able to accommodate members who have behavior problems or wander. Denial of admission due to a determination of incompatibility must be approved by the case manager and the AA. Appropriateness of placement is not a unilateral determination by the ALC. The ADvantage case manager, the member, or member's designated representative, and the ALC in consultation determine the appropriateness of placement.

(iv) The ALC is responsible for meeting the member's needs for privacy, dignity, respect, and freedom from coercion and restraint. The ALC must optimize the member's initiative, autonomy, and independence in making life choices. The ALC must facilitate member choices regarding services and supports, and who provides them. Inability to meet those needs is not recognized as a reason for determining an ADvantage member's placement is inappropriate. The ALC agrees to provide or arrange and coordinate all ~~of the~~ services listed in the Oklahoma State Department of Health (OSDH) regulations, per OAC 310:663-3-3, except for specialized services.

(v) In addition, the ADvantage participating ALC agrees to provide or coordinate the services listed in (I) through (III).

(I) Provide an emergency call system for each participating ADvantage member.

(II) Provide up to three (3) meals per day plus snacks sufficient to meet nutritional requirements, including modified special diets, appropriate to the member's needs and choices; and provide members with twenty-four (24) hour access to food by giving members control in the selection of the foods they eat, by allowing the member to store personal food in his or her room, by allowing the member to prepare and eat food in his or her room, and allowing him or her to decide when to eat.

(III) Arrange or coordinate transportation to and from medical appointments. The ALC must assist the member with accessing transportation for integration into the community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, and control his or her personal resources and receive services in the community to the same degree of access as residents not receiving ADvantage services.

(vi) The provider may offer any specialized service or rental unit for members with Alzheimer's disease and related dementias, physical disabilities, or other special needs the facility intends to market. Heightened scrutiny, through additional monitoring of the ALC by AA, is utilized for those ALC's that also provide inpatient treatment; settings on the grounds of or adjacent to a public institution and/or other

settings that tend to isolate individuals from the community. The ALC must include evidence that the ALC portion of the facility has clear administrative, financial, programmatic and environmental distinctions from the institution.
(vii) When the provider arranges and coordinates services for members, the provider is obligated to ensure the provision of those services.
(viii) Per OAC 310:663-1-2, "personal care" is defined as "assistance with meals, dressing, movement, bathing or other personal needs or maintenance, or general supervision of the physical and mental well-being of a person [Title 63 of the Oklahoma Statutes (O.S.), Section (§) 1-1902.17] and includes assistance with toileting." For ADvantage ALS, assistance with "other personal needs" in this definition includes assistance with grooming and transferring. The term "assistance" is clarified to mean hands-on help, in addition to supervision.
(ix) The specific ALS assistance provided along with amount and duration of each type of assistance is based upon the member's assessed need for service assistance and is specified in the ALC's service plan that is incorporated as supplemental detail into the ADvantage comprehensive person-centered service plan. The ADvantage case manager in cooperation with ALC professional staff, develops the person-centered service plan to meet member needs. As member needs change, the person-centered service plan is amended consistent with the assessed, documented need for change in services.
(x) Placement, or continued placement of an ADvantage member in an ALC, is inappropriate when any one (1) or more of the conditions in I through IV exist.

(I) The member's needs exceed the level of services the center provides. Documentation must support ALC efforts to provide or arrange for the required services to accommodate participant needs.

(II) The member exhibits behaviors or actions that repeatedly and substantially interfere with the rights or well-being of other residents, and the ALC documented efforts to resolve behavior problems including medical, behavioral, and increased staffing interventions. Documentation must support the ALC's attempted interventions to resolve behavior problems.

(III) The member has a complex, unstable, or unpredictable medical condition and treatment cannot be developed and implemented appropriately in the assisted living environment. Documentation must support the ALC's attempts to obtain appropriate member care.

(IV) The member fails to pay room and board charges ~~and/or~~or OKDHS determined vendor payment obligation.

(xi) Termination of residence ensues when inappropriately placed. Once a determination is made that a member is inappropriately placed, the ALC must inform the member, the member's representative, if applicable, the AA, and the member's ADvantage case manager. The ALC must develop a discharge plan in consultation with the member, the member's representative, the ADvantage case manager, and the AA. The ALC and case manager must ensure the discharge plan includes strategies for providing increased services, when appropriate, to minimize risk and meet the higher care needs of members transitioning out of the ALC, when the reason for discharge is inability to meet member needs. When voluntary termination of residency is not arranged, the ALC must provide written notice to the member and

to the member's representative, with a copy to the member's ADvantage case manager and the AA. The written notice provides intent to terminate the residency agreement and move the member to an appropriate care provider. The thirty (30) calendar-day requirement must not apply when emergency termination of the residency agreement is mandated by the member's immediate health needs or when the termination of the residency agreement is necessary for the physical safety of the member or other ALC residents. The written involuntary termination of residency notice for reasons of inappropriate placement must include:

(I) A full explanation of the reasons for the termination of residency;

(II) The notice date;

(III) The date notice was given to the member and the member's representative, the ADvantage case manager, and the AA;

(IV) The date the member must leave ALC; and

(V) Notification of appeal rights and the process for submitting appeal of termination of Medicaid ALS to OHCA.

(D) ADvantage ALS provider standards in addition to licensure standards.

(i) **Physical environment.**

(I) The ALC must provide lockable doors on the entry door of each rental unit and an attached, lockable compartment within each member unit for valuables. Members must have exclusive rights to his or her unit with lockable doors at the entrance of the individual or shared rental unit. Keys to rooms may be held by only appropriate ALC staff as designated by the member's choice. Rental units may be shared only when a request to do so is initiated by the member. Members must be given the right to choose his or her roommate.

(II) The member has a legally enforceable agreement, or lease, with the ALC. The member must have the same responsibilities and protections from eviction as all tenants under the landlord-tenant law of the state, county, city, or other designated entity.

(III) The ALC must provide each rental unit with a means for each member to control the temperature in the residential unit through the use of a damper, register, thermostat, or other reasonable means under the control of the member and that preserves privacy, independence, and safety, provided that the OSDH may approve an alternate means based on documentation that the design of the temperature control is appropriate to the special needs of each member who has an alternate temperature control.

(IV) For ALCs built prior to January 1, 2008, each ALC individual residential unit must have a minimum total living space, including closets and storage areas, of two-hundred and fifty (250) square feet; for ALCs built after December 31, 2007, each ALC individual residential unit must have a minimum total living space, including closets and storage areas, of three-hundred and sixty (360) square feet.

(V) The ALC must provide a private bathroom for each living unit that must be equipped with one (1) lavatory, one (1) toilet, and one (1) bathtub or shower stall.

(VI) The ALC must provide at a minimum; a kitchenette, defined as a space containing a refrigerator, adequate storage space for utensils, and a cooking appliance. A microwave is an acceptable cooking appliance.

(VII) The member is responsible for furnishing the rental unit. When a member is unable to supply basic furnishings defined as a bed, dresser, nightstand, chairs, table, trash can, and lamp, or if furnishings pose a health or safety risk, the member's ADvantage case manager in coordination with the ALC, must assist the member in obtaining basic furnishings for the rental unit. The member must have the freedom to furnish and decorate the rental unit within the scope of the lease or residency agreement.

(VIII) The ALC must meet the requirements of all applicable federal and state laws and regulations including, but not limited to, state and local sanitary codes, state building and fire safety codes, and laws and regulations governing use and access by persons with disabilities.

(IX) The ALC must ensure the design of common areas accommodates the special needs of the resident population and that the rental unit accommodates the special needs of the member in compliance with the Americans with Disabilities Act accessibility guidelines per Nondiscrimination on the Basis of Disability By Public Accommodations and in in Commercial Facilities, 28 Code of Federal Regulations, Appendix A, at no additional cost to the member.

(X) The ALC must provide adequate and appropriate social and recreational space for residents and the common space must be proportionate to the number of residents and appropriate for the resident population.

(XI) The ALC must provide appropriately monitored outdoor space for resident use.

(XII) The ALC must provide the member with the right to have visitors of his or her choosing at any time. Overnight visitation is allowed as permissible by the Landlord/Tenant Agreement.

(XIII) The ALC must be physically accessible to members.

(ii) **Sanitation.**

(I) The ALC must maintain the facility, including its individual rental units in a clean, safe, and sanitary manner, ensuring that they are insect and rodent free, odorless, and in good repair at all times.

(II) The ALC must maintain buildings and grounds in a good state of repair, in a safe and sanitary condition, and in compliance with the requirements of applicable regulations, bylaws, and codes.

(III) The ALC stores clean laundry in a manner that prevents contamination and changes linens at time intervals necessary to avoid health issues.

(IV) The ALC must provide housekeeping in member rental units to maintain a safe, clean, and sanitary environment.

(V) The ALC must have policies and procedures for members' pets.

(iii) **Health and safety.**

(I) The ALC must provide building security that protects members from intruders with security measures appropriate to building design, environmental risk factors, and the resident population.

(II) The ALC must respond immediately and appropriately to missing members,

accidents, medical emergencies, or deaths.

(III) The ALC must have a plan in place to prevent, contain, and report any diseases considered to be infectious or are listed as diseases that must be reported to the OSDH.

(IV) The ALC must adopt policies for the prevention of abuse, neglect, and exploitation that include screening, training, prevention, investigation, protection during investigation, and reporting.

(V) The ALC must provide services and facilities that accommodate the needs of members to safely evacuate in the event of fires or other emergencies.

(VI) The ALC must ensure staff is trained to respond appropriately to emergencies.

(VII) The ALC must ensure that fire safety requirements are met.

(VIII) The ALC must offer meals that provide balanced and adequate nutrition for members.

(IX) The ALC must adopt safe practices for ~~the~~ meal preparation and delivery ~~of meals~~.

(X) The ALC must provide a twenty-four (24) hour response to personal emergencies appropriate to the needs of the resident population.

(XI) The ALC must provide safe transportation to and from ALC sponsored social or recreational outings.

(iv) **Staff to resident ratios.**

(I) The ALC must ensure a sufficient number of trained staff are on duty, awake, and present at all times, twenty-four (24) hours a day, and seven (7) days a week, to meet ~~the~~residents' needs ~~of residents~~ and to carry out all ~~of the~~ processes listed in the ALC's written emergency and disaster preparedness plan for fires and other disasters.

(II) The ALC must ensure staffing is sufficient to meet ADvantage program members' needs in accordance with each member's ADvantage person-centered service plan.

(III) The ALC must have plans in place to address situations where there is a disruption to the ALC's regular work force.

(v) **Staff training and qualifications.**

(I) The ALC must ensure staff has qualifications consistent with their job responsibilities.

(II) All staff assisting in, or responsible for, food service must have attended a food service training program offered or approved by OSDH.

(III) The ALC must provide staff orientation and ongoing training to develop and maintain staff knowledge and skills. All direct care and activity staff receive at least eight (8) hours of orientation and initial training within the first month of employment and at least four (4) hours annually thereafter. Staff providing direct care on a dementia unit must receive four (4) additional hours of dementia specific training. Annual first aid and cardiopulmonary resuscitation (CPR) certification do not count toward the four (4) hours of annual training.

(vi) **Staff supervision.**

(I) The ALC must ensure delegation of tasks to non-licensed staff is consistent and in compliance with all applicable state regulations including, but not limited to, the state's Nurse Practice Act and OSDH Nurse Aide Certification rules.

(II) The ALC must ensure that, where the monitoring of food intake or therapeutic diets is provided at the prescribed services level, a registered dietitian monitors member health and nutritional status.

(vii) **Resident rights.**

(I) The ALC must provide to each member and each member's representative, at the time of admission, a copy of the resident statutory rights listed in 63 O.S. § 1-1918 amended to include additional rights and the clarification of rights as listed in the ADvantage member assurances. A copy of resident rights must be posted in an easily accessible, conspicuous place in the facility. The facility must ensure that staff is familiar with and observes, the resident rights.

(II) The ALC must conspicuously post for display in an area accessible to residents, employees, and visitors, the ALC's complaint procedures and the name, address, and phone number of a person authorized to receive complaints. A copy of the complaint procedure must also be given to each member, the member's representative, or the legal guardian. The ALC must ensure all employees comply with the ALC's complaint procedure.

(III) The ALC must provide to each member and member's representative, at the time of admission, information about Medicaid grievance and appeal rights, including a description of the process for submitting a grievance or appeal of any decision that decreases Medicaid services to the member.

(viii) **Incident reporting.**

(I) The ALC must maintain a record of incidents that occur and report incidents to the member's ADvantage case manager and to the AA, utilizing the AA Critical Incident Reporting form. Incident reports are also made to Adult Protective Services (APS) and to the OSDH, as appropriate, per ALC licensure rules, utilizing the specific reporting forms required.

(II) Incidents requiring report by licensed ALC's are those defined by OSDH, per OAC 310:663-19-1 and listed on the AA Critical Incident Reporting form.

(III) Reports of incidents must be made to the member's ADvantage case manager and to the AA via electronic submission within one (1) business day of the reportable incident's discovery utilizing the AA Critical Incident Reporting form. When required, a follow-up report of the incident must be submitted via electronic submission to the member's ADvantage case manager and to the AA. The follow-up report must be submitted within five (5) business days of the incident. The final report must be filed with the member's ADvantage case manager and the AA when the investigation is complete, not to exceed ten (10) business days after the incident.

(IV) Each ALC having reasonable cause to believe that a member is suffering from abuse, neglect, exploitation, or misappropriation of member property must make a report to APS as soon as the person is aware of the situation per 43A O.S. § 10-104.A. Reports are also made to OSDH, as appropriate, per ALC licensure rules.

(V) The preliminary incident report must at ~~the~~ minimum, include who, what,

when, where, and the measures taken to protect the member and resident(s) during the investigation. The follow-up report must, at ~~the~~ minimum, include preliminary information, the extent of the injury or damage, if any, and preliminary investigation findings. The final report, at ~~a~~ minimum, includes preliminary and follow-up information, a summary of investigative actions representing a thorough investigation, investigative findings and conclusions, and corrective measures to prevent future occurrences. When it is necessary to omit items, the final report must include why such items were omitted and when they will be provided.

(ix) Provision of, or arrangement for, necessary health services. The ALC must:

(I) Arrange or coordinate transportation for members to and from medical appointments; and

(II) Provide or coordinate with the member and the member's ADvantage case manager for delivery of necessary health services. The ADvantage case manager is responsible for monitoring that all health-related services required by the member as identified through assessment and documented on the person-centered service plan, are provided in an appropriate and timely manner. The member has the freedom to choose any available provider qualified by licensure or certification to provide necessary health services in the ALC.

(E) ALCs are billed per diem of service for days covered by the ADvantage member's person-centered service plan and during which the ALS provider is responsible for providing ALS for the member. The per diem rate for ADvantage ALS for a member is one (1) of three (3) per diem rate levels based on a member's need for type of, intensity of, and frequency of service to address member ADLs, instrumental activities of ~~the~~ daily living (IADLs), and health care needs. The rate level is based on the Uniform Comprehensive Assessment Tool (UCAT) assessment by the member's ADvantage case manager employed by a case management agency independent of the ALS provider. The determination of the appropriate per diem rate is made by the AA clinical review staff.

(F) The ALC must notify AA ninety (90) calendar days before terminating or not renewing the ALC's ADvantage contract.

(i) The ALC must give notice in writing to the member, the member's representative(s), the AA, and the member's ADvantage case manager ninety (90) calendar days before:

(I) Voluntary cessation of the ALC's ADvantage contract; or

(II) Closure of all or part of the ALC.

(ii) The notice of closure must include:

(I) The proposed ADvantage contract termination date;

(II) The termination reason;

(III) An offer to assist the member secure an alternative placement; and

(IV) Available housing alternatives.

(iii) The facility must comply with all applicable laws and regulations until the closing date, including those related to resident transfer or discharge.

(iv) Following the last move to the last ADvantage member, the ALC must provide in writing to the AA:

(I) The effective date of closure based on the discharge date of the last resident;

(II) A list of members transferred or discharged and where they are relocated; and

(III) The plan for storage of resident records per OAC 310:663-19-3(g), relating to preservation of resident records and the name, address, and phone numbers of the person responsible for the records.

(19) **Remote Support (RS) services**.

(A) **Purpose and scope.** RS services are intended to promote a member's independence and self-direction. RS services are provided in the member's home to reduce reliance on in person support while ensuring the member's health and safety. RS services are included in the member's person-centered service plan and coordination of these services are made through the case manager.

(i) RS services are:

(I) Based on the member's needs as documented and supported by the member's person-centered service plan and person-centered assessments;

(II) Only authorized when submitted on the member's person-centered service plan with the consent of the member, involved household members, and guardian, as applicable;

(III) The least restrictive option and the member's preferred method to meet an assessed need; and

(IV) Provided when the member and the member's Interdisciplinary Team (IDT) agree to the provision of RS services.

(ii) RS services are not a system of surveillance or for provider convenience.

(B) **Service description**. RS services monitor a member by allowing for live, two-way communication between the member and monitoring staff using one (1) or more of the following systems:

(i) Live video feed;

(ii) Live audio feed;

(iii) Motion-sensor monitoring;

(iv) Radio frequency identification;

(v) Web-based monitoring; or

(vi) Global positioning system (GPS) monitoring devices.

(C) **General provider requirements.** RS service providers must have a valid OHCA SoonerCare (Medicaid) provider agreement to provide provider-based RS services to ADvantage HCBS waiver members and be certified by the AA. Requests for applications to provide RS services are made to AA.

(D) **Risk assessment.** Teams will complete a risk assessment to ensure remote supports can help meet the member's needs in a way that protects the right to privacy, dignity, respect, and freedom from coercion. The risk assessment is reviewed, and any issues are addressed prior to the implementation of remote supports general provider requirements.

(i) Remote support providers ensure the member's health and safety by contacting a member’s informal support or activating the member's back-up plan when a health or safety issue becomes evident during monitoring.

(ii) The risk assessment and service plan require the team to develop a specific back-up plan to address health, safety and behavioral needs while remote supports are utilized so appropriate assistance can be provided. The RS back-up plan includes

how assistance is provided to the member when equipment or technology fails.

(E) **RS guidelines.** Devices or monitors are placed at locations based on the member's individual needs as documented on the member's person-centered service plan and approved by the member and involved family members and guardian, as applicable.

(i) The use of camera or video equipment in the member's bedroom, bathroom, or other private area is prohibited.

(ii) When RS involves the use of audio or video equipment that permits RS staff to view activities or listen to conversations in the residence, the member who receives the service and each person who lives with the member is fully informed of what RS entails. The member's case manager documents consent in the member's person-centered service plan.

(iii) Waiver members have the ability to turn off the remote monitoring device or equipment if they choose to do so. The RS provider educates the member regarding how to turn RS devices off and on at the start of services and as desired thereafter.

(F) **Emergency response staff.**

(i) Emergency response staff are employed by a certified ADvantage Provider with a valid OHCA SoonerCare (Medicaid) contract to provide HCBS to OKDHS HCBS waiver members.

(ii) Informal emergency response persons are unpaid family members or other interested parties who agree to become, and are approved as, an emergency response person by the member and the member's IDT.

(G) **Service limitations.** RS services are limited to twenty-four (24) hours per day. RS services are not provided simultaneously with any other in-home direct care services. However, services may be provided through a combination of remote and in-home services dependent on the member's needs.

(H) **RS service discontinuation**. The member and the member's IDT determine when it is appropriate to discontinue RS services. When RS services are terminated, the RS provider coordinates service termination with the member's case manager to ensure a safe transition.

(20) **Assistive Technology (AT) services.**

(A) AT services include devices, controls, and appliances, specified in the member's person-centered service plan, which enable members to increase their abilities to perform activities of daily living or to perceive, control, or communicate with the environment in which they live.

(B) Devices may include communication technology, such as smart phones and tablets, that allow members to communicate with their providers using video chat to ensure ongoing maintenance of health and welfare.

(C) Only devices that are not covered under the SoonerCare (Medicaid) or Specialized Medical Equipment services are included in this service definition.

(D) Service codes and rates vary based on the nature of the AT device;

(E) AT services may include:

(i) Assessment for the need of AT or auxiliary aids;

(ii) Training the member or provider regarding use and maintenance of equipment or auxiliary aids; and

(ii) Repair of adaptive devices; and

(v) Equipment provided may include:

(I) Video communication technology that allows members to communicate with providers through video communication. Video communication allows providers to assess and evaluate their members' health and welfare or other needs by enabling visualization of members and their environments. Examples include smart phones, tablets, audiovisual or virtual assistant technology, or sensors; and

(II) The cost of internet services may be augmented through the Emergency Broadband Benefit which is available to waiver members.

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

SUBCHAPTER 17. ADVANTAGE WAIVER SERVICES

317:35-17-3. ADvantage program services

(a) The ADvantage program is a Medicaid Home and Community-Based waiver used to finance non-institutional, long-term care services for the elderly and a targeted group of physically disabled adults when there is a reasonable expectation that within a thirty (30) calendar day period, the person's health, due to disease process or disability, would without appropriate services, deteriorate and require long-term care (LTC) facility care to arrest the deterioration. Individuals may not be enrolled in ADvantage for the sole purpose of enabling them to obtain Medicaid eligibility. Eligibility for ADvantage program services is contingent on an individual requiring one (1) or more of the services offered in the waiver, at least monthly, to avoid institutionalization.

(b) The number of individuals who may receive ADvantage services is limited.

(1) To receive ADvantage program services, individuals must meet one of ~~the~~categories~~s~~the categories in (A) ~~though~~through (D) of this paragraph. He or she must:

(A) Be sixty-five (65) years of age ~~and~~or older; or

(B) Be twenty-one (21) to sixty-four (64) years of age~~, physically disabled and not developmentally disabled; or~~with a physical disability; or

(C) ~~When developmentally disabled, and twenty-one (21) to sixty-four (64) years of age; and does not have an intellectual disability or a cognitive impairment related to the developmental disability;~~Be twenty-one (21) to sixty-four years of age with a developmental disability, provided he or she does not have a cognitive impairment (intellectual disability); or

(D) Be twenty-one (21) to sixty-four (64) years of age~~, not physically disabled but has~~ with a clinically documented, progressive, degenerative disease process that responds to treatment and previously required hospital or LTC facility level of care services to maintain the treatment regimen to prevent health deterioration.

(2) In addition, the individual must meet criteria in (A) through (C) of this paragraph. He or she must:

(A) ~~Requirelong-term~~Require long-term care facility level of care, per Oklahoma Administrative Code (OAC) 317:35-17-2;

(B) Meet service eligibility criteria, per OAC 317:35-17-3(f); and

(C) Meet program eligibility criteria, per OAC 317:35-17-3(g).

(c) ADvantage members are eligible for limited types of living arrangements. The specific living arrangements are set forth in (1) ~~though~~through (5) of this subsection.

(1) ADvantage program members are not eligible to receive services while residing in an unlicensed institutional living arrangement, such as a room and board home ~~and/or~~or facility; an institutional setting including, but not limited to, licensed facilities, such as a hospital, a LTC facility, licensed residential care facility, or licensed assisted living facility, unless the facility is an ADvantage assisted living center.

(2) Additional living arrangements in which members may receive ADvantage services are the member's own home, apartment, or independent-living apartment, or a family or friend's home or apartment. A ~~home/apartment~~home or apartment unit is defined as a self-contained

living space having a lockable entrance to the unit and including a bathroom, ~~and~~ food storage ~~and/or~~and preparation amenities in addition to the bedroom ~~and/or~~or living space.

(3) ADvantage program members may receive services in a shelter or similar temporary-housing arrangement that may or may not meet the definition of home ~~and/or~~or apartment in emergency situations, for a period not to exceed sixty (60) calendar days during which location and transition to permanent housing is sought.

(4) For ADvantage members who are full-time students, a dormitory room qualifies as an allowable living arrangement in which to receive ADvantage services while the member is a student.

(5) Members may receive ADvantage respite services in an LTC facility for a continuous period not to exceed thirty (30) calendar days.

(d) Home and Community-Based waiver services are outside of the scope of Medicaid State Plan services. The Medicaid waiver allows the Oklahoma Health Care Authority ~~(OHCA)~~ to offer certain Home and Community-Based services to an annually capped number of persons, who are categorically needy, per Oklahoma ~~Department of~~ Human Services (OKDHS) Appendix C-1, Schedule VIII. B. 1., and without such services would be institutionalized. The estimated cost of providing an individual's care outside of the LTC facility cannot exceed the annual cost of caring for that individual in ~~an~~a LTC facility. When determining the ADvantage service plan cost cap for an individual, the comparable ~~SoonerCare~~Medicaid cost to serve that individual in ~~an~~a LTC facility is estimated.

(e) Services provided through the ADvantage waiver are:

(1) Case management;

(2) Respite;

(3) Adult day health care;

(4) Environmental modifications;

(5) Specialized medical equipment and supplies;

(6) Physical, occupational, or speech therapy or consultation;

(7) Advanced supportive and/or restorative assistance;

(8) Nursing;

(9) Skilled nursing;

(10) Home-delivered meals;

(11) Hospice care;

(12) Medically necessary prescription drugs, within the limits of the ADvantage waiver;

(13) Personal care, State Plan, or ADvantage personal care;

(14) A Personal Emergency Response System (PERS);

(15) ~~Consumer-Directed~~Consumer Directed Personal Assistance Services and Supports (CD-PASS);

(16) Institution Transition Services (Transitional Case Management);

(17) Assisted living; ~~and~~

(18) Remote Supports;

(19) Assistive technology; and

~~(18)~~(20) SoonerCare medical services for individuals, twenty-one (21) years of age and over, within the State Plan scope.

(f) The OKDHS area nurse or nurse designee ~~makes a determination of~~determines service eligibility prior to evaluating the Uniform Comprehensive Assessment Tool (UCAT) assessment for long-term care facility level of care. The criteria in (1) through (5) of this subsection are used

to make the service eligibility determination, which includes:

(1) An open ADvantage program waiver slot, as authorized by the Centers for Medicare and Medicaid Services (CMS), ~~which~~ is available to ensure federal participation in payment for services to the individual. When ~~the~~ Oklahoma ~~Department of~~ Human ~~Services/Aging Services (OKDHS/AS)~~Services Community Living, Aging and Protective Services (CAP) determines all slots are filled, the individual cannot be certified ~~by OKDHS~~ as eligible for ADvantage services, and his or her name is placed on a waiting list for entry when an open slot becomes available~~;~~.

(2) The ADvantage waiver-targeted service ~~group. The target group is~~groups are individuals, who:

(A) Are frail and sixty-five (65) years of age and older; or

(B) ~~are~~Are Twenty-one (21) to sixty-four (64) years of age and physically disabled; or

(C) When developmentally disabled~~,~~ and ~~are~~ twenty-one (21) to sixty-four (64) years of age and do not have an intellectual disability or cognitive impairment related to the developmental disability; or

(D) Are twenty-one (21) to sixty-four (64) years of age~~,~~ and not physically disabled but have a clinically documented, progressive, degenerative disease process that responds to treatment and previously required hospital or long-term care facility level of care services to maintain the treatment regimen to prevent health deterioration. The individual must meet criteria, per OAC ~~317:35-174-3(b)(2)(A through C)~~317:35-17-3(b)(2)(A) through (C).

(3) An ~~ineligible~~ individual ~~because he or she poses~~is ineligible when posing a physical threat to ~~himself or herself~~self or others, as supported by professional documentation.

(4) ~~Members~~An individual is ineligible when members of the household or persons who routinely visit the household~~, as supported by professional documentation that do not~~ pose a threat of harm or injury to the individual or other household visitors, as supported by professional documentation.

(5) An ~~ineligible~~ individual is ineligible when his or her living environment poses a physical threat to ~~himself or herself~~self or others, as supported by professional documentation where applicable, and measures to correct hazardous conditions or assist the individual to move are unsuccessful or not feasible.

(g) The State, as part of the ADvantage waiver program approval ~~authorization~~process, ensures CMS that each member's health, safety, or welfare can be maintained in his or her home. When a member's identified needs cannot be met through provision of the ADvantage program or Medicaid State Plan services and other formal or informal services are not in place or immediately available to meet those needs, the individual's health, safety, or welfare in his or her home cannot be ensured. The ADvantage Administration (AA) determines ADvantage program eligibility through the service plan approval process. An individual is deemed ineligible for the ADvantage program based on criteria (1) through (8) of this subsection.

(1) The individual's needs, as identified by the UCAT and other professional assessments, cannot be met through ADvantage program services, Medicaid State Plan services, or other formal or informal services.

(2) One (1) or more members of the individual's household pose a physical threat to themselves, or others as supported by professional documentation.

(3) The individual or other household members use threatening, intimidating, degrading, or use sexually inappropriate language ~~and/or~~or innuendo or behavior towards service providers,

~~either~~ in the home or through other contact or communications, and significant efforts were attempted to correct such behavior, as supported by professional documentation or other credible documentation.

(4) The individual, or the individual's authorized agent, is uncooperative or refuses to participate in service development or service delivery and these actions result in unacceptable increases of risk to the individual's health, safety, or welfare in his or her home, as determined by the individual, the interdisciplinary team, or the AA.

(5) The individual's living environment poses a physical threat to self or others, as supported by professional documentation, and measures to correct hazardous conditions or assist the person to move are unsuccessful or are not feasible.

(6) The individual provides false or materially inaccurate information necessary to determine program eligibility or withholds information necessary to determine program eligibility.

(7) The individual does not require at least one ADvantage service monthly.

(8) The individual, his or her family member(s), associate(s), or any other person(s) or circumstances as relates to care and coordination in ~~his or her~~the living environment produces evidence of illegal drug activity or substances used illegally as intoxicants. This includes:

(A) The use, possession, or distribution of illegal drugs;

(B) The abusive use of other drugs, such as medication prescribed by a doctor;

(C) The use of substances, such as inhalants including, but not limited to:

(i) Typewriter correction fluid;

(ii) Air conditioning coolant;

(iii) Gasoline;

(iv) Propane;

(v) Felt-tip markers;

(vi) Spray paint;

(vii) Air freshener;

(viii) Butane;

(ix) Cooking spray;

(x) Paint; and

(xi) Glue;

(D) The observed intoxication, consumption, or sensory indicators, such as smell of the use of any drug or intoxicant by the individual, family members, associates, or any other person(s) present at the time care is provided may be construed as evidence indicative of illegal drug activity or intoxication. This includes drug use or intoxicated activity that is menacing to the member or staff providing services;

(E) The observance of drug paraphernalia or any instrument used in the manufacturing, production, distribution, sale, or consumption of drugs or substances including, but not limited to:

(i) Smoking pipes used to consume substances other than tobacco;

(ii) Roach clips containing marijuana cigarettes;

(iii) Needles and other implements used for injecting drugs into the body;

(iv) Plastic bags or other containers used to package drugs;

(v) Miniature spoons used to prepare drugs; or

(vi) Kits used in the production of synthetic controlled substances including descriptive materials that accompany the item, describing or depicting its use.

(F) Instructions, verbal or written, concerning the item or device including, but not limited

to, the manner in which the object is labeled and displayed for sale;

(G) The typical use of such items in the community; ~~and/or~~or

(H) Testimony of an expert witness regarding use of the item.

(h) The case manager provides the AA with professional documentation or other credible documentation to support the recommendation for redetermination of program eligibility. The service providers continue providing services according to the person-centered service plan as provider safety permits until the individual is removed from the ADvantage program. As a part of the procedures requesting redetermination of program eligibility, ~~OKDHS AS~~CAP provides technical assistance to the provider for transitioning the individual to other services.

(i) Individuals determined ineligible for ADvantage program services are notified in writing by ~~OKDHS AS~~CAP of the determination and of the right to appeal the decision.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 41. FAMILY SUPPORT SERVICES

317:30-5-412. Description of services

Family support services include services identified in (1) through (6) of this section. Providers of any family support service must have an applicable SoonerCare Provider Agreement for Home and ~~Community Based~~Community-Based Services (HCBS) Waiver Providers for persons with developmental disabilities.

(1) **Transportation services.** Transportation services are provided per Oklahoma Administrative Code (OAC) 317:40-5-103.

(2) **Assistive technology (AT) devices and services.** AT devices and services are provided per OAC 317:40-5-100.

(3) **Architectural modification.** Architectural modification services are provided per OAC 317:40-5-101.

(4) **Family training.**

(A) **Minimum qualifications.**

(i) Individual providers must have a Developmental Disabilities Services (DDS) Family Training application and training curriculum approved by DDS staff. Individual providers must hold a current licensure, certification, or a ~~Bachelor's Degree~~bachelor's degree in a human service field related to the approved training curriculum, or other ~~Bachelor's Degree~~bachelor's degree combined with a minimum of five 5 years' experience in the intellectual disabilities field. Only individuals named on the SoonerCare Provider Agreement to provide Family Training services may provide service to members.

(ii) Agency or business providers must have a (DDS) Family Training application and training curriculum approved by DDS staff. Agency or business provider training staff must hold a current licensure, certification, or a ~~Bachelor's Degree~~ bachelor's degree in a human service field related to the approved training curriculum or other ~~Bachelor's Degree~~bachelor's degree combined with a minimum of five (5) years experience in the intellectual disabilities field. The credentials of new training staff hired by an approved DDS HCBS Family Training agency or business provider must be submitted to and approved by the DDS programs manager for Family Training prior to new staff training members or members' families.

(B) **Description of services.** Family Training services include instruction in skills and knowledge pertaining to the support and assistance of members. Services are:

(i) ~~intended~~Intended to allow families to become more proficient in meeting the needs of members who are eligible;

(ii) ~~provided~~Provided in any community setting;

(iii) ~~provided~~Provided in either group, consisting of two (2) to ~~15~~fifteen (15) persons, or individual formats; ~~and~~

(iv) ~~for~~For members served through DDS HCBS Waivers and their families. For the purpose of this service, family is defined as any person who lives with, or provides care to a member served on the Waiver;

(v) ~~included~~Included in the member's Individual Plan (Plan) and arranged through the member's case manager; and

(vi) ~~intended~~Intended to yield outcomes as defined in the member's Plan.

(C) **Coverage limitations**. Coverage limitations for family training ~~are:~~include (i) through (iv) of this subparagraph.

(i) The limitation for individual family training~~; Limitation: $5,500~~is $6,500 per Plan of Care (POC) year~~;~~.

(ii) The limitation for group family training~~; Limitation: $5,500~~is $6,500 per ~~Plan of Care~~ POC year~~;~~.

(iii) ~~session~~Session rates for individual and group sessions do not exceed a range comparable to rates charged by persons with similar credentials providing similar services~~; and~~.

(iv) ~~rates~~Rates must be justified based on costs incurred to deliver the service and are evaluated to determine if costs are reasonable.

(D) **Documentation requirements.** Providers must maintain documentation fully disclosing the extent of services furnished that specifies~~:~~ (i) through (ix) of this subparagraph. Progress reports for each member served must be submitted to the DDS case manager per OAC 340:100-5-52.

(i) ~~the~~The service date~~;~~.

(ii) ~~the~~The start and stop time for each session~~;~~.

(iii) ~~the~~The signature of the trainer~~;~~.

(iv) ~~the~~The credentials of the trainer~~;~~.

(v) ~~the~~The specific issues addressed~~;~~.

(vi) ~~the~~The methods used to address issues~~;~~.

(vii) ~~the~~The progress made toward outcomes~~;~~.

(viii) ~~the~~The member's response to the session or intervention~~; and~~.

(ix) ~~any~~Any new issues identified during the session.

~~(x) progress reports for each member served must be submitted to the DDS case manager per OAC 340:100-5-52; and~~

~~(xi) an annual report of the provider's overall Family Training program, including statistical information about members served, their satisfaction with services, trends observed, changes made in the program and program, recommendations must be submitted to the DDS programs manager for Family Training on an annual basis.~~

(5) **Family counseling**.

(A) **Minimum qualifications.** Counseling providers must hold current licensure as clinical social workers, psychologists, licensed professional counselors ~~(LPC)~~, or licensed marriage and family therapists ~~(LMFT)~~.

(B) **Description of services.** Family counseling offered to members and his or her natural, adoptive, or foster family members, helps to develop and maintain healthy, stable relationships among all family members.

(i) Emphasis is placed on the acquisition of coping skills by building upon family strengths.

(ii) Knowledge and skills gained through family counseling services increase the likelihood the member remains in or returns to his or her own home.

(iii) All family counseling needs are documented in the member's Plan.

(iv) Services are rendered in any confidential setting where the ~~member/family~~ member or family resides or the provider conducts business.

(C) **Coverage limitations**. Coverage limitations for family counseling are~~:~~ outlined in (i) and (ii) of this subparagraph.

~~(i) individual family counseling; unit: 15 minutes; limitation: 400 units per Plan of Care year; and~~

~~(ii) group, six person maximum, family counseling; unit: 30 minutes; limitation: 225 units per Plan of Care year.~~

(i) Individual counseling is accounted for in units of 15 minutes with a limitation of 400 units per POC year.

(ii) Group counseling, with a six (6) person maximum, is accounted for in units of 30 minutes with a limitation of 225 units per POC year.

(D) **Documentation requirements.** Providers must maintain documentation fully disclosing the extent of services furnished that specifies:

(i) ~~the~~The service date;

(ii) ~~the~~The start and stop time for each session;

(iii) ~~the~~The signature of the therapist;

(iv) ~~the~~The credentials of the therapist;

(v) ~~the~~The specific issues addressed;

(vi) ~~the~~The methods used to address issues;

(vii) ~~the~~The progress made toward resolving issues and meeting outcomes;

(viii) ~~the~~The member's response to the session or intervention; and

(ix) ~~any~~Any new issue identified during the session.

(E) **Reporting requirements**. Progress reports for each member served must be submitted to the DDS case manager per OAC 340:100-5-52.

(6) **Specialized medical supplies.** Specialized medical supplies are provided per OAC 317:40-5-104.

Part 43. Agency Companion, Specialized Foster Care, Daily Living Supports, Group Homes, and Community Transition Services

317:30-5-422. Description of services

Residential supports include:

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

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

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

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

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

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

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

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

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

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

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

(ii) ~~include~~Include security deposits, essential furnishings, such as major appliances, dining ~~table/chairs~~table and chairs, bedroom set, sofa, chair, window coverings, kitchen ~~pots/pans~~pots and pans, dishes, eating utensils, ~~bed/bath~~bed and bath linens, kitchen dish ~~towel/potholders~~towel and potholders, a one month supply of ~~laundry/cleaning~~laundry and cleaning products, and setup fees or deposits for initiating utility service, including phone, electricity, gas, and water. CTS also includes moving expenses, ~~services/items~~ services and items necessary for the member's health and safety, such as pest eradication, allergen control, a one-time cleaning prior to occupancy, flashlight, smoke detector, carbon monoxide detector, first aid kit, fire extinguisher, and a tempering valve or other anti-scald device when determined by the Personal Support Team necessary to ensure the member's safety; and

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

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

(II) ~~monthly~~Monthly rental or mortgage expenses;

(III) ~~food;~~Food;

(IV) ~~personal~~Personal hygiene items;

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

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

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

(VIII) ~~regular~~Regular ongoing utility charges;

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

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

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

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

PART 55. RESPITE CARE

317:30-5-515. Respite in Home and Community-Based Services (HCBS) Waivers for persons with an intellectual disability or certain persons with related conditions

(a) The Oklahoma Health Care Authority(OHCA) administers ~~Home and Community Based Services (HCBS)~~HCBS Waivers for persons with an intellectual disability or certain persons with related conditions that are operated by ~~the~~ Oklahoma ~~Department of~~ Human Services (OKDHS) Developmental Disabilities Services ~~Division~~(DDS). Each waiver allows payment for respite care as defined in the waiver approved by the Centers for Medicare and Medicaid Services.

(b) Respite providers enter into contractual agreements with the OHCA to provide HCBS services for persons with an intellectual disability or related conditions.

(c) Respite care is included in the member's Individual Plan (Plan). Arrangements for this service are made through the member's DDS case manager.

(d) Respite care is:

(1) Available to eligible members not receiving daily living supports or group home services and who are unable to care for themselves; and

(2) Furnished on a short-term basis due to the absence or need for relief of those persons normally providing the care, and includes:

(A) Daily respite provided in a group home.

(i) Group homes providing respite must be licensed per Oklahoma Administrative Code (OAC) 340:100-6.

(ii) Respite care provided in a group home is authorized as respite at the applicable group home rate as identified in the member's Plan; and

(B) Daily respite provided in an agency companion services (ACS) home.

(i) Respite must be approved in accordance with the home profile process, per OAC 317:40-5-40, and required training, per OAC 340:100-3-38.

(ii) Respite provided in an ACS home is authorized as respite at the applicable level of support per OAC 317:40-5-3.

(iii) Respite providers are limited to providing 52-calendar days of respite per year when they concurrently provide ACS. Exceptions may be made by the DDS director or designee; and

(C) Daily respite provided in a specialized foster care (SFC) home, member's home, or any other approved community site.

(i) Respite must be approved in accordance with the home profile process, per OAC 317:40-5-40, and required training, per OAC 340-100-3-38.

(ii) Respite provided in a SFC or any other approved home other than ACS or a group home is authorized as respite at the applicable rate as identified in the member's Plan.

(iii) The respite provider is at least eighteen (18) years of age.

(3) Not available to members in OKDHS custody and in an out-of-home placement funded by OKDHS Child Welfare Services; and

(4) Limited to thirty (30) calendar days or 720 hours annually per member, exceptions may be made by the DDS director or designee;

(e) Payment is not made for daily respite care and SFC or ACS for the same member on the same date of service.

317:30-5-516. Coverage [REVOKED]

~~All respite care must be included in the member's Individual Plan (IP). Arrangements for this service must be made through the member's case manager.~~

317:30-5-517. Description of services [REVOKED]

~~Respite care is:~~

~~(1) available to eligible members not receiving daily living supports or group home services and who are unable to care for themselves; and~~

~~(2) furnished on a short-term basis due to the absence or need for relief of those persons normally providing the care, and includes:~~

~~(A) homemaker respite per OAC 317:30-5-535 through 317:30-5-538;~~

~~(B) daily respite provided in a group home.~~

~~(i) Group homes providing respite must be licensed per OAC 340:100-6.~~

~~(ii) Respite care provided in a group home is authorized as respite at the applicable group home rate as identified in the member's Plan of Care;~~

~~(C) daily respite provided in an agency companion services (ACS) home.~~

~~(i) Respite must be approved in accordance with the home profile process, per OAC 317:40-5-40, and required training, per OAC 340:100-3-38.~~

~~(ii) Respite provided in an ACS home is authorized as respite at the applicable level of support per OAC 317:40-5-3.~~

~~(iii) Respite providers are limited to providing 52 days of respite per year when they concurrently provide ACS; and~~

~~(D) daily respite provided in any other approved home. Respite:~~

~~(i) must be approved in accordance with the home profile process, per OAC 317:40-5-40, and required training, per OAC 340-100-3-38;~~

~~(ii) is based on the member's needs and includes:~~

~~(I) maximum supervision - for members with extensive needs;~~

~~(II) close supervision - for members with moderate needs; and~~

~~(III) intermittent supervision - for members with minimum needs; and~~

~~(iii) providers must:~~

~~(I) pass a background investigation per OAC 317:40-5-40 and OAC 340:100-3-39; and~~

~~(II) be at least 18 years of age.~~

317:30-5-518. Coverage limitations [REVOKED]

~~(a) Payment is not made for daily respite care and specialized foster care or agency companion services (ACS) for the same member on the same date of service.~~

~~(b) Respite care:~~

~~(1) is not available to members in Oklahoma Department of Human Services (DHS) custody or in out-of-home placement funded by DHS Child Welfare Services; and~~

~~(2) for members not receiving ACS, is limited to 30 days or 720 hours annually per member, except as approved by the DHS Developmental Disabilities Services director and authorized in the member's Plan of Care; or~~
~~(3) for members receiving ACS, is limited per Oklahoma Administrative Code 317:40-5-3.~~

PART 59. HOMEMAKER SERVICES

317:30-5-535. ~~Homemaker Service in~~ Home and Community-Based Services ~~(HCBS)~~ Waiver for persons with an intellectual disability or certain persons with related conditions

(a) **Introduction to waiver services.** The Oklahoma Health Care Authority (OHCA) administers ~~Home and Community-Based Services (~~HCBS~~)~~ Waivers for persons with an intellectual disability or certain persons with related conditions that are operated by ~~the~~ Oklahoma ~~Department of~~ Human Services (OKDHS) Developmental Disabilities Services (DDS) ~~Division~~. Each waiver allows payment for homemaker ~~or homemaker respite services~~ service as defined in the waiver approved by the Centers for Medicare and Medicaid Services.

(b) **Eligible providers**. ~~All homemaker~~Homemaker services providers ~~must~~ enter into contractual agreements with the OHCA to provide HCBS for persons with an intellectual disability or related conditions.

(1) Providers must complete the OKDHS DDS sanctioned training per Oklahoma Administrative Code 340:100-3-38.

(2) Homemaker service is included in the member's Individual Plan (Plan). Arrangements for this service must be made through the member's DDS case manager.

(3) Homemaker service includes general household activities, such as meal preparation and routine household care when the regular caregiver responsible for these activities is temporarily absent or unable to manage the home and care for others in the home.

(4) Limits are specified in the member's Plan.

317:30-5-536. Coverage [REVOKED]

~~All homemaker or homemaker respite services must be included in the member's Individual Plan (IP). Arrangements for care under this program must be made with the member's case manager.~~

317:30-5-537. Description of services [REVOKED]

~~Homemaker services include:~~

~~(1) **Minimum qualifications.** Providers must complete the Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDSD) sanctioned training curriculum in accordance with the schedule authorized by DDSD per OAC 340:100-3-38.~~

~~(2) **Description of services.**~~

~~(A) Homemaker services include general household activities, such as meal preparation and routine household care provided by a homemaker who is trained, when the regular caregiver responsible for these activities is temporarily absent or unable to manage the home and care for others in the home. Homemakers can help members with activities of daily living when needed.~~

~~(B) Homemaker respite services may include respite services provided to members on a short-term basis due to the need for relief of the caregiver. Services may be provided in any community setting as specified per the member's Individual Plan (IP).~~

~~(3) **Coverage limitations.** Limits are specified in member's IP. Members who are in the custody of OKDHS and in out-of-home placement funded by OKDHS Children and Family Services Division are not eligible for respite care.~~

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

SUBCHAPTER 1. GENERAL PROVISIONS

317:40-1-4. Remote support (RS)

(a) **General Information.** RS services are intended to promote a member's independence. RS services are provided in the member's home, family home, or employment site to reduce reliance on in person support while ensuring the member's health and safety. RS services are included in the member's Individual Plan (Plan) and arrangements for this service are made through the case manager. Authorization to provide RS must be obtained from the Developmental Disabilities Services (DDS) division director or designee.

(1) RS services are:

(A) Based on the member's needs as documented and supported by the Plan and Person-Centered Assessment;

(B) The least-restrictive option and the member's preferred method to meet an assessed need;

(C) Provided when all adult members of the household; his or her guardians, when applicable; and Personal Support Team (Team) agree to the provision of RS services as documented in the Plan; and

(D) Reviewed by the Team after sixty (60) calendar days of initial installation to determine continued appropriateness and approval of services.

(2) RS services are not a system to provide surveillance or for staff convenience.

(b) **Service description.** RS is monitoring of an adult member; allowing for live, two-way communication with him or her in his or her residence or employment site, by monitoring staff using one or more of the systems in one (1) through eight (8) ~~that are:~~ of this subsection.

(1) Live-video feed~~;~~.

(2) Live-audio feed~~;~~.

(3) Motion-sensing monitoring~~;~~.

(4) Radio-frequency identification~~;~~.

(5) Web-based monitoring~~;~~.

(6) Personal Emergency Response System ~~(PERS) ;~~.

(7) Global positioning system ~~(GPS)~~ monitoring devices~~; or~~.

(8) Any other device approved by the ~~Developmental Disabilities Services (DDS)~~DDS director or designee.

(c) **General provider requirements.** RS service providers must have a valid Oklahoma Health Care Authority (OHCA) SoonerCare (Medicaid) provider agreement to provide agency-based RS services to Oklahoma Human Services (OKDHS) DDS ~~Home-and-Community-Based~~Home and Community-Based Services (HCBS) Waiver members. Requests for applications to provide RS are made to and approved by OKDHS DDS ~~state office~~State Office.

(1) An assessment for RS ~~Assessment~~services is completed:

(A) Annually;

(B) Prior to RS implementation; and

(C) As required by ongoing progress and needs assessments.

(2) Each member is required to identify at least two (2) emergency response staff. The member's emergency response staff are documented in his or her Plan.

(3) RS observation sites are not located in a member's residence.
(4) The use of camera or video equipment in the member's bedroom or other private area is prohibited.
(5) RS services are provided in real time by awake staff at a monitoring base using the appropriate connection, not by a recording. While RS is provided the RS staff does not have duties other than ~~remote supports~~RS.
(6) RS equipment used in the member's residence includes a visual indicator to the member that the system is on and operating.
(7) RS provider agencies must immediately notify in writing, the member's residential provider agency, vocational provider agency, assigned DDS case manager, or guardian of activity in the household~~, who~~ that could potentially compromise the member's health or safety.
(8) Emergency response provider agency staff records are maintained, per Oklahoma Administrative Code (OAC) 340:100-3-40.
(9) RS provider records are maintained for seven (7) calendar years or until any pending litigation involving the service recipient is completed, whichever occurs last and include at a minimum:
(A) The member's name;
(B) The staff's name who delivered the service;
(C) Service dates;
(D) Service begin and end times;
(E) Provider's location;
(F) Description of services provided or observation note;
(G) Method of contact with member; and
(H) The member's current photograph.
(10) RS providers must have:
(A) Safeguards in place including, but not limited to:
(i) A battery or generator to insure continued coverage during an electrical outage at the member's home and monitoring facility;
(ii) Back-up procedures at the member's home and monitoring site for:
(I) Prolonged power outage;
(II) Fire;
(III) Severe weather; ~~and~~
(IV) The member's personal emergency~~.~~; and
(iii) The ability to receive alarm notifications, such as home security, smoke, or carbon monoxide at each residence monitored, as assessed by the ~~team~~Team as necessary for health and safety~~.~~; and
(B) Two-way audio communication allowing staff monitors to effectively interact with, and address the member's needs in each residence;
(C) A secure Health Insurance Portability and Accountability Act (HIPAA)-compliant network system requiring data authentication, authorization, and encryption to ensure access to computer vision, audio, sensor, or written information is limited to authorized staff or ~~team~~Team members per the Plan;
(D) A current file for each member receiving RS services including:
(i) The member's photograph;
(ii) The member's Plan;

(iii) The member's demographics; and

(iv) Any other pertinent data to ensure the member's safety.; and

(E) Capability to maintain all video and make it available to OKDHS staff upon request for a minimum of twelve (12) calendar months. OKDHS may require an extended timeframe when necessary.

(d) **RS staff requirements.** RS staff:

(1) May not have any assigned duties other than oversight and member support at the time they are monitoring;

(2) Receive member specific training per the member's Plan prior to providing support to a member;

(3) Assess urgent situations at a member's home or employment site and call 911 first when deemed necessary; then contact the member's residential provider agency or employment provider agency designated emergency response staff; or the member's natural support designated emergency response person while maintaining contact with the member until persons contacted or emergency response personnel arrive on site;

(4) Implement the member's Plan as written by the Team and document the member's status at least hourly;

(5) CompleteCompletes and submitsubmits incident reports, per OAC 340:100-3-34, unless emergency backup staff is engaged;

(6) ProvideProvides simultaneous support to no more than sixteen (16)thirty (30) members;

(7) AreIs eighteen (18) years of age and older; and

(8) AreIs employed by an approved RS agency.

(e) **Emergency response requirement.**

(1) Emergency response staff areis employed by a provider agency with a valid OHCA SoonerCare (Medicaid) provider agreement to provide residential services, vocational services or habilitation training specialist (HTS) services to OKDHS/DDSOKDHS DDS HCBS Waiver members and:

(A) May not have any assigned duties other than oversight and support of members at the time they are assigned as response staff;

(B) ReceiveReceives all trainings required, per OAC 340:100-3-38.1, for members in residential settings; OAC 340:100-3-38.2 for members in employment settings; or OAC 340:100-3-38.3, for members in non-residential settings per the Plan prior to providing support;

(C) ProvideProvides a response on site at the member's residence or employment site within twenty (20) minutes when contacted by RS staff unless a shorter timeframe is indicated in the member's Plan;

(D) HaveHas an on-call back-up person who responds when the primary response staff engaged at another home or employment site is unable to respond within the specified time frame;

(E) ProvideProvides written or verbal acknowledgement of a request for assistance from the RS staff;

(F) CompleteCompletes and document emergency drills with the member quarterly when services are provided in the member's home;

(G) ImplementImplements the Plan as written and document each time they are contacted to respond, including the nature of the intervention and the duration;

(H) CompleteCompletes incident reports, per OAC 340:100-3-34; and

(I) ~~Are~~Is eighteen (18) years of age and older.

(2) Natural emergency response persons:

(A) Are unpaid family members or other interested parties who agree to become, and are approved as, an emergency response person by the member's Team;

(B) Are available to respond in the case of an emergency within twenty (20) minutes from the time they are contacted by RS staff, unless a shorter response time is indicated in the Plan;

(C) Have an on-call back-up person who responds when the primary response staff is unable to respond within the specified time frame;

(D) Provide written or verbal acknowledgement of a request for assistance from ~~the remote supports~~RS staff; and

(E) Are eighteen (18) years of age and older.

(f) **Service limitations.** RS is limited to twenty-four (24) hours per day. RS is not provided simultaneously with HTS~~ services~~, homemaker~~ services~~, ~~agency companion services, group home services, specialized foster care,~~ respite, intensive personal supports~~ services~~, daily living supports, per OAC 340:100-5-22.1, or employment services, per OAC 340:100-17 ~~group job coaching, or where foster care is provided to children~~. RS ~~can be provided in conjunction with daily living supports, individual job coaching, employment stabilization services, and center and community based services~~may not be provided to members receiving specialized foster care or agency companion services, per OAC 340:100-5.22.1, or group home services, per OAC 340:100-6.

(1) Services not covered include, but are not limited to:

(A) Direct care staff monitoring;

(B) Services to persons under the age of eighteen (18); or

(C) Services provided in any setting other than the member's primary residence or employment site.

(2) RS services are shared among ~~OKDHS/DDS~~OKDHS DDS Waiver members of the same household in a residential setting. RS provider agencies may only bill for one (1) member of a household at a time. Only one (1) ~~remote supports~~RS provider per household~~;~~.

(3) Assistive technology purchases are authorized, per OAC 317:40-5-100.

(g) **RS Discontinuation.** ~~The member and his or her Team determine when it is appropriate to discontinue RS services. When RS services are terminated, the RS provider agency coordinates termination of service with the member's residential provider agency or vocational provider agency and Team to ensure a safe transition. When a member requests the termination of RS services while RS is being provided, the RS staff~~ RS services can be discontinued:

(1)~~ Notifies the provider to request an emergency response staff;~~

~~(2) Leaves the system operating until the emergency response staff arrives; and~~

~~(3) Turns off the system once relieved by the emergency response staff.~~

(1) When the member and member's Team determine it is appropriate to discontinue RS services. When RS services are terminated, the RS provider agency coordinates termination of service with the member's residential or vocational provider agency and Team to ensure a safe transition. When a member requests the termination of RS services while RS is being provided, the RS staff:

(A) Notifies the provider to request an emergency response staff;

(B) Leaves the system operating until the emergency response staff arrives; and

(C) Turns off the system once relieved by the emergency response staff; or

(2) At the discretion of the RS provider when services do not meet the health or behavioral needs of the individual.

(A) A thirty (30) calendar day termination notice must be provided to the member and the Team prior to discontinuing services so alternative services can be arranged.

(B) Services must continue to be provided to the service recipient until the Team confirms all essential services are in place.

SUBCHAPTER 5. MEMBER SERVICES

PART 1. AGENCY COMPANION SERVICES

317:40-5-3. Agency companion services (ACS)

(a) ACS are:

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

(2) Provider Agency independent contractors and provide a shared living arrangement developed to meet the member's specific needs that include supervision, supportive assistance, and training in daily living skills, and integrates the member into the shared experiences of a family in a home owned or rented by the companion;

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

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

(b) ~~An agency companion:~~Households are limited to one (1) individual companion provider. Exceptions for two individual companion providers are allowed in a household when each provides companion services to different members. Exceptions may be approved by the DDS director or designee. Agency companions may not simultaneously serve more than four (4) members through any combination of companion or respite services. An agency companion:

(1) ~~Must have~~Has an approved home profile, per OAC 317:40-5-3, and contract with a DDS-approved provider agency;

(2) May provide companion services for one (1) member. Exceptions to serve as companion for two (2) members may be approved by the DDS director or designee. Exceptions for up to two (2) members may be approved when members have an existing relationship and to separate them would be detrimental to their ~~well-being~~well-being and the companion demonstrates the skill and ability required to serve as companion for two (2) members. Exceptions for additional members may be granted when the DDS director or designee determines an emergency situation exists and there is no other resolution, and the companion demonstrates the skill and ability required to serve as a companion~~.~~;

~~(3) Household is limited to one (1) individual companion provider. Exceptions for two (2) individual companion providers in a household who each provide companion services to different members may be approved by the DDS director or designee;~~

~~(4)~~ (3) May not provide companion services to more than two (2) household members at any time; and

~~(5) Household may not simultaneously serve more than four (4) members through any combination of companion or respite services.~~

~~(6)~~(4) May not have employment, volunteer activities, or personal commitments that prevent the companion from fulfilling his or her responsibilities to the member, per OAC 317:40-5.

(A) The companion may have employment when:

(i) Employment is approved in advance by the DDS area residential services ~~program~~ programs manager;

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

(iii) ~~Companion provides assurance~~The companion ensures the employment is such that the member's needs ~~will be~~are met by the companion ~~should~~if the member's outside activities ~~be~~are disrupted.

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

(i) His or her employment; or

(ii) His or her contract as an agency companion.

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

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

(1) Therapeutic leave:

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

(B) Is claimed when the:

(i) Member does not receive ACS for twenty-four (24) consecutive hours due to:

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

(II) Vacation without the companion; or

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

(ii) Companion uses authorized respite time; and

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

(D) Cannot be carried over from one (1) POC year to the next.

(2) The therapeutic leave daily rate is the same amount as the ACS per diem rate.

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

(d) The companion may receive a combination of hourly or daily respite per POC year equal to seven-hundred and twenty (720) hours.

(1) The daily respite rate is used when respite is provided for a full twenty-four (24) hour day. A day is defined as the period between 12:00 am and 11:59 pm.

(2) The hourly respite rate is used when respite is provided for a partial day.

(3) The provider may serve more than one (1) member through shared staffing, but may not bill HTS or the hourly respite rate for multiple members at the same time.

(e) Habilitation ~~Training Specialist~~training specialist (HTS) services:

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

(A) Sleeping at night; or

(B) Working or attending employment, educational, or day services; and

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

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

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

(f) The contractor model does not include funding for the provider agency for the provision of benefits to the companion.

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

(1) Determined by authorized DDS staff per levels described in ~~(A) through(D); and~~OAC 317:40-5-3(g)(2)(A) through (C); and

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

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

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

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

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

~~(B)~~(A) **Close level of support**. Close level of support is authorized when the member requires ~~the level of assistance outlined in (g)(2)(A) and~~ assistance in at least two (2) of the ~~following:~~services in (i) through (iii) of this subparagraph.

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

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

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

~~(C)~~(B) **Enhanced level of support**. Enhanced level of support is authorized when the member requires the level of assistance outlined in (g)(2)~~(B)~~(A) and meets at least one (1) of the ~~following~~criteria in (i) through (iii) of this subparagraph. The member:

(i) Is totally dependent on others for:

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

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

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

(iii) Has behavioral issues that ~~requires~~require a protective intervention protocol (PIP) with a restrictive or intrusive procedure, per OAC 340:100-1-2. The PIP must:

(I) Be approved by the Statewide Human Rights Behavior Review Committee ~~(SHRBRC)~~, per OAC 340:100-3-14; or

(II) Have received ~~expedited~~temporary approval, per OAC 340:100-5-57~~;~~.

~~(iv) Meets the requirements of (g)(2)(C)(i) through (ivii); and does not have an available personal support system. The need for this service level:~~

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

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

~~(D)~~(C) **Pervasive level of support.** Pervasive level of support ~~requires the level of assistance outlined in (g)(2)(C), and~~ is authorized when the member is in OKDHS Child Welfare Services custody and efforts to place in traditional foster care have failed due to the extensive level of support required by the member. It is reevaluated only when the member is eighteen (18) years of age or older and his or her individual companion provider changes.

(i) This level of support may continue to be authorized when the member requires:

(I) The level of assistance outlined in (g)(2)(B); and

(II) Additional professional level support to remain in an agency companion setting due to pervasive behavioral or emotional challenges.

~~(i)~~(ii) ~~Requires additional professional level support to remain in an agency companion setting due to pervasive behavioral or emotional challenges. The support must be provided~~Providers of this level of support:

(I) ~~By~~Deliver direct support to the companion by a licensed or certified behavioral health professional ~~counselor (LPC) or professional~~ with a minimum of ~~Masters of Social Work (MSW) degree~~a master's degree; ~~and~~

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

(III) ~~As~~Provide professional level and ongoing support as part of the ACS and not billed as a separate service. Waiver services may be authorized for the development of a PIP, per OAC 340:100-5-57; and

(IV) Market, recruit, screen, and train potential companions for the identified member.

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

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

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

(h) Authorization for payment of ACS is contingent upon receipt of:

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

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

(3) The Plan;

(4) The POC; and

(5) The date the member is scheduled to move to the ~~companions~~companion's home. When a member transitions from a DDS placement funded by a pier diem the incoming provider may request eight (8) hours of HTS for the first day of service.

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

(j) The room and board payment may include all but one-hundred and fifty dollars ($150) per month of the ~~service recipient's~~member's income, up to a maximum of ninety (90) percent of the current minimum Supplemental Security Income ~~(SSI)~~ payment for a single individual.

PART 5. SPECIALIZED FOSTER CARE STANDARDS

317:40-5-50. Purpose of Specialized Foster Care ~~Scope~~(SFC)

(a) ~~Specialized Foster Care (SFC)~~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 SFC member is a child; or

(B) Required by the adult ~~member's~~SFC recipient'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~~SFC is intended to allow relief for the member's family 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. 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 per 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 the member's Individual Plan (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 ~~18~~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.

(h) When natural or other unpaid supports are not available, the SFC provider may request respite support.

(1) Respite units do not replace the responsibilities of the SFC provider on a regular basis.

(2) All respite units must be justified in the member's Plan process.

(3) No more than seven-hundred and twenty (720) hours annually may be authorized unless approved by the DDS director or designee.

(A) The daily respite rate is used when respite is provided for a full twenty-four (24) hour day. A day is defined as the period between 12:00 a.m. and 11:59 p.m..

(B) The hourly respite rate is used when respite is provided for a partial day.

(C) The provider may serve more than one (1) member through shared staffing, but may not bill habilitation training specialist (HTS) services or the hourly respite rate for multiple members at the same time.

(4) No spouse or other adult living in the provider household may serve as paid respite staff.

(5) Consideration is given to authorizing additional respite hours when providing additional relief represents the most cost-effective placement for the member and:

(A) There are multiple members living in the home;

(B) The member has an on-going pattern of not sleeping at night; or

(C) The member has an on-going pattern of not working or attending employment services, in spite of continuing efforts by the Team.

(i) HTS services may be approved by the DDS director or designee when providing SFC with additional staffing support represents the most cost-effective placement for the member when:

(1) There is an ongoing pattern of not sleeping at night; or

(2) There is an ongoing pattern of not working or attending employment, educational, or day services;

(3) There are multiple members living in the home;

(4) A time-limited situation exists in which the foster parent is unable to provide SFC, and the provision of HTS maintains the placement or provides needed stability for the member, and must be reduced when the situation changes;

(5) Must be reviewed annually or more frequently as needed; and

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

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

(1) The payment for a day of therapeutic leave is the same amount as the per diem rate for SFC services.

(2) Therapeutic leave is claimed when the member does not receive SFC services for twenty-four (24) consecutive hours from 12:00 am to 11:59 pm because of:

(A) A visit with family or friends without the SFC provider;

(B) Vacation without the SFC provider; or

(C) Hospitalization.

317:40-5-60. Relief support for providers of Specialized Foster Care [REVOKED]

~~When natural or other unpaid supports are not available, the Specialized Foster Care (SFC) provider may request relief support.~~

~~(1) Relief units do not replace the responsibilities of the SFC provider on a regular basis.~~

~~(2) All relief units must be justified in the service recipient's Plan process.~~

~~(3) No more than 720 hours annually may be authorized unless approved by the Developmental Disabilities Services Division director or designee.~~

~~(4) No spouse or other adult living in the provider household may serve as paid relief staff.~~

~~(5) Consideration is given to authorizing additional relief hours when providing additional relief represents the most cost-effective placement for the service recipient and:~~

~~(A) there are multiple service recipients living in the home;~~

~~(B) the service recipient has an on-going pattern of not sleeping at night; or~~

~~(C) the service recipient has an on-going pattern of not working or attending employment services, in spite of continuing efforts by the Team.~~

PART 9. SERVICE PROVISIONS

317:40-5-100. Assistive technology (AT) devices and services

(a) **Applicability.** This Section applies to AT services and devices authorized by Oklahoma ~~Department of~~ Human Services ~~OKDHS~~(OKDHS) Developmental Disabilities Services (DDS) through Home and ~~Community Based~~Community-Based Services (HCBS) Waivers.

(b) **General information.**

(1) AT devices include the purchase, rental, customization, maintenance, and repair of devices, controls, and appliances. AT devices include:

(A) Visual alarms;

(B) Telecommunication devices ~~(TDDS)~~;

(C) Telephone amplifying devices;

(D) Devices for the protection of health and safety of members who are deaf or hard of hearing;

(E) Tape recorders;

(F) Talking calculators;
(G) Specialized lamps;
(H) Magnifiers;
(I) Braille writers;
(J) Braille paper;
(K) Talking computerized devices;
(L) Devices for the protection of health and safety of members who are blind or visually impaired;
(M) Augmentative and alternative communication devices including language board and electronic communication devices;
(N) Competence-based cause and effect systems, such as switches;
(O) Mobility and positioning devices including:
(i) Wheelchairs;
(ii) Travel chairs;
(iii) Walkers;
(iv) Positioning systems;
(v) Ramps;
(vi) Seating systems;
(vii) Standers;
(viii) Lifts;
(ix) Bathing equipment;
(x) Specialized beds; ~~and~~
(xi) Specialized chairs; and
(P) Orthotic and prosthetic devices, including:
(i) Braces;
(ii) Precribed modified shoes; ~~and~~
(iii) Splints; and
(Q) Environmental controls or devices;
(R) Items necessary for life support, and devices necessary for the proper functioning of such items, including durable and non-durable medical equipment not available through SoonerCare (Medicaid); ~~and~~
(S) ~~Devices~~Enabling technology devices to protect the member's health and safety or support increased independence in the home, employment site or community can include, but are not limited to:
(i) Motion sensors;
(ii) Smoke and carbon monoxide alarms;
(iii) Bed ~~and/or~~ or chair sensors;
(iv) Door and window sensors;
(v) Pressure sensors in mats on the floor;
(vi) Stove guards or oven shut off systems;
(vii) Live web-based remote supports;
(viii) Cameras;
(ix) ~~Automated medication~~Medication dispenser systems;
(x) Software to operate accessories included for environmental control;
(xi) Software applications;
(xii) Personal Emergency Response Systems ~~(PERS)~~ or ~~Mobile;~~mobile;

(xiii) Emergency Response Systems ~~(MER)~~;
(xiv) Global positioning system ~~(GPS)~~ monitoring devices;
(xv) Radio frequency identification;
(xvi) Computers, smart watches and tablets; and
(xvii) Any other device approved by the ~~Developmental; and~~DDS director or designee;
~~(xviii) Disabilities Services (DDS) director or designee.~~

(T) Eye glasses lenses, frames or visual aids.

(2) AT services include:

(A) Sign language interpreter services for members who are deaf;
(B) Reader services;
(C) ~~Auxillary~~Auxiliary aids;
(D) Training the member and provider in the use and maintenance of equipment and auxiliary aids;
(E) Repair of AT devices; ~~and~~
(F) Evaluation of the member's AT needs~~.~~; and
(G) Eye examinations.

(3) AT devices and services must be included in the member's Individual Plan ~~(IP)~~(Plan), prescribed by a physician, or appropriate medical professional with a SoonerCare (Medicaid) contract, and arrangements for this HCBS service must be made through the member's case manager.

(4) AT devices are provided by vendors with a ~~Durable Medical Equipment (DME)~~durable medical equipment or other appropriate contract with the Oklahoma Health Care Authority (OHCA).

(5) AT devices and services are authorized ~~in accordance with~~per requirements of ~~The~~the Oklahoma Central Purchasing Act, other applicable statutory provisions, Oklahoma Administrative Code ~~OAC~~(OAC) 580:15 and OKDHS-approved purchasing procedures.

(6) AT services are provided by an appropriate professional services provider with a current HCBS contract with OHCA and current, unrestricted licensure and certification with their professional board, when applicable.

(7) AT devices or services may be authorized when the device or service:

(A) Has no utility apart from the needs of the person receiving services;
(B) Is not otherwise available through SoonerCare (Medicaid) an AT retrieval program, the Oklahoma ~~Department of Rehabilitative~~Rehabilitation Services, or any other third party or known community resource;
(C) Has no less expensive equivalent that meets the member's needs;
(D) Is not solely for family or staff convenience or preference;
(E) Is based on the assessment and Personal Support Team (Team) consideration of the member's unique needs;
(F) Is of direct medical or remedial benefit to the member;
(G) Enables the member to maintain, increase, or improve functional capabilities;
(H) Is supported by objective documentation included in a professional assessment, except as specified, per OAC 317:40-5-100;
(I) Is within the scope of ~~assistive technology~~ AT, per OAC 317:40-5-100;
(J) Is the most appropriate and cost effective bid, when applicable; ~~and~~ or

(K) Exceeds a cost of seventy-five dollars ($75) AT devices or services with a cost of seventy-five dollars ($75) or less, are not authorized through DDS HCBS Waivers.

(8) The homeowner must sign a written agreement for any AT equipment that attaches to the home or property.

(c) **Assessments.** Recommendations for enabling technology devices are completed by the DDS programs manager for remote supports or their designee. Assessments for AT devices or services are performed by a licensed, professional service provider and reviewed by other providers whose services may be affected by the device selected. A licensed, professional service provider must:

(1) Determine if the member's identified outcome can be accomplished through the creative use of other resources, such as:

(A) Household items or toys;

(B) Equipment loan programs;

(C) Low-technology devices or other less intrusive options; or

(D) A similar, more cost-effective device; and

(2) Recommend the most appropriate AT based on the member's:

(A) Present and future needs, especially for members with degenerative conditions;

(B) History of use of similar AT, and his or her current ability to use the device~~and for the next five (5) years~~; and

(C) Outcomes; and

(3) Complete an assessment, including a decision making review and device trial that provides supporting documentation for purchase, rental, customization, or fabrication of an AT device. Supporting documentation must include:

(A) A device review;

(B) Availability of the device rental with discussion of advantages and disadvantages;

(C) How frequently and in what situations the device ~~will be~~is used in daily activities and routines;

(D) How the member and caregiver(s) ~~will be~~are trained to safely use the AT device; and

(E) The features and specifications of the device necessary for the member, including rationale for why other alternatives are not available to meet the member's needs; and

(4) Upon DDS staff's request, provide a current, unedited video or photographs of the member using the device, including recorded trial time frames.

(d) **Repairs and placement part authorization.** AT device repairs or parts replacements, do not require a professional assessment or recommendation. DDS resource development staff with ~~assistive technology~~AT experience may authorize repairs and replacement of parts for previously recommended AT.

(e) **AT device retrieval.** When a member no longer needs an AT device, OKDHS DDS staff may retrieve the device.

(f) **Team decision-making process.** The member's Team reviews the licensed professional's assessment and decision-making review. The Team ensures the recommended AT:

(1) Is needed by the member to achieve a specific, identified functional outcome.

(A) A functional outcome, in this Section, means the activity is meaningful to the member, occurs on a frequent basis, and would require assistance from others, if the member could not perform the activity independently, such as self-care, assistance with eating, or transfers.

(B) Functional outcomes must be reasonable and necessary given a member's age, diagnosis, and abilities; and

(2) Allows the member receiving services to:

(A) Improve or maintain health and safety;

(B) Participate in community life;

(C) Express choices; or

(D) Participate in vocational training or employment; and

(3) ~~Will be~~Is used frequently or in a variety of situations;

(4) ~~Will~~Is easily fit into the member's lifestyle and work place;

(5) Is specific to the member's unique needs; and

(6) Is not authorized solely for family or staff convenience.

(g) **Requirements and standards for AT devices and service providers.**

(1) Providers guarantee devices, work, and materials for one (1) calendar year, and supply necessary follow-up evaluation to ensure optimum usability.

(2) Providers ensure a licensed occupational therapist, physical therapist, speech therapist, or rehabilitation engineer evaluates the need for AT, and individually customizes AT devices.

(h) **Services not covered through AT devices and services.** AT devices and services do not include:

(1) Trampolines;

(2) Hot tubs;

(3) Bean bag chairs;

(4) Recliners with lift capabilities;

(5) Computers, except as adapted for individual needs as a primary means of oral communication, and approved, per OAC 317:40-5-100;

(6) Massage tables;

(7) Educational games and toys; or

(8) Generators.

(i) **AT approval or denial.** DDS approval, conditional approval for pre-determined trial use, or denial of the purchase, rental, or lease or purchase of the AT is determined, per OAC 317:40-5-100.

(1) The DDS case manager sends the AT request to designated DDS AT-experienced resource development staff. The request must include:

(A) The licensed professional's assessment and decision making review;

(B) A copy of the Plan of Care ~~(POC)~~;

(C) ~~Documentation~~Documentation of the current Team consensus, including consideration of issues, per OAC 317:40-5-100; and

(D) All additional documentation to support the AT device or service need.

(2) The designated AT-experienced resource development staff approves or denies the AT request when the device costs less than $5000.

(3) The State Office programs manager for AT approves or denies the AT request when the device has a cost of $5000 or more. When authorization of an AT device of $5000 or more is requested:

(A) The AT-experienced resource development staff:

(i) Solicits three (3) AT bids; and

(ii) Submits the AT request, bids, and other relevant information identified in (1) of this subsection to the State Office DDS AT programs manager or designee within five (5) business days of receipt of the required bids; and

(B) The State Office DDS AT programs manager or designee issues a letter of authorization, a written denial, or a request for additional information within five (5) business days of receipt of all required AT documentation.

(4) Authorization for purchase or a written denial is provided within ten (10) business days of receipt of a complete request~~:~~.

(A) If the AT is approved, a letter of authorization is issued~~;~~.

(B) If additional documentation is required by the AT-experienced resource development staff, to authorize the recommended AT, the request packet is returned to the case manager for completion~~;~~.

(C) When necessary, the case manager contacts the licensed professional to request the additional documentation~~; and~~.

~~(D) The authorization of an AT device of $5000 or more is completed per (2) of this subsection, and the AT-experienced resource development staff with:~~

~~(i) Solicits three (3) AT bids;~~

~~(ii) Submits the AT request, bids, and other relevant information to the State Office DDS AT programs manager or designee within five (5) business days of receipt of the required bids; and~~

~~(iii) The State Office DDS AT programs manager or designee issues a letter of authorization, a written denial, or a request for additional information within five (5) business days of receipt of all required AT documentation.~~

(j) **Vehicle approval adaptations.** Vehicle adaptations are assessed and approved, per OAC 317:40-5-100. In addition, the requirements in (1) through (3) of this subsection must be met.

(1) The vehicle must be owned or in the process of being purchased by the member receiving services or his or her family in order to be adapted.

(2) The AT request must include a certified mechanic's statement that the vehicle and adaptations are mechanically sound.

(3) Vehicle adaptations are limited to one vehicle in a ten (10) year period per member. Authorization for more than one vehicle adaptation in a ten (10) year period must be approved by the DDS director or designee.

(k) **Eye glasses and eye exams**. Routine eye examination or the purchase of corrective lenses for members twenty-one (21) years of age and older, not covered by SoonerCare (Medicaid), may be authorized for the purpose of prescribing glasses or visual aids, determination of refractive state, treatment of refractive errors, or purchase of lenses, frames, or visual aids. Payment can be made to a licensed optometrist who has a current contract on file with OHCA for services within the scope of Optometric practice as defined by the appropriate State law; provided, however, that services performed by out-of-state providers are only compensable to the extent that they are covered services.

~~(k)~~(l) **AT denial.** Procedures for denial of an AT device or service are described in (1) through (3) of this subsection.

(1) The person denying the AT request provides a written denial to the case manager citing the reason for denial, per OAC 317:40-5-100.

(2) The case manager sends OKDHS Form 06MP004E, Notice of Action, to the member and his or her family or guardian.

(3) AT service denials may be appealed through the OKDHS hearing process, per OAC 340:2-5.

~~(l)~~(m) **AT device returns.** When, during a trial use period or rental of a device, the therapist or Team including the licensed professional who recommended the AT and, when available, determines the device is not appropriate, the licensed professional sends a brief report describing the change of device recommendation to the DDS case manager. The DDS case manager forwards the report to the designated resource development staff, who arranges for the equipment return to the vendor or manufacturer.

~~(m)~~(n) **AT device rental.** AT devices are rented when the licensed professional or AT-experienced resource development ~~staffdetermines~~staff determines rental of the device is more cost effective than purchasing the device or the licensed professional recommends a trial period to determine if the device meets the member's needs.

(1) The rental period begins on the date the manufacturer or vendor delivers the equipment to the member, unless otherwise stated in advance by the manufacturer or vendor.

(2) AT-experienced resource development staff monitor use of equipment during the rental agreement for:

(A) Rental time frame cost effectiveness;

(B) Renewal conditions; and

(C) The Team's, including the licensed professional's re-evaluation of the member's need for the device, per OAC 317:40-5-100.

(3) Rental costs are applied toward the purchase price of the device when the option is available from the manufacturer or vendor.

(4) When a device is rented for a trial-use period, the Team including the licensed professional, decides within ninety (90) calendar days whether the device:

(A) Meets the member's needs; and

(B) ~~Should~~Needs to be purchased or returned.

~~(n)~~(o) **AT committee.** The AT committee reviews equipment requests when deemed necessary by the OKDHS DDS State Office AT programs manager.

(1) The AT committee is comprised of:

(A) DDS professional staff members of the appropriate therapy;

(B) DDS State Office AT programs manager;

(C) The DDS area field administrator or designee; and

(D) An AT expert, not employed by OKDHS.

(2) The AT committee performs a paper review, providing technical guidance, oversight, and consultation.

(3) The AT committee may endorse or recommend denial of a device or service, based on criteria provided in this Section. Any endorsement or denial includes a written rationale for the decision and, when necessary, an alternative solution, directed to the case manager within twenty (20) business days of the receipt of the request. Requests reviewed by the AT committee result in suspension of time frames specified, per OAC 317:40-5-100.

317:40-5-102. Nutrition ~~Services~~services

(a) **Applicability.** The rules in this Section apply to nutrition services authorized for members who receive services through Home and Community-Based Services (HCBS) Waivers operated by the Oklahoma ~~Department of~~ Human Services (OKDHS) Developmental Disabilities Services ~~Division (DDSD)~~(DDS).

(b) **General information.** Nutrition services include nutritional evaluation and consultation to members and their caregivers, are intended to maximize the member's health and are provided in

any community setting as specified in the member's Individual Plan ~~(IP)~~(Plan). Nutrition services must be prior authorized, included in the member's ~~Individual~~ Plan ~~(IP)~~ and arrangements for this service must be made through the member's case manager. Nutrition service contract providers must be licensed in the state where they practice and registered as a dietitian with the Commission of Dietetic Registration. Each dietitian must have a current provider agreement with the Oklahoma Health Care Authority ~~(OHCA)~~ to provide ~~Home and Community Based Services~~HCBS, and a SoonerCare (Medicaid) provider agreement for nutrition services. Nutrition ~~Services~~services are provided per Oklahoma Administrative Code (OAC) 340:100-3-33.1. In order for the member to receive Waiver-funded nutrition services, the requirements in this Section must be fulfilled.

(1) The member must be assessed by the case manager to have a possible eating problem or nutritional risk.

(2) The member must have ~~a physician's order for nutrition services current within one year.~~ an order for nutrition services current within one (1) year signed by a medical or osteopathic physician, physician assistant, or other licensed health care professional with prescriptive authority.

(3) Per OAC 340:100-5-50 through 58, the ~~team~~Personal Support Team (Team) identifies and addresses member needs.

(4) Nutrition services may include evaluation, planning, consultation, training and monitoring.

(5) A legally competent adult or legal guardian who has been informed of the risks and benefits of the service has the right to refuse nutrition services per OAC 340:100-3-11. Refusal of nutrition services must be documented in the ~~Individual~~ Plan.

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

(7) A unit is ~~15~~fifteen (15) minutes.

(8) Nutrition services are limited to ~~192~~one hundred ninety-two (192) units per Plan of Care year.

(c) **Evaluation.** When arranged by the case manager, the nutrition services contract provider evaluates the member's nutritional status and completes the Level of Nutritional Risk Assessment.

(1) The evaluation must include, but is not limited to:

(A) ~~health,~~Health, diet, and behavioral history impacting on nutrition;

(B) ~~clinical~~Clinical measures including body composition and physical assessment~~.~~;

(C) ~~dietary~~Dietary assessment, including:

(i) ~~nutrient~~Nutrient needs;

(ii) ~~eating~~Eating skills;

(iii) ~~nutritional~~Nutritional intake; and

(iv) ~~drug-nutrient~~Drug-nutrient interactions; and

(D) ~~recommendations~~Recommendations to address nutritional risk needs, including:

(i) ~~outcomes;~~Outcomes;

(ii) ~~strategies;~~Strategies;

(iii) ~~staff~~Staff training; and

(iv) ~~program~~Program monitoring and evaluation.

(2) The nutrition services contract provider and other involved professionals make recommendations for achieving positive nutritional outcomes based on the risks identified on ~~the~~ OKDHS Form 06HM040E, Level of Nutritional Risk Assessment.

(3) The nutrition services contract provider sends a copy of the Level of Nutritional Risk Assessment to the case manager within ten (10) ~~working~~ days of receipt of the authorization.

(4) If the evaluation shows the member rated as High Nutritional Risk, the nutrition services contract provider sends a copy of the Level of Nutritional Risk Assessment to the ~~DDSD~~DDS area nutrition therapist or ~~DDSD~~DDS area professional support services designee as well as the case manager within ~~10 working~~ten (10) business days of receipt of the authorization.

(d) **Planning.** The ~~DDSD~~DDS case manager, in conjunction with the Team, reviews the identified nutritional risks that impact the member's life.

(1) Desired nutritional outcomes are developed and integrated into the I~~ndividual~~ Plan using the least restrictive, least intrusive, most normalizing measures that can be carried out across environments.

(2) The Team member(s) identified responsible in the ~~Individual~~ Plan develops methods to support the nutritional outcomes, which may include:

(A) ~~Stragegies;~~Strategies;

(B) Staff training; or

(C) Program monitoring.

(3) When the member has been receiving nutrition services and nutritional status is currently stable and the Team specifies that nutrition services are no longer needed, the Team ~~will identify~~identifies individual risk factors for the member that would indicate consideration of the resumption of nutrition services and assigns responsibility to a named Team Member(s) for monitoring and reporting the members status regarding these factors.

(4) Any member who receives paid ~~24~~twenty-four (24) hour per day supports and requires constant physical assistance and mealtime intervention to eat safely, or is identified for risk of choking or aspiration must have an individualized mealtime assistance plan developed and reviewed at least annually by the Team member(s) identified responsible in the ~~Individual~~ Plan. Team members may include a nutrition services contract provider and a speech therapy contract provider or occupational therapy contract provider with swallowing expertise ~~(mealtime therapists)~~. Documentation ~~should delineate~~delineates responsibilities to insure there is no duplication of services. The mealtime assistance plan includes but is not limited to:

(A) ~~a~~A physician ordered diet;

(B) ~~diet~~Diet instructions;

(C) ~~positioning~~Positioning needs;

(D) ~~assistive~~Assistive technology needs;

(E) ~~communication~~Communication needs;

(F) ~~eating~~Eating assistance techniques;

(G) ~~supervision~~Supervision requirements;

(H) ~~documentation~~Documentation requirements;

(I) ~~monitoring~~Monitoring requirements; and

(J) ~~training~~Training and assistance.

(5) For those members receiving paid ~~24~~twenty-four (24) hour per day supports and nutrition through a feeding tube, the Team develops and implements strategies for tube feeding administration that enables members to receive nutrition in the safest manner and for oral care that enables optimal oral hygiene and oral-motor integrity as deemed possible per OAC 340:100-5-26. The Team reviews the member's ability to return to oral intake following feeding tube placement and annually thereafter in accordance with the member's needs.

(e) **Implementation, Consultation and Training.** Strategies are implemented by the assigned person within a designated time frame established by the Team based on individual need(s).

(1) Direct support staff members are trained per the ~~Individual~~ Plan and OAC 340:100-3-38.
(2) All special diets, nutritional supplements, and aids to digestion and elimination must be prescribed and reviewed at least annually by a physician.
(3) Consultation to members and their caregivers is provided as specified in the ~~IP~~Plan.
(4) Program documentation is maintained in the member's home record for the purpose of evaluation and monitoring.
(5) The contract professional provider(s) sends documentation regarding the member's program concerns, recommendations for remediation of any problem area and progress notes to the case manager per OAC 340:100-5-52.

(A) The designated professional(s) reviews the program data submitted for:

(i) ~~completeness;~~completeness;

(ii) ~~consistency~~Consistency of implementation; and

(iii) ~~positive~~Positive outcomes.

(B) When a member is identified by the Level of Nutritional Risk Assessment to be at high nutritional risk, he or she receives increased monitoring by the nutrition services contract provider and health care coordinator, as determined necessary by the Team.

(C) Significant changes in nutritional status must be reported to the case manager by the health care coordinator.

(D) The Level of Nutritional Risk Assessment:

(i) ~~is~~Is used by the nutrition services contract provider to reassess members at high risk on a quarterly basis; and

(ii) ~~must~~Must be submitted by the nutrition services contract provider to the ~~DDSD~~DDS area nutrition therapist or ~~DDSD~~DDS area professional support services designee within ~~15~~fifteen (15) calendar days following the end of each quarter.

317:40-5-103. Transportation

(a) **Applicability.** The rules in this Section apply to transportation services provided through ~~the~~ Oklahoma ~~Department of~~ Human Services ~~(DHS),~~ Developmental Disabilities Services (DDS); Home and ~~Community Based~~Community-Based Services (HCBS) Waivers.

(b) **General Information.** Transportation services include adapted, non-adapted, and public transportation.

(1) Transportation services are provided to promote inclusion in the community, access to programs and services, and participation in activities to enhance community living skills. Members are encouraged to utilize natural supports or community agencies that can provide transportation without charge before accessing transportation services.

(2) Services include, but are not limited to, transportation to and from medical appointments, work or employment services, recreational activities, and other community activities within the number of miles authorized in the Plan of Care (POC).

(A) Adapted or non-adapted transportation may be provided for each eligible person.

(B) Public transportation may be provided up to a maximum of ~~$5,000~~$15,000 per ~~Plan of Care~~POC year. The DDS director or designee may approve requests for public transportation services totaling more than ~~$5,000~~$15,000 per year when public transportation promotes the member's independence, is the most cost-effective option or only service option available for necessary transportation. For the purposes of this Section, public transportation is defined as:

(i) ~~services,~~Services, such as an ambulance when medically necessary, a bus, or a taxi; or

(ii) ~~a~~A transportation program operated by the member's employment services or day services provider.

(3) Transportation services must be included in the member's Individual Plan (Plan) and arrangements for this service must be made through the member's case manager.

(4) Authorization of Transportation Services is based on:

(A) Personal Support Team (Team) consideration, per Oklahoma Administrative Code (OAC) 340:100-5-52, of the unique needs of the person and the most cost effective type of transportation services that meets the member's need, per (d) of this Section; and

(B) ~~the~~The scope of transportation services as explained in this Section.

(c) **Standards for transportation providers.** All drivers employed by contracted transportation providers must have a valid and current Oklahoma driver license, and the vehicle(s) must meet applicable local and state requirements for vehicle licensure, inspection, insurance, and capacity.

(1) The provider must ensure that any vehicle used to transport members:

(A) ~~meets~~Meets the member's needs;

(B) ~~is~~Is maintained in a safe condition;

(C) ~~has~~Has a current vehicle tag; and

(D) ~~is~~Is operated ~~in accordance with~~per local, state, and federal law, regulation, and ordinance.

(2) The provider maintains liability insurance in an amount sufficient to pay for injuries or loss to persons or property occasioned by negligence or malfeasance by the agency, its agents, or employees.

(3) The provider ensures all members wear safety belts during transport.

(4) Regular vehicle maintenance and repairs are the responsibility of the transportation provider. Providers of adapted transportation services are also responsible for maintenance and repairs of modifications made to vehicles. Providers of non-adapted transportation with a vehicle modification funded through HCBS assistive technology services may have repairs authorized per OAC 317:40-5-100.

(5) Providers must maintain documentation, fully disclosing the extent of services furnished that specifies the:

(A) ~~service~~Service date;

(B) ~~location~~Location and odometer mileage reading at the starting point and destination; or trip mileage calculation from ~~Global Positioning System (GPS)~~global positioning system software;

(C) ~~name~~Name of the member transported; and

(D) ~~purpose~~Purpose of the trip.

(6) A family member, including a family member living in the same household of an adult member may establish a contract to provide transportation services to:

(A) ~~work~~Work or employment services;

(B) ~~medical~~Medical appointments; and

(C) ~~other~~Other activities identified in the Plan as necessary to meet the needs of the member, per OAC 340:100-3-33.1.

(7) Individual transportation providers must provide verification of vehicle licensure, insurance and capacity to the DDS area office before a contract may be established and updated verification of each upon expiration. Failure to provide updated verification of a

current and valid Oklahoma driver license ~~and/or~~ or vehicle licensure may result in cancellation of the contract.

(d) **Services not covered.** Services that cannot be claimed as transportation services include:

(1) ~~services~~Services not approved by the Team;

(2) ~~services~~Services not authorized by the ~~Plan of Care~~POC;

(3) ~~trips~~Trips that have no specified purpose or destination;

(4) ~~trips~~Trips for family, provider, or staff convenience;

(5) ~~transportation~~Transportation provided by the member;

(6) ~~transportation~~Transportation provided by the member's spouse;

(7) ~~transportation~~Transportation provided by the biological, step or adoptive parents of the member or legal guardian, when the member is a minor;

(8) ~~trips~~Trips when the member is not in the vehicle;

(9) ~~transportation~~Transportation claimed for more than one (1) member per vehicle at the same time or for the same miles, except public transportation;

(10) ~~transportation~~Transportation outside Oklahoma unless:

(A) ~~the~~The transportation is provided to access the nearest available medical or therapeutic service; or

(B) ~~advance~~Advance written approval is given by the DDS area manager or designee;

(11) ~~services~~Services that are mandated to be provided by the public schools pursuant to the Individuals with Disabilities Education Act;

(12) ~~transportation~~Transportation that occurs during the performance of the member's paid employment, even when the employer is a contract provider; or

(13) ~~transportation~~Transportation when a closer appropriate location was not selected.

(e) **Assessment and Team process.** At least annually, the Team addresses the member's transportation needs. The Team determines the most appropriate means of transportation based on the:

(1) ~~present~~Present needs of the member. When addressing the possible need for adapted transportation, the Team only considers the member's needs. The needs of other individuals living in the same household are considered separately;

(2) ~~member's~~Member's ability to access public transportation services; and

(3) ~~availability~~Availability of other transportation resources including natural supports, and community agencies.

(f) **Adapted transportation.** Adapted transportation may be transportation provided in modified vehicles with wheelchair or stretcher-safe travel systems or lifts that meet the member's medical needs that cannot be met with the use of a standard passenger vehicle, including a van when the modification to the vehicle was not funded through HCBS assistive technology service and is owned or leased by the DDS HCBS provider agency, family of an adult member, agency companion provider or specialized foster care provider.

(1) Adapted transportation is not authorized when a provider agency leases an adapted vehicle from a member or a member's family.

(2) Exceptions to receive adapted transportation services for modified vehicles other than those with ~~wheelchair/stretcher~~wheelchair or stretcher safe travel systems and lifts may be authorized by the DDS programs manager for transportation services when documentation supports the need, and there is evidence the modification costs exceeded $10,000. All other applicable requirements of OAC 317:40-5-103 must be met.

(3) Adapted transportation services do not include vehicles with modifications including, but not limited to:

(A) ~~restraint~~Restraint systems;

(B) ~~plexi-glass~~Plexi-glass windows;

(C) ~~barriers~~Barriers between the driver and the passengers;

(D) ~~turney~~Turney seats; and

(E) ~~seat~~Seat belt extenders.

(4) The Team determines if the member needs adapted transportation according to:

(A) ~~the~~The member's need for physical support when sitting;

(B) ~~the~~The member's need for physical assistance during transfers from one surface to another;

(C) ~~the~~The portability of the member's wheelchair;

(D) ~~associated~~Associated health problems the member may have; and

(E) ~~less~~Less costly alternatives to meet the need.

(5) The transportation provider and the equipment vendor ensure that the Americans with Disabilities Act requirements are met.

(6) The transportation provider ensures all staff assisting with transportation is trained according to the requirements specified by the Team and the equipment manufacturer.

(g) **Authorization of transportation services.** The limitations in this subsection include the total of all transportation units on the ~~Plan of Care~~POC, not only the units authorized for the identified residential setting.

(1) Up to 12,000 units of transportation services may be authorized in a member's ~~Plan of Care~~ POC per OAC 340:100-3-33 and OAC 340:100-3-33.1.

(2) When there is a combination of non-adapted transportation and public transportation on a ~~Plan of Care~~POC, the total cost for transportation cannot exceed the cost for non-adapted transportation services at the current non-adapted transportation reimbursement rate multiplied by 12,000 miles for the ~~Plan of Care~~POC year.

(3) The DDS area manager or designee may approve:

(A) ~~up~~Up to 14,400 miles per ~~Plan of Care~~POC year for people who have extensive needs for transportation services; and

(B) ~~a~~A combination of non-adapted transportation and public transportation ~~on a Plan of Care,~~ when the total cost for transportation does not exceed the cost for non-adapted transportation services at the current, non-adapted transportation reimbursement rate multiplied by 14,400 miles for the ~~Plan of Care~~POC year.

(4) The DDS division director or designee may approve:

(A) ~~transportation~~Transportation services in excess of 14,400 miles per ~~Plan of Care~~POC year in extenuating situations when person-centered planning identified specific needs that require additional transportation for a limited period; or

(B) ~~any~~Any combination of public transportation services with adapted or non-adapted transportation when the total cost for transportation exceeds the cost for non-adapted transportation services at the current, non-adapted transportation reimbursement rate multiplied by 14,400 miles for the POC year; or

(C) ~~public~~Public transportation services in excess of ~~$5,000~~$25,000, when it promotes the member's independence, is the most cost effective or only service option available for necessary transportation.

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

317:30-5-95.4. Individual plan of care for adults aged twenty-one (21) to sixty-four (64)

(a) ~~Before admission to a psychiatric unit of a general hospital or immediately after admission~~ Before or immediately after admission to a psychiatric unit of a general hospital or psychiatric hospital, the attending physician or staff physician must establish a written plan of care for each member aged twenty-one (21) to sixty-four (64). The plan of care must include:

(1) Diagnoses, symptoms, complaints, and complications indicating the need for admission;

(2) A description of the functional level of the individual;

(3) Objectives;

(4) Any order for medication, 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 plan of care; and

(6) Plans for discharge.

(b) The attending or staff physician and other treatment team personnel involved in the member's care must review each plan of care at least every seven (7) days.

(c) All plans of care and plan of care reviews must be clearly identified as such in the member's medical records. All must be signed and dated by the physician, RN, LBHP or licensure candidate, member, and other treatment team members that provide individual, family, and group therapy in the required review interval. Licensure candidate signatures must be co-signed. All plans of care and plan of care reviews must be signed by the member upon completion, except when a member is too physically ill or his or her acuity level precludes him or her from signing. If the member has designated an advocate, the advocate's signature is also required on all plans of care and plan of care reviews. If the member was too physically ill or his or her acuity level precluded him or her from signing the plan of care and/or the plan of care review at the time of completion, the member must sign the plan when his or her condition improves, but before discharge.

(d) The plan of care must document appropriate member participation in the development and implementation of the treatment plan.

317:30-5-95.41.1 Documentation of records for adults receiving inpatient services

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

(1) Date;

(2) Start and stop time for each session;

(3) Dated signature of the therapist and/or staff that provided the service;

(4) Credentials of the therapist;

(5) Specific problem(s) addressed (problems must be identified on the plan of care);

(6) Method(s) used to address problems;

(7) Progress made towards goals;

(8) Member's response to the session or intervention; and

(9) Any new problem(s) identified during the session.

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

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

317:30-5-95.42. Service quality review (SQR) of psychiatric facilities and residential substance use disorder (SUD) facilities

(a) The SQR conducted by the OHCA or its designated agent meets the utilization control requirements as set forth in 42 C.F.R. Part 456.

(b) There will be an SQR of each in-state psychiatric facility and residential SUD facility that provides services to SoonerCare members which will be performed by the OHCA or its designated agent. Out-of-state facilities that provide services to SoonerCare members will be reviewed according to the procedures outlined in the Medical Necessity Manual. Ad hoc reviews may be conducted at the discretion of the agency.

(c) The OHCA will designate the members of the SQR team. The SQR team will consist of one (1) to three (3) team members and will be comprised of LBHPs or registered nurses (RNs).

(d) The SQR will include, but not be limited to, review of facility and clinical record documentation and may include observation and contact with members. The clinical record review will consist of records of members currently at the facility as well as records of members for which claims have been filed with OHCA for acute, PRTF, or residential SUD levels of care. The SQR includes validation of compliance with policy, which must be met for the services to be compensable.

(e) Following the SQR, the SQR team will report its findings in writing to the facility. A copy of the final report will be sent to the facility's accrediting agency, as well as the State Survey Agency, if applicable, and any licensing agencies.

(f) Deficiencies identified during the SQR may result in full or partial recoupment of paid claims. The determination of whether to assess full or partial recoupment shall be at the discretion of the OHCA based on the severity of the deficiencies.
(g) Any days during which the facility is determined to be out of compliance with Federal Conditions of Participation, excluding residential SUD facilities, or in which a member does not meet medical necessity criteria may result in full recoupment. Full recoupment may also result from a facility's failure to provide requested documentation within the timeframes indicated on requests for such documents or if the SQR team is denied timely admittance to a facility and/or access to facility records during any on-site portion of the SQR.
(h) Items which may result in full or partial recoupment of paid claims shall include, but not be limited to:

(1) **Assessments and evaluations.** Assessments and evaluations must be completed, with dated signature(s), by qualified staff within the timeframes outlined in Oklahoma Administrative Code (OAC) 317:30-5-95.6, 317:30-5-95.37, and 317:30-5-95.47(1).

(2) **Plan of care.** Plans of care must be completed, with all required dated signatures within the timeframes described in OAC 317:30-5-95.4, 317:30-5-96.33, and 317:30-5-95.47(2).

(3) **Certification of need (CON).** CONs for psychiatric facilities must be completed by the appropriate team and in the chart within the timeframes outlined in 42 C.F.R. §§ 441.152, 456.160, and 456.481.

(4) **Active treatment.** Treatment must be documented in the chart at the required frequency by appropriately qualified staff as described in OAC 317:30-5-95.5, 317:30-5-95.7, 317:30-5-95.8, 317:30-5-95.9, 317:30-5-95.10, 317:30-5-95.34, and 317:30-5-95.46(b).

(5) **Documentation of services.** Services must be documented in accordance with OAC 317:30-5-95.4, 317:30-5-95.5, 317:30-5-95.8, 317:30-5-95.10, 317:30-5-95.41, 317:30-5-95.41.1 and 317:30-5-95.47 and 42 C.F.R. §§ 412.27(c)(4) and 482.61. Documentation with missing elements or documentation that does not clearly demonstrate the therapeutic appropriateness and benefit of the service may result in recoupment.

(6) **Staffing.** Staffing must meet the ratios described in OAC 317:30-5-95.24(b)-(d) & (h) and OAC 317:30-5-95.38 per unit/per shift; and credentialing requirements as outlined in OAC 317:30-5-95.8, 317:30-5-95.9, 317:30-5-95.35, 317:30-5-95.36, 317:30-5-95.46 (b) and 42 C.F.R. §§ 412.27(d), 441.153, 441.156, and 482.62.

(7) **Restraint/seclusion.** Orders for restraint and seclusion must be completely and thoroughly documented with all required elements as described in OAC 317:30-5-95.39 and 42 C.F.R. § 482.13(e) & (f) and 42 C.F.R. Part 483. Documentation must support the appropriateness and necessity for the use of restraint/seclusion. For PRTFs, documentation must include evidence that staff and resident debriefings occurred as required by OAC 317:30-5-95.39 and 42 C.F.R. Part 483. For residential SUD facilities, restraint may only be used when less restrictive interventions, according to facility policy, have been attempted or when an immediate intervention is required to protect the resident, a staff member, or others. A written incident report must be completed within twenty-four (24) hours following each use of physical restraint.

(i) If the review findings have resulted in a recoupment, the days and/or services involved will be reported in the notification.
(j) In the event that CMS recoups from OHCA an amount that exceeds the provider's liability for findings described in this Section, the provider will not be held harmless and will be required to reimburse OHCA the total federal amount identified by CMS and/or its designated audit contractor, limited to the amount of the original paid claim less any previously recouped amounts.

(k) Penalties of non-compensable days which are the result of the facility's failure to appropriately provide and document the services described herein, or adhere to applicable accreditation, certification, and/or state licensing standards, are not compensable or billable to the member or the member's family.
(l) Facilities that are determined to owe recoupment of paid claims will have the ability to request a reconsideration of the findings. Details and instructions on how to request a reconsideration will be part of the report documentation sent to the facility.
(m) Facilities that are determined by the SQR process to be out of compliance in significant areas will be required to submit a Corrective Action Plan (CAP) detailing steps being taken to bring performance in line with requirements. Facilities that are required to submit a CAP may be further assessed through a formal, targeted post-CAP review process.

317:30-5-95.45. Residential substance use disorder (SUD) - Coverage by category
(a) **Adults.** Members age twenty-one (21) to sixty-four (64) who meet eligibility and clinical criteria may receive medically necessary residential treatment for SUD.

(1) The member must meet residential level of care as determined through completion of the designated ASAM ~~level of care~~ placement tool no more than seven (7) days prior to a SUD admission and/or extension request and as required in the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) Prior Authorization Manual.

(2) Each presenting member for SUD treatment shall be assessed, according to ASAM criteria, which includes a list of symptoms for all six (6) dimensions and each level of care to determine a clinically appropriate placement in the least restrictive level of care.

(b) **Children.** ~~Coverage for children is the same as adults.~~Children are covered according to their age group as described in OAC 317:30-5-95.46 and 317:30-5-95.47 and as specified by ODMHSAS.
(c) **Individuals with dependent children.** Coverage for individuals with dependent children is the same as adults and/or children.

317:30-5-95.46. Residential substance use disorder (SUD) - Covered services and medical necessity criteria
(a) In order for the services described in this Section to be covered, individuals shall:

(1) Be diagnosed with an SUD as described in the most recent edition of the DSM; and

(2) Meet residential level of care ~~in accordance with the American Society of Addiction Medicine (ASAM) criteria,~~ as determined ~~by the ASAM level of care determination~~ through completion of the designated ASAM placement tool as ~~designated~~required by the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS).

(3) For additional medical necessity criteria, refer to the ODMHSAS Prior Authorization Manual available at http://www.odmhsas.org/arc.htm.

(b) Coverage includes the following services:

(1) **Clinically managed low intensity residential services (ASAM Level 3.1).**

(A) **Halfway house services B Individuals age thirteen (13) to seventeen (17).**

(i) **Service description.** This service places a major emphasis on continuing SUD care and community ancillary services in an environment supporting continued abstinence. The facility shall have scheduled services to assess and address the individual needs of each member. Services include individual, family, and/or group therapy, individual and/or group rehabilitation services, care management, crisis intervention, and for members age sixteen (16) and older, community recovery

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

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

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

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

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

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

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

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

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

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

(iii) **Treatment services for dependent children**. Services are available to the child when provided to address the impacts related to the parent's addiction, including, but not limited to, individual and family therapy. Compliance with separate provider

qualifications, in accordance with OAC 317:30-5-240.2, is required for other treatment services provided to dependent children by the residential SUD provider. Provision of such treatment services shall be provided in accordance with OAC 317:30-5, Part 21.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Oklahoma Medicaid State Plan and OAC 450:18.

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

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

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

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

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

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

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

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

(iii) **Treatment services for dependent children**. Services are available to the child

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

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

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

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

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

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

(iv) **Treatment hours.** A weekly minimum of thirty-five (35) service hours shall be provided to the individual with minor dependent children and women who are pregnant. Treatment hours shall include a minimum of four (4) hours of individual, family, and/or group therapy and a minimum of seven (7) hours of individual and/or group rehabilitation services. A maximum of eleven (11) hours per week of community (peer) recovery support services may count toward the weekly required treatment hours. A week begins on Sunday and ends on Saturday. Dependent children shall be provided treatment services in accordance with the child's service

plan if services are provided by the residential SUD provider.

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

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

(i) **Service description and requirements.** This service is provided under the direction of a licensed physician and a licensed registered nurse supervisor, for members who are withdrawing or are intoxicated from alcohol or other drugs. Members shall be assessed as currently experiencing no apparent medical or neurological symptoms that would require hospitalization. Daily SUD withdrawal management treatment services shall be provided, which include, but are not limited to, taking of vital signs (temperature, pulse, respiration rate, blood pressure), documentation of fluid and food intake a minimum of one (1) time every six (6) hours or more often as indicated by the member's condition. Medications shall be prescribed if needed during withdrawal management. The medications are to include those needed for physical health issues and mental impairment if acquired during the withdrawal process.

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

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

(i) **Service description and requirements.** This service is provided under the direction of a licensed physician and a licensed registered nurse supervisor, for members who are withdrawing or are intoxicated from alcohol or other drugs. Members shall be assessed as currently experiencing no apparent medical or neurological symptoms that would require hospitalization. Daily SUD withdrawal management treatment services shall be provided, which include, but are not limited to, taking of vital signs (temperature, pulse, respiration rate, blood pressure), documentation of fluid and food intake a minimum of one (1) time every six (6) hours or more often as indicated by the member's condition. Medications prescribed if needed during withdrawal management. The medications are to include those needed for physical health issues and mental impairment if acquired during the withdrawal process.

(ii) **Staffing requirements.** A licensed physician providing supervision of withdrawal management must be available on site or on call twenty-four (24) hours a day, seven (7) days a week. A licensed nurse must provide twenty-four (24) hours a day, seven (7) days a week monitoring and statutorily approved personnel administer medication.

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

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

(1) **Assessment.** A biopsychosocial assessment shall be completed for members receiving

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

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

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

(C) **Assessments for dependent children.** ~~In accordance with OAC 450:18-7-25, assessments~~Assessment of children (including infants) accompanying their parent into treatment and receiving services from the residential SUD provider shall include the following items:

(i) Parent-child relationship;
(ii) Physical and psychological development;
(iii) Educational needs;
(iv) Parent related issues; and
(v) Family issues related to the child.

(D) **Assessments for parents/pregnant women.** ~~In accordance with OAC 450:18-7-25, assessments~~Assessment of the parent and/or pregnant women bringing their children into treatment shall include the following items:

(i) Parenting skills;
(ii) Knowledge of age appropriate behaviors;
(iii) Parental coping skills;
(iv) Personal issues related to parenting; and
(v) Family issues as related to the child.

(E) **Assessments for medically supervised withdrawal management**. In accordance with OAC 450:18-13-61, a medical assessment for the appropriateness of placement shall be completed and documented by a licensed physician during the admission process. The assessment shall provide a diagnosis that corresponds to current DSM standards.

(F) **Assessment timeframes.** Biopsychosocial assessments shall be completed within two (2) days of admission or during the admission process for medically supervised withdrawal management.

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

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

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

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

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

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

(B) **Service plan content**. Service plans must include dated signatures for the member ~~[if over fourteen (14)], the parent/guardian [if under sixteen (16) and allowed by law], and the primary service practitioner.~~[if age fourteen (14) or older], the parent/guardian (if required by law), and the LBHP or licensure candidate. Licensure candidate signatures must be co-signed by a fully-licensed LBHP in good standing. If the member is eligible to self-consent to treatment pursuant to state law, a parent/guardian signature is not required. Signatures must be obtained after the service plan is completed. The contents of a service plan shall address the following:

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

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

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

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

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

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

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

(C) **Service plan updates.** Service plan updates shall occur a minimum of once every thirty (30) days while services are provided. Service plan updates must include dated signatures for the member ~~[if over fourteen (14)], the parent/guardian [if under sixteen (16) and allowed by law], and the LBHP and licensure candidate. Licensure candidate signatures must be co-signed by a fully-licensed LBHP in good standing.~~[if age fourteen (14) or older], the parent/guardian (if required by law), and the LBHP or licensure candidate. Licensure candidate signatures must be co-signed by a fully-licensed LBHP in good standing. If the member is eligible to self-consent to treatment pursuant to state law, a parent/guardian signature is not required. Signatures must be obtained after the service plan is completed. Service plan updates shall address the following:

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

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

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

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

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

(D) **Service plans for medically supervised withdrawal management.** Pursuant to OAC 450:18-7-84, a service plan shall be completed for each member receiving ASAM Level 3.7 services that addresses the medical stabilization treatment and services needs of the member. Service plans shall be completed by a licensed physician or licensed registered nursing staff and must include a dated signature of the member [if age fourteen (14) or older], the parent/guardian (if required by law), and the primary service practitioner. The service plan shall provide a diagnosis that corresponds to current DSM standards.

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

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

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

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

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

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

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

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

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

317:30-5-95.51. Residential substance use disorder (SUD) – Reporting of suspected child abuse/neglect

Instances of child abuse and/or neglect are to be reported in accordance with state law, including, but not limited to, Section (§) 1-2-101 of Title 10A of the Oklahoma Statutes and 43A O.S. § 10-104. Any person suspecting child abuse or neglect shall immediately report it to the Oklahoma Department of Human Services (OKDHS) hotline, at 1-800-522-3511; any person suspecting abuse, neglect, or exploitation of a vulnerable adult shall immediately report it to the local DHS County Office, municipal or county law enforcement authorities, or, if the report occurs after normal business hours, the OKDHS hotline. Health care professionals who are requested to report incidents of domestic abuse by adult victims with legal capacity shall promptly make a report to the nearest law enforcement agency, per 22 O.S. § 58.

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

317:30-5-241.4 Crisis Intervention

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

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

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

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

(2) **Limitations**. ~~Crisis Intervention Services~~CIS are not compensable for SoonerCare members who reside in ICF/IID facilities, or who receive RBMS in a group home or ~~Therapeutic Foster Home~~therapeutic foster home. CIS is also not compensable for members who experience acute behavioral or emotional dysfunction while in attendance for other behavioral health services~~,~~ unless there is a documented attempt of placement in a higher level of care. The maximum is eight (8) units per month; established mobile crisis response teams can bill a maximum of four (4) hours per month, and ten (10) hours each ~~12~~twelve (12) months per member.

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

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

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

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

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 2. PHYSICIAN ASSISTANTS

317:30-5-30. Eligible providers

~~The Oklahoma Health Care Authority (OHCA) recognizes medical services rendered by a Physician Assistant in accordance with the rules and regulations covering the Authority's medical care program.~~

~~(1) The application for a Medicaid Provider agreement must be accompanied by copies of the physician assistant's current written authorization to practice from the Oklahoma State Board of Medical Licensure and Supervision. The Application to Practice must be jointly filed by the supervising physician and physician assistant and include a description of the physician's practice, methods of supervision and utilization of the physician assistant, and the name of alternate supervising physician(s) who will supervise the physician assistant in the absence of the primary supervising physician. At any time that the supervising physician(s) change, an updated copy of the certification must be submitted to OHCA, Provider Enrollment.~~

~~(2) All services provided by a Physician Assistant must be within the current practice guidelines for the State of Oklahoma.~~

Eligible providers shall:

(1) Have and maintain current license by the Oklahoma State Board of Medical Licensure and Supervision as specified in Section 519.6 of Title 59 of the Oklahoma Statutes;

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

(3) Have a practice agreement with a SoonerCare contracted delegating physician(s) (who is licensed and in good standing with the State Board of Medical Licensure and Supervision or the State Board of Osteopathic Examiners) concerning the scope of practice of the physician assistant (PA). If at any time the delegating physician(s) change, an updated copy of the practice agreement must be submitted within ten (10) business days to OHCA, Provider Enrollment.

317:30-5-31. ~~General coverage by category~~Coverage

~~Physician Assistant services are subject to all rules and guidelines which apply to Physician services as specified at OAC 317:30-5, Part 1, Physicians.~~

The OHCA covers medical services (as described in OAC 317:30-5, Part 1, Physicians) by a physician assistant (PA) when rendered within the licensure and scope of practice of the PA. Services must be in compliance with the state-specific statutes including Title 59 O.S. § 519.2, rules and regulations of the applicable practice act.

317:30-5-32. ~~Utilization~~Reimbursement

~~Physician Assistant services are included in the Medicaid program in the same way as Physician services and are included in all utilization parameters (refer to OAC 317:30-5, Part 1). An office, nursing home, or hospital visit is considered as one of the allowed visits for a given period. Payment is not made to the Physician Assistant and supervising physician for the same service on the same day.~~

(a) Payment for services within the physician assistant's scope of practice shall be made when ordered or performed by the eligible physician assistant if the same service would have been covered

if ordered or performed by a physician.
(b) Payment is not made to physician assistant when a service(s) is (are) performed simultaneously with the delegating physician and billed by the physician on the same day.
(c) Payment is made per the methodology established in the Oklahoma Medicaid State Plan.

317:30-5-33. Post payment utilization review [Revoked]

~~All inpatient services are subject to post payment utilization review by the OHCA or its designated agent. Post payment utilization reviews are subject to all rules and guidelines which apply to Physician services as specified at OAC 317:30-5, Part 1, Physicians.~~

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~~the first ninety (90) days of treatment.

(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~~second ninety (90) days of treatment.

(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~~third ninety (90) days of treatment.

(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~~last ninety (90) days of the first year of treatment.

(9) **"Phase V"** means the phase of treatment for members who have been ~~admitted~~receiving continuous treatment 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~~have been receiving continuous treatment for more than two (2) years.

(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)~~(16).

(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 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 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) treatment sessions per month~~, including, but not exclusive to,~~. Available services shall include, but not be limited 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,~~. Available services shall include, but not be limited 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,~~. Available services shall include, but not be limited 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.~~ Service plans, including updates, must include dated signatures of the person served [if age fourteen (14) or older], the parent/guardian (if required by law), and the LBHP or licensure candidate. If a minor is eligible to self-consent to treatment pursuant to state law, a parent/guardian signature is not required. Service plans completed by a licensure candidate must be co-signed and dated by a fully-licensed LBHP. Signatures must be obtained after the service plan is completed.

(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) 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 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;

(k) **Reimbursement.** 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~~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 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, 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, 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. 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.

For laboratory policies please refer to Part 7, Laboratories (Independent, Physician, And Hospital), of this Chapter.

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, 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.

~~(c) **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.~~

For policy regarding drug screening and testing, please refer to Oklahoma Administrative Code (OAC) 317:30-5-101.

317:30-5-20.2. Molecular diagnostic testing utilizing polymerase chain reaction for infectious diseases

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

~~(1) "**Polymerase Chain Reaction (PCR)"** means a biochemical laboratory technique used to make thousands or even millions of copies of a segment of DNA. It is commonly used to amplify a small amount of specifically targeted DNA from among a mixture of DNA samples. It is also known as Nucleic Acid Amplification Test (NAAT).~~

~~(2) "**Direct Probe Technique"** means detection methods where nucleic acids are detected without initial amplification processing.~~

~~(3) "**Amplified Probe Technique"** means technique without quantification, a detection method in which the sensitivity of the assay is improved over direct probe techniques.~~

~~(4) "**Probe with Quantification Technique"** means methods used to report absolute or relative amounts of nucleic acid sequences in the original sample.~~

~~(b) **Medical necessity.**~~

~~(1) PCR testing for infectious diseases, following clinical guidelines such as those set forth by the Infectious Disease Society of America's (IDSA) or other nationally recognized medical professional academy or society standards of care, may be compensable.~~

~~(2) For the full PCR guideline which includes medically necessity and prior authorization criteria, and a list of codes that require authorization, please refer to www.okhca.org.~~

~~(c) **Documentation.**~~

~~(1) The medical record must contain documentation that the testing is expected to influence treatment of the condition towards which the testing is directed.~~

~~(2) The laboratory or billing provider must have on file the physician requisition which sets forth the diagnosis or condition that warrants the test(s).~~

~~(3) Examples of documentation requirements for the ordering provider include, but are not limited to, history and physical exam findings that support the decision making, problems/diagnoses, relevant data (e.g., lab testing results).~~

~~(4) Documentation requirements for the performing laboratory include, but are not limited to, lab accreditation, test requisition, test records, preliminary and final report, and quality control record.~~

~~(5) Documentation requirements for lab developed tests/protocols include diagnostic test/assay, lab manufacturer, names of comparable assays/services (if relevant), descriptions of assay, analytical validity evidence, clinical validity evidence, and clinical utility.~~

~~(6) Billing providers are required to code specificity; however, if an unlisted or not otherwise specified Current Procedural Terminology (CPT) code is used, the documentation must clearly identify the unique procedure performed. When multiple procedure codes are submitted (unique, unlisted, and/or not otherwise specified), the documentation supporting each code should be easily identifiable. If on review the billed code cannot be linked to the documentation, this service may be denied.~~

~~(7) When the documentation does not meet the criteria for the service rendered/requested or the documentation does not establish the medical necessity for the service, the service may be denied as not reasonable and necessary.~~

For policy regarding molecular diagnostic testing utilizing polymerase chain reaction for infectious diseases, please refer to Oklahoma Administrative Code (OAC) 317:30-5-102.

PART 3. HOSPITALS

317:30-5-42.10. Laboratory

~~To be eligible for payment as a laboratory/pathology service, the service must be:~~

~~(1) Ordered and provided by or under the direction of a physician or other licensed practitioner within the scope of practice as defined by state law;~~

~~(2) Provided in a hospital or independent laboratory;~~

~~(3) Directly related to the diagnosis and treatment of a medical condition;~~

~~(4) Authorized under the laboratory's CLIA certification; and~~

~~(5) Considered medically necessary as defined in OAC 317:30-3-1(f) and 317:30-5-20.~~

For laboratory policies please refer to Part 7, Laboratories (Independent, Physician, And Hospital), of this Chapter.

PART 7. ~~CERTIFIED LABORATORIES~~LABORATORIES (INDEPENDENT, PHYSICIAN, AND HOSPITAL)

317:30-5-100. ~~Eligible providers~~Laboratory services

~~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. Regulations specify that any and every facility which tests human specimens for the purpose of providing information for the diagnosis, prevention, or treatment of any disease, or impairment of, or the assessment of the health of human beings is subject to CLIA. All facilities which perform these tasks must make application for certification by CMS. Eligible SoonerCare providers must be certified under the CLIA program and have obtained a CLIA ID number from CMS and have a current contract on file with the OHCA.~~

This Part covers the guidelines for payment of laboratory services by a provider in his/her office, a certified hospital or independent laboratory, and for a pathologist's interpretation of laboratory procedures.

(1) **Physician and clinic provider laboratories.** Physician and clinic providers may be reimbursed for compensable clinical diagnostic laboratory services only when they personally perform or supervise the performance of the test. If a physician or clinic 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.

(2) **Independent and hospital laboratories.** Independent and hospital laboratories will be required to submit a letter to OHCA Provider Enrollment along with their other required contracting documents. The reference laboratory must be identified on the claim as well as the following information for any and all reference laboratories:

(A) Name;

(B) Address; and

(C) Clinical Laboratory Improvement Amendment of 1988 (CLIA) ID.

(3) **Compensable services for independent, physician and hospital laboratories.**

(A) Reimbursement for lab services is made in accordance with 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. Regulations specify that any and every facility which tests human specimens for the purpose of providing information for the diagnosis, prevention, or treatment of any disease, or impairment of, or the assessment of the health of human beings is subject to CLIA. All facilities which perform these tasks must make application for certification by CMS. Eligible SoonerCare providers must be certified under the CLIA program and have obtained a CLIA ID number from CMS and have a current contract on file with the 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 member-specific indications in the medical record.

(ii) Testing is only compensable if the results will affect member 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 member and the member'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 or lab panels which have no impact on the member's plan of care are not covered.

(C) Split billing or dividing the billed services for the same member 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 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.

317:30-5-101. ~~Coverage for adults~~Drug screening and testing

~~Payment is made to certified laboratories for medically necessary services to adults as set forth in this Section.~~

~~(1) **Inpatient services.**~~

~~(A) Claims for inpatient anatomical pathology must be billed by the individual pathologist performing the examination.~~

~~(B) Inpatient consultations by Pathologists are compensable. Claim form must include referring physician, diagnosis, and test(s) for which the consultation was requested.~~

~~(2) **Outpatient services.** Payment is made for medically necessary outpatient services.~~

(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 Clinical Laboratory Improvement Amendment of 1988 (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 Oklahoma Administrative Code (OAC) 317:30-5-100(1)(A).

(c) **Compensable services**. Drug testing must be ordered by the physician or non-physician provider and must be individualized to the member and the member's medical history and/or assessment indicators as evidenced in the medical documentation.

(1) Compensable testing must be medically indicated as evidenced by member specific indications in the medical record.

(A) Testing is only compensable if the results will affect member 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 member's history, member'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 member'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 member sample sources of saliva, oral fluids, or hair;

(3) Testing of two (2) different specimen types (urine and blood) from the same member 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, 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 member'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) Member 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 member'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.

317:30-5-102. ~~Coverage for children~~Molecular diagnostic testing utilizing polymerase chain reaction for infectious diseases

~~Coverage of laboratory services for children is as follows:~~

~~(1) **Inpatient services.**~~

~~(A) Claims for inpatient anatomical pathology must be billed by the individual pathologist performing the examination.~~

~~(B) Inpatient pathology consultations are compensable. Claim form must include referring physician, diagnosis and test(s) for which the consultation was requested.~~

~~(2) **Outpatient services.**~~

~~(A) Outpatient clinical laboratory services are covered when performed in conjunction with an Early and Periodic Screening Diagnosis and Treatment EPSDT) examination. The claim must be documented with name of attending physician.~~

~~(B) Medically necessary outpatient clinical laboratory services provided in conjunction with physician office visits are compensable under EPSDT.~~

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

(1) "**Amplified probe technique"** means technique without quantification, a detection method in which the sensitivity of the assay is improved over direct probe techniques.

(2) "**Direct probe technique"** means detection methods where nucleic acids are detected without initial amplification processing.

(3) "**Polymerase chain reaction (PCR)"** means a biochemical laboratory technique used to make thousands or even millions of copies of a segment of DNA. It is commonly used to

amplify a small amount of specifically targeted DNA from among a mixture of DNA samples. It is also known as Nucleic Acid Amplification Test (NAAT).

(4) "**Probe with quantification technique"** means methods used to report absolute or relative amounts of nucleic acid sequences in the original sample.

(b) **Medical necessity.**

(1) PCR testing for infectious diseases, following clinical guidelines such as those set forth by the Infectious Disease Society of America's (IDSA) or other nationally recognized medical professional academy or society standards of care, may be compensable.

(2) For the full PCR guideline which includes medical necessity and prior authorization criteria, and a list of codes that require authorization, please refer to https://oklahoma.gov/ohca/mau.

(c) **Documentation.**

(1) The medical record must contain documentation that the testing is expected to influence treatment of the condition towards which the testing is directed.

(2) The laboratory or billing provider must have on file the physician requisition which sets forth the diagnosis or condition that warrants the test(s).

(3) Examples of documentation requirements for the ordering provider include, but are not limited to, history and physical exam findings that support the decision making, problems/diagnoses, relevant data (e.g., lab testing results).

(4) Documentation requirements for the performing laboratory include, but are not limited to, lab accreditation, test requisition, test records, preliminary and final report, and quality control record.

(5) Documentation requirements for lab developed tests/protocols include diagnostic test/assay, lab manufacturer, names of comparable assays/services (if relevant), descriptions of assay, analytical validity evidence, clinical validity evidence, and clinical utility.

(6) Billing providers are required to code specificity; however, if an unlisted or not otherwise specified Current Procedural Terminology (CPT) code is used, the documentation must clearly identify the unique procedure performed. When multiple procedure codes are submitted (unique, unlisted, and/or not otherwise specified), the documentation supporting each code should be easily identifiable. If the billed code cannot be linked to the documentation during review, the service may be denied.

(7) When the documentation does not meet the criteria for the service rendered/requested or the documentation does not establish the medical necessity for the service, the service may be denied as not reasonable and necessary.

317:30-5-103. ~~Vocational rehabilitation~~Coverage and payment

~~Payment is made for those vocational rehabilitation services which are preauthorized by the patient's counselor.~~

(a) **Payment eligibility.** To be eligible for payment as a laboratory/pathology service, the service must be:

(1) Ordered and provided by or under the direction of a physician or other licensed practitioner within the scope of practice as defined by state law;

(2) Provided in a hospital, physician, or independent laboratory;

(3) Directly related to the diagnosis and treatment of a medical condition;

(4) Authorized under the laboratory's Clinical Laboratory Improvement Amendment of 1988 (CLIA) certification; and

(5) Considered medically necessary as defined in Oklahoma Administrative Code 317:30-3-1(f) and 317:30-5-100.

(b) **Payment for inpatient/outpatient services.** Payment is made to laboratories for medically necessary services to children and adults as follows:

(1) **Inpatient services.**

(A) Claims for inpatient anatomical pathology must be billed by the individual pathologist performing the examination.

(B) Inpatient consultations by pathologists are compensable. Claim form must include referring physician, diagnosis, and test(s) for which the consultation was requested.

(2) **Outpatient services.**

(A) For children, payment is made for medically necessary outpatient clinical laboratory services which are provided in conjunction with physician office visits that are compensable under EPSDT.

(B) For adults, payment is made for medically necessary outpatient services.

(c) **Payment rates.** Payment will be made for covered laboratory services in accordance with methodology approved under the Oklahoma Medicaid State Plan.

(d) **Vocational rehabilitation.** Payment for laboratory services is made for those vocational rehabilitation services which are preauthorized by the member's counselor.

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

317:30-5-104. ~~Individuals eligible for Part B of Medicare~~Non-covered procedures

~~Payment is made utilizing the Medicaid allowable for comparable services.~~The following procedures by laboratories are not covered:

(1) Tissue examinations of teeth and foreign objects.

(2) Tissue examination of lens after cataract surgery except when the member is under twenty-one (21) years of age.

(3) Charges for autopsy.

(4) Hair analysis for trace metal analysis.

(5) Procedures deemed experimental or investigational. For more information regarding experimental or investigational including clinical trials, see Oklahoma Administrative Code 317:30-3-57.1.

(6) Professional component charges for inpatient clinical laboratory services.

(7) Inpatient clinical laboratory services.

317:30-5-105. Non-covered procedures [REVOKED]

~~The following procedures by certified laboratories are not covered:~~

~~(1) Tissue examinations of teeth and foreign objects.~~

~~(2) Tissue examination of lens after cataract surgery except when the patient is under 21 years of age.~~

~~(3) Charges for autopsy.~~

~~(4) Hair analysis for trace metal analysis.~~

~~(5) Procedures deemed experimental or investigational. For more information regarding experimental or investigational including clinical trials, see Oklahoma Administrative Code 317:30-3-57.1.~~

~~(6) Professional component charges for inpatient clinical laboratory services.~~

~~(7) Inpatient clinical laboratory services.~~

317:30-5-106. Payment rates [REVOKED]

~~Payment will be made for covered clinical laboratory services in accordance with methodology approved under the Oklahoma Medicaid State Plan.~~

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-3.1. Medicaid Income Deferral Program [REVOKED]

~~(a) The Medicaid Income Deferral Program is a program that enables physician corporations, as defined in Title 59 of the Oklahoma Statutes, to voluntarily defer income that is paid to the corporation by the Single State Medicaid Agency.~~

~~(b) The voluntary income deferral by physician corporations (medical doctors, osteopathic physicians, dentists, surgeons, podiatrists, chiropractors, optometrists, and ophthalmologists) shall be subject to any federal provisions imposed by the Internal Revenue Code, Title 26 of the United States Code. The Health Care Authority may adopt a Plan which provides for the investment of deferral amounts in life insurance or annuity contracts which offer a choice of underlying investment options. The Plan shall provide that each physician corporation exercise those options independently from among choices offered by such contracts. Contract issuing companies shall be limited to companies which are licensed to do business in the state of Oklahoma.~~

~~(c) To be eligible for this program a physician corporation must have an existing contract with the Oklahoma Health Care Authority and the corporation must perform that contract for the term of the agreement. If a physician corporation fails to fulfill its service obligations under the contract, all deferral amount assets held for the benefit of that corporation shall be forfeited.~~

~~(d) No physician corporation shall be permitted to participate in the Plan without having prior independent tax and legal advice to do so.~~

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 5. PHARMACIES

317:30-5-70.4. Federal/State cost share-optional program [REVOKED]

~~The Medicaid prescription drug program is an optional program under Title XIX of the Social Security Act. The program is administered through a partnership between federal and state agencies. Program costs are shared between the federal and state government at variable rates depending on the economic status of the State.~~

317:30-5-80. National drug code [REVOKED}

~~All products billed must have a valid National Drug Code. Products which do not have an NDC code are not compensable.~~

317:30-5-86.2. Case management [REVOKED]

~~OHCA contracts with a designated agent to evaluate and manage the medication therapies of the individuals who comprise the top percentage of drug utilization. Clinical pharmacists will do case management based on the clinical needs of each patient.~~

PART 6. INPATIENT PSYCHIATRIC AND SUBSTANCE USE DISORDER SERVICES

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

(a) **Purpose**. The purpose of sections OAC 317:30-5-95.43 - 317:30-5-95.49 is to establish the procedures and requirements for residential treatment facilities providing SUD treatment services.

(b) **Definitions**. The following words and terms, when used in the aforementioned sections, shall have the following meanings unless the context clearly indicates otherwise.

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

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

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

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

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

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

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

(E) **"ASAM level 3.7"** means medically monitored high-intensity inpatient services for adolescents and medically monitored intensive inpatient withdrawal management for adults. This level of care provides twenty-four (24) hour nursing care with physician supervision and medication availability. This level of care is appropriate for individuals withdrawing from alcohol or other drugs with subacute biomedical and emotional, behavioral, or cognitive problems severe enough to require inpatient treatment but for whom hospitalization is not necessary. The corresponding service description for this level of care is medically supervised withdrawal management.

(4) **"Care management services"** means an assessment of a member, development of a care plan, and referral and linkage to SUD community supports and community-based or lower level of care services to promote continued recovery after the individual discharges from the treatment facility.

(5) **"Co-occurring disorder (COD)"** means any combination of mental health symptoms and SUD symptoms or diagnoses that affect a member and are typically determined by the Diagnostic and Statistical Manual of Mental Disorders (DSM).

(6) **"DSM"** means the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association.

(7) "**ODMHSAS**" means the Oklahoma Department of Mental Health and Substance Abuse

Services (ODMHSAS).

(8) **"Per diem"** means an all-inclusive rate for covered SUD treatment services provided each day during a facility stay.

~~(8)~~(9) **"Rehabilitation services"** means face-to-face individual or group services provided by qualified staff to develop skills necessary to perform activities of daily living and successful integration into community life. Rehabilitation services for substance use disorders are also referred to as skill development services.

~~(9)~~(10) "**Service plan**" means the document used during the process by which an LBHP or a licensure candidate and the member together and jointly identify and rank problems, establish agreed-upon immediate short-term and long-term goals, and decide on the treatment process and resources to be utilized.

~~(10)~~(11) "**Substance use disorder (SUD)"** means alcohol or drug dependence, or psychoactive SUD as defined by the most recent DSM criteria.

~~(11)~~(12) "**Therapeutic services"** means professional services during which members engage in identifying, addressing and/or resolving issues identified in the member's service plan.

~~(12)~~(13) **"Treatment hours B residential"** means the structured hours in which a member is involved in receiving professional services to assist in achieving recovery.

317:30-5-95.50. Residential substance use disorder (SUD) – Reimbursement

(a) In order to be eligible for payment, residential treatment providers of SUD treatment services must have an approved provider agreement on file with the OHCA. Through this agreement, the residential provider 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.

(b) Covered SUD treatment services for adolescents and adults in SUD residential treatment shall be reimbursed utilizing the per diem rates for each level of care. All SUD residential treatment services must be prior authorized by the OHCA or its designated agent before the service is rendered by an eligible provider. Without prior authorization, payment is not authorized.

(c) ~~Covered SUD treatment services for adolescents and adults in SUD residential treatment shall be reimbursed utilizing the per diem rates for each level of care.~~ Separate payment may be made for medications, physician services, and treatment services provided to dependent children in accordance with the Oklahoma Medicaid State Plan. Separate payment for such services will follow existing prior authorization requirements, if applicable.

(d) Treatment services for dependent children accompanying a parent to treatment shall be reimbursed on a fee-for-service basis in accordance with the Oklahoma Medicaid State Plan. Outpatient services rendered to dependent children may be provided by the residential facility if appropriately certified or a separate outpatient provider. Such services shall not duplicate any services provided by the residential provider that are reimbursed through the residential per dime rate.

(e) The following services are excluded from coverage/reimbursement:

(1) Room and board;

(2) Services or components that are not provided to or exclusively for the treatment of the member;

(3) Services or components of services of which the basic nature is to supplant housekeeping or basic services for the convenience of a member receiving covered services;

(4) Physician directed services and medications (these services are reimbursed outside of the

residential SUD per diem);
(5) Telephone calls or other electronic contacts (not inclusive of telehealth); and
(6) Field trips, social, or physical exercise activity groups.

PART 33. TRANSPORTATION BY AMBULANCE

317:30-5-336.3. Destination and transport outside of locality

(a) Transportation is covered from the point of origin to the Hospital, Critical Access Hospital or Nursing Facility that is capable of providing the required level and type of care for the member.
(b) Ambulance transportation from a hospital with a higher level of care to a hospital with a lower level of care in the locality is covered, provided all other criteria are met and approved by the OHCA.
(c) Non-emergency transportation to the outpatient facilities of a Hospital, free-standing Ambulatory Surgery Center (ASC), Independent Diagnostic Testing Facility (IDTF), Physician's office or other outpatient facility is compensable if the member's condition necessitates ambulance or stretcher transportation and all other conditions are met.
(d) Ambulance Transportation to a Veteran's Administration (VA) Hospital is covered when the trip has not been authorized by the VA.
(e) If ambulance transportation is provided out of the transport locality, the claim must be documented with the reason for the transport outside of the service area.
(f) If it is determined the member was transported out of locality and the closest facility could have cared for the member, payment will be made only for the distance to the nearest medical institution with the appropriate facilities.
(g) Any transportation which begins or ends outside of the Oklahoma geographic border requires prior authorization. The exception to this rule is if transportation begins or ends within one hundred (100) miles of Oklahoma's geographic border, no prior authorization is required.

317:30-5-336.4. Transport outside of locality [REVOKED]

~~(a) If ambulance transportation is provided out of the transport locality, the claim must be documented with the reason for the transport outside of the service area.~~
~~(b) If it is determined the member was transported out of locality and the closest facility could have cared for the member, payment will be made only for the distance to the nearest medical institution with the appropriate facilities.~~
~~(c) Any transportation which begins or ends outside of the Oklahoma geographic border requires prior authorization. The exception to this rule is if transportation begins or ends within 100 miles of Oklahoma's geographic border, no prior authorization is required.~~

PART 61. HOME HEALTH AGENCIES

317:30-5-547. Reimbursement and procedure codes

(a) Nursing services and home health aide services are covered services on a per visit basis. 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 Oklahoma Health Care Authority (OHCA) fee schedule or the

provider's usual and customary charge. 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 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. 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.

(d) All home health services are billed using Healthcare Common Procedure Coding System (HCPCS) codes.

317:30-5-548. Procedure codes [REVOKED]

~~All home health services are billed using Healthcare Common Procedure Coding System (HCPCS) codes.~~

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 17. MEDICAL SUPPLIERS

317:30-5-211.10. Medical supplies, equipment, and appliances

(a) **Medical supplies, equipment, and appliances**. 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 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) ~~External infusion pumps;~~Enteral and parenteral nutrition; and

(2) ~~Hospital beds;~~Support surfaces.

~~(3) Oxygen and oxygen related products;~~

~~(4) Pneumatic compression devices;~~

~~(5) Support surfaces;~~

~~(6) Enteral and parenteral nutrition; and~~

~~(7) Osteogenesis stimulator.~~

(c) **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.

(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.

(e) **Backup equipment.** Backup equipment is considered part of the rental cost and is not a covered service without prior authorization.

(f) **Home modification.** 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.

317:30-5-211.11. Oxygen and oxygen equipment

(a) **Medical necessity.** Oxygen and oxygen supplies are covered when medically necessary. Medical necessity is determined from results of arterial blood gas analysis (ABG) or pulse oximetry (SaO2) tests. ABG data are not required for children, but may be used if otherwise available. The test results to document Medical Necessity must be within ~~30~~thirty (30) days of the date of the qualified medical practitioner's ~~Certificate of Medical Necessity~~order. Prior authorization is required after the initial three (3) months of billing whether qualifying tests were done at rest, during sleep, or during exercise. Appropriate documentation of ABG or SaO2 data from the member's chart should be attached to the prior authorization request (PAR).

(1) The ABG or oximetry test used to determine medical necessity must be performed by a

medical professional qualified to conduct such testing. The test may not be performed or paid for by a DMEPOS supplier, or a related corporation. A referring qualified medical practitioner may perform the test in his/her office as part of routine member care.

(2) In addition to ABG data, the following three (3) tests are acceptable for determining medical necessity for oxygen prescription:

(A) At rest and awake "spot oximetry."

(B) During sleep:

(i) Overnight Sleep Oximetry done inpatient or at home.

(ii) Polysomnogram, which may be used only if medically necessary for concurrent evaluation of another condition while in a chronic stable state.

(C) During exercise with all three (3) of the following performed in the same testing session.

(i) At rest, off oxygen showing a non-qualifying result.

(ii) During exercise, off oxygen showing a qualifying event.

(iii) During exercise, on oxygen showing improvement over test (C) ii above.

(3) Certification criteria:

(A) All qualifying testing must meet the following criteria:

(B) **Adults.** Initial requests for oxygen must include ABG or resting oximetry results. At rest and on room air, the arterial blood saturation (SaO2) cannot exceed ~~89%~~eighty-nine percent (89%) or the pO2 cannot exceed 59mm Hg.

(C) **Children.** Members ~~20~~twenty (20) years of age or less must meet the following requirements:

(i) birth through three (3) years, SaO2 equal to or less than ~~94%~~ninety-four percent (94%); or

(ii) ages four (4) and above, SaO2 level equal to or less than ~~90%~~ninety percent (90%).

(iii) Requests from the qualified medical practitioner for oxygen for children who do not meet these requirements should include documentation of the medical necessity based on the child's clinical condition. These requests are considered on a case-by-case basis.

~~(b) **Certificate of medical necessity.**~~

~~(1) The DMEPOS supplier must have a fully completed current CMN(CMS-484 or HCA-32 must be used for members 20 years of age and younger) on file to support the claims for oxygen or oxygen supplies, and to establish whether coverage criteria are met and to ensure that the oxygen services provided are consistent with the physician's prescription (refer to instructions from Palmetto Government Benefits Administration, the Oklahoma Medicare Carrier, for further requirements for completion of the CMN).~~

~~(2) The CMN must be signed by the qualified medical practitioner prior to submitting the initial claim. If a verbal order containing qualifying data is received by the DME provider, oxygen and supplies may be dispensed using the verbal order date as the billing date. The CMN initial date, the verbal order date, and the date of delivery should be the same date. It is acceptable to have a cover letter containing the same information as the CMN, stating the qualified medical practitioner's orders. The CMN signed by the qualified medical practitioner must be attached to the PAR.~~

~~(3) The medical and prescription information on the CMN may be completed by a non-physician clinician, or an employee, for the qualified medical practitioner's review and~~

~~signature.~~

~~(4) When a Certificate of Medical Necessity for oxygen is recertified, a prior authorization request will be required.~~

~~(5) Re-certification and related retesting will be required every 12 months.~~

~~(6) CMN for oxygen services must be updated at least annually and at any time a change in prescription occurs during the year. All DMEPOS suppliers are responsible for maintaining the prescription(s) for oxygen services and CMN in each member's file.~~

~~(7) The OHCA or its designated agent will conduct ongoing monitoring of prescriptions for oxygen services to ensure guidelines are followed. Payment adjustments will be made on claims not meeting these requirements.~~

(b) **Guidelines.** For full guidelines, please refer to www.okhca.org/mau.

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.

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OPERATIONAL METRICS

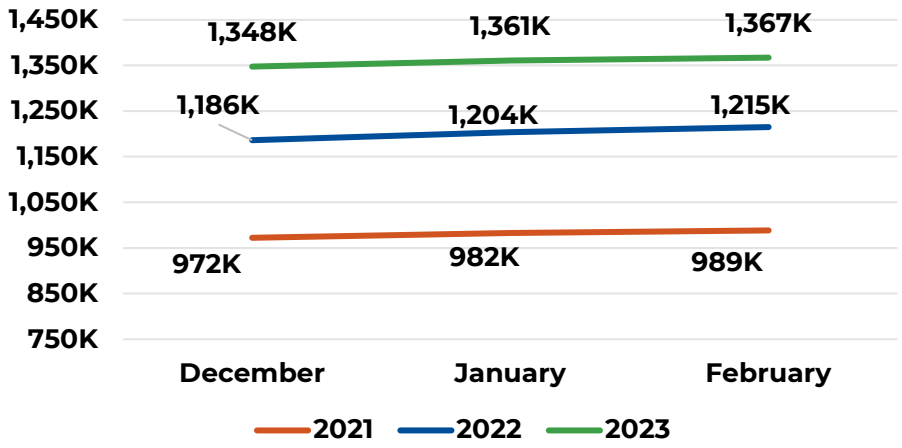
March 2023 Board Meeting

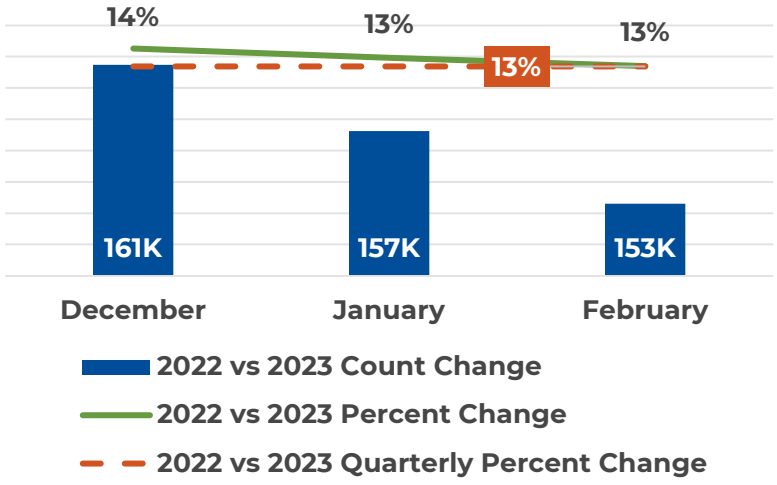
OKLAHOMA HEALTH CARE AUTHORITY

4345 N. LINCOLN BLVD. | OKHCA.ORG |

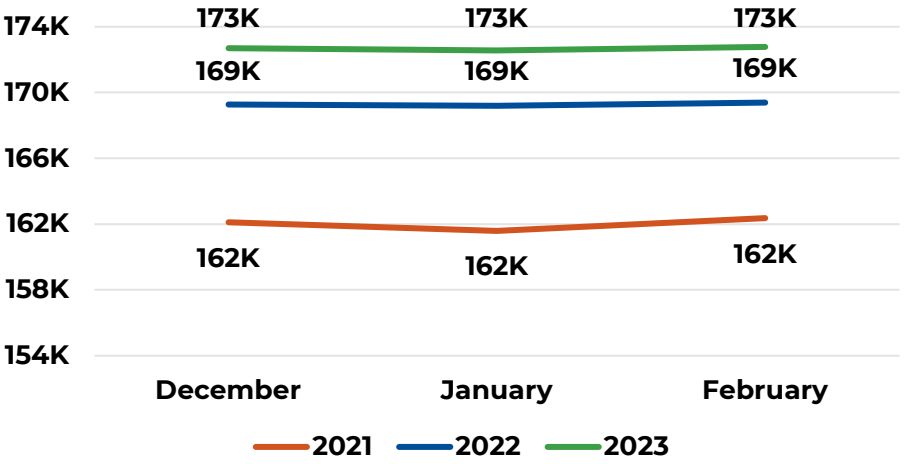
Enrollment & Utilization

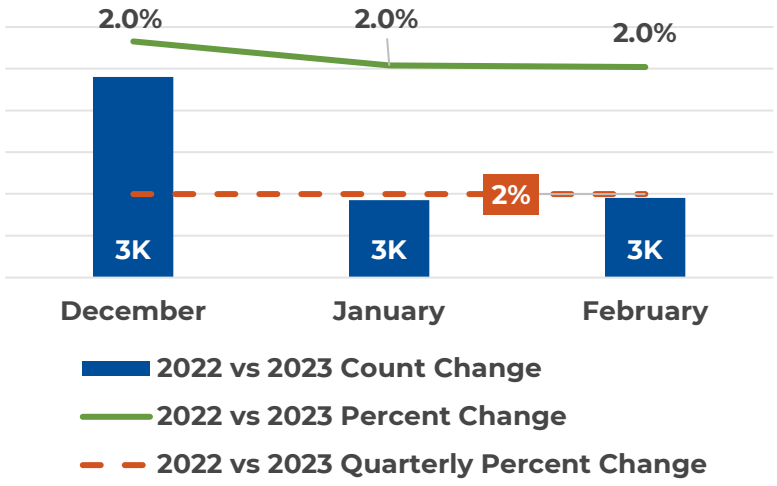
Total Enrolled Members





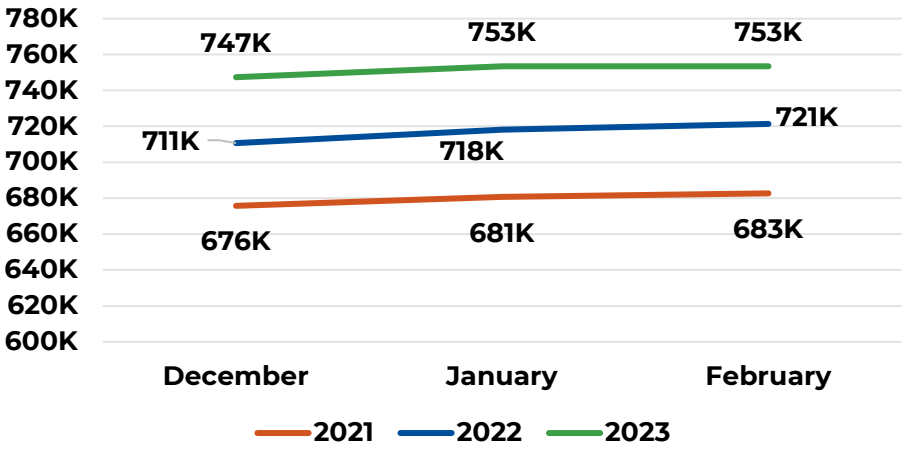
Aged/Blind/Disabled Enrolled

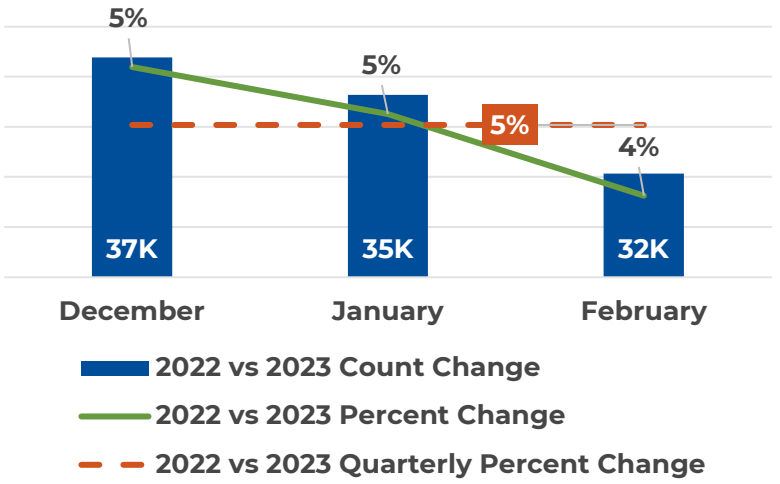




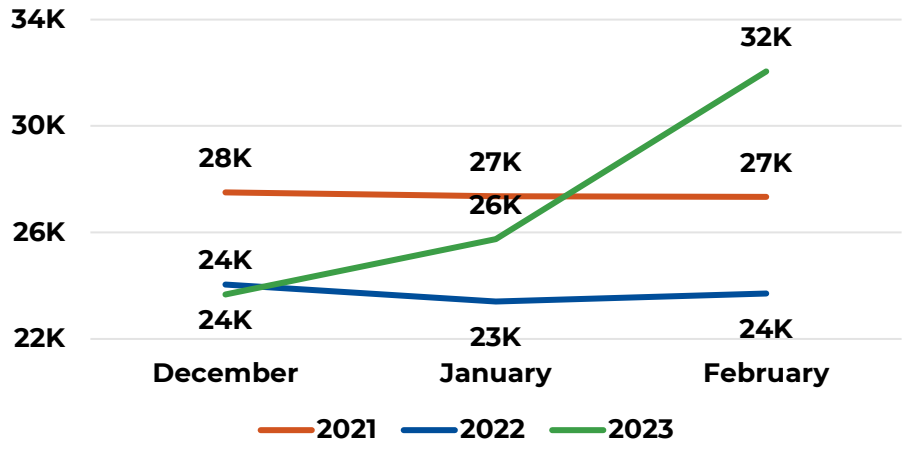
Enrollment & Utilization (Cont.)

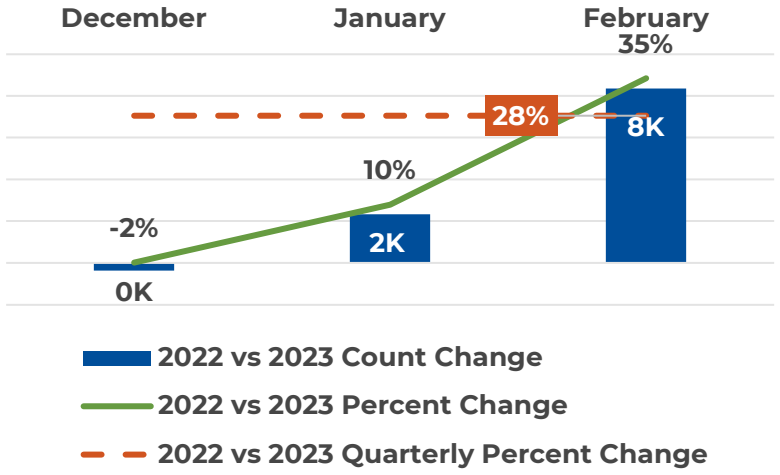
Children & Parent/Caretaker Enrolled





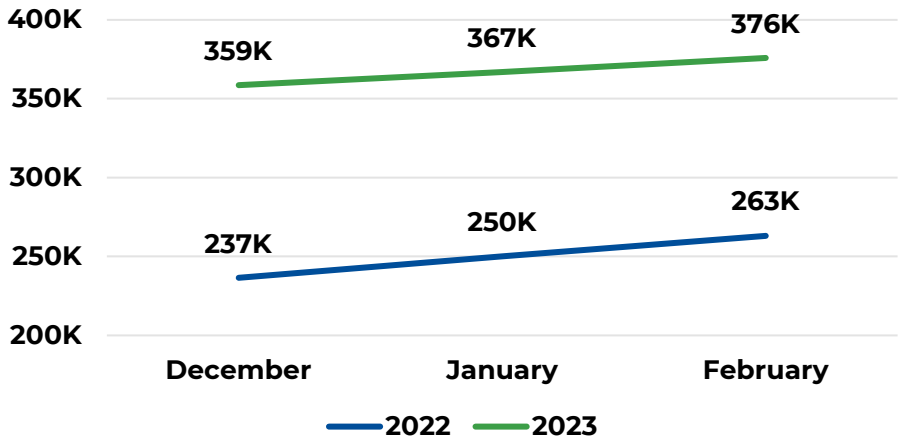
Pregnant (Full Scope) Enrolled

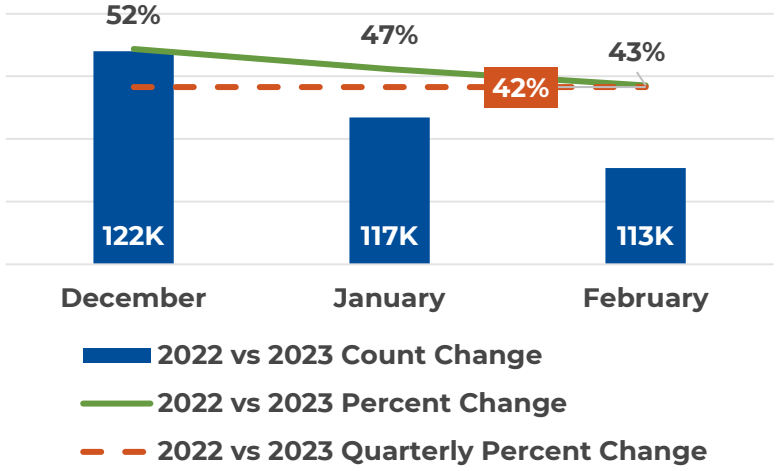




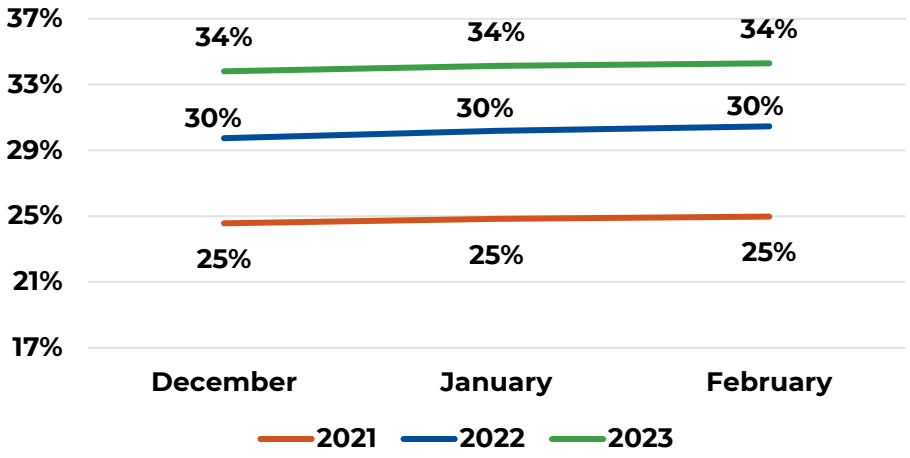
Enrollment & Utilization (Cont.)

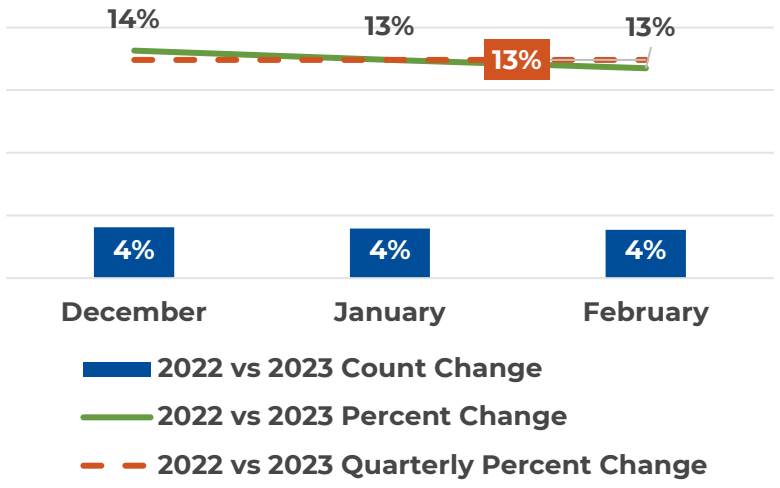
Expansion Enrolled (Effective July 2021)





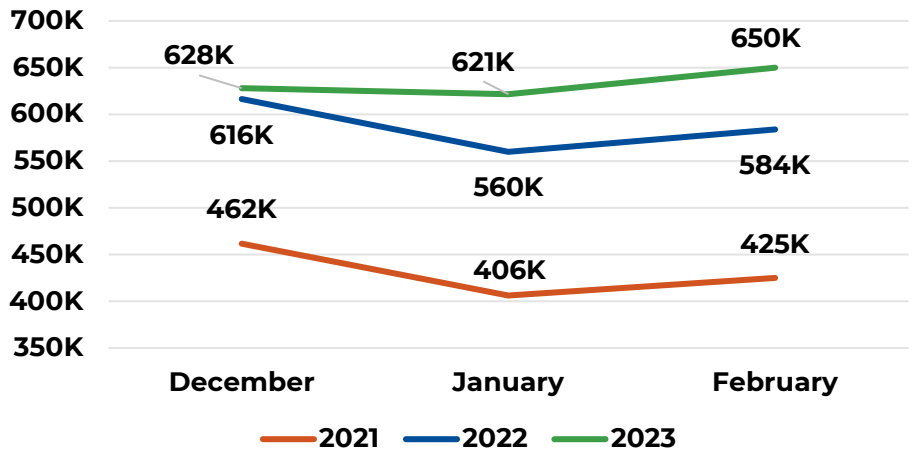
Percent of OK Population Enrolled

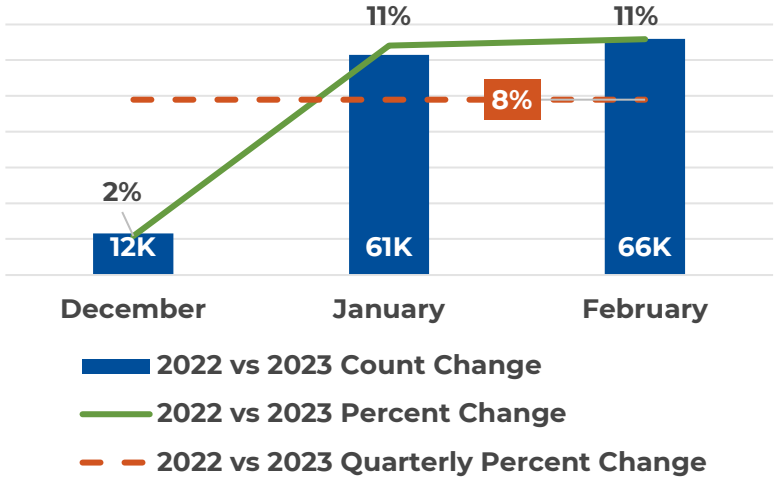




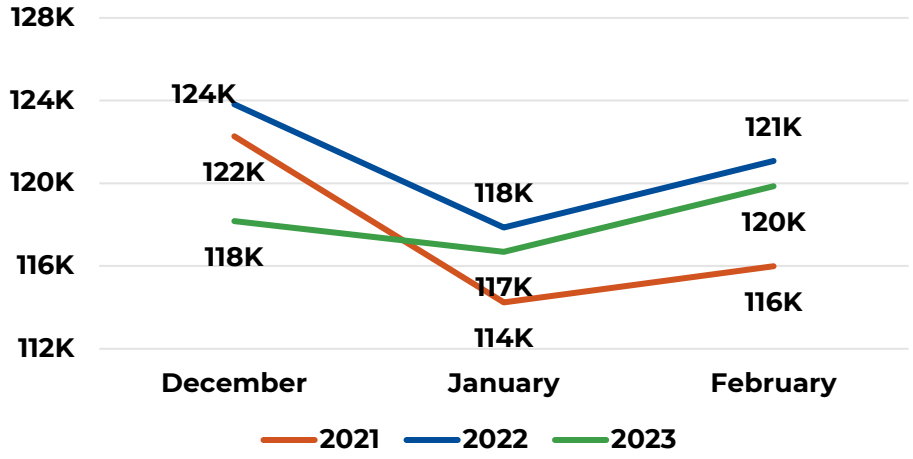
Enrollment & Utilization (Cont.)

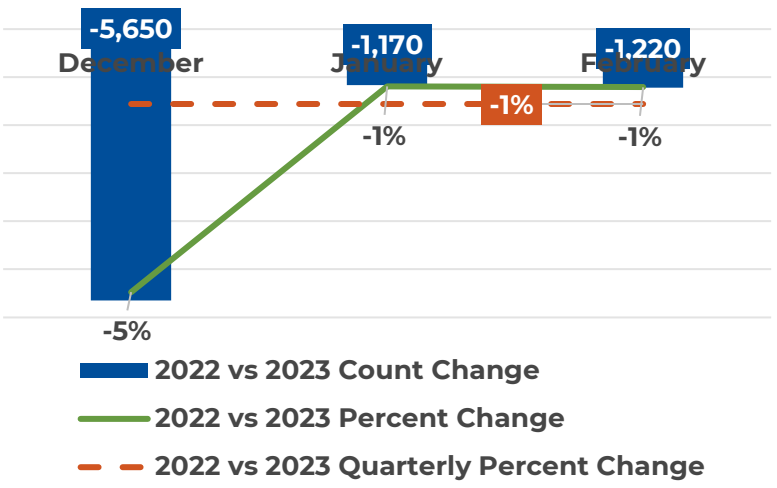
Total Members Utilization





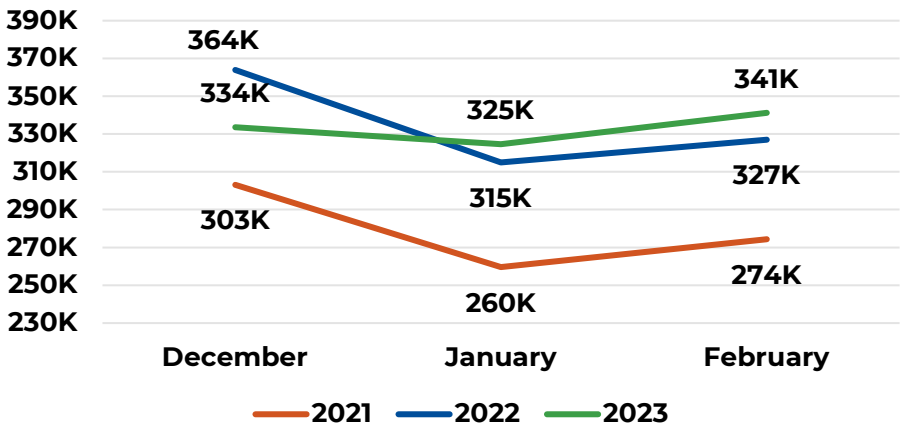
Aged/Blind/Disabled Utilization

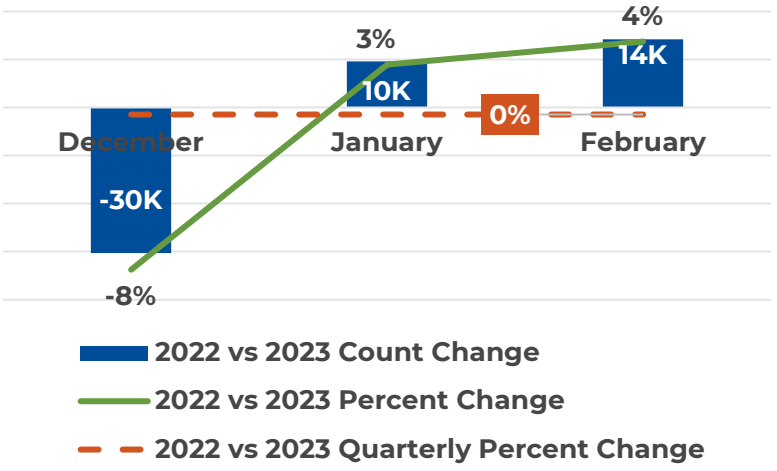




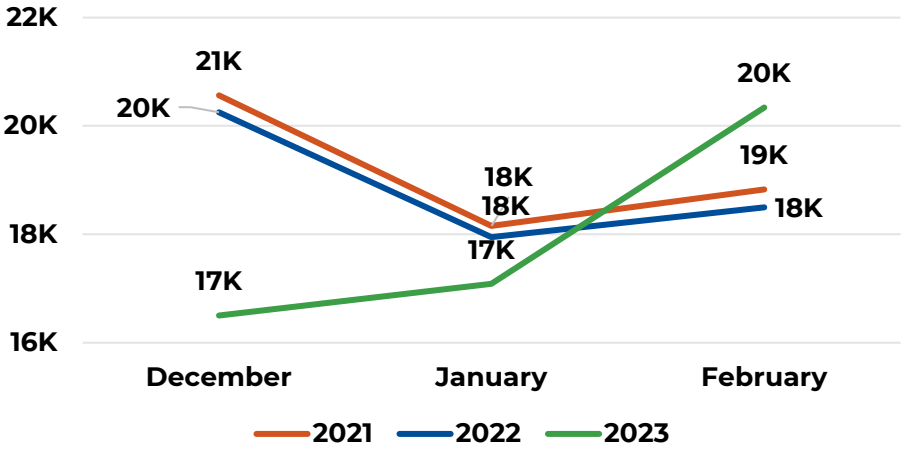
Enrollment & Utilization (Cont.)

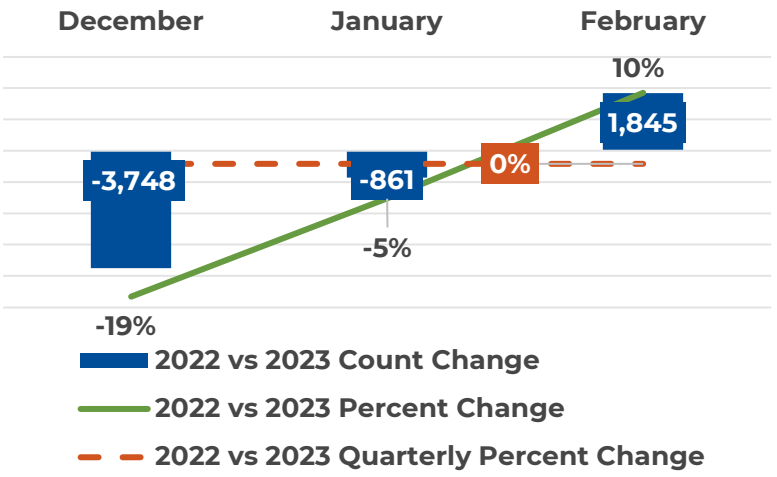
Children & Parent/Caretaker Utilization





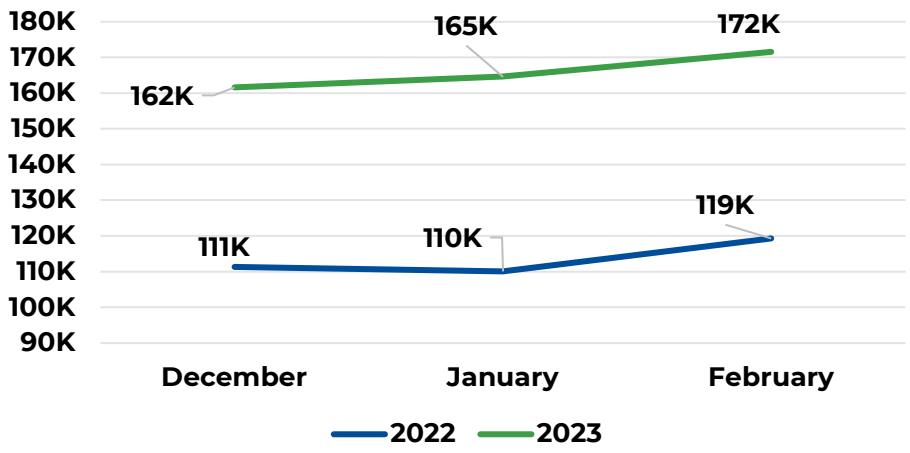
Pregnant (Full Scope) Utilization

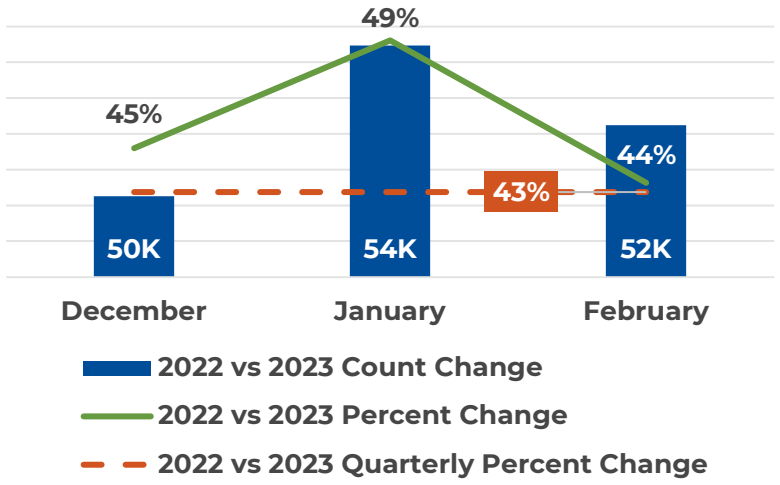




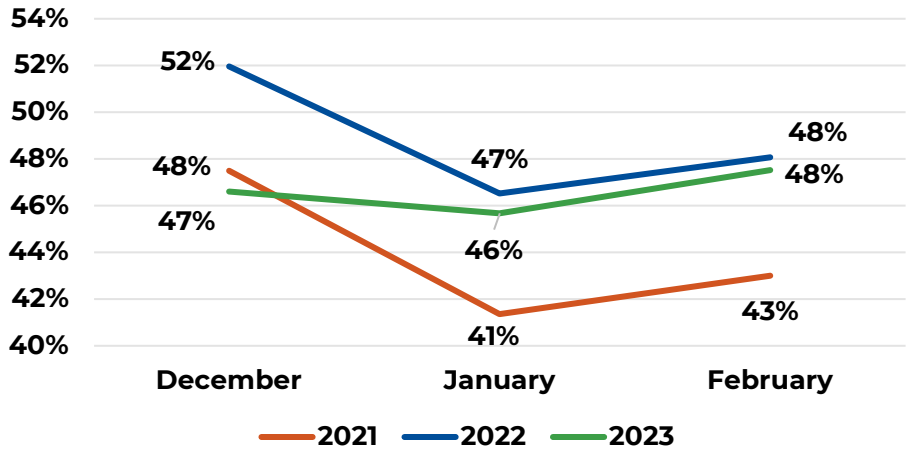
Enrollment & Utilization (Cont.)

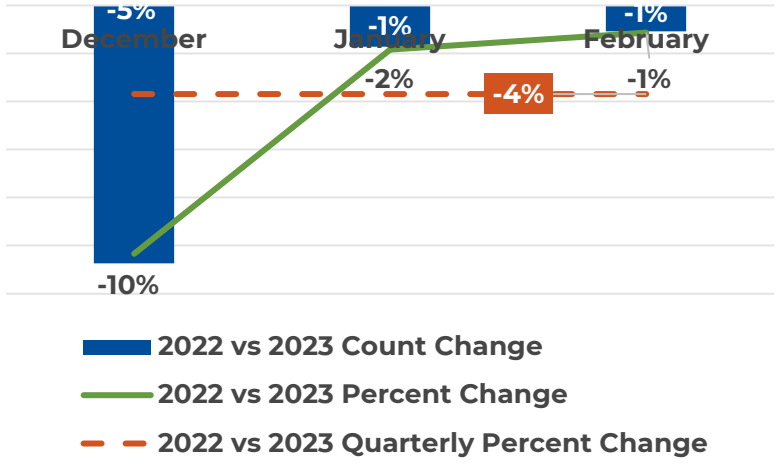
Expansion Utilization (Effective July 2021)





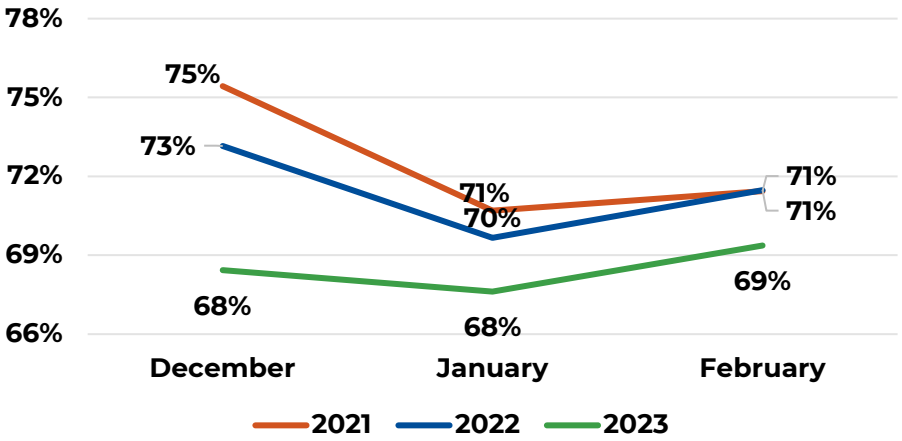
Percent of Total Enrolled Members Utilization

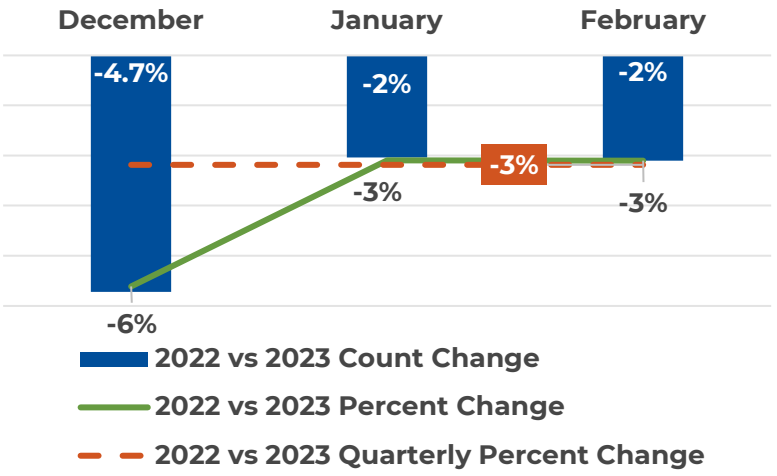




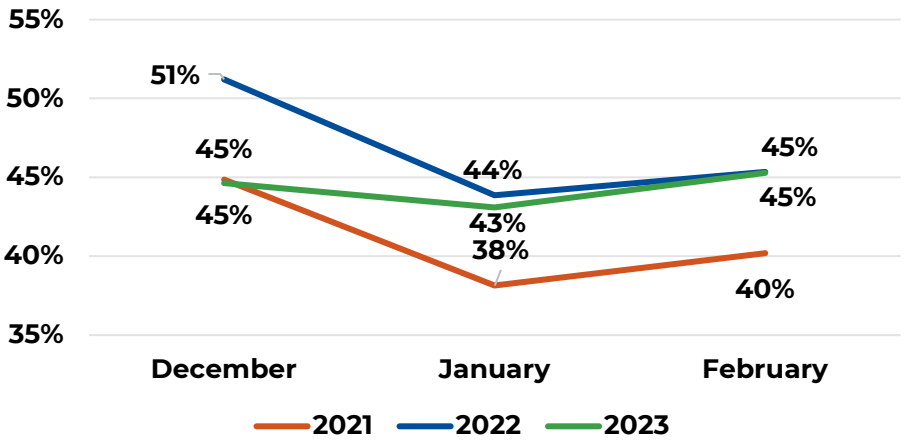
Enrollment & Utilization (Cont.)

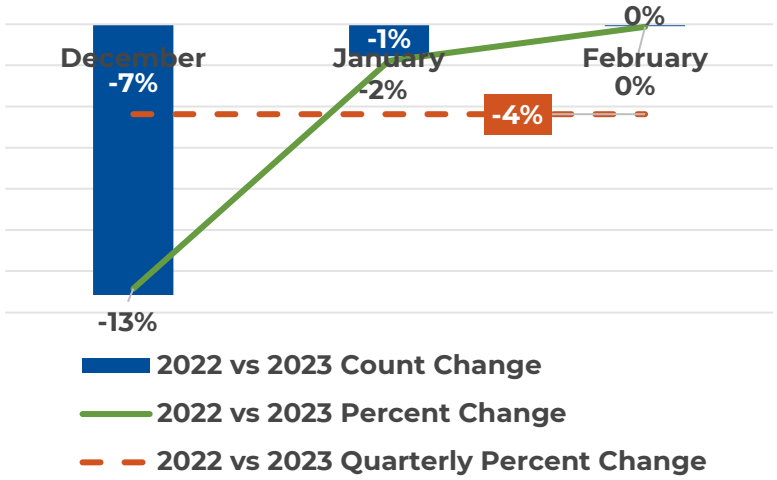
Percent of Aged/Blind/Disabled Enrolled Members Utilization





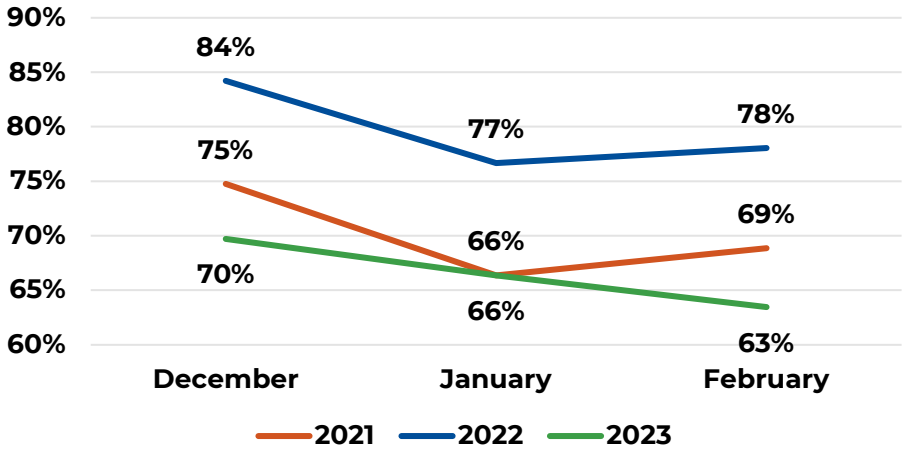
Percent of Children & Parent/Caretaker Enrolled Members Utilization

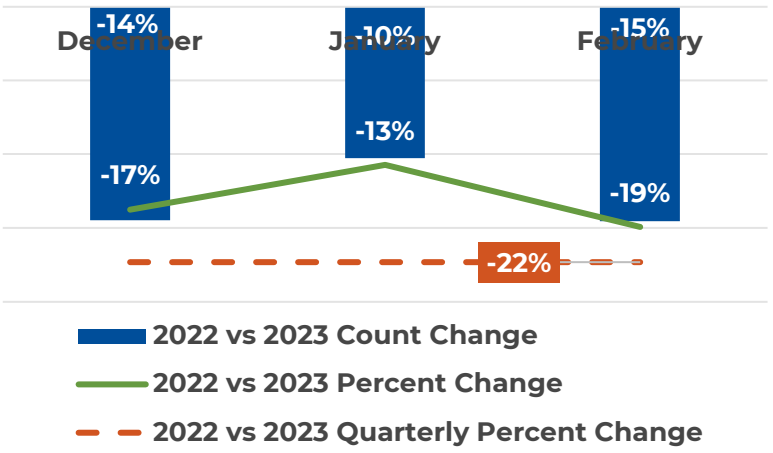




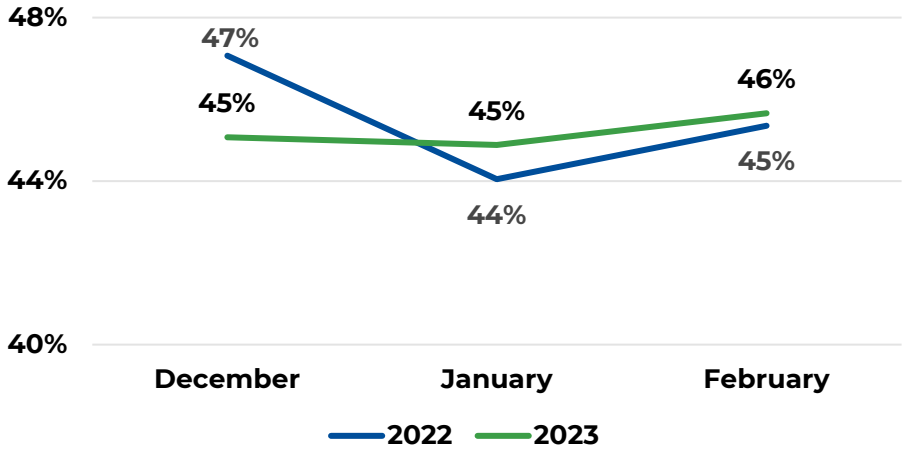
Enrollment & Utilization (Cont.)

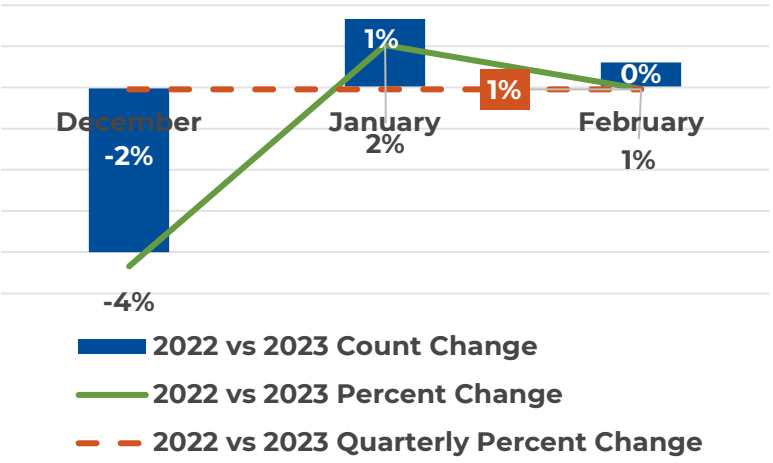
Percent of Pregnant (Full Scope) Enrolled Members Utilization





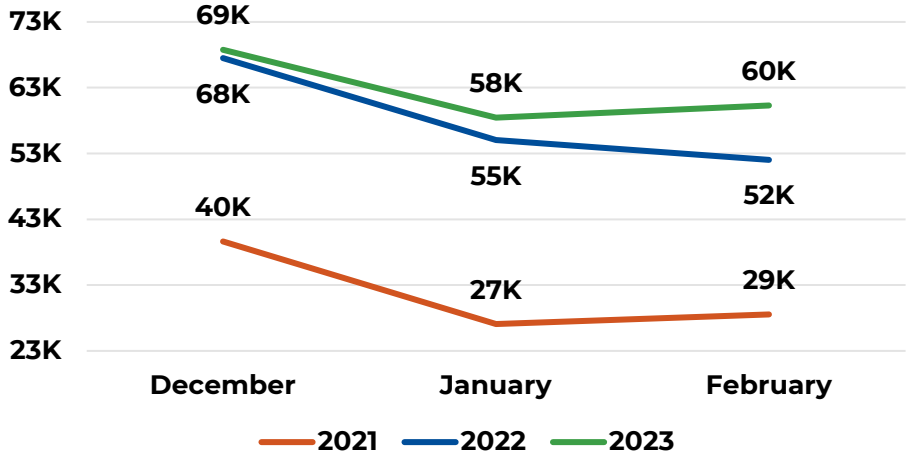
Percent of Expansion Enrolled Members Utilization (Effective July 2021)

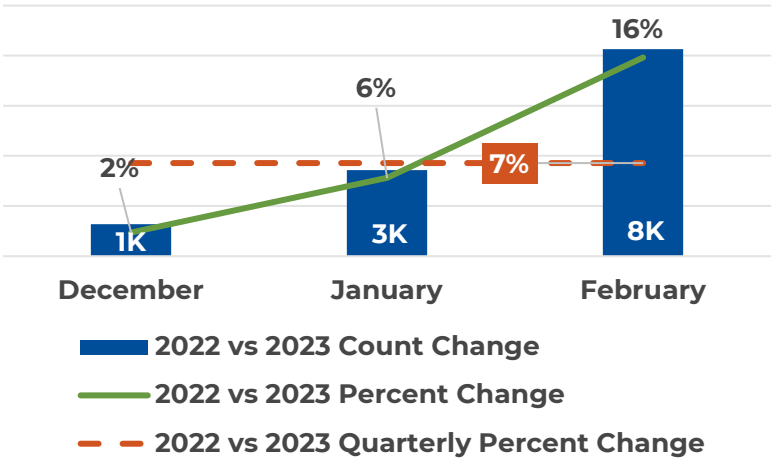




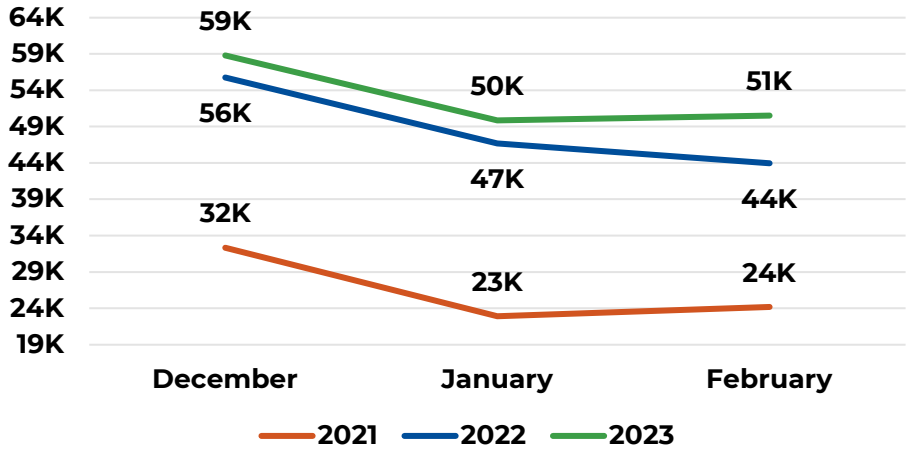
Utilization

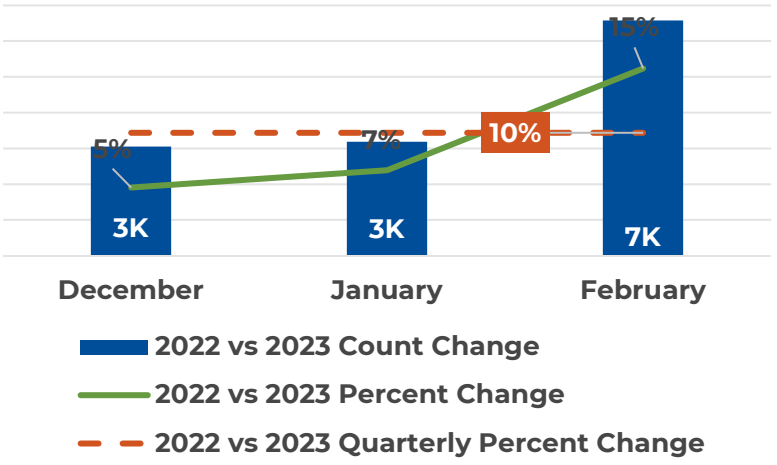
Emergency Department Visits (Claims)





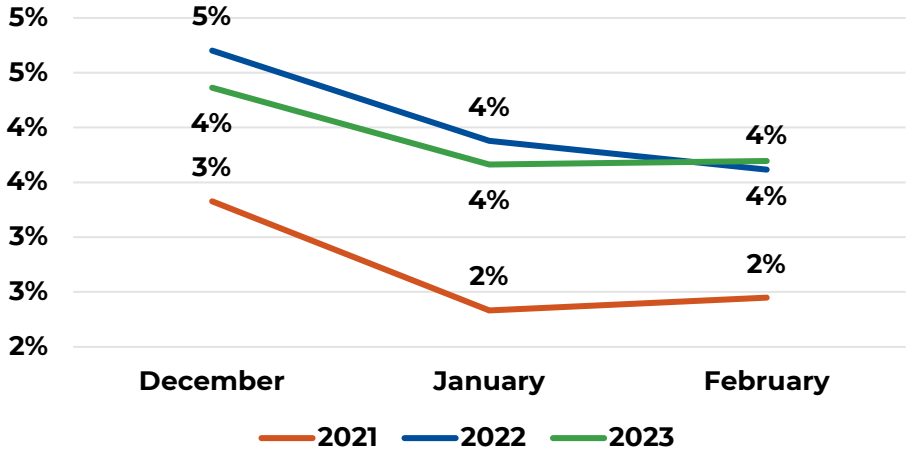
Members Utilizing Emergency Department

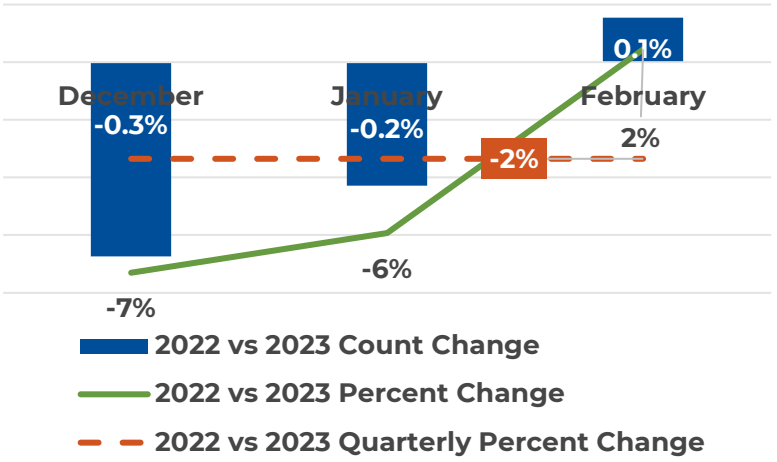




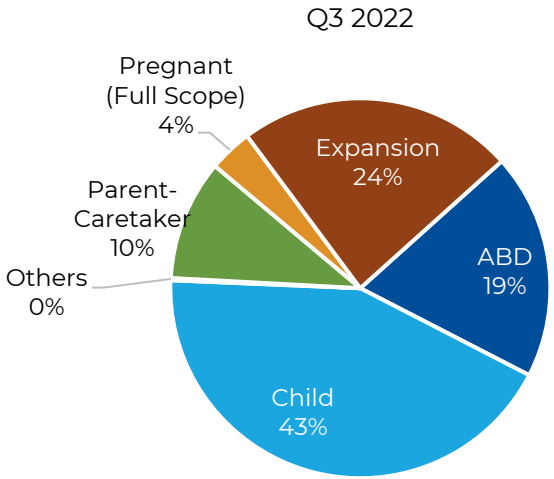
Utilization (Cont.)

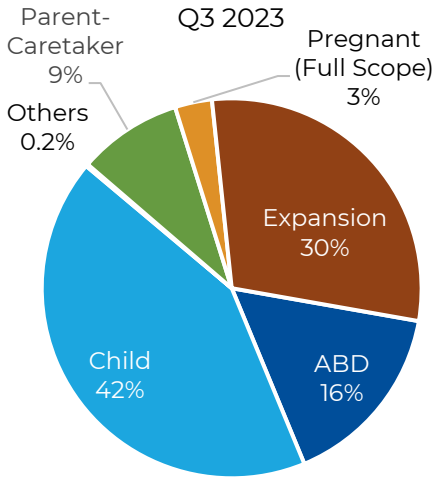
Percent Total Enrolled Using ED





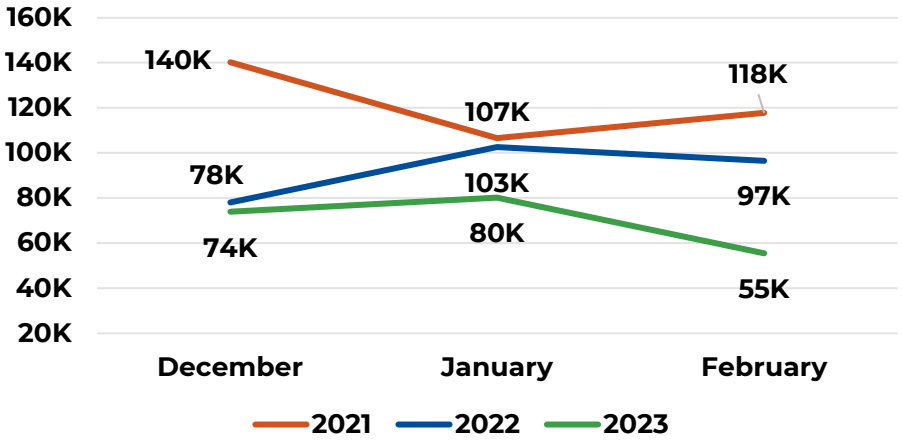
Members Utilizing Emergency Department By Qualifying Group

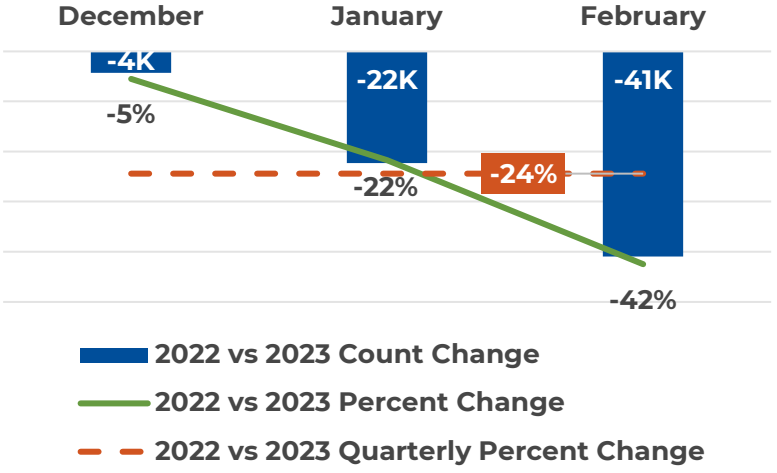




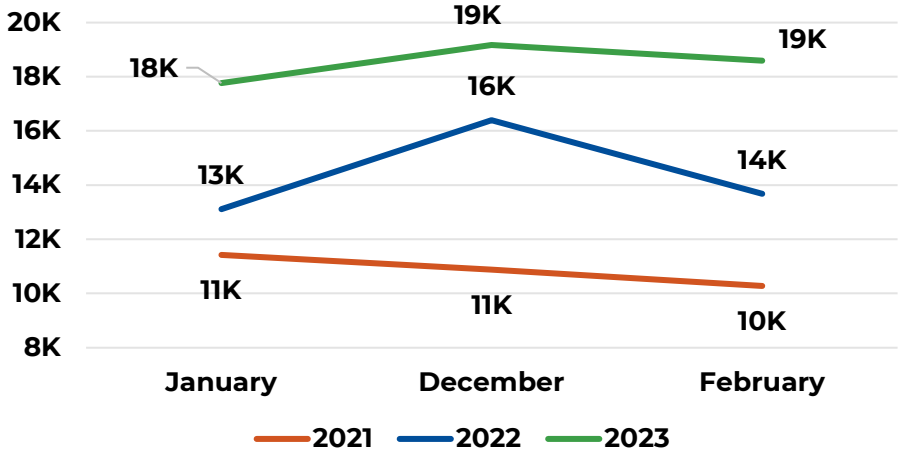
Utilization (Cont.)

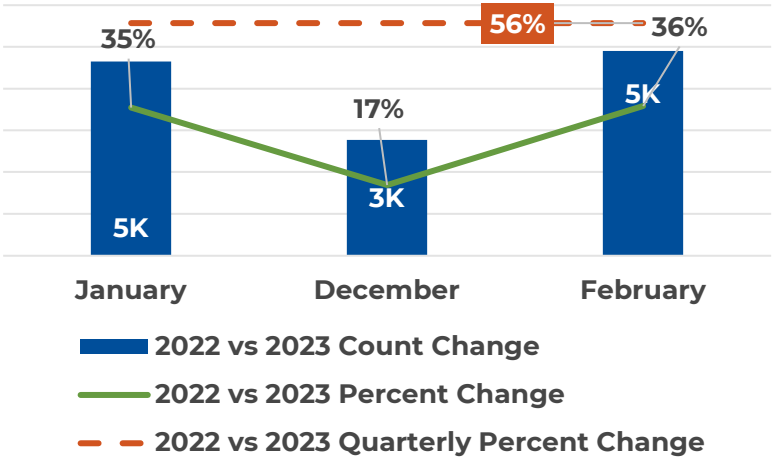
Telemedicine - Total Visits





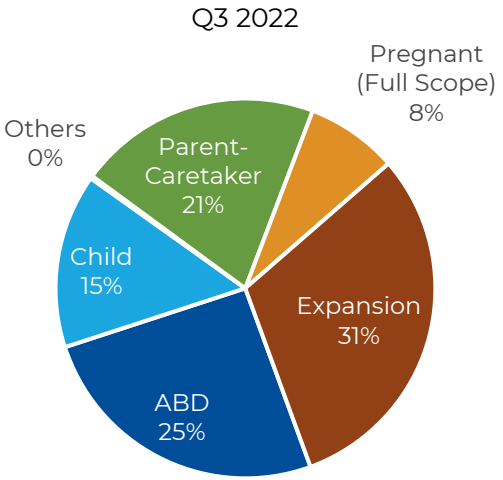
Members With Opioid Claims

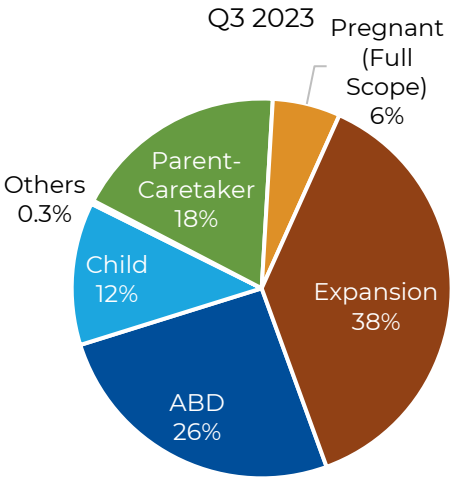




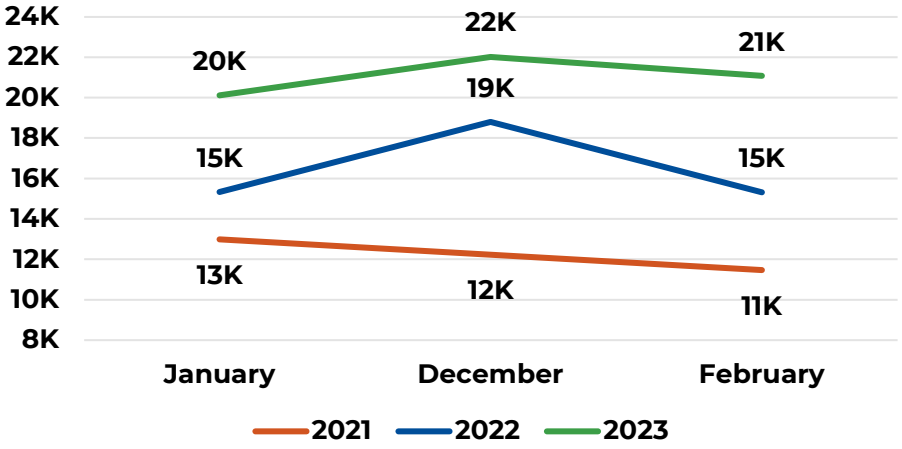
Utilization (Cont.)

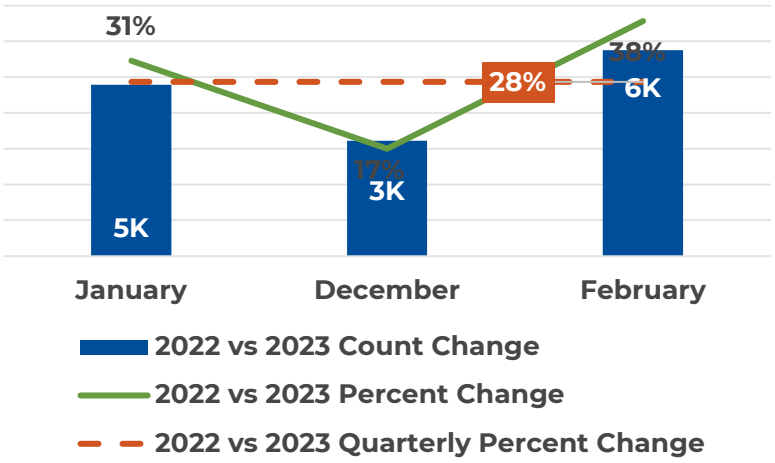
Members With Opioid Claims By Qualifying Group





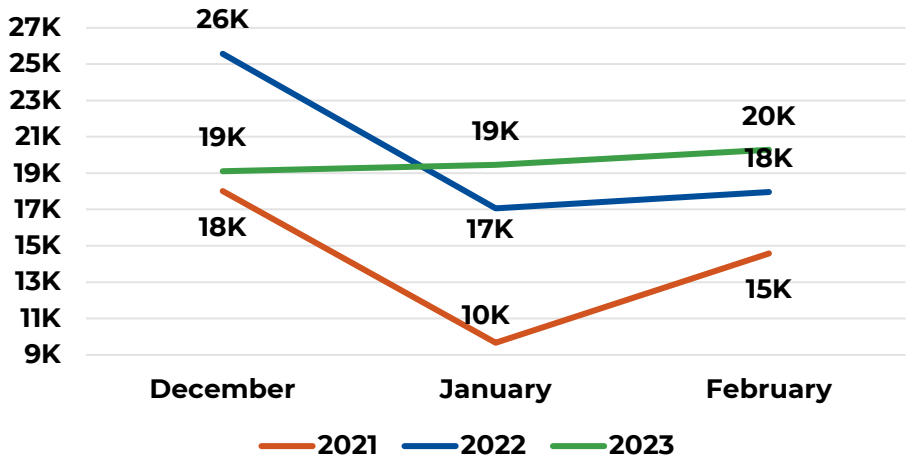
Total Opioid Claims

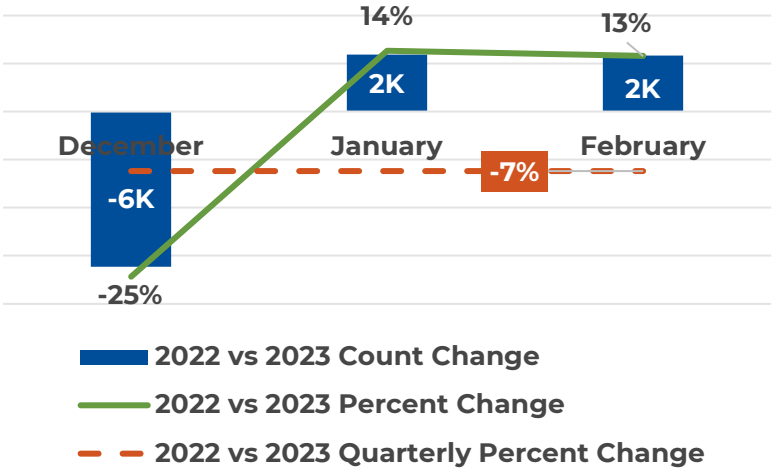




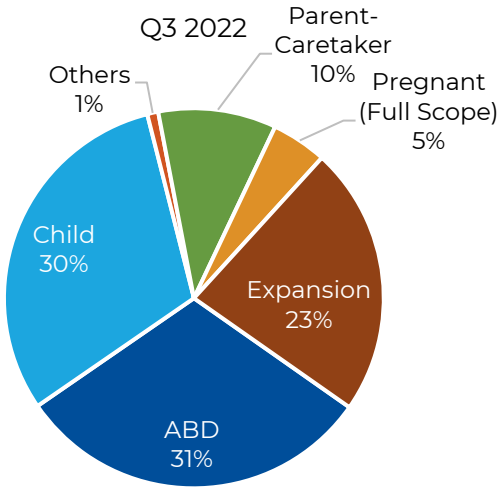
Utilization (Cont.)

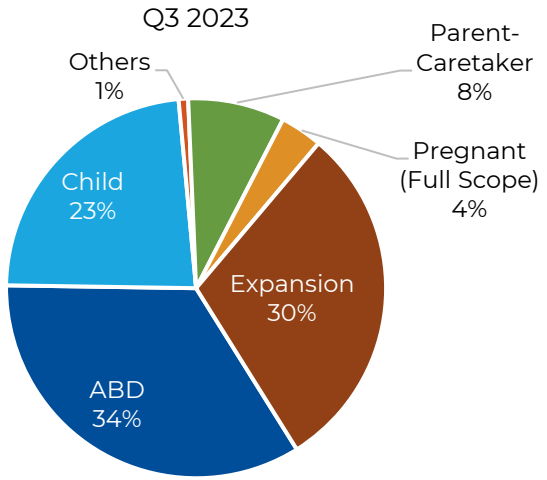
Out of State Services - Total Members Utilization





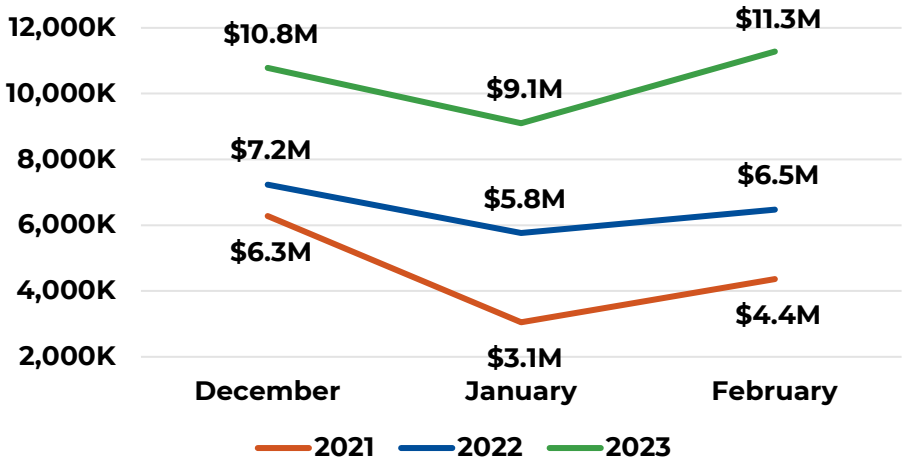
Out of State Services - Total Members Utilization By Qualifying Group

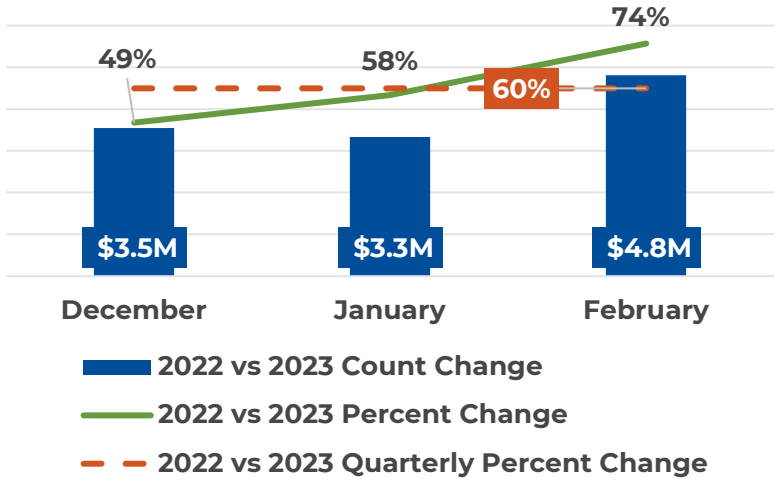




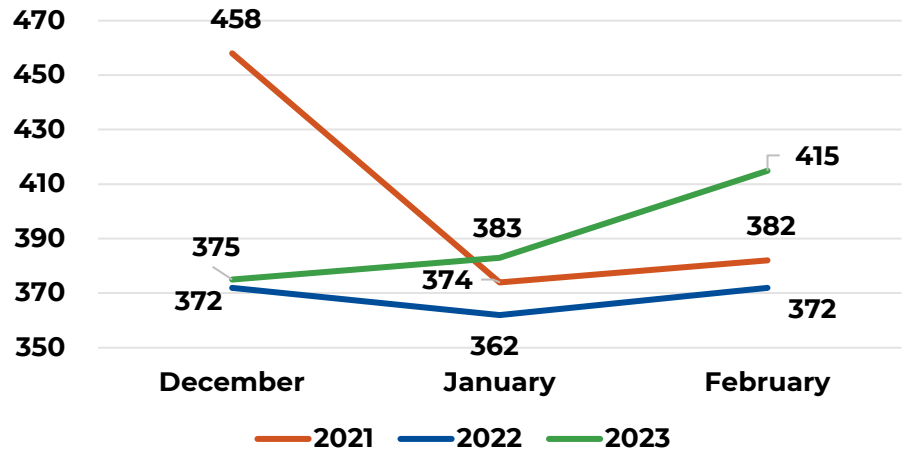
Utilization (Cont.)

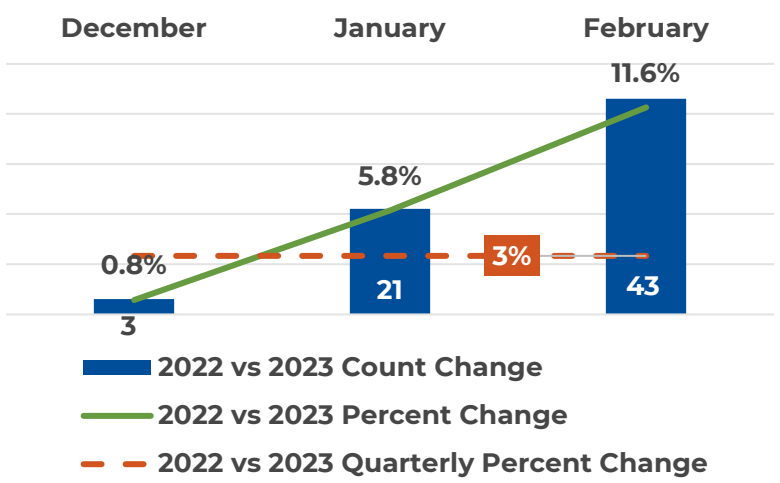
Out of State Services - Total Reimbursements





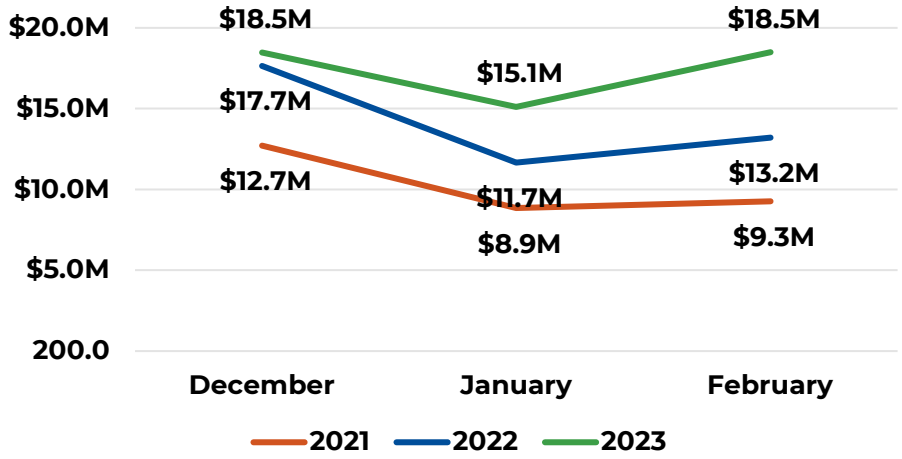
Out of State Services - Total Active Billing Providers

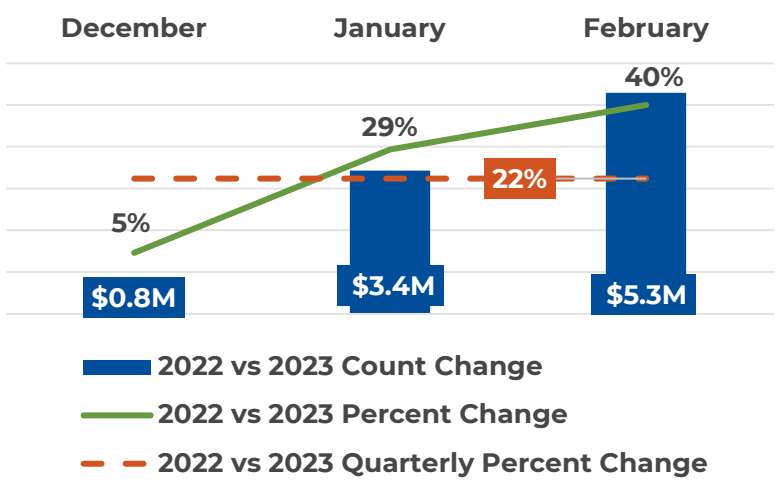




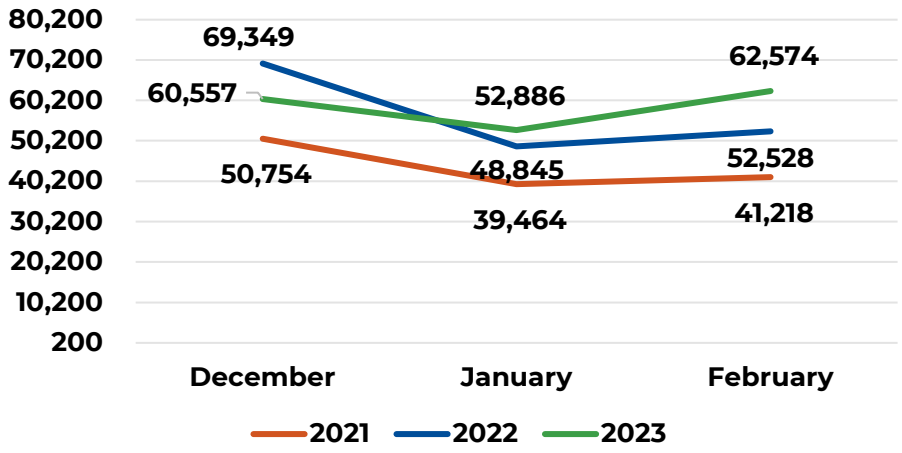
Utilization (Cont.)

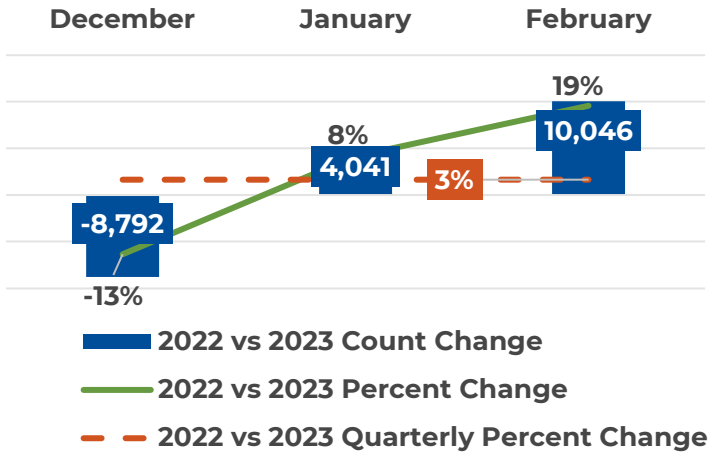
Dental Claims





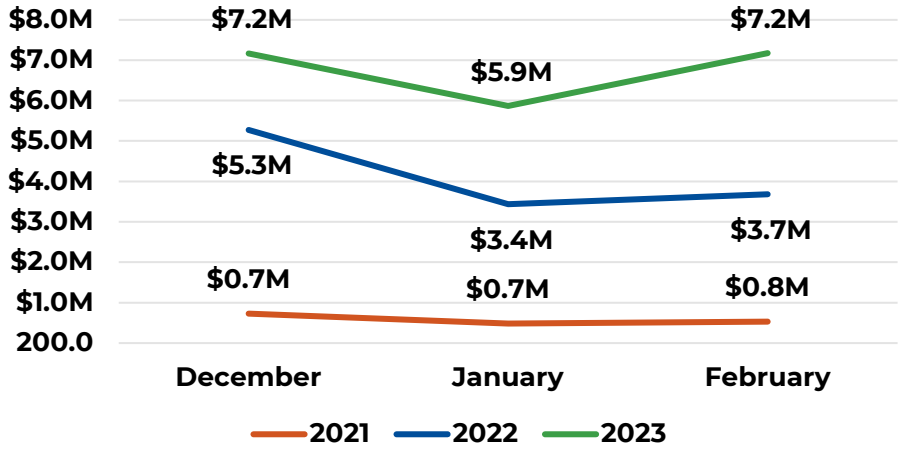
Total Members with Dental Claims

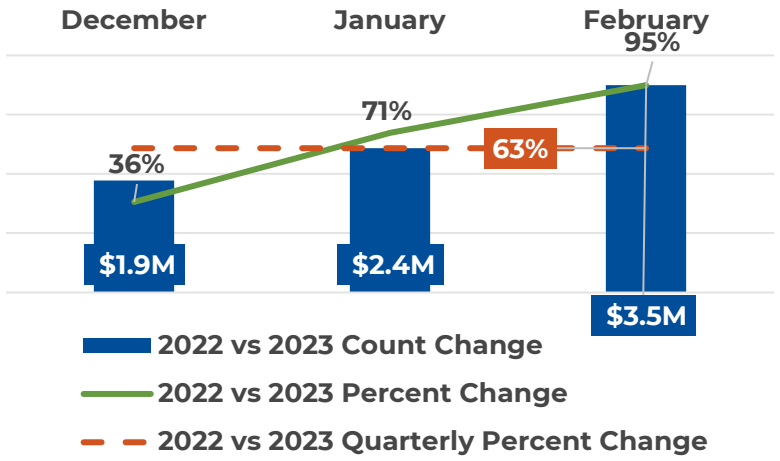




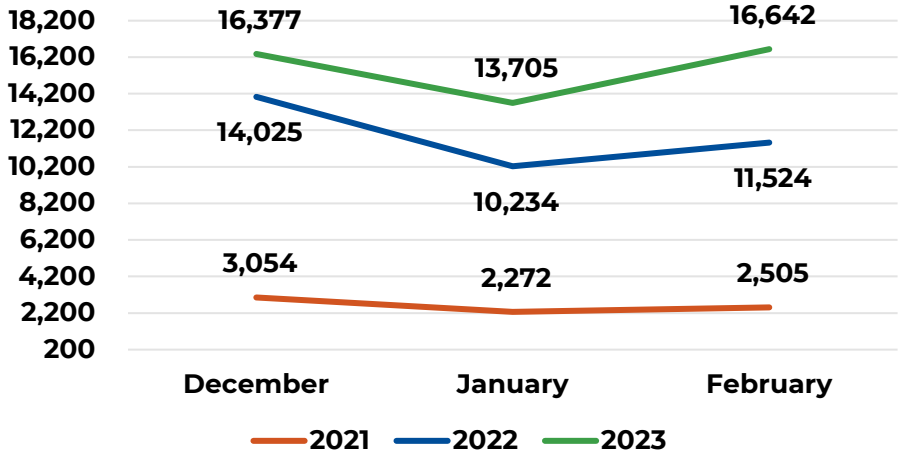
Utilization (Cont.)

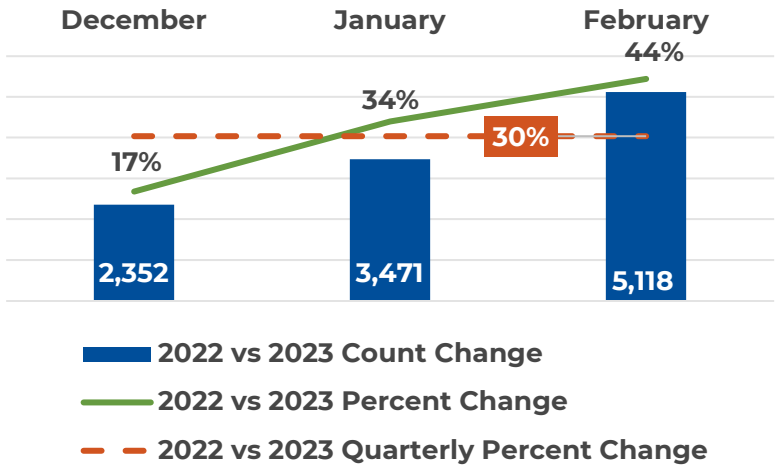
Adult (21 & Over) Dental Claims





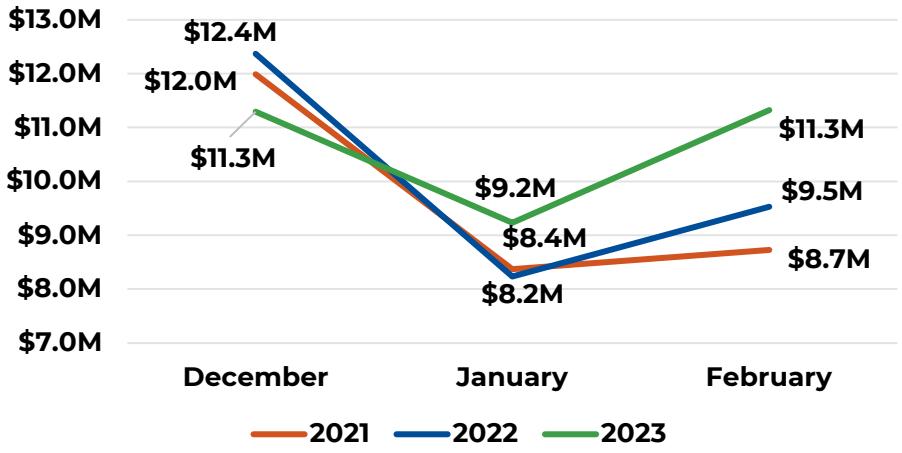
Adults (21 & Over) with Dental Claims

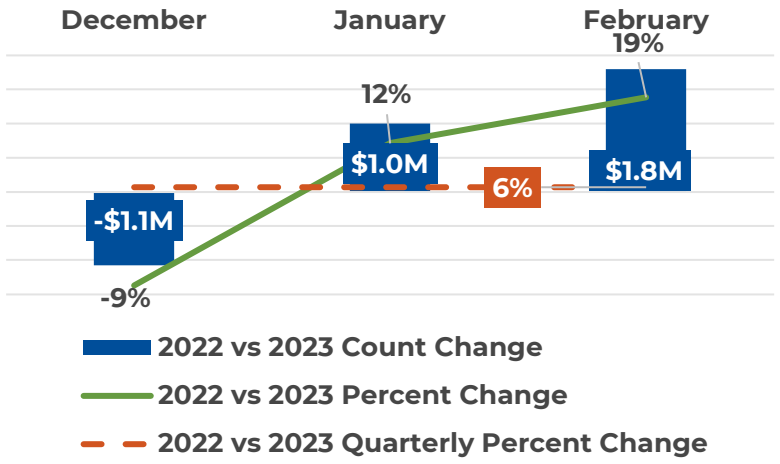




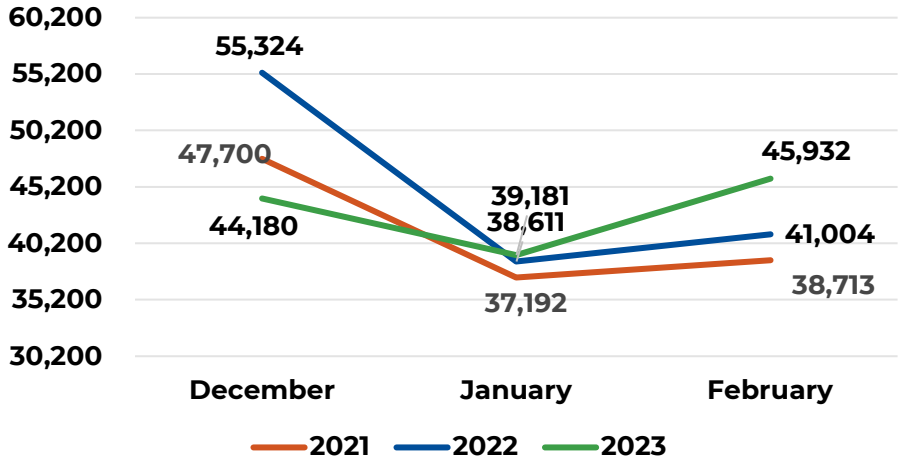
Utilization (Cont.)

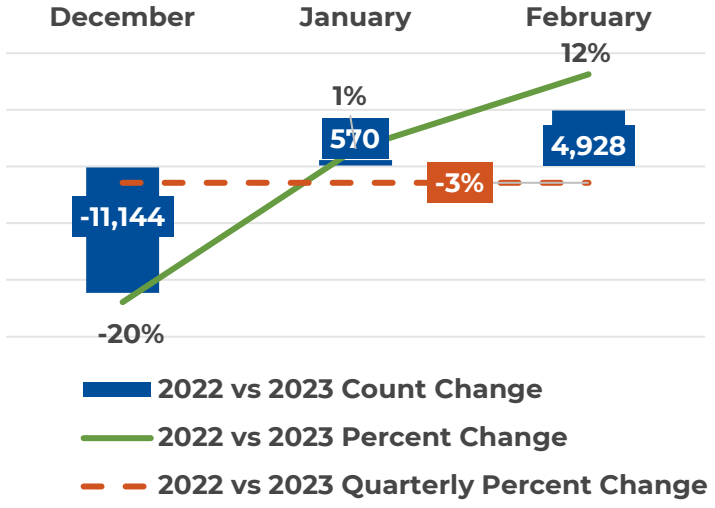
Children (Under 21) Dental Claims





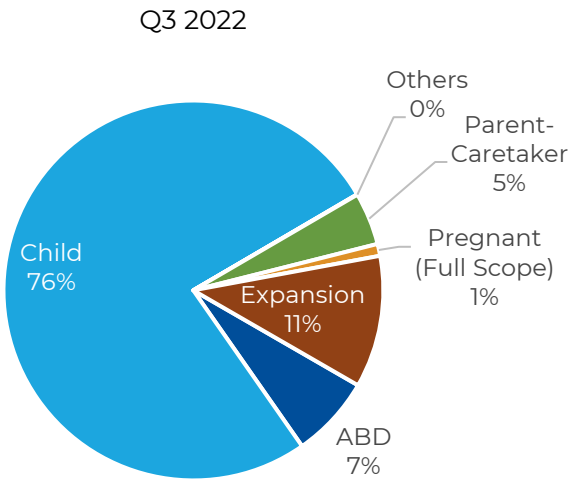
Children (Under 21) with Dental Claims

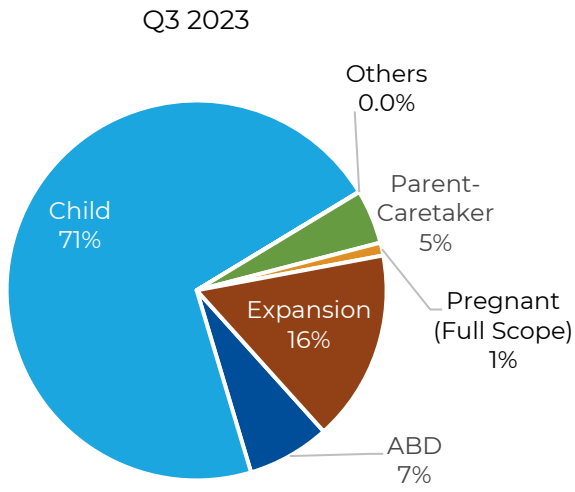




Utilization (Cont.)

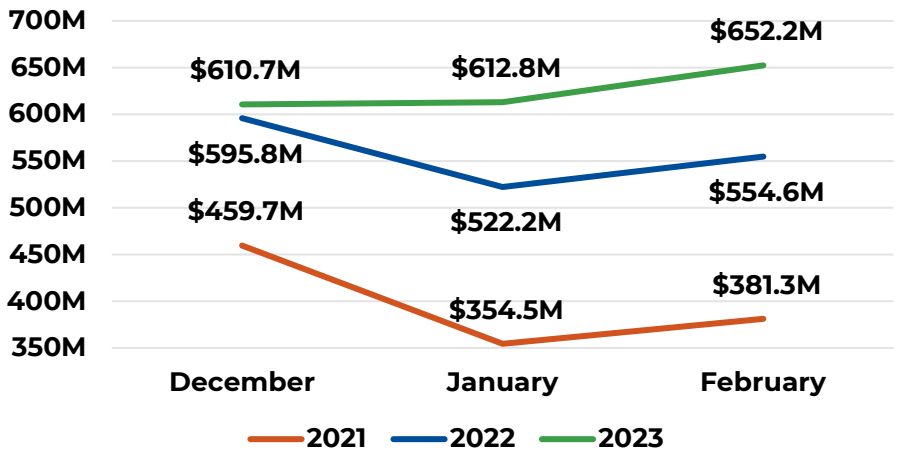
Members With Dental Claims By Qualifying Group

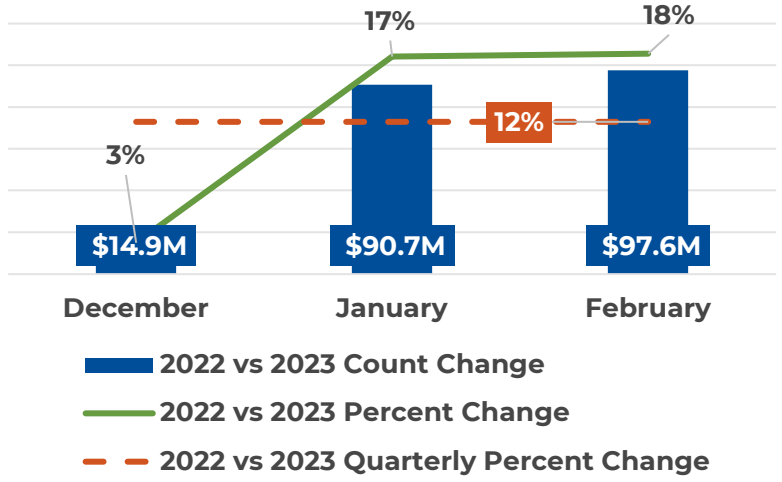




Financials

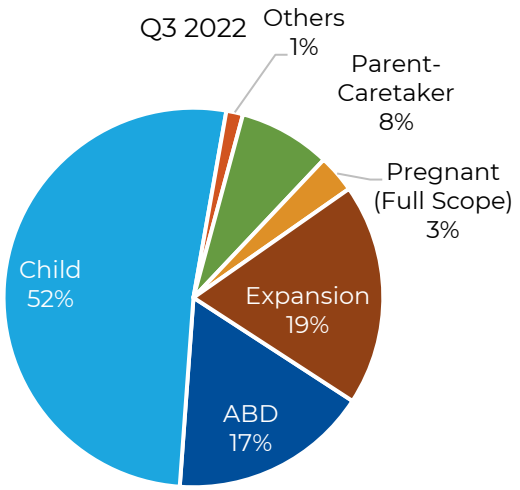
Total Agency Expenditures

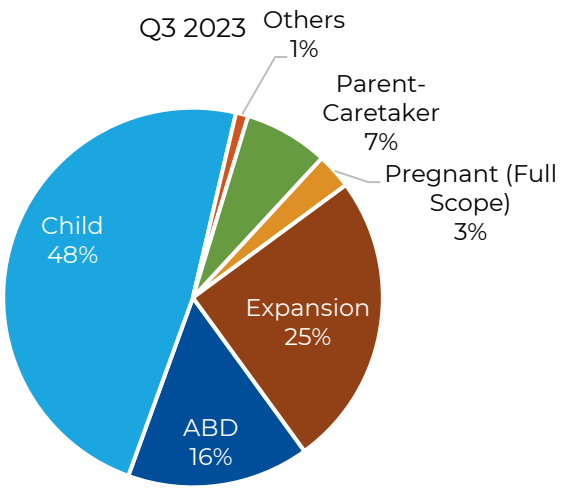




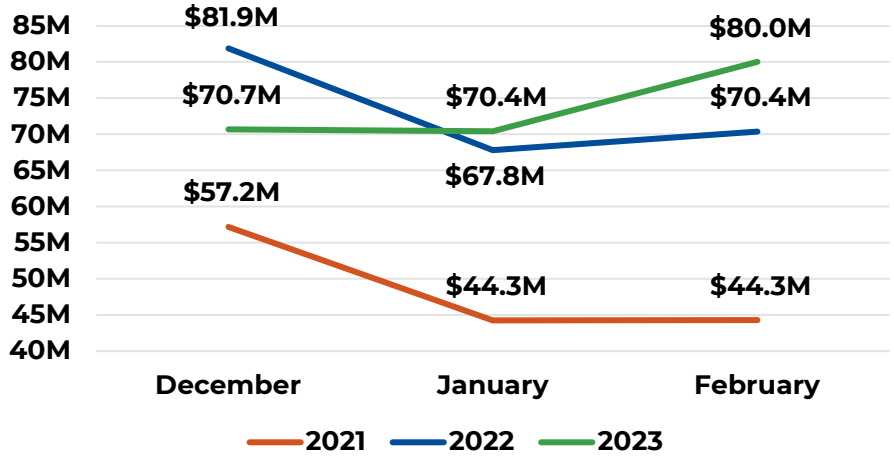
Financials (Cont.)

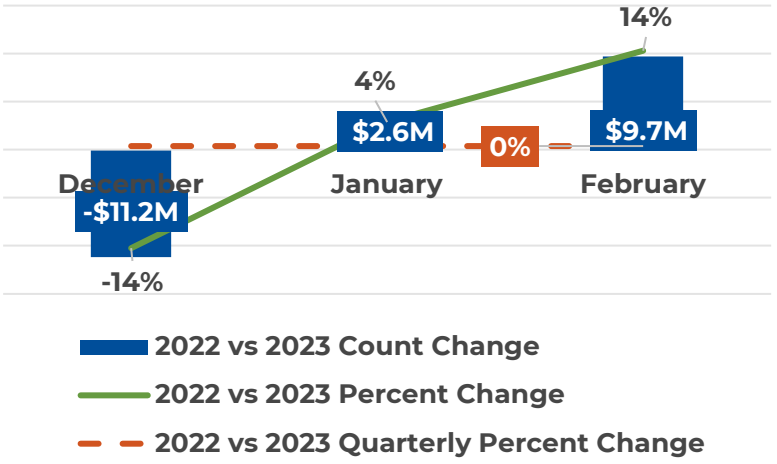
Total Agency Members Utilization by Qualifying Group





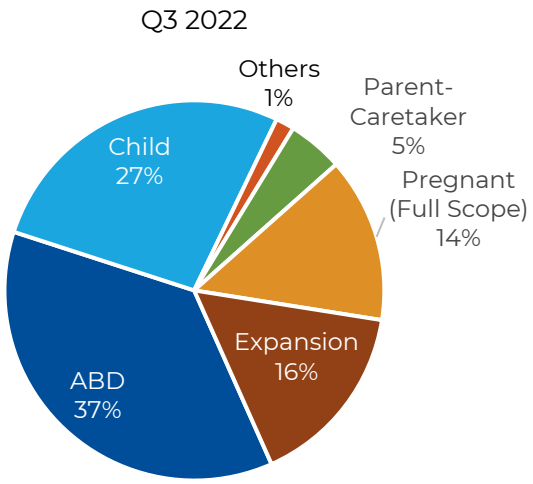
Inpatient Services Expenditures

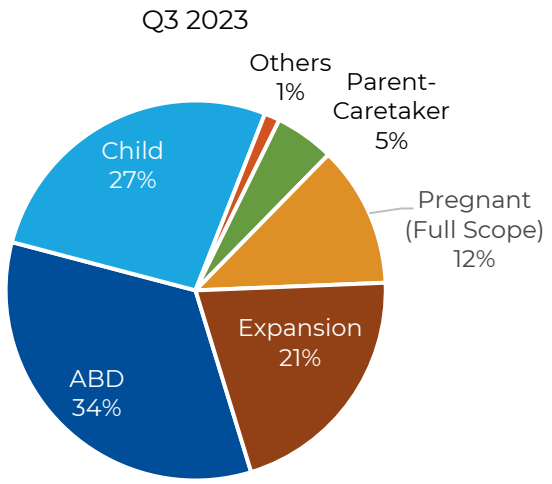




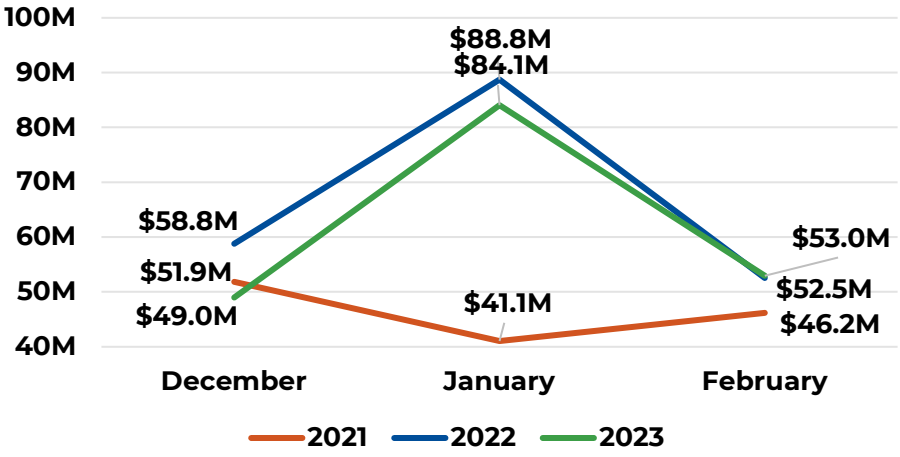
Financials (Cont.)

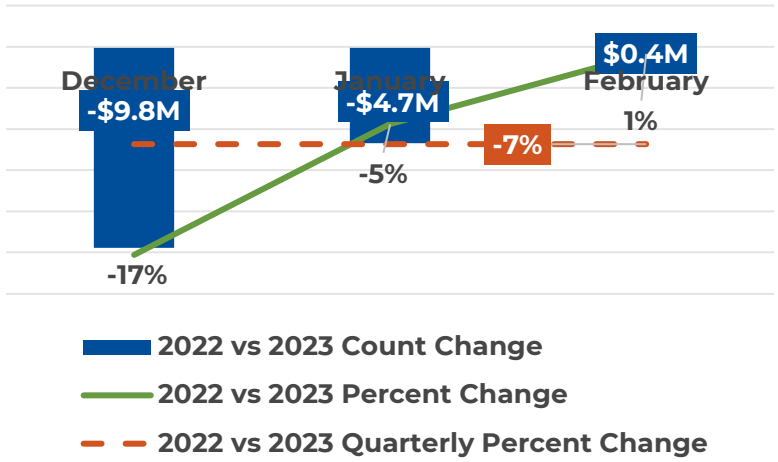
Inpatient Services Members Utilization by Qualifying Group





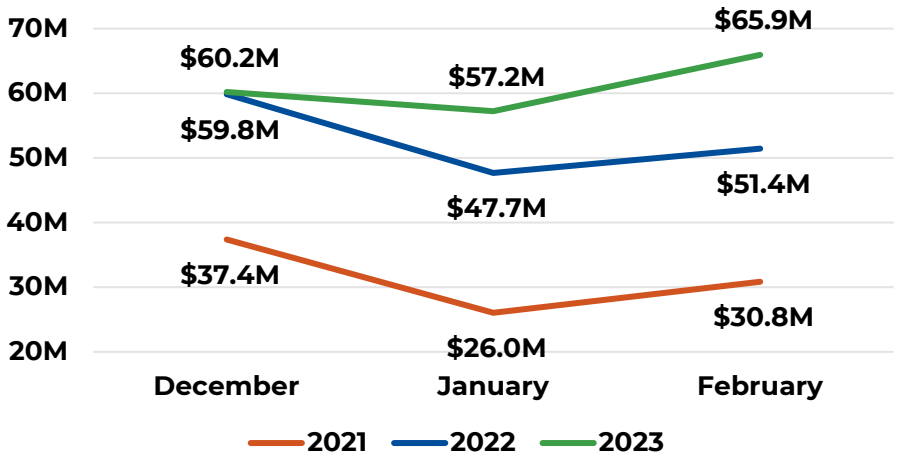
Nursing Facility Expenditures

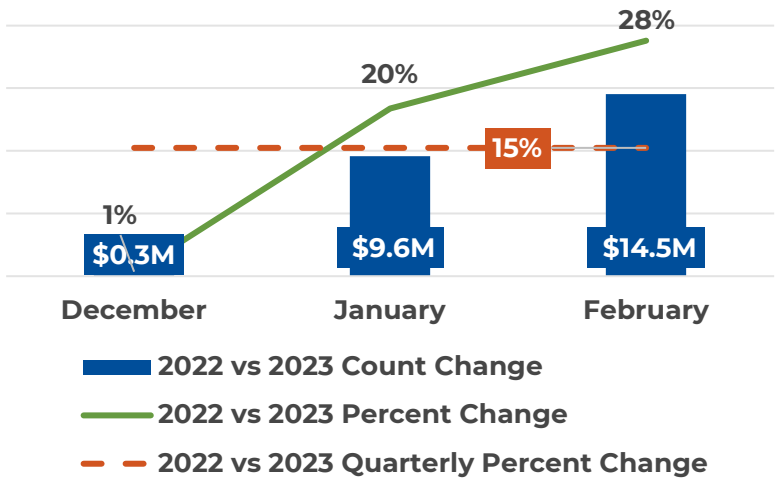




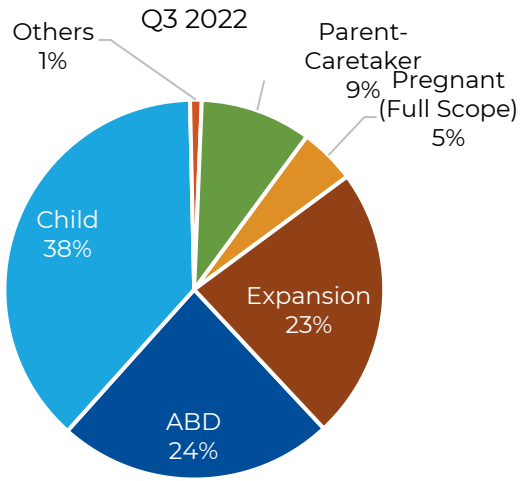
Financials (Cont.)

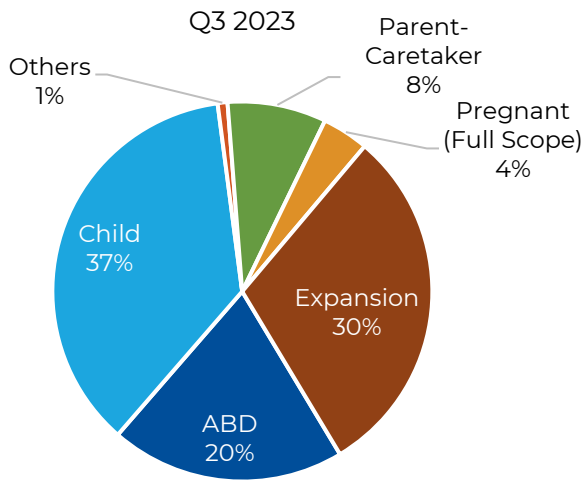
Outpatient Hospital Expenditures





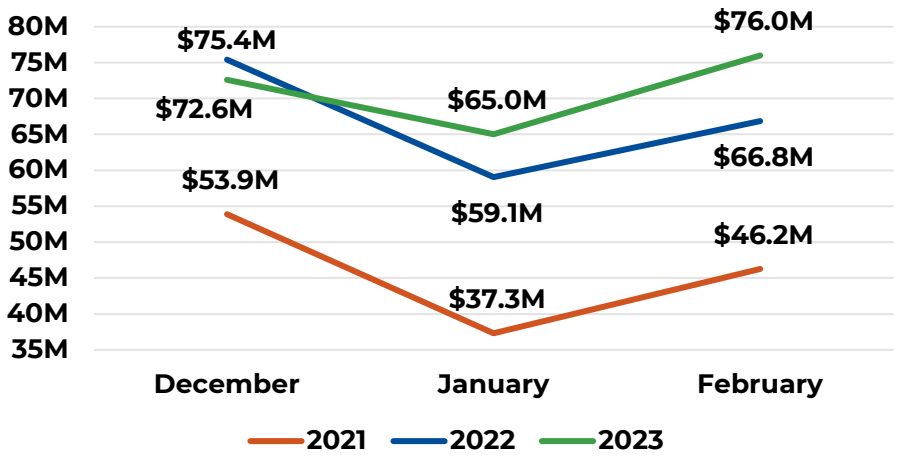
Outpatient Hospital Members Utilization by Qualifying Group

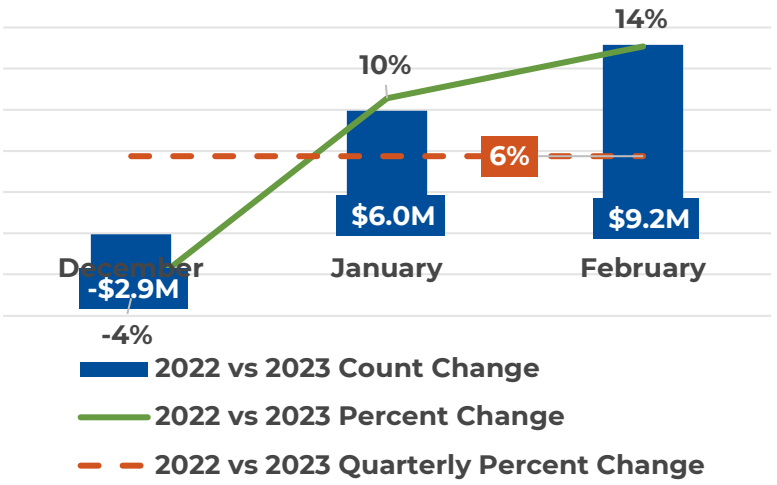




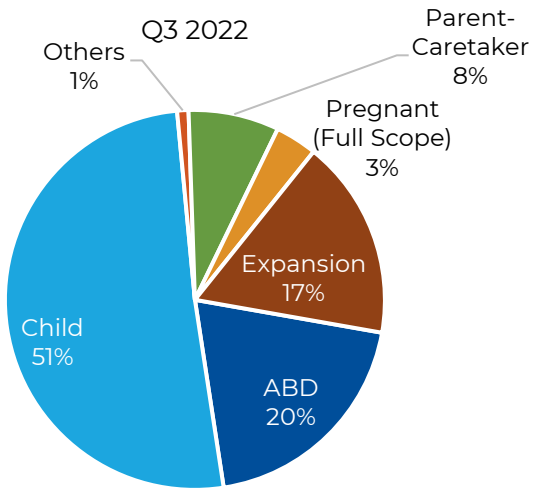
Financials (Cont.)

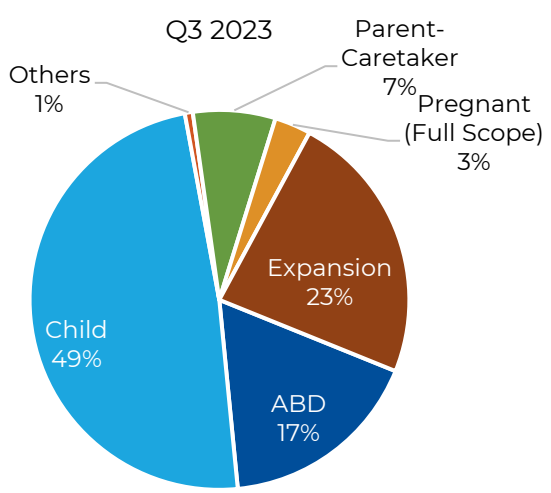
Physician Expenditures





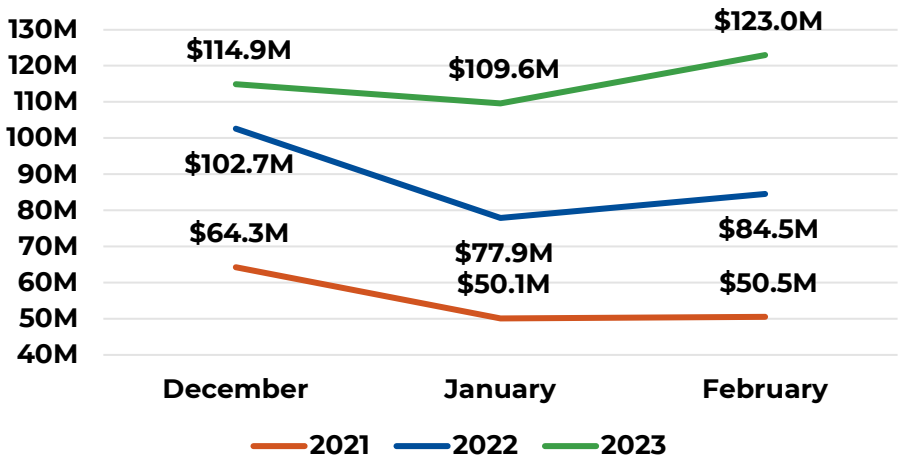
Physician Members Utilization By Qualifying Group

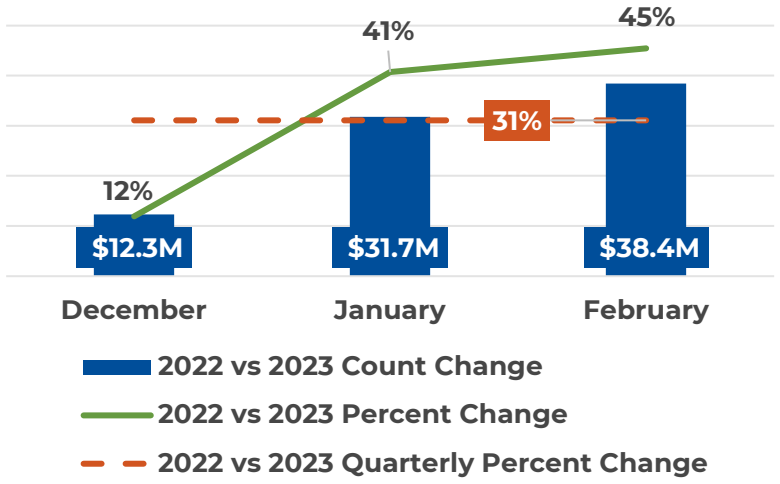




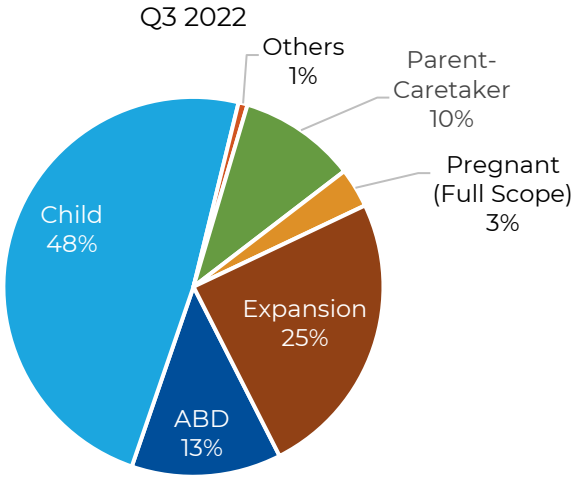
Financials (Cont.)

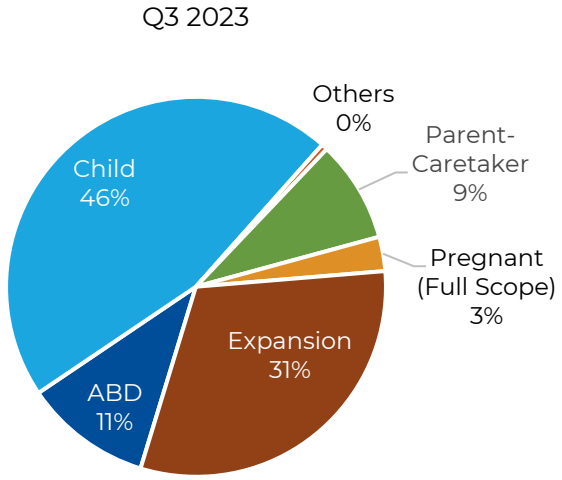
Prescribed Drugs Expenditures





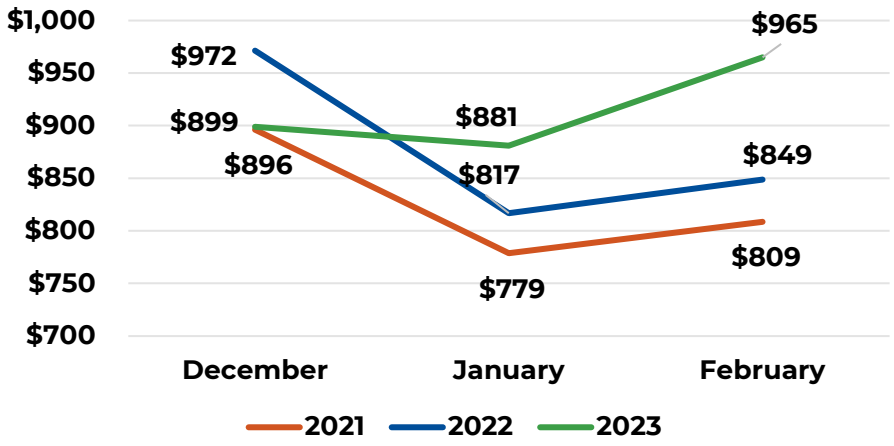
Prescribed Drugs Members Utilization By Qualifying Group

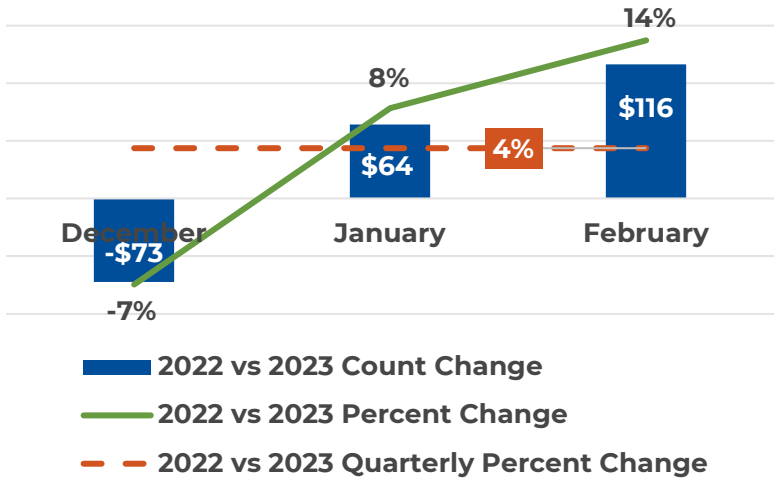




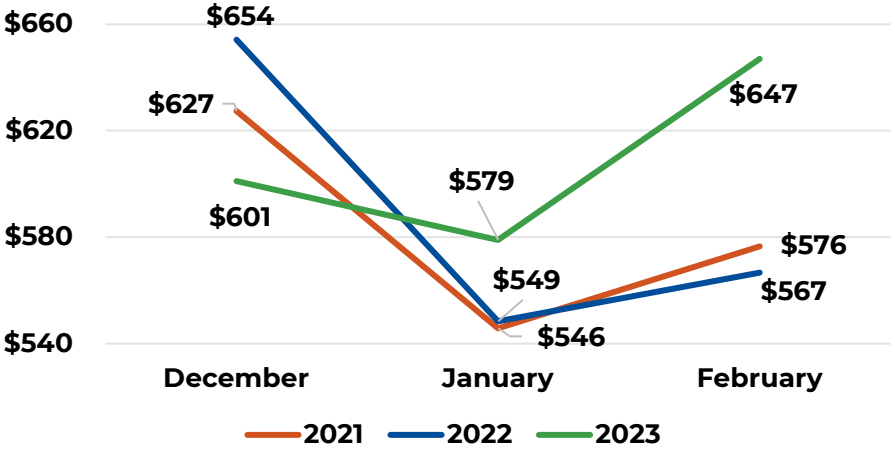
Financials (Cont.)

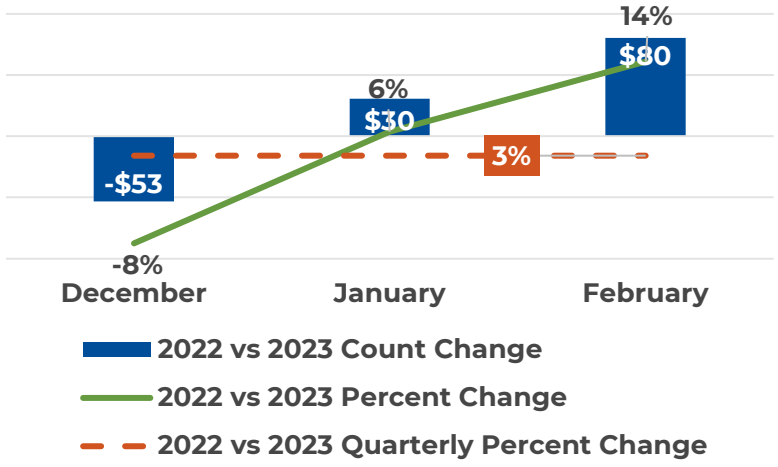
Average Per Total Member Served





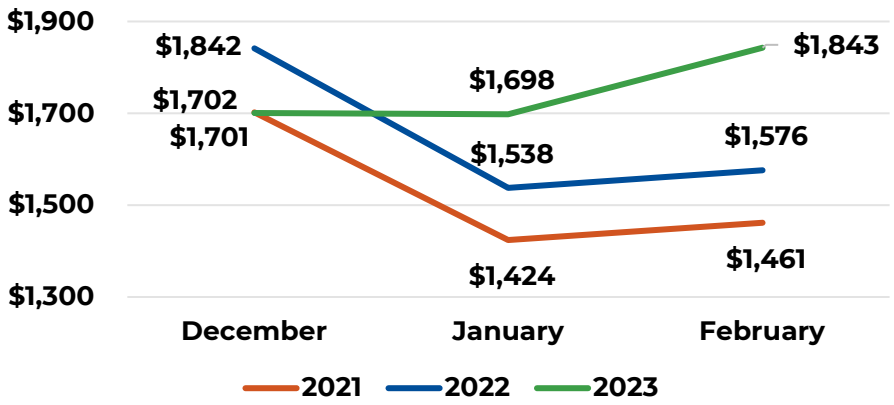
Average Per Child (Under 21) Member Served

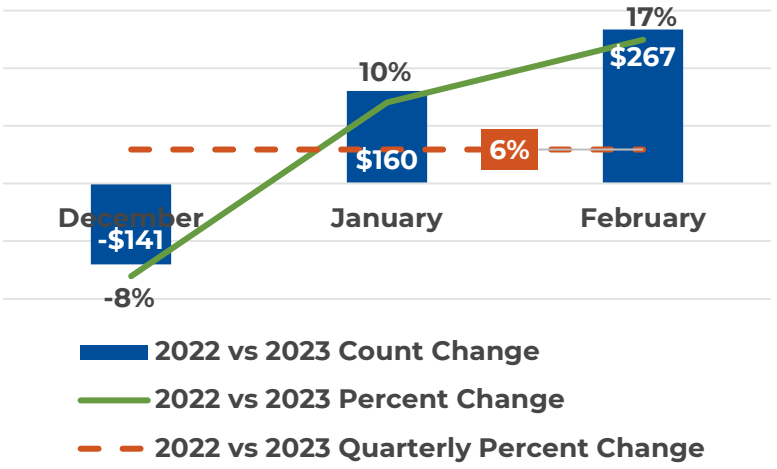




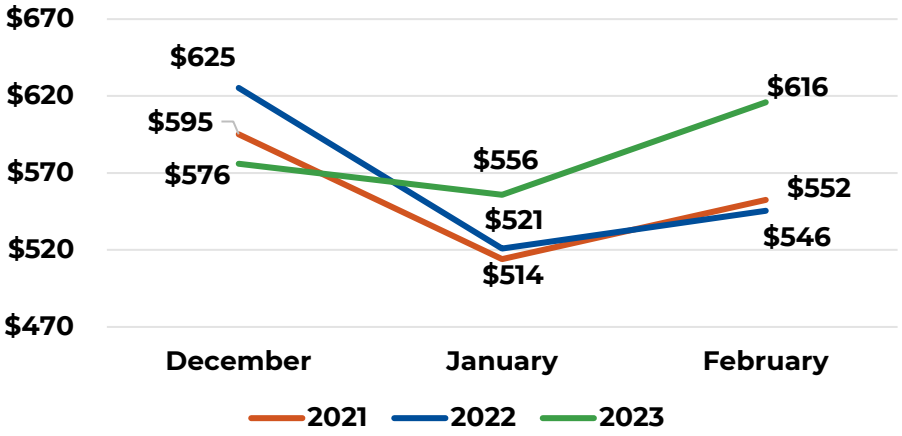
Financials (Cont.)

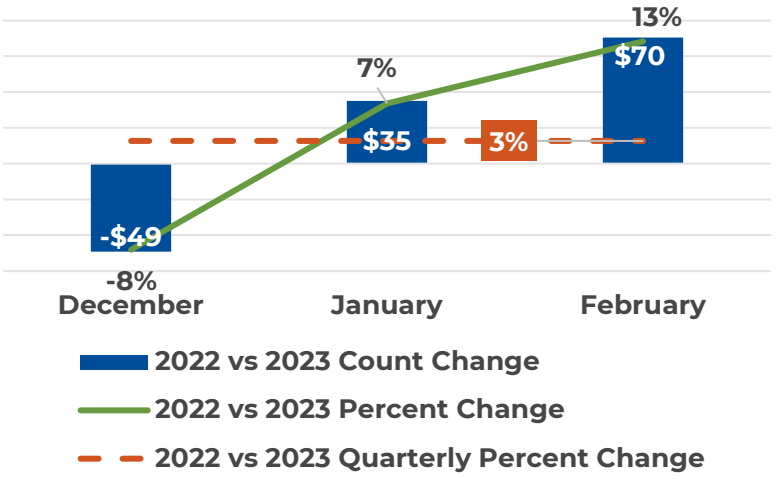
Average Per Aged/Blind/Disabled Member Served





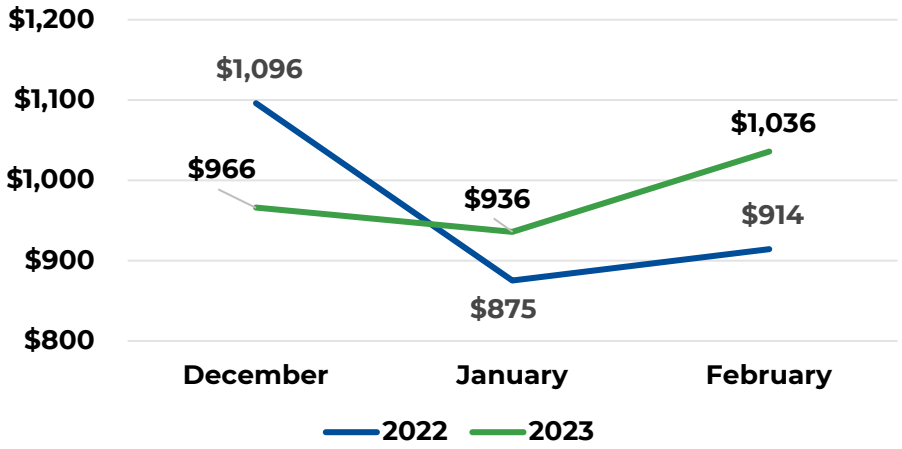
Average Per Children & Parent/Caretaker Member Served

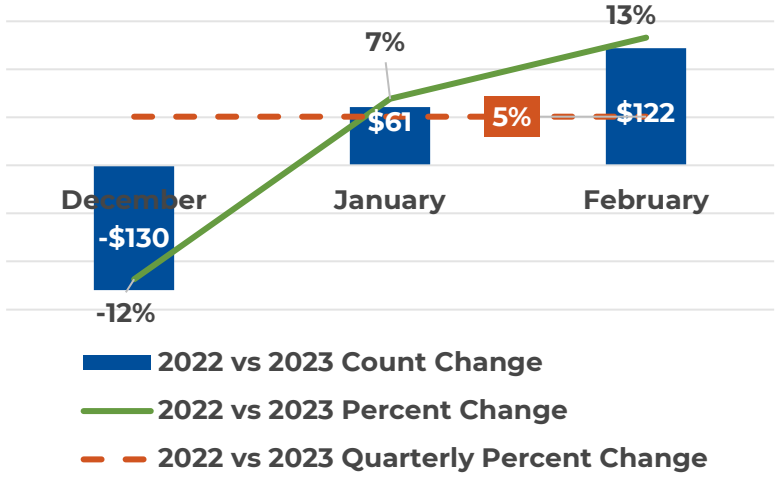




Financials (Cont.)

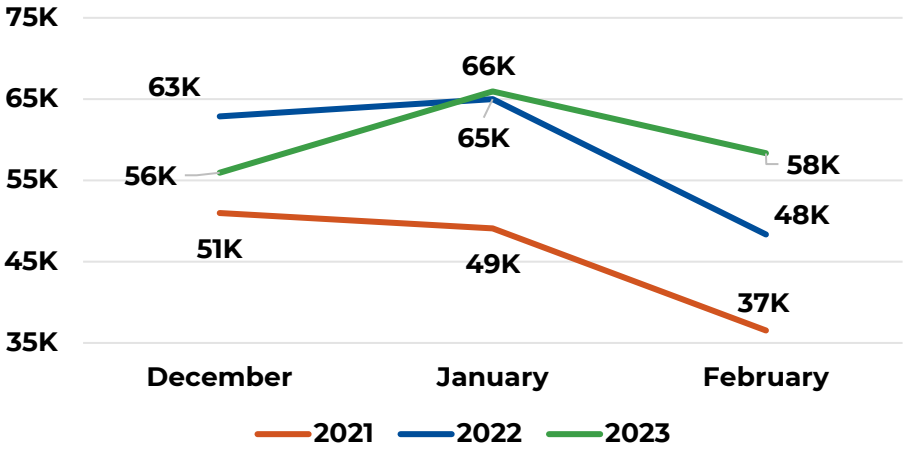
Average Per Expansion Member Served (Effective July 2021)

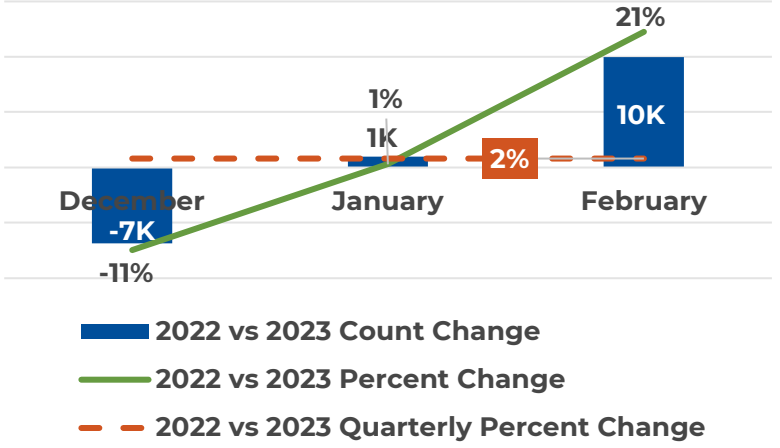




Call Center

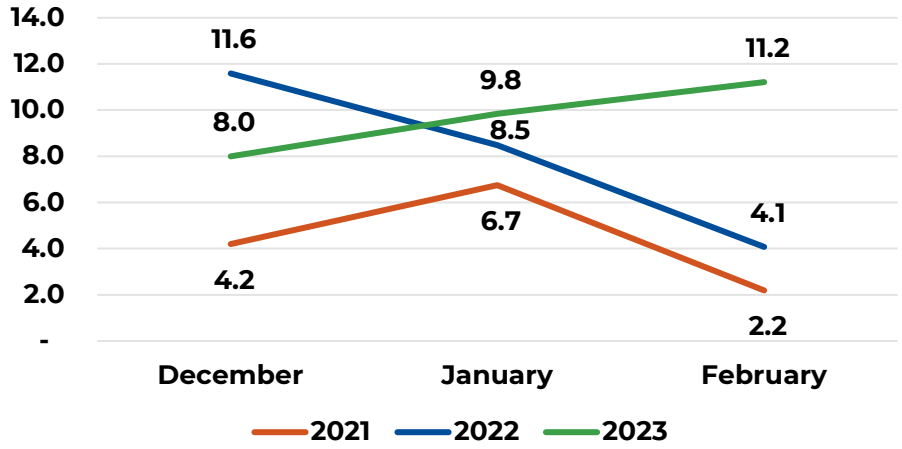
Call Center - Member Calls Answered

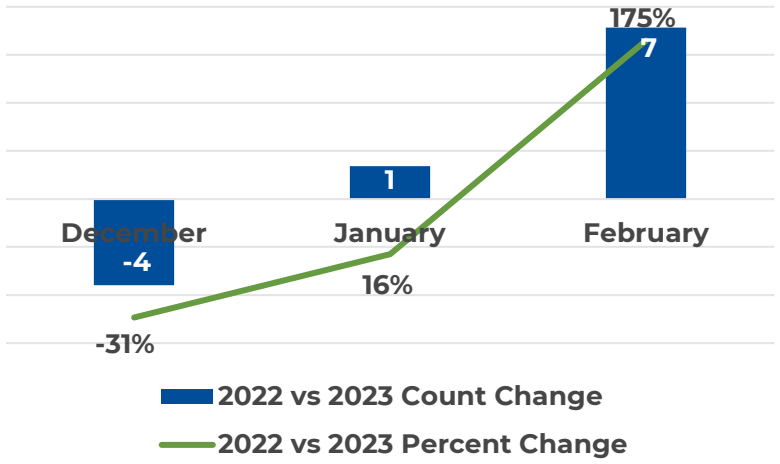




Call Center (Cont.)

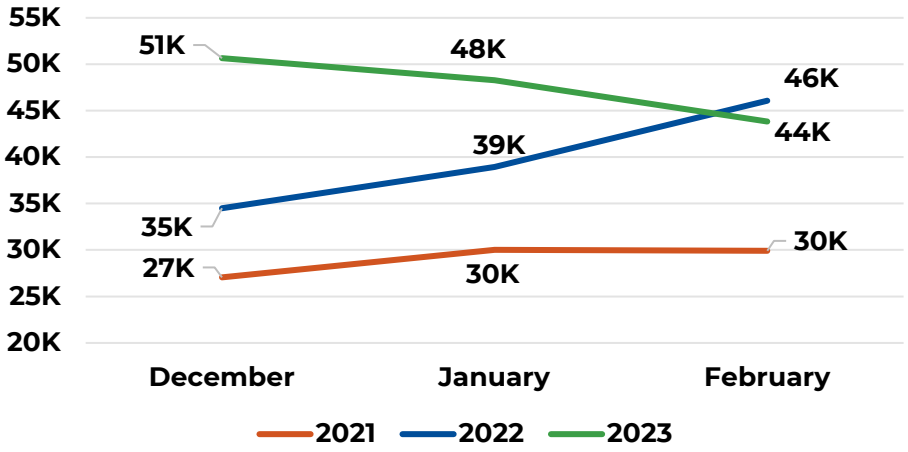
Call Center - Average Wait Time (In Seconds)

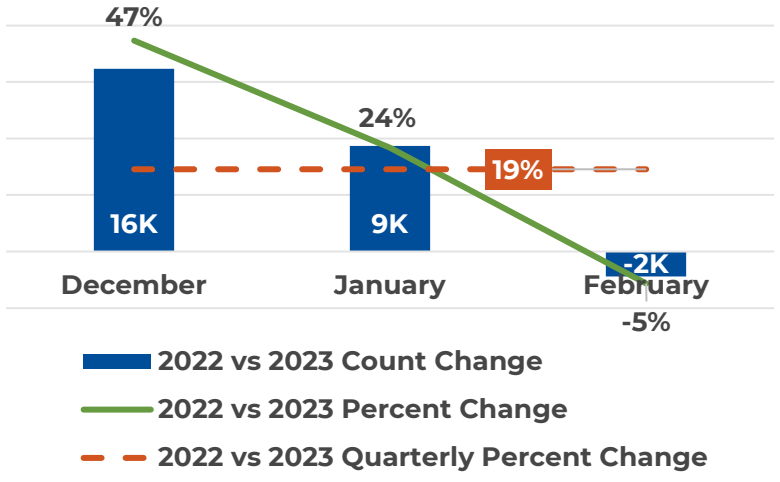




Prior Authorization

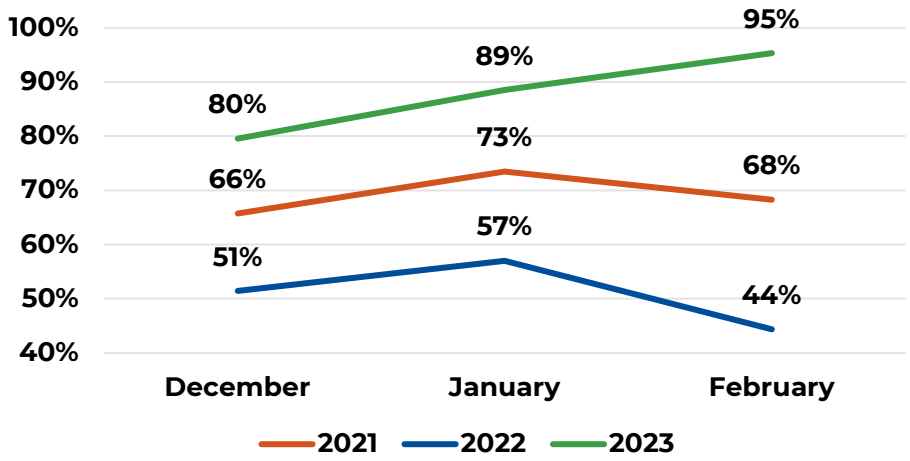
Prior Authorization - Total Combined - Total Completed PA Volume

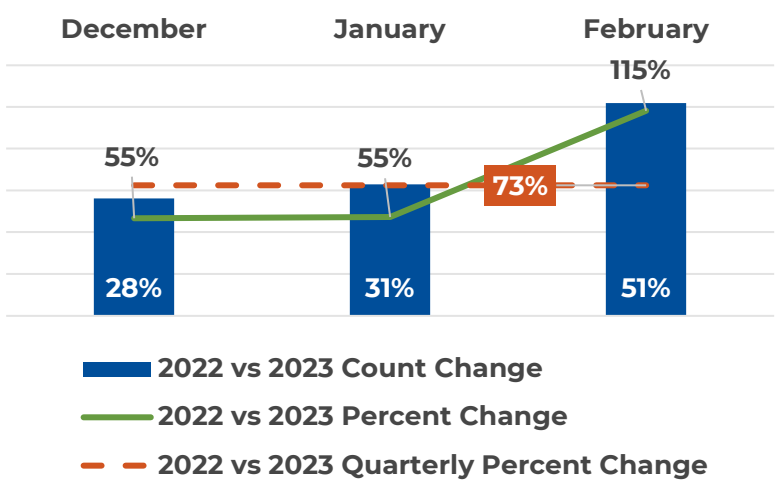




Prior Authorization (Cont.)

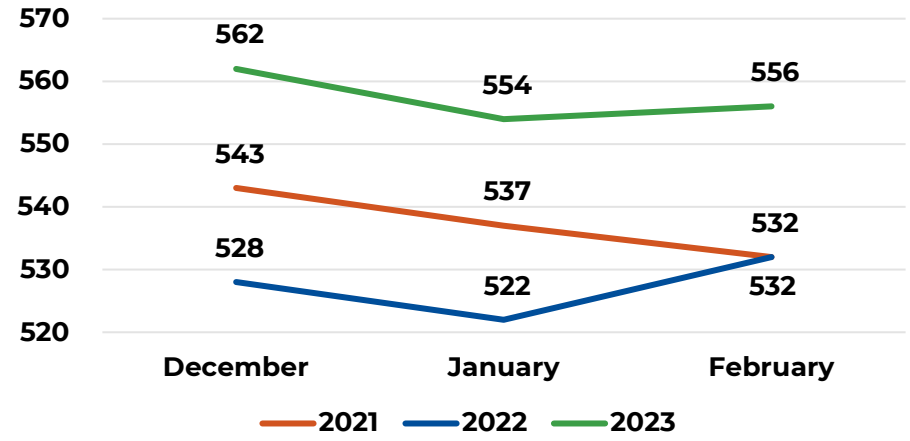
Prior Authorization - Total Combined - Total Percent Completed 0-6 Days

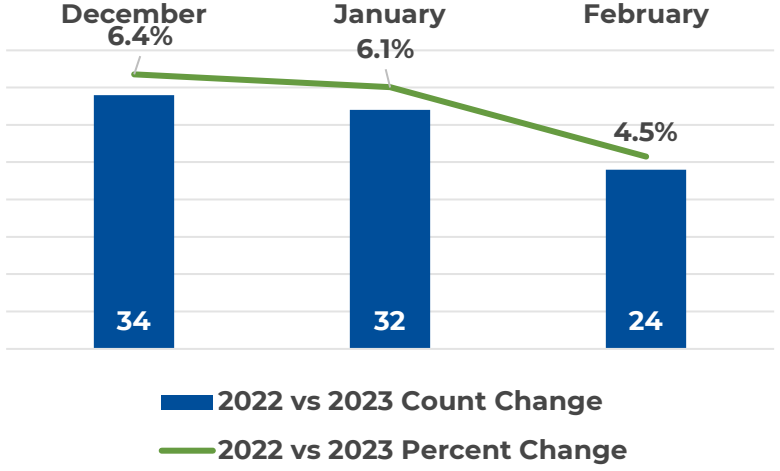




Agency Stats & Provider Network

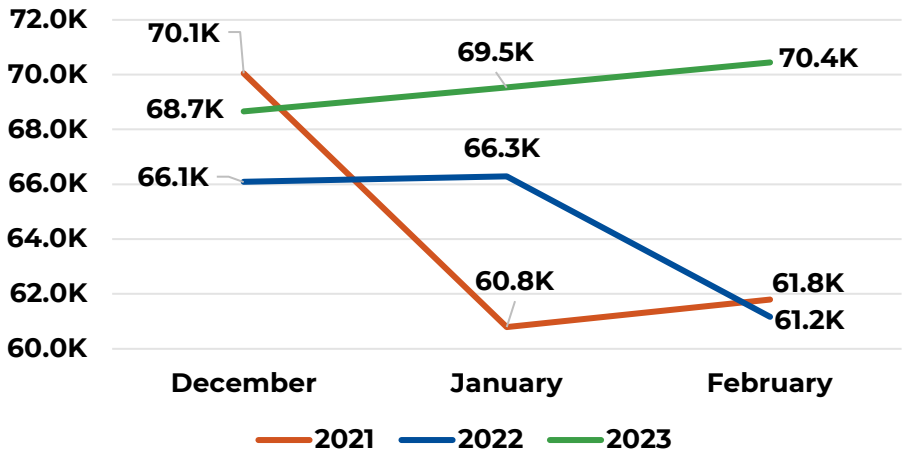
OHCA Admin - Number of FTEs

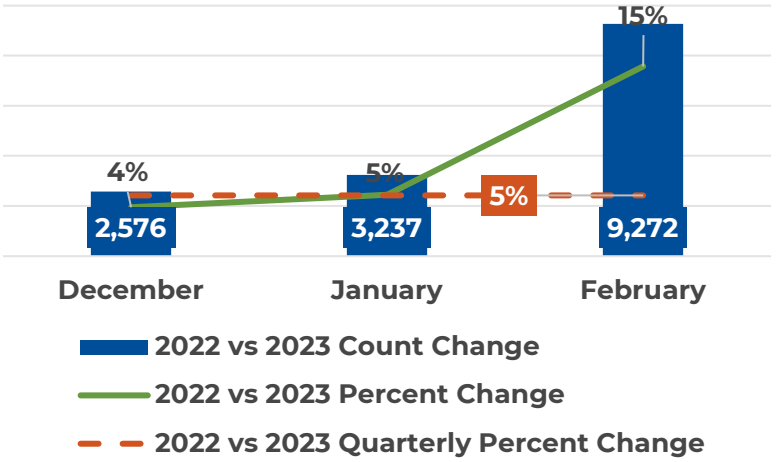




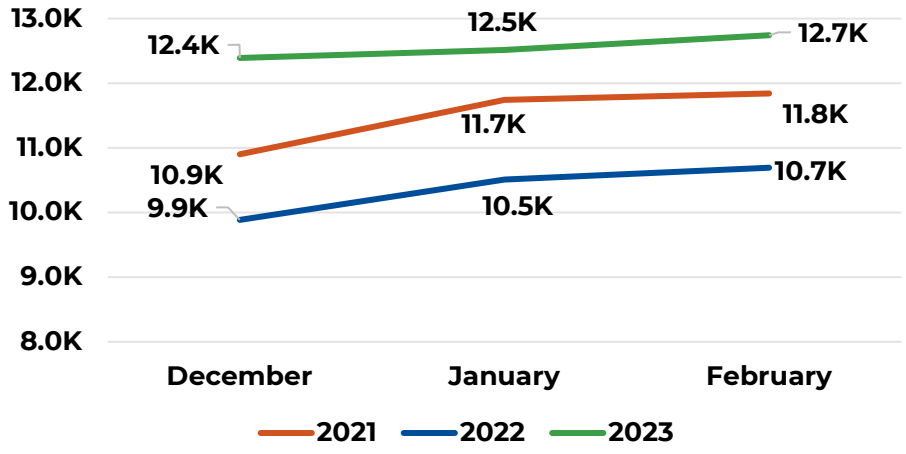
Agency Stats & Provider Network (Cont.)

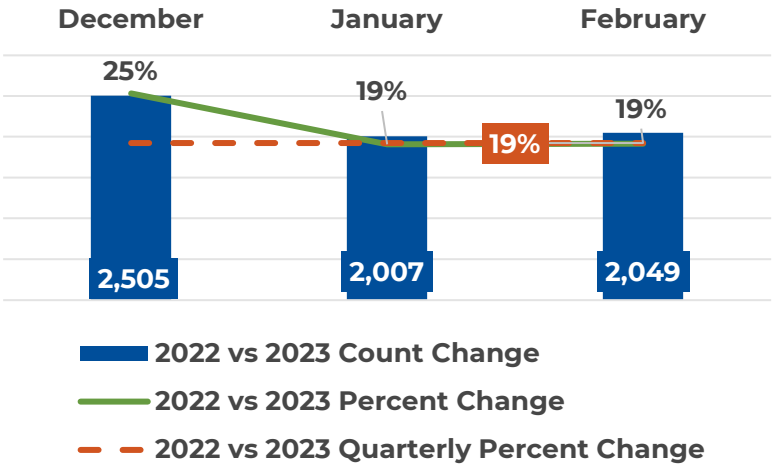
Total Providers





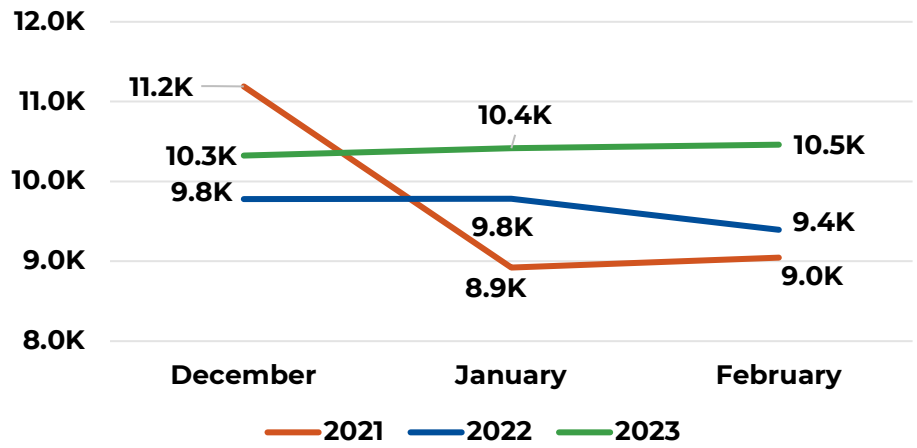
Mental Health Providers (In-State Only)

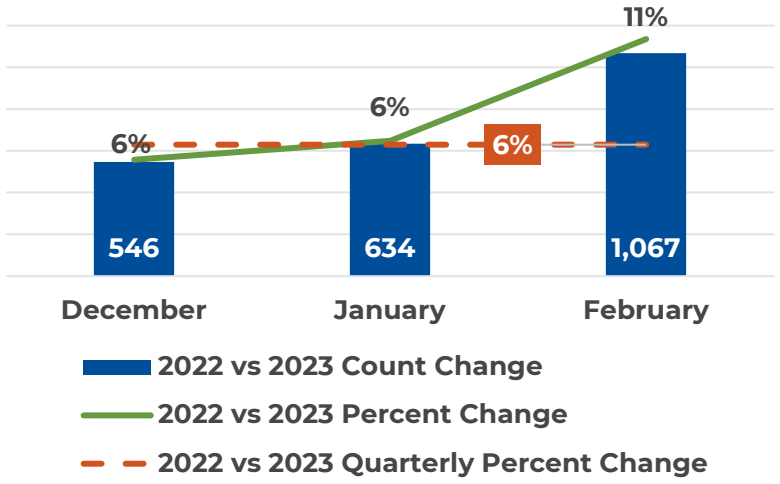




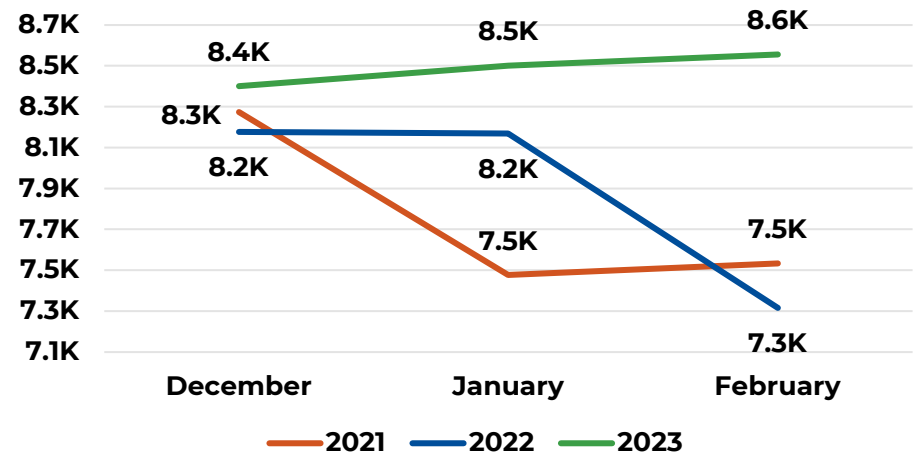
Agency Stats & Provider Network (Cont.)

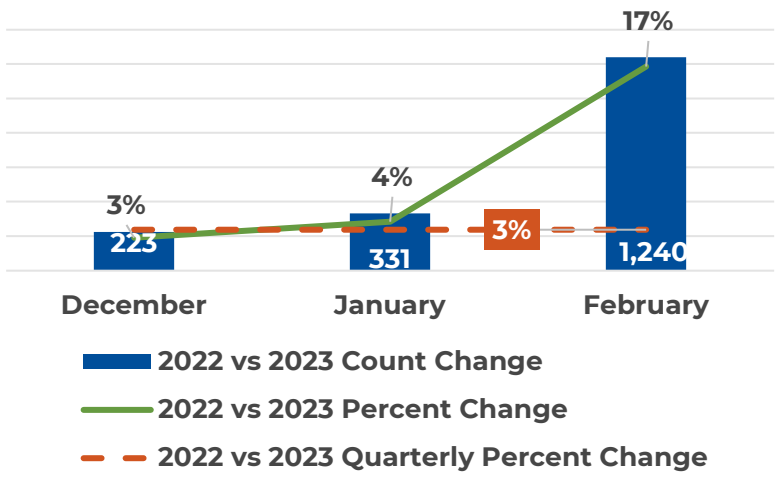
Physicians (In-State Only)





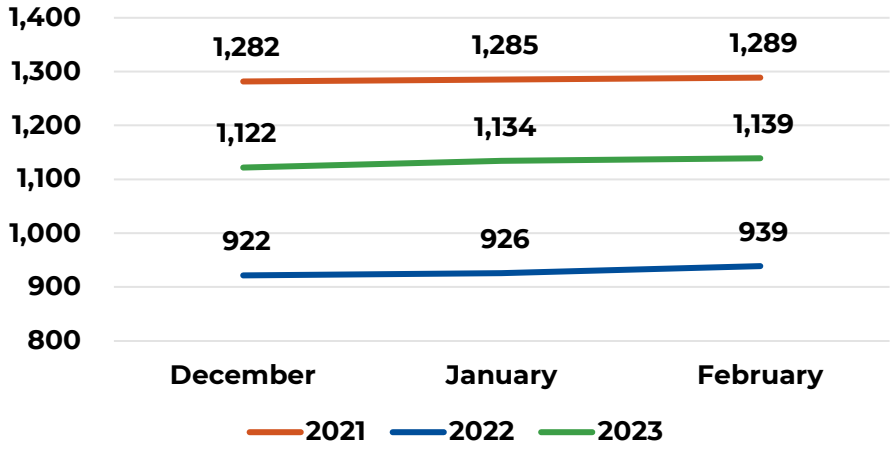
Primary Care Providers (In-State Only)

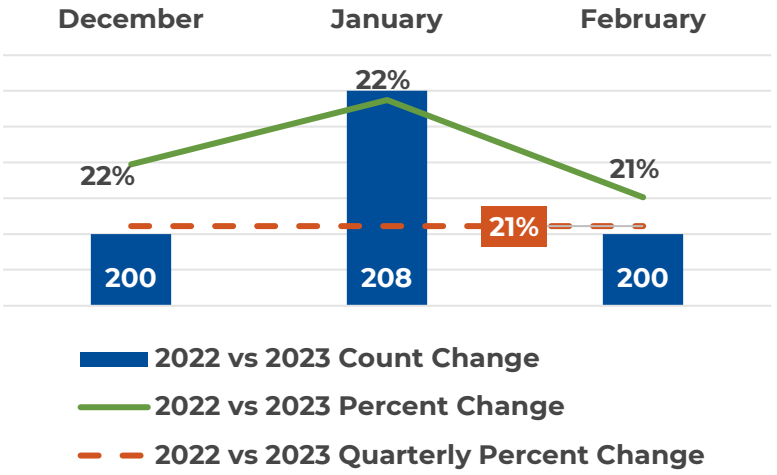




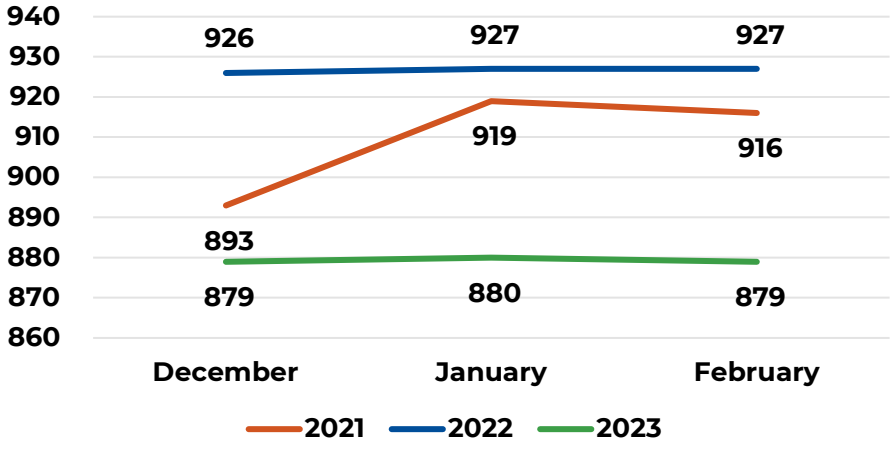
Agency Stats & Provider Network (Cont.)

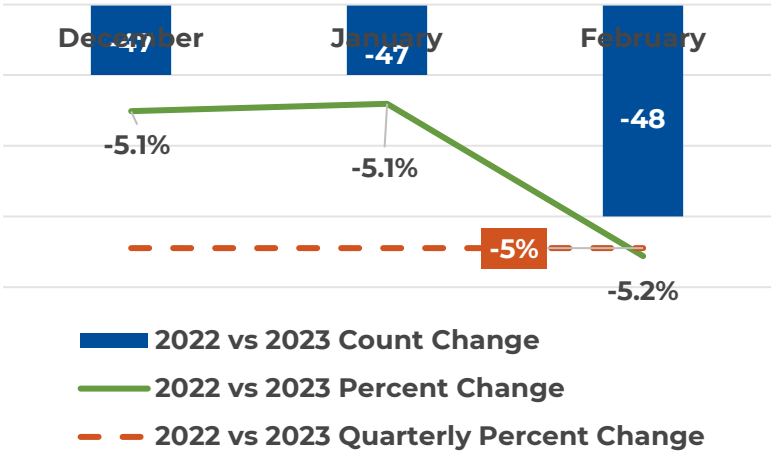
Dentists (In-State Only)





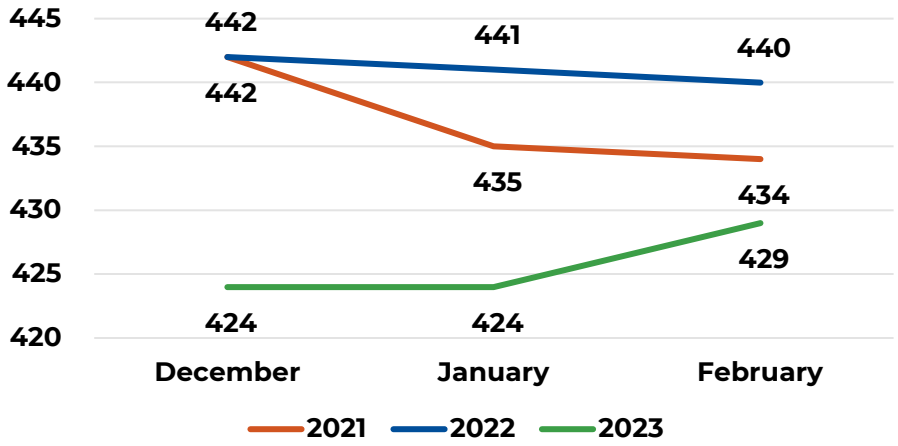
Pharmacy (In-State Only)

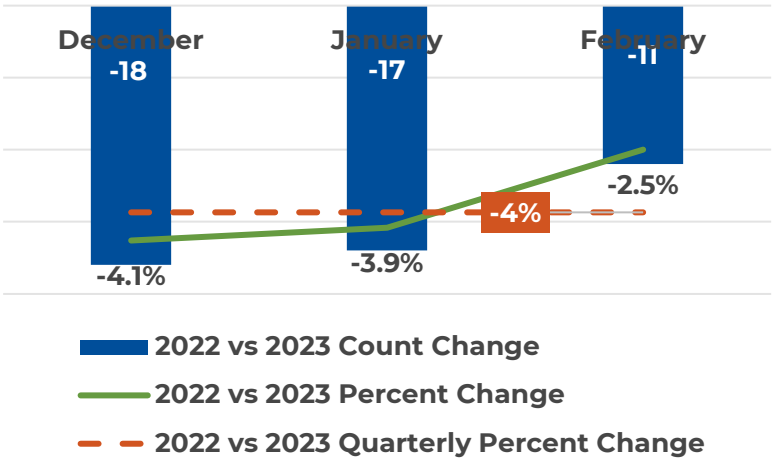




Agency Stats & Provider Network (Cont.)

Extended Care Facilities (In-State Only)





Hospitals (In-State Only)