OKLAHOMA HEALTH CARE AUTHORITY
REGULAR BOARD MEETING
January 15, 2025, 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_IVXpByTuQRKeuv8RsDCYCw
Telephone: 1-669-216-1590 Webinar ID: 160 340 1310

*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. Public Comment……Marc Nuttle, Chair

3. Discussion and Vote on the December 11, 2024, OHCA Board Meeting Minutes……...…..…..Marc Nuttle, Chair

4. Chief Executive Officer Report (Attachment "A")…..……..Ellen Buettner, Chief Executive Officer

    a) Member Moment

5. State Medicaid Director Report (Attachment "B")…….……Traylor Rains, State Medicaid Director

6. Legislative Update……Christina Foss, Chief of Staff

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

    a) Discussion and Possible Vote to Approve the State Plan Amendment Rate Committee Rates pursuant to 63 O.S. Section 5006 (A)(2) under OAC 317:1-3-4 (Attachment "C")

        i. Developmental Disabilities Services Increase

8. Discussion of Report of Administrative……..…Tanya Case
   Rules Advisory Committee and Possible Action Chair, Administrative Rules Advisory Committee
   (Attachment "D")

   The following PERMANENT rules were not previously adopted and are new to the Board:

    i. APA WF # 24-11 Doula Certifying Organization Criteria
    ii. APA WF # 24-17A & B Electronic Visit Verification (EVV) Revisions
    iii. APA WF # 24-28 Crisis Intervention Services Limitations
    iv. APA WF # 24-29 Diagnosis Clarification for Inpatient Psychiatric Services
    v. APA WF # 24-30 Updates to Residential Substance Use Disorder (SUD) Policy
    vi. APA WF # 24-31A & B Removal of Outdated Language
    vii. APA WF # 24-33 In Lieu of Service or Setting (ILOS)
    viii. Employees Group Insurance Division (EGID)
        a. **Chapter 120** Oklahoma Employees Insurance and Benefits Board
        b. **Chapter 145** Employees Group Insurance Division – Administrative and General Provisions

c. **Chapter 150** Employees Group Insurance Division – Health, Dental, Vision, and Life Plans
d. **Chapter 155** Employees Group Insurance Division – HealthChoice Disability Plan

The following PERMANENT rules were previously adopted by the Board under EMERGENCY rulemaking apart from the additions to Item R (APA WF # 24-13).

ix. APA WF # 24-02 Federally Qualified Health Center (FQHC) Substance Use Disorder (SUD) Certification Requirements
x. APA WF # 24-03 Collaborative Care Model Reimbursement
xi. APA WF # 24-05 Private Duty Nursing (PDN)
xii. APA WF # 24-06 Living Choice
xiii. APA WF # 24-07 Secure Mental Health Transportation
xiv. APA WF # 24-08 Biosimilar Reimbursement
xv. APA WF # 24-09 Continuous Eligibility for Children
xvi. APA WF # 24-10 Non-Payment of Provider Preventable Conditions (PPC)
xvii. APA WF # 24-13 Program of All-Inclusive Care for the Elderly (PACE) Policy
xviii. APA WF # 24-14 Hospice Benefit Expansion
xix. APA WF # 24-18 Third Party Liability (TPL) for School-Based Services
xx. APA WF # 24-19 Updating Abortion Policy
xxi. APA WF # 24-20 Pharmacists as Providers
xxii. APA WF # 24-21 Certified Registered Nurse Anesthetists (CRNA) Equalization
xxiii. APA WF # 24-22 High Acuity Tracheostomy Rate
xxiv. APA WF # 24-23 Applied Behavioral Analysis (ABA) Change
xxv. APA WF # 24-24 Medication Assisted Treatment (MAT) Clarification
xxvi. APA WF # 24-25 Psychological Testing Limit Increase
xxvii. APA WF # 24-26A & B Developmental Disabilities Services (DDS)
xxviii. APA WF # 24-27 Hospital Provision of Emergency Opioid Antagonist
xxix. APA WF # 24-34 Community Health Services

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

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

11. Adjournment……..…….Marc Nuttle, Chair

NEXT BOARD MEETING
March 26, 2025, at 2:00PM
Oklahoma Health Care Authority
4345 N. Lincoln Blvd
Oklahoma City, OK 73105

MINUTES OF AMENDED BOARD MEETING
OF THE HEALTH CARE AUTHORITY BOARD
December 11, 2024
Oklahoma Health Care Authority
4345 N. Lincoln Blvd
Oklahoma City, Oklahoma

Manner and Time of Notice of Meeting: A statutorily required public meeting notice was placed on the front door of the Oklahoma Health Care Authority on December 10, 2024 at 1:45 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 December 6, 2024 at 3:15 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, Vice-Chairman Yaffe, Member Case, Member Christ Member Corbett, Member Cruzan, Member Kennedy, Member Jolley Member Leland

ITEM 2 / DISCUSSION AND POSSIBLE VOTE ON THE SEPTEMER 17, 2024, OHCA BOARD MEETING MINUTES
Chairman Nuttle, OHCA Board Chairman

MOTION: Member Jolley moved for approval of the September 17, 2024, board meeting minutes, with the correction. The motion was seconded by Vice-Chairman Yaffe

FOR THE MOTION: Chairman Nuttle, Vice-Chairman Yaffe, Member Case, Member Christ Member Corbett, Member Cruzan, Member Kennedy, Member Jolley Member Leland

ITEM 3 / CHIEF EXECUTIVE OFFICER REPORT
Ellen Buettner, Chief Executive Officer

CEO Buettner invited Clay Franklin, President of Oklahoma Complete Health, to present this month's member moment.

CEO Buettner highlighted OHCA's Servant Leadership Key Principle, highlighting the EGID staff that worked through the upcoming option period.

Key Initiatives Update:

- Programmatic:
  - Enhancement of School-Based Services – CEO Buettner stated that OHCA is in the process of working with the State Department of Education to implement a School-Based Services manual and billing guide that was received earlier this year. OHCA is also working with them on determining how to enhance those School-Based Services in terms of what OHCA offers and to whom they offer services to, which are the children who Medicaid eligible, and on an IEP. OHCA is looking to expand that outside the IEP context and add additional services including substance abuse related services, medication administration management, and specialized transportation services.
  - Juvenile Reentry Waiver – CEO Stated that this waiver was a mandate of the Consolidated Appropriations Act and would provide reentry services for juveniles who are exiting the juvenile justice system. OHCA is on track to submit its plan to CMS by January 1, 2025. CMS is giving states leeway in how they implement, so long as they get the plan submitted.
  - Correctional Reentry Waiver – Similarly, OHCA is participating in conjunction with the Department of Corrections and the Department of Mental Health on the Correctional Reentry Waiver Policy Academy that is sponsored by the US Department of Justice. The team is in the early stages of formulating a strategic plan with the other agencies to look at the next steps moving forward.
  - Public Health Emergency Unwind – CEO Buettner reminded the Board about an audit that CMS would open on some states and their unwind processes. She was happy to announce that the audit has concluded and OHCA received the glowing remarks from CMS, no reportable findings. CMS was incredibly appreciative of the staff and the plan that OHCA executed. Member Corbett asked if there were any other states that experienced clawbacks. CEO Buettner stated that she was not aware of any.
  - Primary Care and Rural Health Initiatives – CEO Buettner stated that staff are still talking through how to meet primary care spend requirements that was mandated by Senate Bill 1337, as well as, just broadly speaking, what can OHCA do to help improve rural health access and ensure that there is sustainable

access to care in those parts of the state for the future. OHCA is in the process of having discussions with the Oklahoma Hospital Association, Osteopathic Association, and Academy of Family Physicians. All parties have been engaged and coalesced around the idea of an advanced primary care model in terms of other opportunities for regional collaborative care models where all can coalesce and appreciate the unique needs of different parts of the state, so we can tailor the investments to make the biggest difference possible.

- Administrative:
    - EGID Move – EGID will be moving into OHCA this week, in the garden level. Member Corbett asked what the scope of EGID is, as it relates to the oversight of the OHCA board. CEO Buettner stated that the commercial contracting piece that was administered by EIGD will stay with OMES. The biggest function is the Health Choice administration, which has moved over to OHCA. Statutorily, even after the legislative move, EGID has a governing board that oversees their finances and compliance, so they will continue to meet. OHCA is working on a legislative cleanup bill for EGID to ensure everyone's roles and responsibilities are defined.
    - Energage Survey – CEO Buettner stated that OHCA participates in an annual Energage Survey to measure employee engagement, satisfaction, and commitment. Ms. Cooper will give a more fulsome report during her update.
    - Call Center Metrics – CEO Buettner updated the board on the call center metrics. After the PHE Unwind, OHCA was still experiencing high call volumes compared to a couple of years ago, as well as high wait times. One of the things OHCA continues to do is invest in understanding why it is members are calling, what is driving this type of volume even with the Managed Care transition. With the implementation of Qualtrics, OHCA was able to see that a lot of the calls are related to eligibility efforts, which wouldn't necessarily be directed to the plans. Also, a lot of the calls were related to members who couldn't find something on the website. That information was great to know, because those are certainly fixable problems. CEO Buettner stated that month to month, OHCA has seen a decrease after some concerted staffing efforts.
    - Utilization Management Efforts – With the new Federal Administration moving in, OHCA wants to be intention and mindful about reviewing the services that are provided to ensure that OHCA is seeing the outcomes that it hoped to see when the State and the Federal Government invested money in the services. OHCA has an internal group that is making some targeted efforts to see what outcomes are produced from the services that were added and if there were any changes that needed to be made. CEO Buettner stated that the team will share opportunities and insights as they move forward in that process. Member Corbett asked if there were any early indications of the intent and why Oklahoma went to Managed Care, in terms of increasing preventative care, wellness visits, and screenings. Is OHCA seeing that in the data or is it too early to tell. CEO Buettner stated that it is a little too early. The team is working on setting baseline data this year. She added that, broadly speaking, what OHCA sees looking forward to next year with the budget, though, is, OHCA continues to see a lot of spend in inpatient hospitalizations, primary care, and behavioral health care. Member Case asked how OHCA will receive information related to OHCA from the Efficiency Portal. CEO Buettner stated that she was not sure but believes that is a public portal that OHCA would be able to access. OHCA has been working closely with existing and new legislative leadership so that they understand the OHCA programs from a programmatic and budgetary perspective. Her hope would be that if there is anything in there that catches someone's attention, that OHCA could have conversations with them about it.

Traction Goals – CEO Buettner highlighted Kristine West and her team for their work on the US Department of Treasury Deathmatch. The work on this was a Program Integrity effort, especially with the move to a Managed Care Environment paying a capitated rate. Currently, there is a delay in receiving information and making, identifying, and pursuing recovery of inappropriate payments based on those deathmatch inefficiencies. OHCA Program Integrity began exploring options to prevent the inappropriate payments on the front end. The Program Integrity team is finalizing the contract with the US Department of Treasury which oversees the program, which would help OHCA get ahead of any potential eligibility errors moving forward.

Stakeholder Engagement – CEO Buettner highlighted a few of the engagements with various stakeholders. The Osteopathic Association invited CEO Buettner and Ms. Foss to the hospitals in Enid to meet with their leadership. CEO Buettner and Mr. Rains also met with the George Kaiser Family Foundation to discuss maternal health efforts. The Foundation fund and operate several targeted programs aimed at supporting women and families. Leadership from OHCA continue to meet with new and continued House and Senate leadership.

CEO Buettner was excited to announce that, for the fifth year in a row, OHCA has been named a top place to work in Oklahoma. OHCA will announce the news publicly next week.

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

ITEM 4 / STATE MEDICAID DIRECTOR REPORT
Traylor Rains, State Medicaid Director

Mr. Rains provided a State Medicaid Director update, which included information on the Quality Withhold Program, Transition to Value-Based Payments, and the SoonerSelect Monitoring and Oversight award. Regarding Member Corbett's Clawback question, Mr. Rains stated that he has not seen clawbacks, but CMS did require some states to stop their unwinding due to problems with their process.

Member Corbett asked what the 1% means in terms of dollars. Mr. Franklin stated that it would be 1% of a billion dollars. The hope is to pay that amount back. Member Jolley followed up, asking what the impact on the load flow is. Mr. Rains stated that it will vary at the provider level., but added that in general, it does incentivize the plans especially in the first implementation year. The margins are tight, so every dollar will matter to the local market. There will be a financial incentive for the providers, who will start getting financial incentives based on getting a certain threshold, which will be even more important because the medical home payments will go away in July. Regarding the transition to Value-Based Payments, Member Case stated that we can't assume that because we're withholding 1%, we can't not assume that that's how the plans are incentivizing their PCPs and that is it up to the plans as to how they incentivize their physicians to meet these targets. Mr. Rains stated that that was correct, but OHCA would need to approve it. Member Christ asked how much transparency there will be for providers to be able to see how they are doing against those targets. Mr. Rains stated he would need to follow up on that but added that a lot of that would be dependent upon the Contracted Entities, how they measure it and what kind of technology resources or portals they provide to the members. He added that he would follow up with more specifics at the next meeting.

For more detailed information, see attachment "B" of the board packet.

ITEM 5 / CHIEF ADMINISTRATIVE OFFICER REPORT
Elizabeth Cooper, Chief Administrative Officer

Ms. Cooper updated the board on the Energage survey sent to all employees and upcoming training. OHCA works with Energage to send the annual survey to all OHCA employees around August or September. Ms. Lamb-Hornby and her team are still working through the feedback. Overall, OHCA had an 84% response rate, totaling about 534 employees. Through the survey, OHCA received about 1,400 comments from staff, including comments that say the agency is doing something well, as well as comments suggesting an opportunity for improvement. The highest scoring theme reflects that employees feel that they are doing something meaningful and ranked 78%. Over the last year, the statement that the organization is moving in the right direction increased 5%. The team will be able to provide more detailed information about the results after their review.

OHCA is working on rolling out an ethics training for all OHCA staff in January. OHCA is working with Linda Clark, who's a partner OHCA has worked closely with on implementing core theory competencies and other leadership strategies throughout the agency. This will be a virtual training course and will also be recorded so it can be used for new employees who are onboarding throughout the year. Ms. Cooper announced that Mike Williams will be joining OHCA as the new Deputy Chief Administrative Officer next week.

ITEM 6 / CHIEF OF STAFF REPORT
Christina Foss, Chief of Staff

Ms. Foss provided a brief legislative update, adding that OHCA leadership has been meeting with new legislative leadership to discuss OHCA's budget and legislative priorities for the new year. OHCA will host a legislative deep dive for the new, as well as current legislative staff to provide an overview of all OHCA components. The deep dive will be similar to the board orientation we provide, and will include overviews of SoonerSelect implementation, budgetary items, and district-specific Medicaid impacts for each legislator. Ms. Foss stated that this legislative session will mainly focus on budget, which Mr. Morris will go into more detail during his budget presentation. She added that OHCA will have a large budget request to maintain current operations, which includes some unfunded mandates and a change in FMAP. A total of 3,676 bills have been submitted for the upcoming session, five of which were submitted by OHCA.

- EGID Clean Up Bill – This bill will clean up references since EGID has transitioned under OHCA. The clean up will also clarify the roles and responsibilities between OHCA and EGID.
- Medicaid Managed Care Regulation Clarification – OHCA has been working with the Insurance Department to understand Title 36.
- Reimbursement Methodology for Nursing Homes – This is a carryover bill from last session. The new methodology would emphasize quality and enhance OHCA's Pay for Performance Program, as well as establish a price-based methodology and strictly for any new dollars that would be coming into the system.
- Paid Family Caregiver Program – This is also a carryover bill from last session and would allow caregivers, under the supervision of a nurse and employed by a home health agency, to be reimbursed for services provided to that child.

- Medical Advisory Committee Update – This request bill is due to federal requirements, which requires 25% of the MAC also be represented on OHCA's Member Advisory Task Force. The bill would also require a representative from a managed care plan or association that represents managed care.

The deadline for filing language will be in late January, so we are unsure what all that looks like yet. Member Corbett asked to what level of involvement is OHCA planning to have engagement with federal delegation. CEO Buettner stated that some of those conversations have already started via Mr. Rains role at the National Association of Medicaid Directors. OHCA also has meetings set up with the congressional delegation to get their thoughts moving forward and make sure they understand what programs OHCA has in place. Ms. Foss introduced Bradley Downs, who will be the new Legislative Liaison at OHCA. Member Case asked if the board members could receive the same information provided to the legislators, since some members of the board will be interacting directly with them. Ms. Foss stated she would get that information to them.

ITEM 7 / DISCUSSION OF REPORT FROM THE PHARMACY ADVISORY COMMITTEE

Dr. Jeff Cruzan, Pharmacy Committee Member

Member Jolley asked Member Cruzan to distinguish other treatments available versus other options available compared to other treatments first line and not first line. Member Cruzan stated that there are other options and there are step measures that OHCA goes through in order to get to the other items first.

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")

Item:	Drug Name:	Used For:
i.	Filsuvez® (birch triterpenes 10% topical gel)	Epidermolysis Bullosa (EB)
ii.	Kisunla™(donanemabazbt)	Alzheimer's Disease (AD)
iii.	Defencath® (taurolidine/heparin)	Prevention of Dialysis Catheter-Related Blood Stream Infections
iv.	Wegovy® (semaglutide)	Risk Reduction of Major Adverse Cardiovascular Disease (MACE)
v.	Avzivi® (bevacizumab-tnjn) Fruzagla® (fruquintinib)	Colorectal Cancer (CC)
vi.	Accrufer® (ferric maltol)	Iron Deficiency Anemia (IDA)
vii.	Exblifeb® (cefepime/enmetazobactam) Meropenem 2 gram Nitrofurantoin 50mg/5ml Suspension Zevtera® (ceftobiprole/medocaril sodium	Various Infections
viii.	Penicillamine 250mg tablet Trientine HCl 500mg capsule	Wilson's Disease (WD)
ix.	Eohilia™ (budesonide oral suspension)	Eosinophilic Esophagitis (EoE)
x.	Hercessi™ (trastuzumab-strf) Truqap™ (capivasertib)	Breast Cancer (BC)
xi.	Wainua™ (eplonterse)	Polyneuropathy of Hereditary Transthyretin-Mediated Amyloidosis (haTTR-PN)
xii.	Rivfloza® (nedosiran)	Primary Hyperoxaluria Type 1 (PH1)
xiii.	Casgevy™ (exagamglogene autotemcel) Lyfgenia® (lovotibeglogene autotemcel) Xromi® (hydroxyurea oral solution) Vafseo® (vadadustat)	Sickle Cell Disease (SCD) Anemia of Chronic Kidney Disease (CKD)

MOTION: Member Jolley moved for approval of item 7ai-xiii, as published. The motion was seconded by Member Kennedy.

FOR THE MOTION: Chairman Nuttle, Vice-Chairman Yaffe, Member Case, Member Christ, Member Corbett, Member Cruzan, Member Jolley, Member Kennedy, Member Leland

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

Chairman Kennedy provided the Compliance Committee Update, which included information on OHCA Financials, Audit Findings, Program Integrity, and the FY26 OHCA Budget Request.

OHCA Financials – For the period ended October 31, 2024, the OHCA's expenditures were 3.3% under budget while revenues were 2.1% under budget. This gives the agency a positive budget variance of $36.7 million. Our receivables from sister agencies are current. We continue to spend down the 340 program fund cash reserve but are monitoring cash flow closely and currently project sufficient cash for the remainder of the fiscal year.

Audit Findings – The internal audit division reported completion of two external audits.

- The state fiscal year (SFY) 2023 Statewide Annual Comprehensive Financial Report (ACFR) was issued. The OHCA had one reportable finding. The reporting error was corrected, and review process enhancements are being implemented to catch future errors prior to report submission.
- CMS completed the COVID-19 Public Health Emergency (PHE) Unwinding Medicaid Beneficiary Eligibility Audit which resulted in a commendable report with no reportable audit findings.

Program Integrity: For the first quarter of 2025, Provider Audits closed 674 audits totaling a final identified overpayment of $1,052,202.69. Of the 674 audits closed, 194 had errors resulting in overpayments and findings. Program Integrity also shared current status updates for the active Payment Error Rate Measurement (PERM) audit. PERM has 3 specific areas of review:

- Data processing - 41% complete with no errors
- Medical review - 97% complete with 5 identified errors. 3 errors substantiated and 2 under OHCA review.
- Eligibility - 90% complete with no errors

Program Integrity also provided an update for the MEQC (Medicaid Eligibility Quality Control) audit. The last review cycle was calendar year 2022 which resulted in 1,146 total errors. To date, 824 of those errors or 72% of the total errors have been resolved. The remaining corrective action plans are being closely monitored for completion. It is anticipated that all 166 remaining findings associated with OKDHS will be resolved by the end this month. OHCA has 156 findings that are pending completion. These are expected to be resolved by December 31, 2025. The unit responsible for this audit is actively preparing to begin the next audit cycle January 1st.

FY26 OHCA Budget Request – OHCA staff presented an overview of the FY 26 agency budget request to both the compliance committee and strategic planning committee. This request has been submitted to OMES and Senate & House Fiscal. Member Kennedy asked Mr. Morris to present the agency budget request to the board.

Mr. Morris provided a brief overview of the FY26 budget request. OHCA's budget is organized by priorities and the number one priority is to recognize the change of the federal funds the agency will receive. OHCA received a decreased FMAP for FY26 from 67.08% to 66.47%, which resulted in a large reduction in federal funds and increase in OHCA's state appropriation. The budget request has Medicaid and CHIP broken out, but in the end, it is about a $26 million increase to OHCA's state appropriation request. The second priority is maintenance, which is primarily for traditional growth for volume utilization services and cost of services. The increase to that is also large, about 3.7% for OHCA's traditional population. OHCA Finance is tracking that closely. There is also an adjustment for Part D, which is increasing clawback from the Federal Government for the prescription drug program. OHCA is also asking to replace a year over year decline in its tobacco tax revenues of about $9 million. The third priority is for mandates. OHCA had a nursing facility rate increase mandated in 2025 that was self-funded, and OHCA is asking for the funds for the state appropriations to fund that increase which is about $30 million. There is also a premium tax surplus that is being requested to account for to decrease OHCA's total request. The premium tax will increase as OHCA matures as a managed care program and will offset some of OHCA's request as it continues to grow. The total state request is $126 million, and total budget growth is $358 million. Mr. Morris reminded the board that that is the OHCA portion and does not account for potential changes in the portion of the Medicaid program that is shared with other state agencies. The total projected appropriation need is about $1.436 billion for FY26. Member Case asked how the Public Health Unwind has increased utilization. Mr. Morris stated that the Unwind hasn't increased utilization, but the members who remain on the program post Unwind utilize services at a much higher rate. Member Corbett asked if the OHCA Board has the ability or responsibility to see the

budgets for all the Medicaid programs and have some oversight over the appropriateness of those budgets. Mr. Morris stated that they do. The budget work program is presented to and approved by the board, which includes all of the other state agency expenditures. Member Jolley asked if OHCA is anticipating a reduction of $26 million, why is OHCA asking the state appropriation to be equal to that reduction since the federal match is 2%. Why is it not $13 million? Mr. Morris stated that that is a complicated question but stated that it is built into OHCA's calculations such that OHCA is ending the calculation with that the state need is rather than saying, this is a state need that we are going to match. Chairman Nuttle asked if OHCA's per capita cost is increasing. Mr. Morris stated that if you looked at just total program growth, the answer would be yes.

ITEM 9 / DISCUSSION OF REPORT FROM THE ADMINISTRATIVE RULES ADVISORY COMMITTEE AND POSSIBLE ACTION REGARDING AGENCY RULEMAKING
Tanya Case, Chair, Administrative Rules Advisory Committee

Member Case asked Traylor Rains, State Medicaid Director, to provide a brief overview of the rules listed below. Member Jolley asked, apart from the last two rules, are any of the other rules not being done to comply with either federal rule to bring in alignment with federal rule or bring alignment to state statute. Mr. Rains stated that that was correct, however the third-party liability for school-based services is not a mandated requirement but came out to the states through updated school-based services guidance from CMS, allowing states to take up that option. Member Case asked that rule #4 be voted on separately.

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 #24-13 PACE Licensure Policy
ii. APA WF #24-14 Hospice Benefit Expansion
iii. APA WF #24-18 Third Party Liability (TPL) for School Based Services
iv. APA WF #24-19 Updating Abortion Policy
v. APA WF #24-21 Certified Registered Nurse Anesthetist (CRNA) Rate Increase
vi. APA WF #24-24 Medication Assisted Treatment (MAT) Clarification
vii. APA WF #24-25 Psychological Testing Limit Increase
viii. APA WF #24-34 Community Health Services

MOTION:	Vice-Chairman Yaffe motioned to approve the declaration of a compelling public interest for the promulgation of the emergency rules in item 9i-viii. The motion was seconded by Member Christ.
FOR THE MOTION:	Chairman Nuttle, Vice-Chairman Yaffe, Member Case, Member Corbett, Member Jolley, Member Kennedy, Member Leland
BOARD MEMBERS ABSTAIN:	Member Christ, Member Cruzan
MOTION:	Member Jolley moved to approve the emergency rules listed in item 9i-iii and 9v-viii as published. The motion was seconded by Member Corbett.
FOR THE MOTION:	Chairman Nuttle, Vice-Chairman Yaffe, Member Case, Member Corbett, Member Jolley, Member Kennedy, Member Leland
BOARD MEMBERS ABSTAIN:	Member Christ, Member Cruzan
MOTION:	Member Jolley moved to approve the emergency rules listed in item 9iv as published. The motion was seconded by Member Kennedy.
FOR THE MOTION:	Chairman Nuttle, Vice-Chairman Yaffe, Member Case, Member Corbett, Member Jolley, Member Kennedy, Member Leland
BOARD MEMBERS ABSTAIN:	Member Christ, Member Cruzan

ITEM 10 / DISCUSSION OF REPORT OF THE STRATEGIC PLANNING & OPERATIONAL ADVISORY COMMITTEE
Marc Nuttle, OHCA Board Chairman

Chairman Nuttle provided an overview of the items discussed at the December 10th Strategic Planning Committee meeting, which included updates on Value-Based Payments, Traction Dashboard, and OHCA's Operational Metrics. Chairman Nuttle reminded the board that there are changes coming at the third level, to what extent is unknown. He

added that there is an opportunity to make recommendations to the new administration on any changes we'd like to make. Chairman Nuttle believes the new administration will respond to the idea of federal/state cooperation.

ITEM 11 / DISCUSSION AND POSSIBLE ACTION OF THE ELECTION OF THE OHCA 2025 BOARD OFFICERS
Marc Nuttle, OHCA Board Chairman

MOTION:	Member Jolley moved to keep the officers for 2025 the same as they were for 2024. The motion was seconded by Member Kennedy.
FOR THE MOTION:	Chairman Nuttle, Vice-Chairman Yaffe, Member Case, Member Christ, Member Corbett, Member Cruzan, Member Jolley, Member Kennedy, Member Leland

ITEM 12 / DISCUSSION AND POSSIBLE ACTION OF THE OHCA BOARD MEETING DATES AND TIMES FOR CALENDAR YEAR 2025
Marc Nuttle, OHCA Board Chairman

MOTION:	Vice-Chairman Yaffe moved to approve the proposed 2025 meeting dates and times, as published. The motion was seconded by Member Jolley.
FOR THE MOTION:	Chairman Nuttle, Vice-Chairman Yaffe, Member Case, Member Christ, Member Corbett, Member Cruzan, Member Jolley, Member Kennedy, Member Leland

ITEM 12 / ADJOURNMENT
Marc Nuttle, OHCA Board Chairman

MOTION:	Member Jolley moved to adjourn. The motion was seconded by Member Corbett
FOR THE MOTION:	Chairman Nuttle, Vice-Chairman Yaffe, Member Case, Member Christ, Member Corbett, Member Cruzan, Member Jolley, Member Kennedy, Member Leland

Meeting adjourned at 3:53 p.m., 12/11/2024.

NEXT BOARD MEETING
January 15, 2025
Oklahoma Health Care Authority
4345 N. Lincoln Blvd
Oklahoma City, OK 73105

Martina Ordonez
Board Secretary

Minutes Approved: _____

*Initials:*_____

This page intentionally left blank

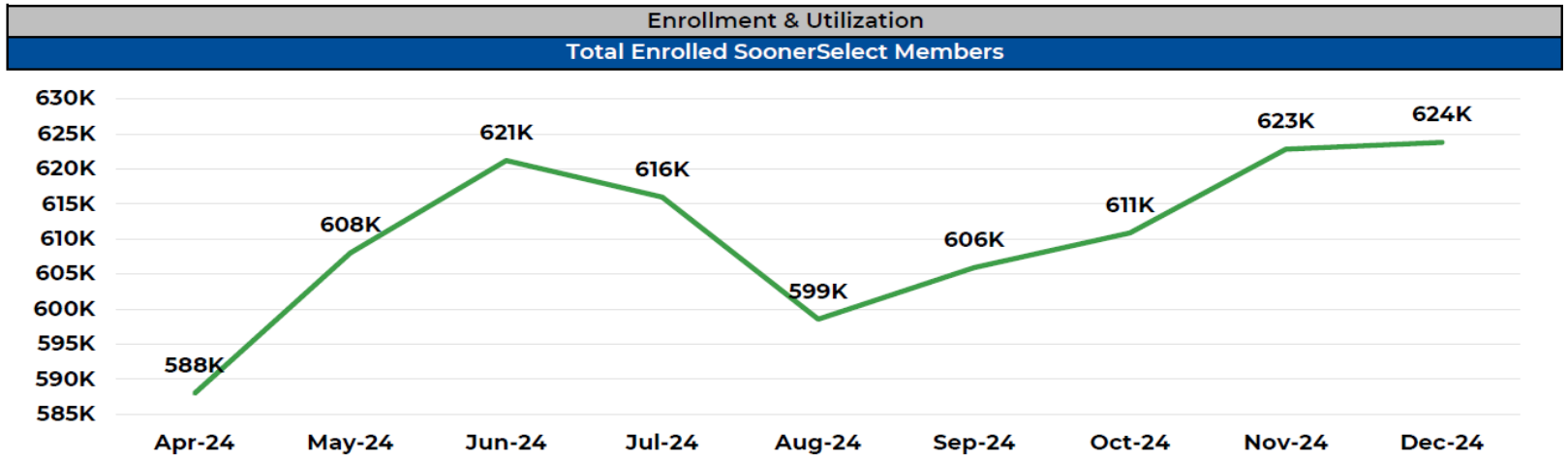
Attachment B

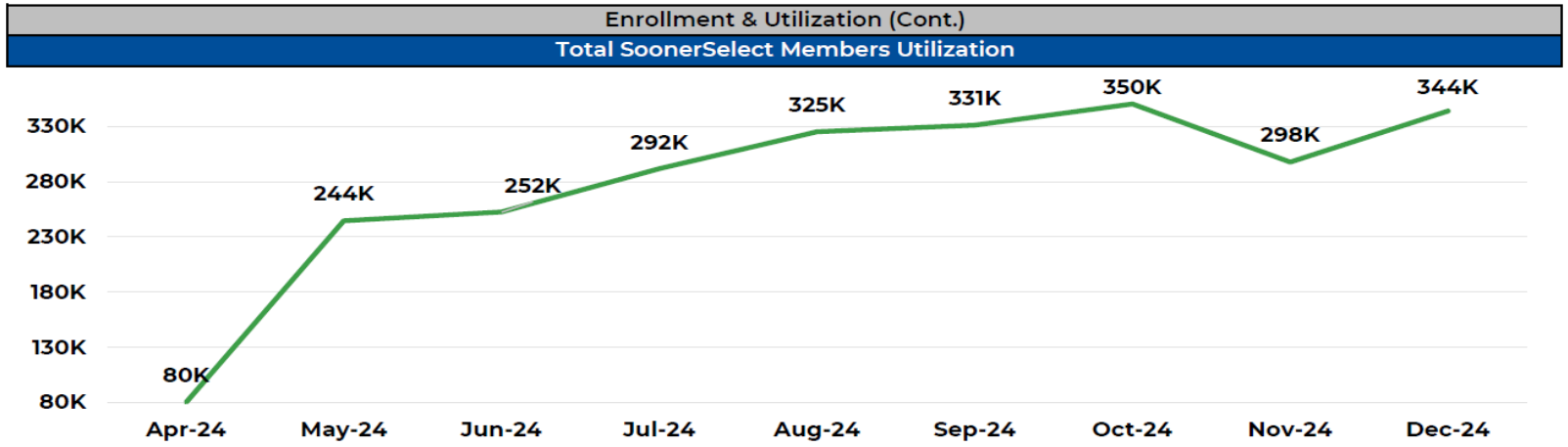
MEDICAID DIRECTOR UPDATE

JANUARY 15, 2025

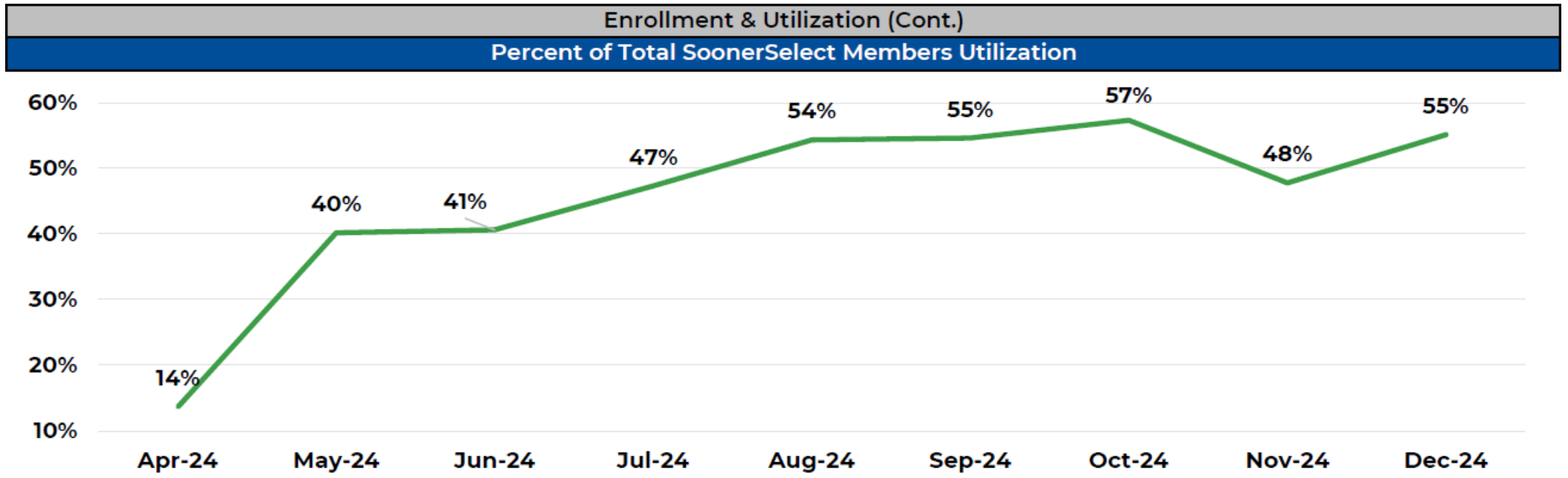
SOONERSELECT UPDATE

ENROLLMENT & UTILIZATION

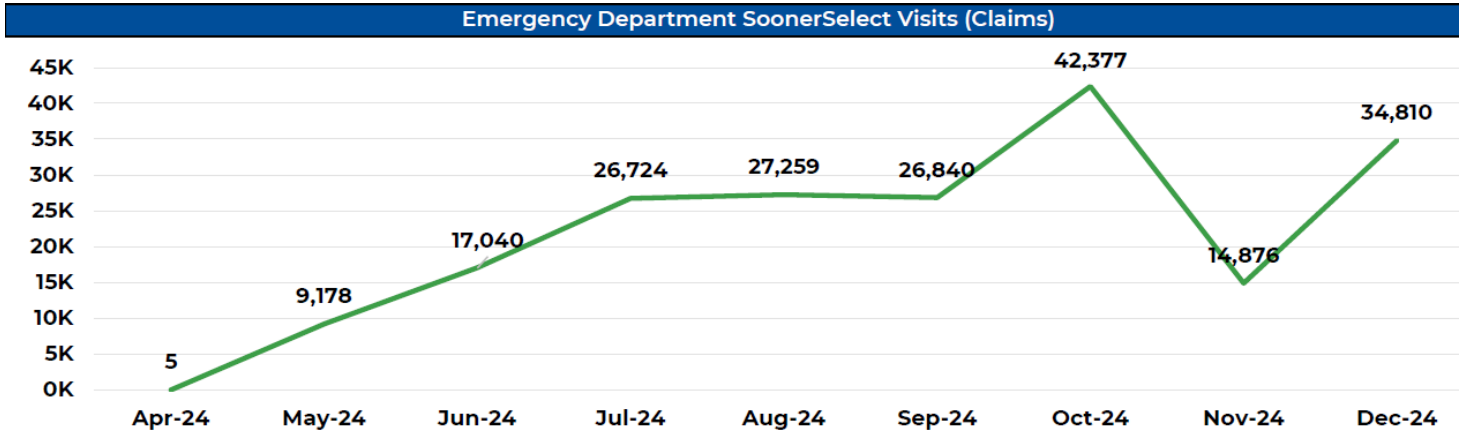


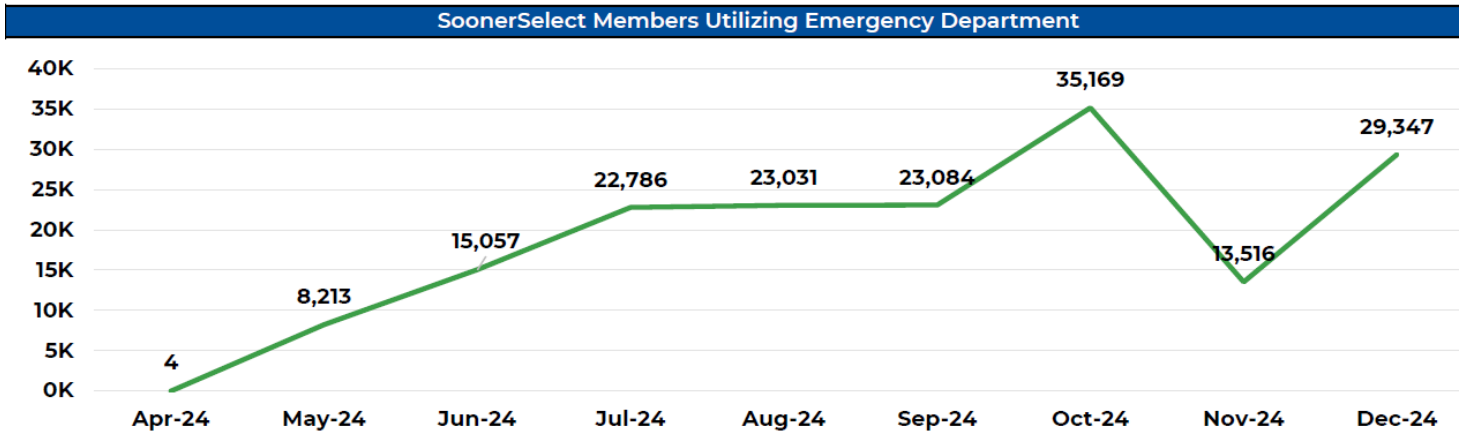


ENROLLMENT & UTILIZATION



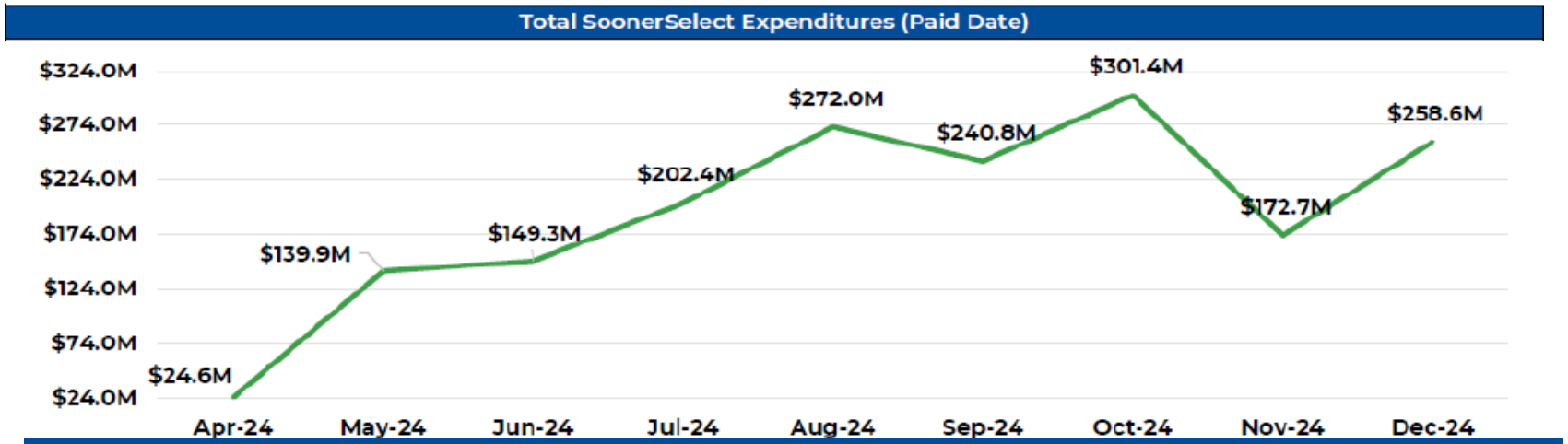
SOONERSELECT ER UTILIZATION

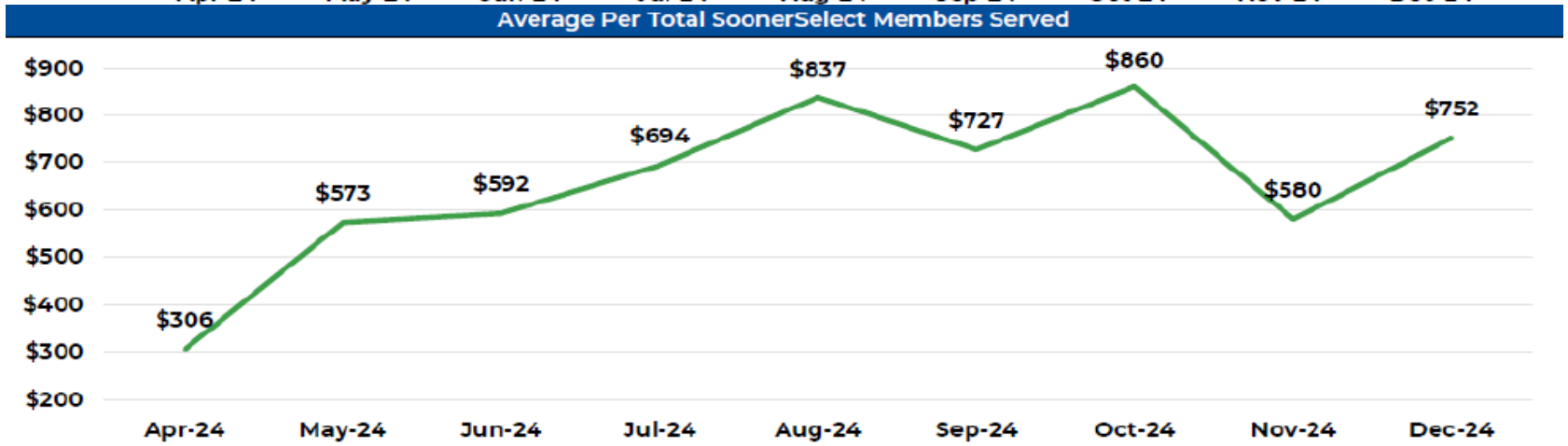




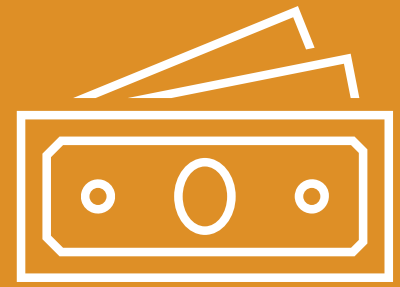
9 month total: 199,109 visits (annualized 265,478 visits)
SFY2023 total ER Visits: 389,273 Emergency Department FF SFY2023.pdf

TOTAL EXPENDITURES



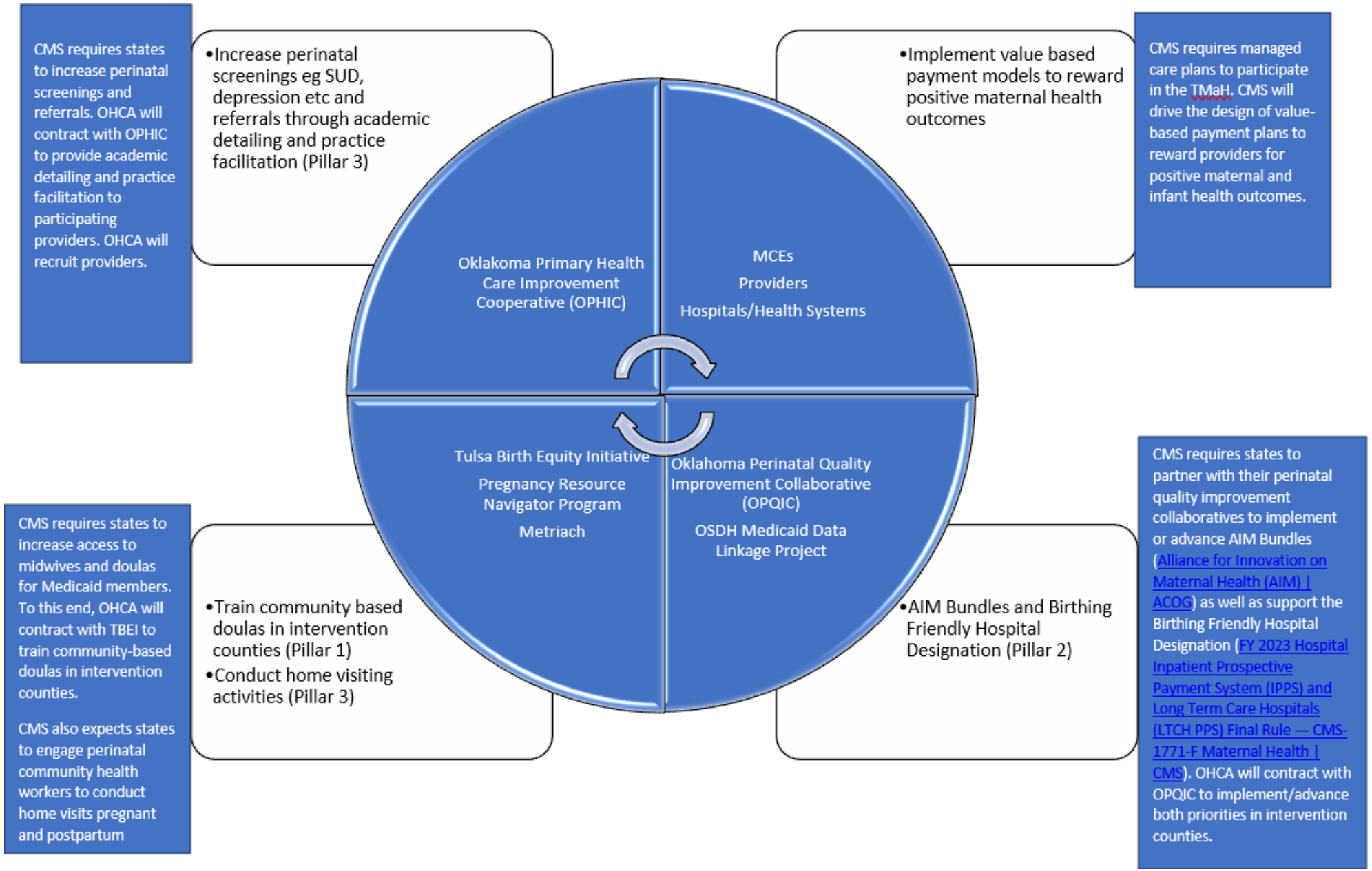


RECENT GRANT AWARDS



TRANSFORMING MATERNAL HEALTH GRANT

- Oklahoma received award along with 13 other states and the District of Columbia.
- Total Budget Requested: **$16, 903,575.20**
- Year 1 Budget: **$999,709** based on ability to justify spend.
- **2025-2027**: Planning years with milestones expectations set by CMS. Expectations include completion of contracts with partners, recruitment of providers and partner locations including tribal health systems and FQHCs, mapping out the data needs for the project etc. Planning years will also include technical assistance from CMS.
- **2028-2034:** Implementation years. OHCA will work with partners to implement, track and evaluate Oklahoma TMaH. Year 10 has been proposed for the evaluation of the project.


CMS requires states to increase perinatal screenings and referrals. OHCA will contract with OPHIC to provide academic detailing and practice facilitation to participating providers. OHCA will recruit providers.
•Increase perinatal screenings eg SUD, depression etc and referrals through academic detailing and practice facilitation (Pillar 3)
Oklakoma Primary Health Care Improvement Cooperative (OPHIC)
MCEs
Providers
Hospitals/Health Systems
•Implement value based payment models to reward positive maternal health outcomes
CMS requires managed care plans to participate in the TMaH. CMS will drive the design of value-based payment plans to reward providers for positive maternal and infant health outcomes.
Tulsa Birth Equity Initiative
Pregnancy Resource Navigator Program
Metriach
Oklahoma Perinatal Quality Improvement Collaborative (OPQIC)
OSDH Medicaid Data Linkage Project
CMS requires states to increase access to midwives and doulas for Medicaid members. To this end, OHCA will contract with TBEI to train community-based doulas in intervention counties.
CMS also expects states to engage perinatal community health workers to conduct home visits pregnant and postpartum
•Train community based doulas in intervention counties (Pillar 1)
•Conduct home visiting activities (Pillar 3)
•AIM Bundles and Birthing Friendly Hospital Designation (Pillar 2)
CMS requires states to partner with their perinatal quality improvement collaboratives to implement or advance AIM Bundles (Alliance for Innovation on Maternal Health (AIM) | ACOG) as well as support the Birthing Friendly Hospital Designation (FY 2023 Hospital Inpatient Prospective Payment System (IPPS) and Long Term Care Hospitals (LTCH PPS) Final Rule — CMS-1771-F Maternal Health | CMS). OHCA will contract with OPQIC to implement/advance both priorities in intervention counties.

INNOVATION IN BEHAVIORAL HEALTH MODEL GRANT

- Oklahoma received award along with 4 other states (MI, NY & SC)
- Total award: $1,250,000 over 10 years
- Goal 1: Equip practice participants with certified EHRs to improve the quality of health care and communication with other treating providers.
- Goal 2: Connect practice participants with the statewide HIE to have instant access to medical information and receive admission, discharge, and transfer alerts for their service recipients.
- Goal 3: Implement an integrated referral system that connects various healthcare providers and services to ensure seamless, continuous care for individuals.
- Goal 4: Provide practice facilitation that will involve hands-on support to healthcare providers, helping them implement evidence-based practices and improve care coordination for individuals with complex needs.

CELEBRATING SUCCESS

LIVING CHOICE PROGRAM EXCEEDS CMS BENCHAMARK

- Oklahoma's Living Choice Program exceeded CMS benchmark expectations for the 4th year in a row!
- In 2024, the program transitioned 86 members in 2024 which represents 113% of CMS' benchmark.
- Oklahoma's Living Choice program gives eligible Oklahomans the opportunity to live in their own homes in a community setting while receiving the necessary services and support to meet their needs. The Medicaid program is designed to transform the current long-term care system by promoting home and community-based care instead of institutional care.
- To date, Living Choice has transitioned approximately 1,000 Oklahomans and saved the state over $9 million
- For more information, visit Living Choice/Money Follows the Person

OKLAHOMA
Health Care Authority

GET IN TOUCH

4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

oklahoma.gov/ohca
mysoonercare.org

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

This page intentionally left blank

OKLAHOMA
Health Care Authority

STATE PLAN AMENDMENT RATE COMMITTEE

DEVELOPMENTAL DISABILITIES SERVICES INCREASES

1. **IS THIS A RATE CHANGE OR A METHOD CHANGE?**
   Rate Change

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

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The Oklahoma State Legislature passed legislation requiring the rate increase and provided funding for the rate increase through Senate Bill 1137. The services are available to recipients on the Medicaid Homeward Bound Waiver and Community Waiver.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The current rate structure for services provided in the proposed rate changes are fixed and uniform rates established through the State Plan Amendment Rate Committee process. The services, current service codes and rates are as follows:

Description	Service Code	Current Rate
T1020C6 - Group Home Community Living 6 Bed	T1020 6	216.78
T1020C7 - Group Home Community Living 7 bed	T1020 7	185.90
T1020C8 - Group Home Community Living 8 bed	T1020 8	179.73
T1020C9 - Group Home Community Living 9 bed	T1020 9	159.58

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   The new rates are based on the categories described in Senate Bill 1137.

Description	Service Code	Proposed Rate	Annualized Cost
T1020C6 - Group Home Community Living 6 Bed	T1020 6	238.46	
T1020C7 - Group Home Community Living 7 bed	T1020 7	204.49	
T1020C8 - Group Home Community Living 8 bed	T1020 8	197.70	
T1020C9 - Group Home Community Living 9 bed	T1020 9	175.54	-
Total			910,726

6. **BUDGET ESTIMATE.**
   The estimated budget impact for the remainder of SFY 2025 will be an increase in the total amount of $683,045; with $224,858 in state share.
   The estimated budget impact for SFY 2026 will be an increase in the total amount of $910,726; with $299,811 in state share.
   OHS attests that it has adequate funds to cover the state share of the projected cost of services.

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
   The rate increase is expected to raise wages of Direct Support Professionals to bring the rate up to a competitive level and incentivize new entrants into the DSP labor force. This will have a positive impact and increase access to care.

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
   Oklahoma Human Services requests the State Plan Amendment Rate Committee approve the proposed provider rate increase at the total and state dollar costs presented.

9. **EFFECTIVE DATE OF CHANGE.**
   A retroactive date of October 1, 2024. CMS approval has been received.

January 15, 2025 Board
Proposed Rule Amendment Summaries

All proposed rules were consulted on at Tribal Consultation and considered by Medical Advisory Committee.

Items A through H were subject to a 30-day public review period from Dec. 2 through Jan. 6, 2025. Item I underwent public review from Oct. 19 through Nov. 19, 2024.

The Agency is requesting the effective date to be Sept. 2025, contingent upon receiving legislature and gubernatorial approval.

The following **PERMANENT** rules were not previously adopted and are new to the Board.

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

   Budget Impact: Budget neutral.

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

   Budget Impact: Budget neutral.

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

   Budget Impact: Budget neutral.

D. **APA WF # 24-29 Diagnosis Clarification for Inpatient Psychiatric Services —** Proposed policy revisions remove autism spectrum disorder (ASD) and intellectual disability (ID) as primary presenting diagnoses for admission into inpatient psychiatric services. A diagnosis of ASD or ID cannot be exclusionary and may be present and documented as coexisting with other qualifying conditions for admission as the secondary

diagnosis. The primary presenting diagnosis must be consistent with the primary reason for admission. These changes shall not be used to preclude or exclude any member with ASD or ID.

Budget Impact: Budget neutral.

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

Budget Impact: Budget neutral.

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

Budget Impact: Budget neutral.

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

Budget Impact: Budget neutral.

H. Employees Group Insurance Division (EGID) — Senate Bill 1301 of the 2024 Regular Legislative Session moved the EGID from the Office of Management and Enterprise Services (OMES) to the Oklahoma Health Care Authority necessitating the transfer of administrative rules. The proposed rules are verbatim what is currently in place except for "OMES" is replaced with "OHCA" and the mailing address is updated. These rules create the following new chapters in Title 317:

- **Chapter 120** Oklahoma Employees Insurance and Benefits Board
- **Chapter 145** Employees Group Insurance Division – Administrative and General Provisions
- **Chapter 150** Employees Group Insurance Division – Health, Dental, Vision and Life Plans
- **Chapter 155** Employees Group Insurance Division – HealthChoice Disability Plan

Budget Impact: Budget neutral.

The following **PERMANENT** rules were previously adopted by the Board under **EMERGENCY** rulemaking apart from the additions to Item Q (APA WF # 24-13).

I. **APA WF # 24-02 Federally Qualified Health Center (FQHC) Substance Use Disorder (SUD) Certification Requirements —** In accordance with state law, these revisions excluded FQHCs from the ODHMSAS certification requirement to provide SUD services.

Budget Impact: Budget neutral.

J. **APA WF # 24-03 Collaborative Care Model Reimbursement —** Policy revisions implemented a "Collaborative Care Model" as per state law. This model provides reimbursement for behavioral health and substance use disorder ("behavioral health integration") services delivered in a primary care setting.

Budget Impact: The estimated total cost for SFY 2025 is $1,527,145; with $501,056 in state share.

K. **APA WF # 24-05 Private Duty Nursing (PDN) —** Revisions clarified the criteria for virtual visits when a member is assessed for PDN services, changed the designated care hours from "per day" to "per week", changed the maximum hours authorized to 112 hours per week (from 16 hours per day), and added that a member's medical necessity can be determined by an OHCA physician's appointed designee.

Budget Impact: Budget neutral.

L. **APA WF # 24-06 Living Choice —** These revisions aligned Living Choice policy which requires a member to live in a qualifying facility for at least 60 days before applying for the program with federal requirements which includes a skilled nursing facility (SNF) as a qualified facility.

Budget Impact: Budget neutral.

M. **APA WF # 24-07 Secure Mental Health Transportation —** These additions implemented secure mental health transportation as a covered benefit to SoonerCare members by delineating the services as well as requirements for: eligible providers (driver/contractor), member program eligibility, and distance when transporting members. Reimbursement is made in accordance with the Oklahoma Medicaid State Plan.

Budget Impact: The estimated total cost for SFY 2025 is $6,153,652; with $1,939,170 in state share.

N. **APA WF # 24-08 Biosimilar Reimbursement —** Based on CMS guidance, reimbursement policy (Average Sales Price [ASP] + 6%) for certain biosimilar products was replaced with language indicating payment will match the Medicare Part B fee schedule (currently reimbursed at ASP + 8%).

Budget Impact: The estimated total cost for SFY2026, will be an increase in the total amount of $500,575.83; with $167,843.08 in state share. The estimated budget impact for SFY2027 will be an increase in the total amount of $600,691.00 with $201,411.69 in state share.

O. APA WF # 24-09 Continuous Eligibility for Children — In accordance with federal law, policy now provides 12-months of continuous Medicaid eligibility for children, regardless of a change in circumstances, with limited exceptions.

Budget Impact: The estimated total cost for SFY 2025 is $57,941,044; with $17,588,002 in state share.

P. APA WF # 24-10 Non-Payment of Provider Preventable Conditions (PPC) — Policy was amended to clarify the statutory provisions for non-payment of PPCs and improve reporting of PPCs to align with federal regulations which prohibit the State from paying for services that relate to PPCs including health care-acquired conditions (HCACs) and other provider-preventable conditions (OPPCs). This includes medical conditions or complications that a patient develops during a hospital stay, or ambulatory surgical encounter that was not present at admission.

Budget Impact: Budget neutral.

Q. APA WF # 24-13 Program of All-Inclusive Care for the Elderly (PACE) Policy — Previously adopted emergency rules removed the requirement that providers be licensed as an adult day care and clarified regulatory requirements for PACE providers in accordance with state law. Within the proposed permanent rules, the agency clarifies the PACE organization's responsibilities in addressing housing insecurity for a potential or current participant, requirements of the involuntary disenrollment process, and participant use of assisted living.

Budget Impact: Budget neutral.

R. APA WF # 24-14 Hospice Benefit Expansion — In accordance with state law, the OHCA expanded hospice coverage to include all full-benefit Medicaid members. Existing criteria and payment methodologies apply to any new populations.

Budget Impact: The estimated total cost SFY 2025 is $20,277.00; with $6,675.19 in state share. The estimated total cost for SFY 2026 is $40,554.00; with $13,350.38 in state share.

S. APA WF # 24-18 Third Party Liability (TPL) for School-based Services — Rule revisions permitted an exception to current TPL rules so that Medicaid is the payor of first resort, or prior to federal IDEA funds, for Medicaid-covered services documented within a student's an Individualized Education Program (IEP) and (IFSP) in accordance with section 1903(c) of the Social Security Act. Schools can still bill third party payors; however, it is not required.

Budget Impact: The estimated total cost for SFY 2025 is $35,253; with $11,605 in state share. The estimated total cost for SFY 2026 is $70,507; with $23,533 in state share.

T. **APA WF # 24-19 Updating Abortion Policy —** The proposed revisions aligned OHCA policy with state law on abortion by removing the exceptions for rape and incest.

Budget Impact: Budget neutral.

U. **APA WF 24-20 Pharmacists as Providers —** The proposed policy revisions established coverage and reimbursement guidelines for pharmacists' services in accordance with state law. Pharmacists will continue to be reimbursed for services within their scope of practice at the same rate paid to other providers for provision of the same services. At this time, covered pharmacists' services are limited to covered medical services within the statutory scope of practice of pharmacists. If scope of practice is expanded by the Board of Pharmacy, additional services will be reimbursable.

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

V. **APA WF # 24-21 Certified Registered Nurse Anesthetists (CRNA) Equalization —** Proposed revisions increased rates to 100% of the physician fee schedule for CRNAs practicing within scope of practice, in collaboration with a physician or dentist licensed in this state.

Budget Impact: The estimated total cost for SFY 2025 is $6,642,110; with $2,183,594 in state share. The estimated total cost for SFY 2026 is $7,970,533; with $2,750,817 in state share.

W. **APA WF # 24-22 High Acuity Tracheostomy Rate —** Proposed policy established an add-on rate for nursing facilities that serve tracheostomy patients who meet the high-acuity criteria by using existing cost data based on four components: direct care and allied staff costs, social and support staff costs, cost of drugs and medical supplies, and general and administrative costs.

Budget Impact: The estimated total cost for SFY2026 is $2,076,299; with $664,623 in state share.

X. **APA WF # 24-23 Applied Behavioral Analysis (ABA) Change —** Revisions updated ABA policies which now include new or updated requirements for documenting Behavior Intervention Plans and prior authorization requests, critical incident reporting, family training, billing guidelines, frequency of comprehensive diagnostic assessments, medical necessity criteria, and exclusions to treatment.

Budget Impact: Budget neutral.

Y. **APA WF # 24-24 Medication Assisted Treatment (MAT) Clarification —** In accordance with federal regulation, rule revisions ensured that a member's refusal to participate in treatment phases of therapy, rehabilitation, case management, and peer recovery

support services as described in policy will not prohibit them from receiving medications from an Opioid Treatment Program.

Budget Impact: Budget neutral.

Z. APA WF # 24-25 Psychological Testing Limit Increase — Rule revisions increased the initial limit on psychological testing hours from eight to 10. Providers may still request an additional six hours for complex testing, bringing the total to 16 hours.

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

AA. APA WF # 24-26 A&B Developmental Disabilities Services (DDS) — The proposed revisions aligned DDS rules with the approved DDS 1915(c) Home and Community Based Services (HCBS) waivers. Rules added Global Developmental Delay as an acceptable diagnosis for admission to a DDS HCBS waiver for individuals under 6 years of age and clarify that a diagnosis of intellectual disability (ID) is based on Social Security Administration criteria. Revisions also removed the requirement for authorization of community transition services to be issued for the date a member transitions. Additionally, revisions added a new residential service to be provided to members in custody of OKDHS and adult members with extensive behavioral support needs that cannot be safely met with current available support. Finally, revisions permitted legally responsible individuals to serve as a Habilitation Training Specialist to individuals for whom they are legally responsible.

Budget Impact: The estimated total cost for SFY 2024 is $3,551,158; with $1,259,049 in state share. The estimated total cost for SFY 2025 is $15,980,211; with $5,717,272 in state share.

BB. APA WF # 24-27 Hospital Provision of Emergency Opioid Antagonist — As directed by state law, Oklahoma Health Care Authority sought federal and state approval to allow for separate reimbursement of opioid antagonists provided to members in an emergency department with symptoms of an opioid overdose, opioid disorder, or any other adverse event related to opioid use.

Budget Impact: The estimated total cost for SFY 2025 is $284,406; with $93,314 in state share.

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

Budget Impact: The estimated total cost for SFY 2025 is $130,704; with $43,028 in state share. The estimated total cost for SFY26 is $871,360; with $285,980 in state share. The state share will be covered by OSDH.

This page intentionally left blank

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 114. DOULA SERVICES

317:30-5-1216. Eligible providers

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

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

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

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

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

(1) Birth doula;

(2) Postpartum doula;

(3) Full-spectrum doula; or

(4) Community-based doula.

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

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

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

(A) Birth doula;

(B) Postpartum doula;

(C) Full-spectrum doula; or

(D) Community-based doula.

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

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

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

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

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

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

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

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

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

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

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

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

(A) Standards of practice;

(B) Code of ethics and conduct;

(C) Social media policy; and

(D) Grievance and disciplinary policy.

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 1. GENERAL SCOPE AND ADMINISTRATION

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

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

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

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

(B) Date of service;

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

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

(E) Location where service starts and ends; and

(F) Time the service starts and ends.

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

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

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

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

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

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

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

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

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

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

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

(E) Ensure that the system:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 85. ADVANTAGE PROGRAM WAIVER SERVICES

317:30-5-764. Reimbursement

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) Service;

(2) Service provider;

(3) Units authorized; and

(4) Begin and end dates of service authorization.

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

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

PART 95. AGENCY PERSONAL CARE SERVICES

317:30-5-950. Eligible providers

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

317:30-5-953. Billing

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

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

SUBCHAPTER 15. STATE PLAN PERSONAL CARE SERVICES

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

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

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

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

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

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

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

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

(2) **Issue resolution.**

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

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

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

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

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

SUBCHAPTER 17. ADVANTAGE WAIVER SERVICES

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

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

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

(1) Service;

(2) Service provider;

(3) Units authorized; and

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

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

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

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

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

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

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

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

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

PART 21. OUTPATIENT BEHAVIORAL HEALTH SERVICES

317:30-5-241.4 Crisis Intervention

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

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

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

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

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

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

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

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

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

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 6. INPATIENT PSYCHIATRIC HOSPITALS

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

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

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

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

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

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

(4) Adult must be medically stable.

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

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

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

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

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

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

(A) Stabilization of acute psychiatric symptoms.

(B) Needs extensive treatment under physician direction.

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

twenty-four (24) hour medical supervision.

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

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

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

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

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

(A) Need for active and aggressive pharmacological interventions.

(B) Need for stabilization of acute psychiatric symptoms.

(C) Need extensive treatment under physician direction.

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

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

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

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

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

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

(4) Child must be medically stable.

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

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

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

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

patterns of escalating physical aggression in intensity and duration.

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

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

(A) Stabilization of acute psychiatric symptoms.

(B) Needs extensive treatment under physician direction.

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

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 6. INPATIENT PSYCHIATRIC HOSPITALS

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

(a) **Purpose**. The purpose of sections OAC 317:30-5-95.43 - 317:30-5-95.49 is to establish the procedures and requirements for residential treatment facilities providing SUD treatment services.

(b) **Definitions**. The following words and terms, when used in the aforementioned sections, shall have the following meanings unless the context clearly indicates otherwise.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) Parent-child relationship;

(ii) Physical and psychological development;

(iii) Educational needs;

(iv) Parent related issues; and

(v) Family issues related to the child.

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

(i) Parenting skills;

(ii) Knowledge of age appropriate behaviors;

(iii) Parental coping skills;

(iv) Personal issues related to parenting; and

(v) Family issues as related to the child.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(vi) Change in discharge criteria.

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

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

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

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

(i) Date;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 9. LONG TERM CARE FACILITIES

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

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

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

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

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

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

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

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

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

(A) Record reviews will include confirmation of whether:

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

(ii) The habilitation plan is complete and current.

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

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

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

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

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

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

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

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

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

(i) The habilitation plans are followed.

(ii) All ordered services are provided.

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

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

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

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

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

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

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

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

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

(A) The facility inspected;

(B) The facility's utilization review committee;

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

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

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

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

317:30-5-423. Coverage limitations

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

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

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

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

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

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

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

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

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

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

SUBCHAPTER 5. ELGIBILITY AND COUNTABLE INCOME

PART 3. NONMEDICAL ELIGIBILTY REQUIREMENTS

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

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

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

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

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

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

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

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

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

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

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

PART 1. SERVICES

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

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

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

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

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

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

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

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

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

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

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

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

PART 2. MEDICAID RECOVERY PROGRAM

317:35-9-15. Medicaid recovery

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

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

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

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

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

(i) a surviving spouse residing in the home;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) **Recovery from estates**.

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

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

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

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

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

PART 3. APPLICATION PROCEDURES

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

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

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

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

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

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

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

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

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

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

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

PART 11. PAYMENT, BILLING, AND OTHER ADMINSTRATIVE PROCEDURES

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

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

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

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

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

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

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

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

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

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

SUBCHAPTER 19. NURSING FACILITY SERVICES

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

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

317:35-19-9. PASRR screening process

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

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

(A) The NF administrator or co-administrator;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 55. MANAGED CARE

SUBCHAPTER 1. GENERAL PROVISIONS

317:55-1-3. Definitions

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

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

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

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

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

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

"Act" means the Social Security Act.

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

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

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

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

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

"Applicant" means an individual who seeks SoonerCare coverage.

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

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

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

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

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

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

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

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

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

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

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

"CEO" means Chief Executive Officer.

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

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

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

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

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

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

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

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

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

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

"CMS" means Centers for Medicare & Medicaid Services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"FPL" means federal poverty level.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"OAC" means Oklahoma Administrative Code.

"OHCA" means the Oklahoma Health Care Authority.

"OJA" means the Office of Juvenile Affairs.

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

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

"O.S." means Oklahoma Statutes.

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

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

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

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

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

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

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

(C) Does not have a comprehensive risk contract.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) Have experience serving Medicaid members and:

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

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

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

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

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

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

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

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

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

"SoonerCare" means the Oklahoma Medicaid program.

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

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

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

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

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

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

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

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

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

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

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 120. OKLAHOMA EMPLOYEES INSURANCE AND BENEFITS BOARD

317:120-1-1. Purpose

The purpose of this chapter is to outline the structure of the Oklahoma Health Care Authority (OHCA) Oklahoma Employees Insurance and Benefits Board (OEIBB).

317:120-1-2. Definitions

The following words and terms as defined by OEIBB shall have the following meaning unless the content clearly indicates otherwise:

1. **"The Board"** means the seven [7] members of the Oklahoma Employees Insurance and Benefits Board designated by statute [74 O.S. §1303(1)].
2. **"OEIBB"** means Oklahoma Employees Insurance and Benefits Board.

317:120-1-3. Regular meetings

The Board shall meet at least once each quarter in Oklahoma City, with the date, time and place determined by the Board. Four [4] members must be present to constitute a quorum in the transaction of the Board's business and a majority vote of those present shall be necessary to approve any motion before the Board. The Board shall hold an annual meeting each year at which officers shall be elected.

317:120-1-4. Special meetings

Special meetings may be called upon written notice of the Chair or by agreement of any four [4] members of the Board. Notice of a special meeting is to be delivered to all members in person or by electronic mail not less than forty-eight [48] hours prior to the fixed date of the meeting, unless waived.

317:120-1-5. Open Meeting Act

All meetings and notices thereof shall be held in strict accordance with the Open Meeting Act [25 O.S. §§301 et seq., as amended].

317:120-1-6. Committees

The Chair may appoint subcommittees and committees as is deemed appropriate**.** Such appointments shall be in writing and may be changed as needed, upon written notice to all Board members.

317:120-1-7. Cancellation of meetings

The Chair of the Board, or the Vice-Chair in the Chair's absence, shall have the power to cancel or reschedule any regular or special meeting of the Board due to anticipated lack of quorum, inclement weather or other emergency. Notice of cancellation of said meeting shall be posted as soon as reasonably possible and in the same manner as the agenda.

317:120-1-8. Board records; release of information

All official records of the Board shall be public records open to public inspection under reasonable circumstances at any reasonable time during business hours by any person, but such records shall not be taken from the OHCA office. Copies of public records may be obtained pursuant to the current fee schedule as adopted by OHCA.

317:120-1-9. Minutes of the Board

A summary shall be made of all proceedings before the Board which shall show those members present and absent, all matters considered, all actions taken, and the vote of each member on any motion, and shall be open to public inspection, as prescribed in 317:120-1-8.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 145. EMPLOYEES GROUP INSURANCE DIVISION – ADMINISTRATIVE AND GENERAL PROVISIONS

SUBCHAPTER 1. PURPOSE, DEFINITIONS, RULES AND REFERENCES

317:145-1-1. Purpose

The purpose of this chapter is to outline the structure of the Oklahoma Health Care Authority (OHCA) Employees Group Insurance Division (EGID), to outline the use and confidentiality of members' personal health information and to identify the availability and procedures to be used to access a grievance hearing.

317:145-1-2. Definitions

The following words and terms as defined by EGID shall have the following meaning unless the content clearly indicates otherwise:

"Adverse determination" means a determination by or on behalf of EGID or its designee utilization review organization that an admission, availability of care, continued stay or other healthcare service is a covered benefit but, after review, based upon the information provided, does not meet EGID's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service is therefore denied, reduced, or terminated.

"EGID" means the Employees Group Insurance Division of the Oklahoma Health Care Authority.

"Grievance Panel" means EGID's independent constitutionally created administrative court. [Const. Art. 7. § 1.]

"Independent review organization" means properly accredited entity that conducts independent external reviews of adverse determinations on behalf of EGID.

"OEIBB" means the Oklahoma Employees Insurance and Benefits Board.

317:145-1-3. Rules, cumulative

The Employees Group Insurance Division of the Oklahoma Health Care Authority hereinafter "EGID" will, from time to time, adopt handbooks, policies and procedures for the implementation of the rules set forth herein. Nothing in this chapter shall be read, interpreted, understood or applied so as to affect the validity and enforceability of any additional requirements, statutes, rules or regulations of any other governmental entity, public agency or instrumentality which may be otherwise applicable to those transactions, conduct and facilities regulated herein. The rules in this title shall not be deemed cumulative and supplemental but shall replace all previously promulgated rules of this agency.

317:145-1-4. Rules in this title and benefit administration procedures or guidelines as adopted by EGID are controlling in all situations

The rules in this title and the benefit administration procedures or guidelines as adopted by EGID shall be controlling in all situations, without exception, and any and all written information contained in any handbook, summary or other document prepared by or for EGID shall be superseded and limited by the rules in this title and the benefit administration procedures or guidelines as adopted by EGID.

317:145-1-5. Disclaimer of conflicting information

In the event there appears to be a conflict between information contained in the rules in this title and the benefit administration procedures or guidelines as adopted by EGID, and any information contained within any handbook or any other written materials, including any letters, bulletins, notices, or any other written document, or oral communication, regardless of the source, such conflict shall always be resolved by a strict application of the rules in this title or the benefit administration procedures or guidelines as adopted by EGID, and no conflict will be resolved by application of the erroneous information contained within the handbook or other written document when the result would be contrary to the limitations set forth in the rules in this title, and the benefit administration procedures or guidelines as adopted by EGID. All erroneous, incorrect, misleading or obsolete language contained within any handbook or any other written document or oral communication, regardless of the source, shall be void from the inception, and of no effect under any circumstances.

317:145-1-6. Amending of rules

This chapter may be amended or repealed from time to time and new rules adopted by EGID pursuant to the Administrative Procedures Act.

317:145-1-7. Gender reference

All references to "he" or "his" are not intended to be gender related, but shall apply equally to both sexes.

SUBCHAPTER 3. RECORDS AND INFORMATION

317:145-3-1. EGID records; release of information

All official records of EGID shall be public records open to public inspection under reasonable circumstances at any reasonable time during business hours by any person, but such records shall not be taken from the EGID office. Copies of public records may be obtained pursuant to the current fee schedule as adopted by EGID.

317:145-3-2. Confidentiality of medical records

(a) All information, documents, medical reports and copies thereof contained in a member's insurance file held by EGID shall be confidential and shall not be reviewed by unauthorized parties, without permission of the individual or provider, or by court order. The confidentiality of a member's information is maintained when the member's information held by EGID is utilized for health management and communicated among:

(1) employees of EGID;

(2) EGID's contracted third party administrators and consultants;

(3) providers to the member and

(4) the member, according to statutory provisions for privilege and confidentiality or written agreements to protect the confidentiality and non-disclosure of the information.

(b) Authorizations to use or share protected health information will remain valid until termination of the member's or dependent's enrollment in HealthChoice, unless a shorter period of time has been specified, or unless rescinded.

(c) A member's health information is protected by this rule and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy regulations as codified in 45 Code of Federal Regulations Parts 160 and 164.

(1) EGID requires a signed HIPAA compliant authorization from a member or dependent before any confidential information is released to a person, company, or law firm.

(2) When individual circumstances arise in specific cases, EGID has authority to ask the member or dependent to independently confirm that EGID has permission to disclose confidential information before responding to any pending request.

(3) EGID's obligation to respond to record requests is discharged when EGID has responded to the original request, or if permission of the member or dependent is withdrawn. EGID requires a new authorization or subpoena if more records are requested after EGID has responded.

317:145-3-3. Participating entities/business associate protection of confidential health Information

(a) The participating entity/business associate may only use and disclose the member's health information for the purposes of a member's treatment, to facilitate payment for Plan benefits or for participating entity/business associate business operations on behalf of the member. The participating entity/business associate may not use or further disclose a member's health information other than permitted by EGID rules or described in a written contract between EGID and the participating entity/business associate.

(b) Participating entities/business associates shall protect a member's confidential health information according to the following guidelines. Participating entity/business associate shall:

(1) not use or disclose a member's health information other than permitted in these rules; described in a written contract with EGID or required by law,

(2) ensure that subcontractors or agents of the participating entity/business associate maintain confidentiality of any health information provided to its subcontractors or agents,

(3) not use or disclose confidential health information for employment related actions concerning the member, unless required by law,

(4) notify EGID within five [5] working days when the participating entity/business associate becomes aware of any use or disclosure of a member's health information that is inconsistent with this rule and make an accounting of these disclosures available for EGID and each member,

(5) allow a member to access and review health information on file with the participating entity/business associate and submit amending statements for inclusion in their health information file,

(6) establish procedures to protect a member's health information and account for disclosures not authorized by these rules,

(7) identify the participating entity/business associate employees who may access a member's health information and restrict access to those persons,

(8) return to EGID or destroy a member's health information when no longer required by the participating entity/ business associate, and if not feasible, limit the use or disclosure to the required purposes,

(9) ensure that proper security is in place to protect electronically stored health information and

(10) make internal practices, books and records concerning uses and disclosures of protected health information available for inspection by the appropriate authority. A written contract between EGID and participating entity/business associate shall not limit the participating entity/business associate protection of a member's health information to an extent less than described in this rule.

317:145-3-4. HealthChoice authorization for release of medical records

Through the submission of claims, each member for whom coverage is applied authorizes, without further notice or consent, EGID to obtain from any provider of medical services, all records and information pertaining to that service which will aid in the proper payment of said claims. EGID is further authorized to use and release to third party payers any information and records so obtained. In all instances, the Rules of Confidentiality shall be applied without regard to the requirements of 317:145-3-2.

317:145-3-5. Right to receive and release necessary information

For the purpose of determining applicability of and implementing the terms in this Plan or any provision of similar purpose of any other Plan, the Administrator may, without the consent of or notice of any person, release to or obtain from any other insurance company or other organization or person any information, with respect to any person, which the Administrator deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish to the Administrator such information as may be necessary to implement this section.

317:145-3-6. Call monitoring for quality control

The Administrator may institute procedures for monitoring of telephone calls for purposes of providing quality control.

317:145-3-7. Electronic records and facsimile, electronic or copies of signatures

Use of electronic records, electronic signatures, facsimile signatures and handwritten signatures executed to electronic records.

(1) Electronic records, electronic signatures, handwritten signatures executed to sign electronic records, handwritten signatures used to effectuate an electronic record for network contracting purposes, and facsimile or copies of signatures on EGID forms received from participating entities or members, may be used as an alternative or duplicate of paper records and handwritten signatures executed on paper to comply with any of the record and signature requirements of 12A O.S. §15-101 et seq. these rules or applicable Oklahoma law.

(2) Combinations of paper records and electronic records, electronic records and handwritten signatures executed on paper, or paper records and electronic signatures or handwritten signatures executed to sign electronic records, may be used to comply with any of the record and signature requirements of 12A O.S. §15-101 et seq., these rules or applicable Oklahoma law.

(3) The EGID Administrator or a Deputy Administrator may utilize a facsimile signature stamp to execute EGID contracts of any kind.

SUBCHAPTER 5. GRIEVANCE PANEL PROCEDURES

317:145-5-1. Request for hearing

(a) **Grievances.** EGID has established procedures by which:

(1) Independent Review Organizations shall act as an appeals body for complaints by insured members regarding adverse benefit determinations based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit,

(2) A three [3] member Grievance Panel shall act as an appeals body for complaints by insured members regarding all other issues.

(b) **Court Administrator Appointees.** The Court Administrator shall designate Grievance Panel members as shall be necessary. The members of the Grievance Panel shall consist of two [2] Attorneys licensed to practice law in this state and one [1] state licensed health care professional or health care administrator who has at least three [3] years practical experience, has had or has admitting privileges to a State of Oklahoma hospital, has a working knowledge of prescription medication, or has worked in an administrative capacity at some point in their career.

(c) **Governor Appointees.** The state health care professional shall be appointed by the Governor. At the Governor's discretion, one or more qualified individuals may also be appointed as an alternate to serve on the Grievance Panel in the event the Governor's primary appointee becomes unable to serve.

(d) **Right to a Hearing.** Any covered member who has exhausted EGID's internal review procedures and has timely requested in writing a hearing before the Grievance Panel pursuant to 317:145-5-1(a)(2) shall receive a hearing in person or through licensed counsel before the panel.

(e) **Remedy.** Grievance procedures conducted by the three [3] member Grievance Panel shall be subject to the Oklahoma Administrative Procedures Act, including provisions thereof for review of agency decisions by the district court.

(f) **Failure to timely submit hearing request.** All Grievance Panel requests must be filed within sixty [60] days from the date the member is notified that the member's claim, benefit, coverage, or other matter has been denied and that EGID's internal review procedures have been exhausted. After more than sixty [60] days from the date the member was first notified that the member's claim, benefit, coverage, or other matter has been denied and that EGID's internal review procedures have been exhausted, the matter shall be deemed finally resolved.

(g) **Aggrieved member covered by an HMO.** Any member covered by an HMO is entitled to a hearing before the Panel in the same manner as all other covered members for those matters not covered by an Independent Review Organization. The member must exhaust the HMO's internal grievance procedure, except for an emergency or if the HMO fails to timely respond, before requesting a Grievance Panel hearing. The member must file, along with his request for hearing, a written certification from the HMO that the member has exhausted said procedure, or a detailed explanation of the emergency or of the HMO's failure to respond.

(h) **Submission of Grievance request.** Any Grievance request shall be in writing on a form provided by EGID for such purpose or in writing by the employee if in substantial compliance with the form and shall contain the following information:

(1) Name of employee, Social Security Number and address;

(2) Name of dependent for whom claim was submitted, if not the covered employee;

(3) Name of employee's employing entity, location, and identifying number;

(4) Nature of claim: Health, Dental, Life, Eligibility, Disability, HIPAA or HMO;

(5) Date claim submitted for payment, claim number;

(6) The reason given, if any, by the claims administration contractor for denying the claim in whole or in part; and

(7) A short statement as to the nature of the illness or injury giving rise to the claim.

(i) **Mailing address for submission of Request for Hearing.** The Request for Hearing shall be mailed or delivered to EGID to the attention of Attorney - Grievance Department at PO Box 11137, Oklahoma City, OK 73136-9998.

317:145-5-2. Notice of hearing

Upon receipt of a Grievance request, after a member has exhausted EGID's applicable internal review procedures, a hearing number shall be assigned in grievances involving the three [3] member Grievance Panel and notice shall be forwarded to the claims administration contractor by email, secure workflow, or by regular mail at its closest office. The employee shall be notified of the hearing date by mail with delivery confirmation. A copy of all rules pertinent to the hearing shall be forwarded with the Notice, along with a statement of claimant's rights.

317:145-5-3. Prehearing conference

For grievance hearings conducted by the three [3] member Grievance Panel the Attorney representing EGID, the claimant, or the claimant's attorney may request a pre-hearing conference to determine legal or factual issues. The Attorney representing EGID may conduct such a conference.

317:145-5-4. Grievance hearings conducted by the three [3] member Grievance Panel

(a) **Witness list.** Each party must submit, in writing, at least forty-eight [48] hours prior to the date of a grievance hearing a complete list of witnesses he or she intends to call, along with a brief comment as to the nature of the testimony. Witnesses shall not be called to testify at the hearing unless notice has been given to the opposing parties.

(b) **Assignment of Panel and Chairman.** All hearings shall be held before a three-member Grievance Panel, as assigned by the Office of the Administrative Director of the Courts. All hearings shall be conducted in accordance with and be governed by the provisions of the Oklahoma Administrative Procedures Act, 75 O.S. §301-326. At each convening of the Panel, one member shall be designated to act as the Chairman.

(c) **Admissibility of evidence.** Rulings on admissibility of evidence shall be made by the Panel Chairman; provided, however, that the remaining members of the Panel may, by affirmative vote, overrule the Chairman's decision, on their own motion or upon motion of any party to the hearing.

(d) **Oaths and subpoena.** The Chairman of the Panel shall have the authority to administer oaths for obtaining testimony for the hearing; and any member of the Panel or the Attorney representing EGID shall have the authority to issue subpoenas for witnesses or subpoenas duces tecum to compel the production of books, records, papers and other objects for the hearing. Said subpoenas may be served by any duly qualified officer of the law, or any employee of EGID in any manner prescribed for the service of a subpoena in a civil action.

(e) **Court reporter.** The Attorney representing EGID shall cause a recording of the proceedings to be made by a certified court reporter at EGID's expense. If transcribed, such written transcript shall become a part of the official record of the hearing, and a copy shall be furnished to any other party having a direct interest therein at the request and expense of such party. The cost of preparing the written transcript of the hearing and providing a copy of the transcript to the other party shall be paid by the party on whose behalf the written transcript is requested.

(f) **Procedure.** In all hearings, opportunity shall be afforded the party or parties requesting same to respond and present evidence and argument on all issues involved. The hearing shall be conducted in an orderly manner. The party or parties requesting the hearing shall appear in person

or through licensed counsel and be heard first; those, if any, who oppose the relief sought by the requesting party shall next be heard. Each party shall have the opportunity to present closing arguments.

(g) **Standard of review.** When considering complaints by insured members, the three [3] member Grievance Panel shall determine by a preponderance of the evidence whether EGID has followed its statutes, rules, plan documents, policies and internal procedures. The Grievance Panel shall not expand upon or override any EGID statutes, rules, plan documents, policies and internal procedures.

317:145-5-5. Continuance; disposition; Attorney representation

Any request for continuance of a hearing conducted by the three [3] member Grievance Panel may be granted by the Attorney representing EGID or the Panel if requested for any of the following reasons: illness or unavailability of the party requesting the hearing, unavailability or illness of a material witness, unavoidable conflict of schedule, unavailability of relevant documents, or other good cause. All parties to the hearing shall be notified of the continuance as soon as possible.

(1) Unless precluded by law, informal disposition may be made of any individual proceedings by stipulation, agreed settlement, consent order, or default.

(2) Any party shall at all times have the right to be represented by counsel at their own expense, provided such counsel is licensed to practice law by the Supreme Court of Oklahoma.

317:145-5-6. Certificate of mailing

All filings, including Orders, Notices and Briefs, considered or issued by a three [3] member Grievance Panel shall include a Certificate of Mailing showing the names and mailing addresses of adverse parties or their attorneys of record.

317:145-5-7. Final order; appeals

(a) **Final Order.** The Grievance Panel shall enter a Final Order within no more than forty-five [45] days after the date of the hearing in all cases in which evidence and testimony has been offered and admitted. The Final Order shall separately state all Findings of Fact, Conclusions of Law and an Order approving or denying the claim.

(b) **District Court appeals.** The Grievance Panel's Final Order shall be considered a final decision of EGID for purposes of appeal. Any party to the hearing has the right to appeal to District Court from Final Orders entered by the Panel. This appeal shall be governed by the Administrative Procedures Act, 75 O.S. §301, et seq., and by other pertinent statutes such as 74 O.S. §1301, et seq.

317:145-5-8. Scheduling of hearings

All requests for hearings assigned to the three [3] member Grievance Panel shall be placed on the Grievance Panel docket to be heard in open court following the receipt of a properly submitted Request For Grievance Panel Hearing form.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 150. EMPLOYEES GROUP INSURANCE DIVISION - HEALTH, DENTAL, VISION AND LIFE PLANS

SUBCHAPTER 1. PURPOSE AND DEFINITIONS

317:150-1-1. Purpose

The purpose of this chapter is to outline definitions, plan administration, coverage, and exclusions pertaining to health, dental, vision and life benefits.

317:150-1-2. Definitions

The following words and terms as defined by EGID, when used in this chapter, shall have the following meaning, unless the content clearly indicates otherwise:

"Administrative error" occurs when the coverage elections the member makes are not the same as those entered into payroll for deduction from the member's paycheck. This does not include untimely member coverage elections or member misrepresentation. When such an administrative error results in underpaid premiums, full payment to EGID shall be required before coverage elected by the member can be made effective. If overpayment occurs, EGID shall refund overpaid funds to the appropriate party.

"Administrator" means the Administrator of the Employees Group Insurance Division or a designee.

"Allowable fee" means the maximum allowed amount based on the HealthChoice Network Provider Contracts payable to a provider by EGID and the member for covered services.

"Attorney representing EGID" means any attorney designated by the Administrator to appear on behalf of EGID.

"The Board" means the seven [7] Oklahoma Employees Insurance and Benefits Board members designated by statute [74 O.S. §1303(1)].

"Business Associate" shall have the meaning given to "Business Associate" under the Health Insurance Portability and Accountability Act of 1996, Privacy Rule, including, but not limited to, 45 CFR §160.103.

"Carrier" means the State of Oklahoma.

"Comprehensive benefits" means benefits which reimburse the expense of facility room and board, other hospital services, certain out-patient expenses, maternity benefits, surgical expense, including obstetrical care, in-hospital medical care expense, diagnostic radiological and laboratory benefits, providers' services provided by house and office calls, treatments administered in providers' office, prescription drugs, psychiatric services, Christian Science practitioners' services, Christian Science nurses' services, optometric medical services for injury or illness of the eye, home health care, home nursing service, hospice care and such other benefits as may be determined by EGID. Such benefits shall be provided on a copayment or coinsurance basis, the insured to pay a proportion of the cost of such benefits, and may be subject to a deductible that applies to all or part of the benefits as determined by EGID. [74 O.S. §1303 (14)]

"Cosmetic procedure" means a procedure that primarily serves to improve appearance.

"Current employee" means an employee in the service of a participating entity who receives compensation for services actually rendered and is listed on the payrolls and personnel records of

said employer, as a current and present employee, including employees who are otherwise eligible who are on approved leave without pay, not to exceed twenty-four [24] months. A person elected by popular vote will be considered an eligible employee during his tenure of office. Eligible employees are defined by statute. [74 O.S. §1303 and §1315]

"Custodial care" means treatment or services regardless of who recommends them or where they are provided, that could be given safely and reasonably by a person not medically skilled. These services are designed mainly to help the patient with daily living activities. These activities include but are not limited to: personal care as in walking, getting in and out of bed, bathing, eating by spoon, tube or gastrostomy, exercising, dressing, using toilet, preparing meals or special diets, moving the patient, acting as companion or sitter, and supervising medication which can usually be self-administered.

"Dependent" means the primary member's spouse (if not legally separated by court order), including common-law. Dependents also include a member's daughter, son, stepdaughter, stepson, eligible foster child, adopted child, child for whom the member has been granted legal guardianship or child legally placed with the primary member for adoption up to the child's twenty-sixth [26th] birthday. In addition other unmarried children up to age twenty-six [26] may be considered dependents if the child lives with the member and the member is primarily responsible for the child's support. A child that meets the definition of a disabled dependent in this section and also all requirements in 317:150-3-18, may also be covered regardless of age if the child is incapable of self-support because of mental or physical incapacity that existed prior to reaching age twenty-six [26]. Coverage is not automatic and must be approved with a review of medical information. A disabled dependent deemed disabled by Social Security does not automatically mean that this disabled dependent will meet the Plan requirements. [74 O.S. §1303(14)]. See additional eligibility criteria for disabled dependents over the age of twenty-six [26] at 317:150-3-18. Participating employer groups may have a more restrictive definition of Dependent.

"Durable medical equipment" means medically necessary equipment, prescribed by a provider, which serves a therapeutic purpose in the treatment of an illness or an injury. Durable medical equipment is for the exclusive use of the afflicted member and is designed for prolonged use. Specific criteria and limitations apply.

"Eligible Provider" means a practitioner who or a facility that is recognized by EGID as eligible for reimbursement. EGID reserves the right to determine provider eligibility for network and non-Network reimbursement.

"Emergency" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so 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 a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd (e)(1)(A)). (In that provision of the Social Security Act, clause (i) refers to placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.)

"Enrollment period" means the time period in which an individual may make an election of coverage or changes to coverage in effect.

"Excepted Benefits" means the four categories of benefits as established in section 2791 of the PHS Act, section 733 of ERISA and section 9832 of the Internal Revenue Code, as summarized in IRS Bulletin 2015-14 and subsequent regulatory guidance. These Excepted Benefits include but are not limited to vision coverage, dental coverage, long-term care insurance, Medicare

supplement coverage, automobile liability insurance, workers compensation, accidental death and dismemberment insurance and specific disease coverage (such as cancer).

"Facility" means any organization as defined by EGID which is duly licensed under the laws of the state of operation and meets credentialing criteria established by EGID.

"Fee schedule" means a listing of one or more allowable fees.

"Former participating employees and dependents" means eligible former employees who have elected benefits within thirty [30] days of termination of service and includes those who have retired, or vested through an eligible State of Oklahoma retirement system, or who have completed the statutory required years of service, or who have other coverage rights through Consolidated Omnibus Budget Reconciliation Act (COBRA) or the Oklahoma Personnel Act. An eligible dependent is covered through the participating former employee or the dependent is eligible as a survivor or has coverage rights through COBRA.

"Health information" means any information, whether oral or recorded in any form or medium: (1) that relates to the past, present or future physical or mental condition of a member; the provision of health care to a member; or the past, present or future payment for the provision of health care to a member; and (2) that identifies the member or with respect to which there is a reasonable basis to believe the information can be used to identify the member.

"Home health care" means a plan of continued care of an insured person who is under the care of a provider who certifies that without the Home health care, confinement in a hospital or skilled nursing facility would be required. Specific criteria and limitations apply.

"Hospice care" means a concept of supportive care for terminally ill patients. Treatment focuses on the relief of pain and suffering associated with a terminal illness. Specific criteria and limitations apply.

"Inaccurate or erroneous information" means materially erroneous, false, inaccurate, or misleading information that was intentionally submitted in order to obtain a specific coverage.

"Initial enrollment period" means the first thirty [30] days following the employee's entry-on-duty date. A group initial enrollment period is defined as the thirty [30] days following the enrollment date of the participating entity.

"Insurance Coordinator" means Insurance/Benefits Coordinator for Education, Local Government, and State Employees.

"Insured(s)" means both the Primary insured and covered Dependents.

"Maintenance care" means there is no measurable progress of goals achieved, no skilled care required, no measurable improvement in daily function or self-care, or no change in basic treatment or outcome.

"Medically necessary" means services or supplies which are provided for the diagnosis and treatment of the medical and/or mental health/substance abuse condition and complies with criteria adopted by EGID. Direct care and treatment are within standards of good medical practice within the community, and are appropriate and necessary for the symptoms, diagnosis or treatment of the condition. The services or supplies must be the most appropriate supply or level of service, which can safely be provided. For hospital stays, this means that inpatient acute care is necessary due to the intensity of services the member is receiving or the severity of the member's condition, and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting. The services or supplies cannot be primarily for the convenience of the member, caregiver, or provider. The fact that services or supplies are medically necessary does not, in itself, assure that the services or supplies are covered by the Plan.

"Members" means all persons covered by one or more of the group insurance plans offered by EGID including eligible current and qualified former employees of participating entities and their eligible covered dependents.

"Mental health and substance abuse" means conditions including a mental or emotional disorder of any kind, organic or inorganic, and/or alcoholism and drug dependency.

"Network provider" means a practitioner who or facility that is duly licensed or operates under the laws of the state, satisfies credentialing criteria as established by EGID, and has entered into a contract with EGID to accept scheduled reimbursement for covered health care services and supplies provided to members.

"Non-Network out-of-pocket" means the member's expenses include the total of the member's deductibles and co-insurance costs plus all amounts that continue to be charged by the non-Network provider after the HealthChoice allowable fees have been paid.

"OEIBB" means Oklahoma Employees Insurance and Benefits Board.

"Open enrollment period" means a limited period of time as approved by either EGID or the Legislature in which a specified group of individuals are permitted to enroll.

"Option period" means the time set aside at least annually by EGID in which enrolled plan members may make changes to their enrollments. Eligible but not enrolled employees may also make application for enrollment during this time. Enrollment is subject to approval by EGID.

"Orthodontic limitation" means an individual who enrolls in the Dental Plan will not be eligible for any orthodontic benefits for services occurring within the first twelve [12] months after the effective date of coverage. Continuing orthodontic services for newly hired employees who had previous group dental coverage will be paid by prorating or according to plan benefits.

"Other hospital services and supplies" means services and supplies rendered by the hospital that are required for treatment, but not including room and board nor the professional services of any provider, nor any private duty, special or intensive nursing services, by whatever name called, regardless of whatever such services are rendered under the direction of the hospital or otherwise.

"Participating entity" means any employer or organization whose employees or members are eligible to be participants in any plan authorized by or through the Oklahoma Employees Insurance and Benefits' Act.

"The Plan or Plans" means the self-insured Plans by the State of Oklahoma for the purpose of providing health benefits to eligible members and may include such other benefits as may be determined by EGID. Such benefits shall be provided on a coinsurance basis and the insured pays a proportion of the cost of such benefits.

"Primary insured" means the member who first became eligible for the insurance coverage creating eligibility rights for dependents.

"Prosthetic appliance" means an artificial appliance that replaces body parts that may be missing or defective as a result of surgical intervention, trauma, disease, or developmental anomaly. Said appliance must be medically necessary.

"Provider" means a practitioner who or facility that is duly licensed or operates under the laws of the state in which the Provider practices and is recognized by this Plan, to render health and dental care services and/or supplies.

"Qualifying Event" means an event that changes a member's family or health insurance situation and qualifies the member and/or dependent for a special enrollment period. The most common qualifying life events are the loss of health care coverage, a change in household (such as marriage or birth of a child), or a change of residence or other federally required mandates. A complete summary of qualifying events are set out in Title 26, Treasury Regulations, Section 125.

"Schedule of benefits" means the EGID plan description of one or more covered services.

"Skilled care" means treatment or services provided by licensed medical personnel as prescribed by a provider. Treatment or services that could not be given safely or reasonably by a person who is not medically skilled and would need continuous supervision of the effectiveness of the treatment and progress of the condition. Specific criteria and limitations are applied.

SUBCHAPTER 3. ADMINISTRATION OF PLANS

317:150-3-1. Open enrollment period

The Board or the Legislature may, at its discretion, declare an open enrollment period during which time eligible individuals may enroll in optional coverage on behalf of themselves or eligible dependents.

317:150-3-2. Approval of exceptional claims and eligibility matters

The Administrator shall have the authority to approve individual exceptional claims or eligibility matters when circumstances require.

317:150-3-3. Insurance/Benefits Coordinator for Education, Local Government, and State Employees

The appointing authority or governing body of each participating entity shall designate an Insurance/Benefits Coordinator and at least one [1] Alternate to properly enroll members of the entity. Any information given by an Insurance/Benefits Coordinator shall not supersede or modify the statutes, rules in this title or any Insurance/Benefits Coordinator Guide governing the Group Insurance Plan. Insurance/Benefits Coordinator representing retirees may be provided by the retirement system from which the retiree is receiving benefits. It is the employee's duty to notify his Insurance/Benefits Coordinator of a change in eligibility for himself, his spouse or his dependents. It is the Coordinator's duty to notify EGID within ten [10] working days of the employee's notice of change. EGID is not obligated to accept untimely notifications of change, and may elect to refuse to permit said changes.

317:150-3-4. Right of recovery

(a) **Error in payment.** Any benefits paid erroneously by EGID are fully recoverable from the recipient. No such erroneous payment shall constitute waiver or estoppel or result in any equitable obligation by EGID to pay any benefits which are not specifically payable according to the rules in this title and the benefit administration procedures or guidelines as adopted by the Board. [74 O.S. §1321]

(b) **Excessive amounts.** Whenever payments have been made by EGID with respect to allowable expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at the time to satisfy the intent of this part, the Administrator shall have the right to recover such excess, from any person, organization or company with respect to whom such payments were made.

(c) **Right to Audit.** EGID reserves the right to audit any enrollment or insurance change form and to require that supporting documentation showing the participant's eligibility, including (but not limited to) proof of a qualifying event, be provided. EGID may retroactively terminate coverage on any individual who was not eligible to be enrolled in the Plan and recover any claims paid on the individual's behalf.

317:150-3-5. Responsibility for premium payment

(a) **Participating entity premiums.** Employer and employee premiums for participating entities are due to EGID no later than the tenth [10th] day of each month following the month of coverage. The first payroll deductions for insurance premiums of individuals paid bi-weekly will be withheld from the first pay period that extends into the month during which insurance coverage begins. It is ultimately the employing agency's responsibility to check and verify that premiums paid to EGID are a true and accurate accounting of the member's approved coverage selections. If premium for coverage selected by the employee differs from the amount deducted from the member's check, then the participating entity is responsible for payment to EGID for any deficiencies in premium for the member's coverage. Any shortage of premiums due and payable will result in suspension of benefits for Plan participants.

(1) An employee may continue coverage while on approved leave without pay status for up to twenty-four [24] months as long as the entity continues to remit premiums with the entity's monthly payment. The twenty-four [24] month limitation shall be extended to eight [8] years for education employees who are absent from employment because of election or appointment as a local, state, or national education association officer. Except as protected by federal statute, employees on leave whose premiums are not remitted in a timely manner shall have their coverage terminated at the end of the month for which last payment was received. If coverage is terminated for non-payment all coverage is terminated. Upon return to work, the employee may re-enroll. All Plan limitations apply and evidence of insurability is required to re-enroll in any life coverage.

(2) Provided that if a State employee is on leave without pay due to an injury or illness arising out of the course of his employment, the employee may continue the insurance during the maximum period of the time allowed by law, and the employing agency shall pay the benefit allowance allowed by law.

(3) An employee may continue coverage while on suspension without pay for up to ninety [90] days following the date of suspension or the duration of the administrative appeals process, whichever is greater, as long as premiums are remitted by the entity for the coverage.

(4) Collecting any employee share from an employee on leave without pay or suspension without pay is the responsibility of the entity.

(b) **Premiums remitted by retirement systems.** Any State of Oklahoma retirement system establishing a withholding system for its retired employees shall forward the retirement contribution and employees' withholding to EGID by the tenth [10th] of the month following the month for which payment is due. This same time frame also applies to members receiving disability benefits.

(c) **Premiums remitted by former employees, COBRA participants or survivors.** Premiums are due by the twentieth [20th] day of the month of coverage. All premiums due, in excess of the retirement system contributions, shall be paid by the member. The member may elect to have the premiums withheld from their retirement benefit if the retirement benefit is sufficient to cover the entire premium. If the total monthly premium is the same as or greater than the retirement benefit, the member shall remit the entire amount due directly to EGID.

317:150-3-6. Cancellation of coverage

After notice and opportunity for a hearing according to the Oklahoma Administrative Procedures Act and these rules, coverage may be cancelled.

(1) **Cancellation of coverage due to non-payment of premium**. If payment is not received by the end of the month in which the payment is due, coverage shall be canceled effective the end of the month for which the last premium was received. EGID may reinstate coverage within sixty [60] days after the date EGID canceled coverage, if it is shown that the failure to pay premiums was not due to the member's negligence, subject to payment of any required premiums. The employee shall be notified in writing by EGID of cancellation of coverage and provided an opportunity for a hearing.

(2) **Cancellation of coverage due to insufficient funds.** In the event the member's payment is returned or refused due to insufficient funds or closed account, coverage may be cancelled unless the check is returned due to no fault of the member.

(3) **All coverage canceled.** If coverage is canceled for either of the reasons listed above all coverage will be terminated. When the employee is eligible to re-enroll, all Plan limitations apply and evidence of insurability is required to enroll in any life coverage.

(4) **Cancellation of coverage for Medicare members.** If payment is not received by the twentieth [20th] of the month, Medicare members will be notified of the delinquency and given thirty [30] days to make the payment. If payment is not made within the thirty [30] day grace period, coverage will be terminated effective the first [1st] day of the following month.

317:150-3-7. Underpaid premiums

When premiums are underpaid for coverage which has been selected and provided, future payments will first be applied to the shortage and the shortage will be rolled forward. Employees may not choose to retroactively cancel coverage that was selected. The full amount of the underpaid premium shall be submitted within sixty [60] days after the date EGID notifies the insured or the insured's employer of the error. When the underpayment occurs because an employee has entered into a salary reduction agreement pursuant to the Internal Revenue Code, and the insured's employer has erroneously failed to withhold and submit the proper premiums to EGID, the insured's employer shall be solely responsible for the payment of outstanding underpaid premiums to EGID. Failure to submit premiums could result in loss of coverage in accordance with 317:150-3-5(a)(3).

317:150-3-8. Refunds

(a) **Refunds of premium overpayments.** Any refund of payment for any premium overpayment shall be made only when EGID is notified in writing of the overpayment.

(b) **Administrative Error.** Refunds for overpayment due to administrative error, as limited and defined in the rules in this title, of the Insurance/Benefits Coordinator or the payroll clerk for EGID, shall be made at one hundred percent [100%].

(c) **Refunds on behalf of employees.** Refunds on behalf of employees shall be paid to the appropriate party. For an entity to receive a refund, the entity must have a credit balance.

(d) **Inaccurate or erroneous information**. If EGID finds that materially erroneous, false, inaccurate, or misleading information was intentionally submitted in order to obtain a specific coverage, then:

(1) For optional or supplemental life insurance coverage in excess of any guaranteed amounts of coverage, EGID shall extinguish its liability by tendering a refund of premiums paid to the insured or the beneficiary;

(2) Health or dental coverage would be canceled retroactive to the effective date of the coverage obtained by the misrepresentation. Refunded premiums would be reduced by any claims paid by HealthChoice.

(e) **Medicare eligibility**. There shall be no refund of premiums for prior months during which the member was eligible for Medicare, and written notice was not provided to EGID. An exception shall be made for individuals who are retroactively awarded Medicare coverage by the Social Security Administration, when written notice of the retroactive award is provided to EGID within thirty [30] days after the member's notification of the Social Security Administration award. A member's sixty-fifth [65th] birthday is considered automatic notification of Medicare eligibility.

(f) **Deceased member**. All refunds for overpayment resulting from the death of an employee or former employee will be capped at the overpayment amount received by EGID within twenty four [24] months of notification.

(g) **Dependent life insurance premium reimbursement.** If, after a receipt of a life insurance application, EGID finds that the deceased dependent does not meet eligibility requirements for dependent life coverage, EGID may reimburse the member for qualifying premiums paid to EGID. Any premium reimbursement shall not exceed the amount of the dependent life insurance policy.

317:150-3-13. Rights of eligible former employees to continue in the Group Health, Dental, and Vision Insurance Plan

(a) Health, dental and vision coverage may be elected as determined by State Statute or retained at the time of termination of employment from an employer who participates in that health, dental or vision coverage, if such election to continue in force or begin is made within thirty [30] days from the date of termination of service, and if the following conditions are met:

(1) The former employee either retires or has a vesting right with a State funded retirement plan, or has the requisite years of service with an employer participating in the Plan.

(2) The election must be received by EGID no later than thirty [30] days after the date of termination of service.

(b) If an eligible former employee does not elect coverage at the time of termination of employment, or subsequently drops the coverage that was elected, the coverage may not be reinstated at a later date, except as permitted for former State employees exercising insurance retention rights available through a reduction in force (RIF) severance agreement.

(c) A participating eligible former employee cannot add dependents to coverage after termination of employment, except as follows:

(1) During an open enrollment period; or

(2) Eligible dependent(s) not covered at the time of the former employee's termination from active employment, as long as the dependent election is made within thirty [30] days of the termination date.

(3) If the dependent is newly acquired. New dependent[s] or additional dependent coverage must be added within thirty [30] days after acquiring the new dependent[s].

(4) If the dependent has lost other health or group dental insurance coverage and notice has been given to EGID within thirty [30] days after the loss of the other coverage. Excepted Benefits do not qualify as other health coverage for purposes of this rule, and replacement is limited to the corresponding type of coverage lost.

(d) During an option period, covered former employees may make changes to their existing benefits but not add additional benefits with the exception of vision coverage. Vision coverage cannot be dropped mid-year except as allowed at 317:150-3-22(c).

(e) If an eligible former employee has a spouse who is participating in the Plan as an employee of a participating entity, the former employee may defer or transfer his or her health, dental and vision coverage to be dependent coverage under the spouse at any time, so long as the following conditions are met:

(1) Coverage must remain continuous; and

(2) All eligible dependents must be insured unless they have other verifiable coverage.

(3) The eligible former employee, at a later date, may cancel deferment and defer or transfer his or her insurance coverage from dependent status back to former employee status if coverage with the Plan has remained continuous, and the former employer of the eligible former employee continues to participate in the Plan.

(f) An individual who has retained health, dental or vision coverage who is returning to current employment for a participating entity and meets the eligibility criteria for a current employee is entitled to transfer his present coverage to that employer as long as the employer is a participant in the benefit transferred. The employee may retain his present life coverage and may add life coverage so long as the total amount of life coverage does not exceed the guaranteed issue amount. Evidence of insurability must be submitted and approved for any amount exceeding guaranteed issue or the amount previously held in retirement, whichever is greater.

(g) An eligible former employee who has retained any coverage and is returning to work for a participating entity but does not meet the eligibility criteria for a current employee is not entitled to coverage through that employer.

(h) In the event an otherwise eligible former employee returns to current employment who did not retain health coverage upon termination of employment, the eligibility requirements of a new employee must be met in order to obtain that coverage through the employer. Such individuals must work for three [3] years in order to qualify for retaining any benefits not previously elected upon ceasing current employment when they re-retire. This includes members who terminated from employers not participating in the Group Plans authorized by the Oklahoma State Employees Benefits Act [74 O. S. §1301] when they originally ended employment.

(i) Enrollment in a Medicare Plan:

(1) **Medicare Supplement coverage enrollment required regardless of age.** All covered individuals who are eligible for Medicare, except current employees and their dependents as addressed in 317:150-5-41, must be enrolled in a Medicare Plan, offered through EGID, regardless of age.

(2) **Effective date of Medicare Supplement coverage.** Medicare Supplement coverage shall become effective on the first [1st] day of the month following the date EGID receives actual notice of the member's eligibility for Medicare. There shall be no refund of premiums for prior months during which the member was eligible for Medicare, and written notice was not provided to EGID. An exception shall be made for individuals who are retroactively awarded Medicare coverage by the Social Security Administration, when written notice of the retroactive award is provided to EGID within thirty [30] days after the member's notification of the Social Security Administration award. A member's sixty-fifth [65th] birthday is considered automatic notification of Medicare eligibility.

(3) **Non-Medicare eligible individuals.** Nothing in the rules in this chapter prohibits individuals who are not eligible for Medicare from being enrolled in EGID's regular health plan; however, individuals eligible to purchase Medicare coverage are excluded and are presumed to be enrolled in both Parts A and B of Medicare.

317:150-3-14. Coverage for eligible non-vested employee

A non-vested employee must apply for continuation of coverage thirty [30] days after the date of termination of employment. Coverage must be continuous and eligibility to continue must be based upon the length of service required by statute. [74 O.S. §1316.2; 74 O.S. §1316.3]

317:150-3-15. Effective dates of coverage for current employees

An employee other than an education employee is eligible to participate if not classified as seasonal or temporary and whose actual performance of duties normally requires one thousand [1,000] hours per year or more. An education employee who is a member of or eligible to participate in the Oklahoma Teacher's Retirement System and working a minimum of four [4] hours per day or twenty [20] hours per week may participate in the Plan. Part-time education employees are those who meet the requirements of a half-time employee as defined by the Oklahoma Teachers Retirement System. Eligible employees shall be covered on the first [1st] day of the month following the month in which the employee is in an eligible status.

(1) If an employee is absent due to accident or illness on the date the employee coverage would normally become effective, benefits shall not be payable until the employee returns to the job. If the employee is absent from work because of a holiday, vacation or nonscheduled working day and the employee was on the job on a scheduled working day immediately preceding the effective date, this effective date will not be changed. An employee coming to work during the latter part of a payroll period who is not able to complete an insurance change form should be placed on the appropriate plans on the first [1st] day of the following month with employee only coverage, so that the employee life, dental and health will be in effect. Members may add optional coverages within the member's initial thirty [30] day enrollment period to be effective the first [1st] day of the month following the date the member enrolled for optional coverages.

(2) Participating entities shall forward members' enrollment information and any changes to enrollment information during the initial enrollment period to the Administrator within ten [10] days after the last day a member may enroll.

(3) If an employee leaves a participating entity and is hired by another participating entity within the following thirty [30] day period, premiums must be forwarded to EGID to avoid a break in coverage.

(4) An enrolled member who terminates employment or is in leave without pay status and whose spouse is also an enrolled employee may transfer coverage to their spouse to be insured as a dependent. The health, dental, vision and basic life may be transferred. The employee's basic life amount will transfer to a dependent spouse amount. If there are dependent children, they must also be insured unless they have other group or qualified individual health insurance.

(5) An employee that terminates from a participating employer and is hired by another participating employer shall be entitled to be treated as a new employee with new health, dental, vision and life benefit options available. A rehired employee returning to a former employer has new health, dental and vision benefit options only after a thirty [30] day break in coverage and may be subject to orthodontic limitations.

(6) Except as provided by statute, an individual employee may choose not to be enrolled in the health or dental plans or may disenroll from these plans because of other health or group dental coverage or by reason of eligibility for military or Indian health services within thirty [30] days after the date the employee becomes eligible for the other health or group dental

coverage. Such employees who subsequently lose the other coverage or eligibility for military or Indian health services may enroll in the corresponding health or dental plans offered through EGID if the election is made no later than thirty [30] days after the date of loss of the other coverage. At the insured's option, in order to avoid a break in coverage and the application of the dental limitation, coverage under this Plan shall become effective on the first [1st] day of the month during which the insured actually lost the previous coverage, provided the insured pays the full premium for that month. Otherwise, coverage shall become effective under this Plan on the first [1st] day of the month following the election of health and/or dental coverage, and any break in coverage shall result in the application of the HealthChoice dental limitations. Excepted Benefits do not qualify as other health coverage for purposes of this rule.

317:150-3-16. Participating entities

(a) **Participation in plans offered by EGID.** Entities electing to participate in the dental, life, vision, or disability plans offered by EGID must participate in one of the authorized health plans, unless the Administrator grants a waiver. Coverage offered by EGID to eligible education employees will also be offered to all elected members of the school board for that entity.

(b) **Enrollment in group term life benefits.** An entity may elect to participate in the group term life coverage offered by EGID. This includes basic and optional supplemental life coverage for the employee and dependent life coverage. Entities electing to participate in the life plan offered by EGID must participate in the health plan, unless the Administrator grants a waiver.

(c) **Non-participating entities in other group plans.** The group plans offered by EGID shall not be offered to any entity which is participating in any other group insurance program, regardless of the percentage or number of employees eligible to enroll, unless the Administrator grants a waiver.

(d) **Right of Board to approve or deny applications for coverage.** EGID shall retain the right to approve or deny any employer group applications for coverage. Upon approval, coverage will become effective at 12:01 a.m. on the first [1st] day of the month following the month in which approval is granted unless a subsequent month is requested and approved in advance.

(e) **Coverage without preexisting conditions.** When an entity enrolls all employees of the new entity are covered without penalty for preexisting conditions.

(f) **Enrollment of all individuals presently insured.** Upon the group initial enrollment of an institution of higher education, all individuals presently insured by the institution's previous group health plan may become enrolled. If any such individual does not meet the eligibility requirements of this plan, they are eligible for coverage only for the remaining period of the institution's contractual liability. The institution must provide written proof of its contractual liability at the time of said individual's enrollment.

(g) **Attestation of continuous coverage for retirees.** Upon beginning or reinstating participation in health coverage offered by EGID, the entity must provide EGID with an attestation that retirees over age sixty-five [65] that will gain coverage through EGID have had continuous creditable coverage for prescription drugs (coverage that is at least as good as Medicare's) since the retirees became eligible for Medicare. The entity must provide an accurate list of any retiree over age sixty-five [65] that does not meet this requirement in order for EGID to properly report uncovered months to Medicare.

317:150-3-17. Dependents

Eligible dependents may be enrolled by new employees with their coverage effective concurrently with the employee's coverage if the member has signed the insurance change form requesting such coverage within the member's initial thirty [30] day enrollment period. Dependent coverage not elected at that time shall not become available until the next enrollment period. Dependents are not eligible for any coverage in which the member is not enrolled. Exceptions may apply for dependents electing COBRA or Survivor coverage. When one eligible dependent is covered, all eligible dependents must be covered for all elected coverage. The spouse or dependent may elect not to be covered when the spouse or dependent is covered by other corresponding and verifiable health, group dental or vision coverage. The member can elect not to cover dependents who do not reside with the member, are married, are not financially dependent on the member for support, have other coverage or are eligible for Indian or military health benefits. The spouse may elect not to be covered provided a statement signed by the employee and the spouse is submitted to the Insurance/Benefits Coordinator. Dependent's benefits shall only be covered under one primary insured except in the case of dependent life. Excepted Benefits do not qualify as other coverage for purposes of this rule.

(1) Newborns may be added to coverage with the completion of an insurance change form and remittance of any appropriate premium for the month of birth to the Insurance/Benefit Coordinator within thirty [30] days after the date of birth of the newborn.

(2) When one or more eligible dependents are currently covered, the newborn must be added to the same coverage.

(3) Where a newborn is added to coverage, all other eligible dependents must be enrolled in coverage if they are not currently enrolled. A member can waive health, dental, or vision coverage for their spouse.

(4) Eligible dependents who lose other health, group dental or vision insurance coverage may be added to the equivalent health, dental or vision coverage offered through EGID within thirty [30] days after the loss of the other insurance coverage if those dependents have been continuously covered by the other health, dental or vision insurance, or have been eligible for treatment at military or Indian health facilities. Notice and proof of the loss of other coverage and termination date of other coverage must be submitted within thirty [30] days after the loss of the other coverage. At the insured's option, in order to avoid a break in coverage this Plan shall become effective on the first [1st] day of the month during which the insured actually lost previous coverage, provided the insured pays the full premium for that month. Otherwise, coverage shall become effective under this Plan on the first [1st] day of the month following notice of the loss of other coverage. Excepted Benefits do not qualify as other health coverage for purposes of this rule.

(5) Newly acquired dependents may be added if the election is made within thirty [30] days after the qualifying event, or other federally required mandate, or during the annual enrollment period as established by EGID. Documentation proving the qualifying event may be required. The effective date of coverage will be the first [1st] day of the month following notification to EGID of the qualified event except for newborn or adopted dependent children.

(6) Provided all other eligibility requirements are satisfied, adopted eligible dependent children, eligible children for which guardianship has been newly granted to the insured or the insured's spouse, or eligible children of which the insured has been newly granted physical custody pending adoption, guardianship, or other legal custody, may be covered from the first [1st] day they are placed in the insured's physical custody, only upon payment of the full monthly premium for that individual, not prorated, and only after written notice has been given

to EGID within thirty [30] days after obtaining physical custody. Copies of all documents relating to the matter are also required.

(7) At the insured's option, coverage for eligible dependent children newly placed in the insured's physical custody may become effective on the first [1st] day of the second month following placement, if written notice is provided within thirty [30] days after the date of placement, or at the next option period as established by EGID.

(8) In the absence of a court order indicating adoption, guardianship, legal separation or divorce, an insured may apply for coverage on other unmarried children living with the insured provided: (1) the insured submits a copy of his most recent federal income tax return showing the child was listed as the insured's dependent for income tax deduction purposes; and (2) if the last federal income tax form requested above does not list the child, the insured shall be required to provide an Application for Coverage for Other Dependent Children form prescribed by the Plan; and (3) coverage, if approved, shall begin on the first [1st] day of the month following approval, and will never apply retroactively except in the case of a newborn which shall be added the first [1st] of the month of birth; and (4) all other applicable eligibility requirements must be satisfied; and (5) all necessary premiums have been paid. EGID shall have the right to verify the dependent's status, to request copies of the insured's federal income tax returns from time to time, and to discontinue coverage for such dependents if they are found to be ineligible for any reason.

317:150-3-18. Eligibility criteria for disabled dependent over the age of twenty-six [26]

Eligibility criteria for covering a disabled dependent beyond the age of twenty-six [26] pursuant to 74 O. S. §1303(14) are as follows, provided all other eligibility requirements are also satisfied:

(1) It is intended that the following dependents beyond the age of twenty-six [26] are eligible for coverage under this provision:

(A) An individual who has been medically determined to be incapable of self-support because of mental or physical incapacity that currently exists and has continuously existed since before reaching the age of twenty-six [26] years; and

(B) The individual resides in the primary member’s home at least six [6] months of the year, and is the primary member's natural child, foster child, adopted child, or a child of the primary member's spouse when the spouse has been ordered by a Court to provide health insurance for the child; and

(C) If the requirements of subsection (A) and (B) are met, eligibility through court appointed guardianship will be accepted for disabled children, foster children and grandchildren, but only when guardianship existed prior to the dependent reaching age nineteen [19]. The assessment/application for coverage must be submitted within thirty [30] days of obtaining legal guardianship. Power of attorney, including durable power of attorney, does not qualify as guardianship. Coverage ceases at the end of the month in which the primary member's appointment as guardian is terminated.

(D) An approved disabled dependent who has been medically determined to be incapable of self-support because of mental or physical incapacity that currently exists and has continuously existed since before reaching the age of twenty-six [26] years can only be added to coverage within thirty [30] days of a qualifying event. While changes to coverage (benefits or plan options) may be made during the annual Option Period, enrollment of a disabled dependent will not be considered without a qualifying event.

(2) Other criteria required for disabled dependent status are:
(A) For a primary member who is a new hire or a re-hire, assessment/application for disabled dependent status must be completed and submitted to EGID within thirty [30] days of primary member's initial enrollment. As stated above, the disabled dependent must have been medically determined to be incapable of self-support because of mental or physical incapacity that currently exists and has continuously existed since before reaching the age of twenty-six [26] years.
(B) Primary members must submit a copy of their federal and/or state income tax returns for the prior year reflecting their support of the dependent.
(C) Dependents are eligible only for the coverage in which the primary insured is enrolled. Only dependent life insurance can be carried by both parents if each is a primary member under the plan; and
(D) Primary members must apply for disabled dependent status for an eligible individual who has been medically determined to be incapable of self-support because of mental or physical incapacity that currently exists and has continuously existed since before reaching the age of twenty-six [26] years at least thirty [30] days prior to the dependent's twenty-six [26th] birthday.

317:150-3-19. Termination of dependent coverage
Dependent reaches age twenty-six [26]. Coverage will be terminated for dependents reaching age twenty-six [26] on the first [1st] day of the month following their twenty-sixth [26th] birthday, except disabled dependents who are incapable of self-support and who have been deemed eligible for coverage by EGID.

317:150-3-20. Withdrawal from plan; termination or loss of coverage
(a) **Withdrawal from plan.** Those eligible entities participating on a voluntary basis that elect to withdraw cannot re-enter the Plan for one [1] year following the date of withdrawal except for extraordinary circumstances. Notice of the election to withdraw must be provided to EGID thirty [30] days prior to the actual withdrawal date.
(b) **Termination of coverage due to insolvency of carrier.** Any eligible entities who have withdrawn and purchased other coverage, then have been notified by their other health and/or group dental insurance carrier that coverage is being terminated due to insolvency of the carrier may re-enroll in the corresponding coverages within thirty [30] days after the loss of coverage by submitting a completed application form which must be approved by EGID prior to enrollment. Excepted Benefits do not qualify as other health coverage for purposes of this rule.
(c) **Individual member withdrawal and re-enrollment.** An individual employee who discontinues coverage on himself cannot re-enroll in any coverage for himself or his dependents for a period of twelve [12] months. Subsequent to the end of this twelve [12] month period, he may reapply for coverage offered by EGID provided that he is eligible through a participating entity. The orthodontic limitations will apply.
(d) **Loss of other health, group dental or group life insurance coverage.** The twelve [12] month requirement does not apply when the individual member has lost other health, group dental and/or group life insurance coverage and is seeking reinstatement pursuant to Rule 317:150-3-20(c). Excepted Benefits do not qualify as other health coverage for purposes of this rule.

317:150-3-21. Continuation of coverage for survivors

(a) The surviving dependents of a deceased employee who was on current work status or authorized leave at time of death, or of a participating retiree, or any person who has elected to receive a vested benefit under the Oklahoma Public Employees Retirement System, the Oklahoma Teachers Retirement System, the Uniform Retirement System for Justices and Judges, or the Oklahoma Law Enforcement Retirement system or is eligible to continue in force the life insurance coverage following retirement or termination of employment with the required minimum years of service with a participating employer, or who meets each and every requirement of the HealthChoice Disability Plan, may continue the health or dental benefits in force provided said dependents pay the full cost of such coverage and they were covered as eligible dependents at the time of such death. Such election must be made within sixty [60] days after death and coverage must be continuous. The eligibility for said benefits shall terminate for the surviving children when such children cease to qualify as dependents under the provisions of this plan.

(b) The surviving spouse of a deceased employee who was on active work status or authorized leave at time of death, or a surviving spouse of a participating retiree, or surviving spouse of any person who has elected to receive a vested benefit under the Oklahoma Public Employees Retirement System, the Oklahoma Teachers Retirement System, the Uniform Retirement System for Justices and Judges, or the Oklahoma Law Enforcement Retirement system or is eligible to continue in force the life insurance coverage following retirement or termination of employment with the required minimum years of service with a participating employer, or who meets each and every requirement of the State Employees Disability Plan, and who had elected the optional dependent life benefit prior to his or her death, may continue the dependent life coverage for the surviving spouse and children that were covered as dependents on the date of deceased employee's death, provided the surviving spouse pays the full cost of such coverage and the surviving spouse and children were eligible dependents on the date of the deceased employee's death. Such election must be made within sixty [60] days after the date of the deceased employee's death and coverage must be continuous. The eligibility for life benefits shall terminate for the surviving spouse's children when the children cease to qualify as dependents under the provisions of this plan.

(1) Upon the death of the surviving spouse, life benefits granted under this paragraph are payable to the beneficiary designated by the surviving spouse.

(2) Upon the death of any covered dependent children under this paragraph, life benefits are payable to the surviving spouse.

(3) The amount of life insurance coverage elected by the surviving spouse or, if no spouse, the surviving eligible dependent children shall not exceed the amount elected by the deceased employee prior to the date of the employee's death.

(4) Coverage for all dependent children of the surviving spouse, if any, terminates simultaneously with the death of the surviving spouse or termination of the surviving spouse's life insurance coverage.

317:150-3-22. Mid-year benefit election changes

(a) Mid-year elections will be allowed in accordance with and under those circumstances stated within Title 26 Treasury Regulations, Section 125 of the Internal Revenue Code. The determination of Title 26 Treasury Regulations, Section 125 of the Internal Revenue Code compliance for the current employee will be through certification from the employer.

(b) EGID will accept any change for any current employee certified as being compliant by the employer of that current employee so long as the notification of change is received by EGID within thirty [30] days of the employee's mid-year plan election. The employer must further certify that

the documentation supporting compliances is available to EGID and will be provided upon written request. An employer's cafeteria plan may permit an employee to revoke an election during a period of coverage and to make a new election only as provided in Title 26 Treasury Regulations 1.125-4. This is discretionary with the employer. Employees should be aware that Title 26 Treasury Regulations, Section 125 of the Internal Revenue Code does not require a cafeteria plan to permit any of these changes.

(c) For all other members not on current employee status or whose employer does not operate his employee benefit plan under a Section 125 plan, the rules for mid-year changes will be subject to the Section 125 guidelines as detailed in Title 26 Treasury Regulations 1.125-4.

(d) In all cases, mid-year election changes will only be considered in the event of a qualifying status change as described within Title 26 Treasury Regulations, Section 125 of the Internal Revenue Code and other federally required mandates. All other changes not in conjunction with a qualifying event can only be made during the annual Option Period.

317:150-3-23. Corrections to benefit elections

Members shall review their confirmation of coverage statement to ensure that the coverage elected is correct. Any corrections shall be submitted to the member's Insurance/Benefits Coordinator and EGID within sixty [60] days of the election. Errors reported after the sixty [60] days shall be effective the first [1st] day of the month following the notification of the error.

317:150-3-24. Double coverage prohibited

An eligible person shall not be insured as a primary insured and also as a dependent for any benefit options except dependent life, nor can any dependent be covered simultaneously by more than one primary insured, except for dependent life. Double enrollment, whether it occurs intentionally or by error, shall be deemed void from the inception, and EGID reserves the right to decide which form of single enrollment coverage to allow, whether primary or dependent.

317:150-3-25. Basic disclosure plan for HealthChoice Medicare beneficiaries

(a) The following words and terms as defined by EGID, when used in this section, shall have the following meaning: "Medicare beneficiary" means individuals eligible for HealthChoice Medicare plan coverage who are also entitled to Medicare benefits as designated by the United States Social Security Administration.

(b) In order to assure Medicare beneficiaries with an understanding of the medical and pharmacy benefits provided by, and the operation of, the HealthChoice Medicare plans; EGID shall maintain, adopt, and implement a basic disclosure plan for Medicare beneficiaries. This basic disclosure plan includes but is not limited to informational materials such as:

(1) A Medicare beneficiary benefits handbook providing a summary of medical and pharmacy benefits available under EGID's Medicare HealthChoice plan. Such handbooks shall be updated when material benefits or covered services change, or when reductions occur. A separate notification of material changes will be sent to all Medicare beneficiaries in a timely fashion prior to the updating of the Medicare beneficiary benefits handbook.

(2) A pre-enrollment package which shall be provided to all plan eligible Medicare beneficiaries. The pre-enrollment package shall, within a reasonable person's determination, be written in clear and understandable language providing the Medicare beneficiary detailed

and necessary information upon which to make a selection of coverage for an upcoming plan year.

(3) A confirmation of benefit coverage form which will be distributed in a timely fashion after enrollment of a Medicare beneficiary, and by which HealthChoice shall notify the Medicare beneficiary of the plan coverage for the upcoming year.

(4) An explanation of benefit determination letter explaining the outcome of each medical or pharmacy claim processed for payment or denial. In the case of denial the explanation of benefit determination letter shall provide information of the appeals process available to the Medicare beneficiary.

(5) Material which provides all Medicare beneficiaries with basic disclosure information on special enrollment rights, medical child support orders, and any Medicare service or benefit that EGID by law has been directed to provide.

317:150-3-26. Termination of benefits

(a) **Termination of coverage.** The coverage under this plan will terminate at the earliest time stated below:

(1) On the last day of the calendar month in which employment terminates.

(2) When the plan is discontinued.

(3) When any required premiums cease to be paid.

(4) The individual does not begin or continue coverage as an eligible participating former employee and/or dependent.

(5) For a dependent when said dependent becomes ineligible for coverage.

(6) A participating entity ceases to participate in this plan.

(b) **Representation of eligibility.** Individuals who enroll a family member in the plan are representing that the individual is eligible under the terms of the plan and must provide evidence of eligibility upon request. The plan relies upon the member's representation of eligibility in accepting the enrollment of the family member, and the intentional provision of false evidence or the failure to provide required evidence of eligibility is evidence of fraud and material misrepresentation. The intentional provision of false evidence or the failure to provide evidence of eligibility will result in disenrollment of the individual, which may be retroactive to the date as of which the individual became ineligible for plan coverage, as determined by the plan.

(c) **Rescission of coverage obtained through false information.** If material facts are submitted as a result of fraud, substantive error, inaccuracy, omission, misrepresentation, or any illegal or unauthorized activity, on any form or application for insurance coverage by or on behalf of a member or dependent, the coverage will be rescinded retroactively to the effective date. Written notice shall be sent by first class mail by EGID to the member's last known address of record no less than thirty [30] days prior to retroactive rescission of coverage. EGID reserves the right to recover the costs of any and all claims paid through such falsely obtained coverage from the ineligible member and/or dependent through all available means, at the discretion of EGID.

(d) **Dependent termination of coverage.** In addition to (a), (b), (c) and (e) of this section, the coverage terminates with respect to an individual dependent on the last day of the calendar month in which such person ceases to be an eligible dependent.

(e) **Unlimited contestability period.** There shall be no time limitation imposed upon EGID during which coverage based on materially false information submitted to EGID can be rescinded, if it is found that information as listed above in paragraph (c) was provided in order to obtain coverage, and that such information was material to EGID providing such coverage.

317:150-3-27. Procedures and implementation

Notice of right to continue coverage. EGID shall advise each covered employee of his right to continue coverage under Federal COBRA provisions. COBRA coverage applies only to health, dental, and vision benefits. Life and disability coverage are not available through COBRA.

317:150-3-28. COBRA administration

(a) **COBRA coverage is identical to coverage provided at date of the qualifying event.** The coverage elected shall be identical to the coverage provided at the date of the qualifying event. Should a beneficiary move out of the service area of their current plan, the beneficiary will be allowed to change to a plan whose service area covers the beneficiary's new location.

(b) **Payment of back premiums.** All back premiums from the termination of coverage to the election and approval of continuation must be paid before coverage is effective. Coverage will then be retroactive to provide continuous coverage. All time limits are mandatory and cannot be waived under any circumstances.

(c) **Responsibility of qualified beneficiary to inform EGID of ineligibility.** It is the responsibility of the qualified beneficiary to provide timely notice if he is not eligible for any reason. Failure to do so will result in cancellation of COBRA insurance coverage, retroactive to the time of ineligibility.

(d) **Primary member premium.** For any benefit continued under COBRA, one person must pay the primary member premium. In cases where a spouse, child, or children are insured for a particular benefit where the primary member did not retain coverage, one person will be billed at the primary member rate.

(e) **Federal regulations.** Federal regulations regarding COBRA extension of coverage shall be controlling in all situations where applicable.

SUBCHAPTER 5. COVERAGE AND LIMITATIONS

PART 1. POLICY PROVISIONS

317:150-5-1. Selection of health plans

(a) **Requirements for selection of HMO.** Eligible employees may select either the state's comprehensive health plan (HealthChoice) or an HMO option. In order to select an HMO option, the employee must reside or be employed within the selected HMO's service area. The HMO election will apply not only to the employee, but also to all covered dependents. Eligible retirees, vested, non-vested, COBRA or survivor members and eligible dependents must reside within the selected HMO's service area to participate in the HMO.

(b) **Selection of HMO during enrollment period.** A choice of comprehensive benefits or the HMO may be made on an annual basis by the member during the enrollment period as set by EGID. The eligibility requirements set by EGID as applied to the comprehensive health plan will apply to the HMO. Eligible members in all cases will retain eligibility for dental, basic life and AD&D. Selection of the comprehensive health plan or the HMO option will not affect eligibility for life and AD&D, dependent dental, or dependent Life.

PART 3. HEALTHCHOICE PLANS

317:150-5-2. Schedule of benefits and benefit administration procedures or guidelines as adopted by EGID

All benefits for HealthChoice plans offered through EGID as described in the rules in this title shall be paid according to the handbooks, schedule of benefits and benefit administration procedures or guidelines as adopted by EGID. The schedule of benefits and benefit administration procedures or guidelines as adopted by EGID shall be available for inspection by the public. To make an appointment to review, please submit a written request to OHCA EGID, PO Box 11137, Oklahoma City, OK 73136-9998.

317:150-5-10. Plan limits

EGID will adopt handbooks, policies and procedures for the implementation of the HealthChoice benefit plans. These documents shall clearly describe any limits associated with:

(1) Individual and family deductibles;
(2) Network and Non-Network out-of-pocket maximums; and
(3) Charges associated with Non-Network providers.

317:150-5-11. Covered charges

Items which will be considered for payment under HealthChoice will be referred to as covered charges that are medically necessary. Specific criteria and limitations apply. Covered charges may include:

(1) Hospital services;
(2) Provider's services;
(3) Skilled Nurse facility expense;
(4) Skilled nurse care;
(5) Dentist's or oral surgeon's services;
(6) Oral surgery;
(7) Rehabilitative care;
(8) Outpatient expense; and
(9) Hospice care.
(10) Approval of exceptional claims

(A) EGID's Health Care Management Unit may recommend exceptions to the benefits provided by HealthChoice for situations which would otherwise be denied or subject to limited coverage.

(B) Each request for exception must first be reviewed by the Health Care Management Unit on an individual basis. All responsibility for providing the documentation necessary to complete the review falls to the member. Recommendations will then be given to the Medical Director and Administrator both of whom must review all requested exceptions. Exceptions that have been reviewed but not approved in writing by the Medical Director and Administrator are deemed not approved. Approval of exceptions shall not establish precedent for other requests. All requests shall confirm that the requested exception is:

(i) medically necessary, and
(ii) within medically-accepted standards of care, and
(iii) cost effective, and/or
(iv) in compliance with all criteria as established by the Medical Director or designee.

(C) Requests conforming with all listed criteria shall remain subject to approval or denial at the discretion of the Medical Director or designee.

(11) **Facility of benefit payment.** Whenever payments which should have been made under this plan in accordance with this section have been made under any other plans, EGID shall have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this section, and amounts so paid shall be deemed to be benefits paid under this plan and, to the extent of such payments, EGID shall be fully discharged from liability under this plan.

(12) **Right of recovery.** Whenever payment has been made by EGID with respect to allowable expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this section, EGID shall have the right to recover such payments, to the extent of such excess, from among one or more of the following, as EGID shall determine:

(A) any persons to or for or with respect to whom such payments were made;

(B) any other insurers; or

(C) service plans or any other organizations.

317:150-5-12. HealthChoice plan limitations and exclusions

For the health plans provided by EGID, there is no coverage for expenses incurred for or in connection with conditions, services, procedures, treatments, expenses, items, and supplies excluded by EGID's benefit guidelines. There is no coverage or reimbursement for services or supplies provided by ineligible providers. [317:150-1-2]

317:150-5-13. Payment of HealthChoice health, dental and life benefits

(a) Life insurance benefits are payable to the beneficiary designated by the employee. Premiums and overpaid disability benefits due and payable to EGID at the time of the insured's death may be withheld from life insurance benefits before payment of the remainder to the beneficiary or estate. Life proceeds are not assignable, except a beneficiary may assign proceeds in an amount equal to the decedent's burial expenses. If no beneficiary form is on file with EGID, benefits will be paid to the decedent's estate.

(b) Health and dental benefits are payable to the employee or the provider. If any health or dental benefits remain unpaid at the employee's death, EGID, may at its option, pay the benefits to the employee's estate or to any one or more relatives such as follows: spouse, father, mother, children, brothers or sisters. Any such payment will constitute complete discharge of EGID's obligation to the extent of the amount paid.

(c) If a minor or person otherwise legally incapable of giving a valid receipt of discharge of any payment is selected as a beneficiary, a guardian must be appointed by a court of competent jurisdiction before benefits shall be paid.

317:150-5-14. Timely filing of HealthChoice health and dental claims

Proof of health and dental claims for services received (bill/receipt) must be furnished per the Plan policy. If such proof is not furnished within the time allowed, at EGID's discretion the claim will still be considered if the Insured or Provider shows that it was not reasonably possible to furnish the notice of proof within the specified time and that the notice of proof was furnished as soon as reasonably possible.

317:150-5-15. HealthChoice examination

EGID reserves the right and opportunity to order the examination of the person whose injury or sickness is the basis of a claim as often as may be reasonable during the pending of the claim.

317:150-5-16. Action to recover

No action at law or in equity shall be brought to recover on this Plan unless brought pursuant to the Administrative Procedures Act, nor shall such action be brought at all unless brought within three [3] years from the expiration of the time within which proof of loss is required by the policy.

317:150-5-17. Program integrity

EGID may have a Program Integrity Initiative. The purpose is to identify, recover, and prevent inappropriate provider billings and payments through provider audits. The provider shall furnish any and all claims information and medical documentation, upon request and at no cost, to EGID. The requested documentation will be verified to substantiate the provision of medical, dental, or durable medical equipment/supplies, and the charges for such services, if the member and the provider are seeking reimbursement through EGID. EGID will ensure appropriate payment to providers and recovery of misspent funds, while providers shall ensure they only provide appropriate services and exercise appropriate billing practices. EGID may implement additional procedures and processes to effectuate this section.

PART 5. HEALTHCHOICE LIFE BENEFITS

317:150-5-20. Term life coverage

(a) **Group Term Life Benefits.** A former employee who is reemployed by a participating employer within twenty-four [24] months after the date of termination of previous employment shall not be enrolled for a greater amount of life insurance than the individual had at the time of termination of previous employment with the employer, unless the individual provides satisfactory evidence of insurability or the guaranteed issue based on the employee's current salary exceeds his or her prior coverage. Any life insurance amount requested exceeding both prior coverage and the guaranteed issue based on the employee's current salary would require the individual to provide satisfactory evidence of insurability. The amount of coverage provided by the employer is specified in the administration procedures or guidelines as adopted by EGID. However, to elect this benefit, the member must be either a) enrolled in one of the group health plans offered through EGID or b) be enrolled in other qualified health coverage. In the event of death, the proceeds of this coverage are payable to the beneficiary listed on the most recently signed beneficiary designation subject to the limitations in Title 15. [15 O.S. §178] If no beneficiary form is on file at EGID, benefits will be paid to the decedent's estate.

(b) **Unlimited contestability period.** There shall be no time limitation imposed upon EGID, during which coverage based on evidence of insurability submitted to EGID can be contested, if it is found that materially erroneous, false, inaccurate, or misleading information was provided in order to obtain optional or supplemental coverage in excess of any guaranteed amounts of coverage. In the event EGID determines coverage was granted based upon erroneous, false, inaccurate or misleading information, and that such information was material to EGID providing any optional or supplemental coverage, EGID shall extinguish its liability by tendering a refund of premiums paid to the insured or the beneficiary.

317:150-5-21. Optional dependent life coverage

(a) **Current employees.** Current employees may select life insurance coverage for eligible dependents if the employee is enrolled in basic life. This coverage does not include accidental death or dismemberment benefits. This benefit is available even if the dependent is a participating employee.

(b) **Former employees.** Former employees may continue this coverage if the member is enrolled in basic life.

317:150-5-22. Optional supplemental life coverage for eligible employees

(a) **Supplemental life coverage.** Supplemental life coverage is available for eligible employees who are covered by the basic term life coverage.

(b) **Enrollment.** At the time of initial enrollment, supplemental life may be requested up to the pre-established level set forth in the benefit administration procedures or guidelines as adopted by EGID, without submitting evidence of insurability. All supplemental life insurance requested which exceeds the pre-established level will require evidence of insurability. Coverage selected in the supplemental life insurance program begins on the first [1st] day of the month following the date of employment. Optional coverages not selected within the member's initial enrollment period may be added only during the next enrollment period. Members who waive or do not select supplemental life insurance coverage shall be required to obtain approval of current evidence of insurability to obtain coverage at a later date. Coverage obtained under this provision will be subject to certain additional restrictions as adopted by EGID. Individuals who waived this coverage because they were covered by other group life insurance coverage will be allowed to enroll without being subject to these additional restrictions if they request the coverage in writing and supply proof of the loss of other group coverage within thirty [30] days following the loss of the other group life coverage.

(c) **Changes in levels of coverage.** Increases or reductions in coverage limits (except termination of coverage) are only accepted during the option period. Beneficiary changes may be made at any time, but must be communicated to EGID in writing. All changes in coverage levels will be subject to the benefit administration procedures or guidelines as adopted by EGID.

(d) **Waiver of life insurance premiums.** In the event the employee becomes disabled, life insurance premiums may be waived for employee and dependent life insurance coverage. Provider certification shall be required, as specified by EGID, and premium waiver shall start on the first [1st] day of the month after the employee has been disabled for thirty [30] consecutive days, and shall continue for as long as the employee remains disabled. The waiver shall terminate on the earliest of the following events: the employee has been found to be able to return to current duty in any capacity by any provider; the employee returns to any active duty for any period of time; the employee changes in status to former or retired; the employee notifies EGID in writing that life insurance coverage is to be terminated; the employee is terminated for any reason, including, but not limited to resignation or discharge from his or her position; any termination of life insurance coverage occurs as set forth in 317:150-3-26.

(e) **Accidental Death and Dismemberment and loss of sight benefit.** The basic term life and the first twenty thousand dollars [$20,000] of the supplemental life coverage includes the accidental death and dismemberment and loss of sight benefit and will pay a scheduled benefit in the event of accidental death and dismemberment or loss of sight injury within ninety [90] days

after the date of accident or accidental injury. Death must be a direct result of the accidental bodily injury independent of all other causes.

317:150-5-23. Rights of retired and vested employees to continue life insurance coverage

(a) **Continuation of coverage.** Any person who retires or who has elected to receive a vested benefit under the provisions of the Oklahoma Public Employees Retirement System, the Oklahoma Teachers Retirement System, the Uniform Retirement System for Justices and Judges, or the Oklahoma Law Enforcement Retirement system or is eligible to continue in force the life insurance coverage following retirement or termination of employment with the required minimum years of service with a participating employer, or who meets each and every requirement of the State Employees Disability Plan, or the spouse or dependent of any such employee, may continue in force life benefits purchased prior to severance in a face amount of no less than one-fourth [1/4] of the basic life coverage amount in five thousand dollar [$5,000.00] increments, and the full amount of any additional life insurance that was in effect prior to the date of retirement. Said individual shall pay actuarially determined cost of such coverage and shall make such election within thirty [30] days following the date of severance. Said election to continue coverage becomes effective on the first [1st] day of the month following termination of current employment. Eligible employees may continue in force the dependent life coverage in effect at time of termination of employment in five hundred dollar [$500] increments per dependent if the member is enrolled in basic life coverage.

(b) **Decrease or termination of coverage.** Coverage may be decreased or terminated after severance from current employment, but shall not be increased or reinstated after severance, except as permitted by rule or statute.

(c) **Unavailability to retirees, vested or eligible non-vested members or dependents.** Accidental death and dismemberment and loss of sight benefits are not available to retired, vested, or eligible non-vested members or dependents.

(d) **Retirees returning to active employment.** When an individual has retired and then returns to active employment, that individual may not retain any more life insurance upon termination of active employment than the amount that was retained when the individual initially retired, unless the period of active employment is for at least three [3] years.

PART 7. LIMITATIONS AND EXCLUSIONS FOR HEALTHCHOICE LIFE PLANS

317:150-5-24. Limitations and exclusions for life plans

For the life plans provided by EGID, there is no coverage for expenses incurred for or in connection with any of the items listed below:

(1) There is no coverage for employee life or dependent life benefits during the first twenty-four [24] months of coverage when death is the result of suicide. The twenty-four [24] month exclusion for death by suicide will begin on the effective dates of all elective increases in coverage, and will apply to all increased amounts of coverage which have been in effect for less than twenty-four [24] months on the date of the act causing the insured's death.

(2) There is no coverage for accidental death and dismemberment benefits or loss of sight benefits when such occurs as a result of the following:

(A) Suicide, attempted suicide or intentional self destruction, or intentionally self-inflicted injury while sane or insane,

(B) Committing an assault or felony, including participation as an aggressor in a riot or insurrection,
(C) Wholly or partly, directly or indirectly, by disease, physical or mental, or by medical or surgical treatment or the diagnosis of any of the foregoing,
(D) Wholly or partly, directly or indirectly by bacterial infection, other than septic infection of and through a visible wound sustained solely through external and accidental means,
(E) Any narcotic, drug, poison, gas or fumes, voluntarily taken, administered, absorbed or inhaled, unless prescribed for the exclusive use of the deceased, or administered by a licensed provider for a legal purpose,
(F) Hang gliding, sky diving and flying experimental aircraft.

PART 9. HEALTHCHOICE DENTAL BENEFITS, LIMITATIONS, AND EXCLUSIONS

317:150-5-30. Scope of coverage

The dental expense benefit applies to eligible covered employees and dependents. This benefit provides payment for dental expenses incurred in excess of any applicable deductible. –However, to elect this benefit, the member must either be a) enrolled in one of the group health plans offered through EGID or b) be enrolled in other qualified health coverage. It is not necessary for dependents to be covered by health benefits to receive the benefits of this Plan.

317:150-5-31. Plan limits

(a) **Deductible.** The deductible amounts are the out-of-pocket expenses for a class of benefits incurred by the employee for himself or on behalf of a covered dependent during each calendar year.
(b) **Family deductible.** During any benefit period, EGID will pay a percentage of the covered charges incurred which exceed the family deductible amount, if applicable.
(c) **Maximum benefits.** The dental plan has a maximum benefit on a calendar year basis as established by EGID.

317:150-5-32. HealthChoice Dental limitations and exclusions

For the dental plans provided by EGID, there is no coverage for expenses incurred for or in connection with conditions, services, procedures, treatments, expenses, items, and supplies excluded by EGID's benefits guidelines.

PART 11. HEALTHCHOICE MEDICARE SUPPLEMENT

317:150-5-40. Medicare Supplement and Medicare Part D Prescription Drug Plan (PDP)

Members who are eligible for Medicare will be assumed to be enrolled in both Parts A and B of Medicare. Benefits payable under the Medicare Supplement will be determined in accordance with this assumption. The Medicare Supplement is either connected with a Medicare Part D Prescription Drug Plan or contains pharmacy benefits that are considered creditable coverage by Medicare.

317:150-5-41. Primary insurer of current employees

The health plan(s) offered through EGID may be primary for current employees eligible for Medicare and their eligible covered dependents as set forth in the Federal statutes governing Medicare.

317:150-5-42. Limitations of Medicare Supplement

The Medicare Supplement health coverage is a supplement to the coverage provided by Medicare.

(1) This Supplement applies only after Medicare benefits are determined.
(2) Coverage is limited to Medicare's scheduled amount.

PART 15. HEALTHCHOICE SUBROGATION

317:150-5-49. Right of subrogation

(a) EGID reserves the right to recover funds from members, dependents, tortfeasors, liability policies, underinsured/uninsured motorist policies, medical payments policies and/or other identifiable sources of funds, in amounts equal to any and all claim payments made on behalf of a member or dependent for injury caused by a third party's wrongful act or negligence.

(b) EGID has the right to recover any sums collected by or on behalf of a member or dependent even if the member or dependent has not been made whole. EGID is entitled to reimbursement from any recovery even if the recovery does not fully compensate the member or dependent for their injury. The make-whole doctrine shall not apply. The sole exception to this paragraph exists only to the limited extent that EGID voluntarily elects to invoke its exclusive statutory authority to waive or reduce EGID's subrogation interest in an individual case.

(c) The act of submitting claims by or on behalf of a member or dependent constitutes notice and acceptance of EGID's right of recovery against the third party and creates a lien upon any identifiable funds referenced in (a) above.

(d) A member or dependent will not take any action to prejudice EGID's right of subrogation, such as settlement of the claim without first giving notice of EGID's subrogation rights to the responsible party and any and all known liability or other insurers.

(e) The member or dependent will cooperate in doing what is reasonably necessary to assist EGID in any recovery, including but not limited to promptly providing all information requested by EGID.

(f) Subrogation will exist only to the extent of plan benefits paid.

(g) Claims submitted after a member or dependent has released the responsible party may be denied at the option of EGID, by the issuance of routine written notice to the member, dependent, or their attorney.

(h) If claims relating to a specified injury are paid by EGID after the member or dependent has released the responsible party, when the member or dependent has failed to inform EGID in a timely manner prior to executing a release, EGID at its option, may require reimbursement from the member, dependent or provider.

(i) Claims submitted will initially be pended as incomplete and subsequently denied if information regarding possible third party responsibility is not voluntarily provided to EGID within a reasonable time period [not less than ninety (90) days] after the date the information was first requested in writing by or on behalf of EGID.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 155. EMPLOYEES GROUP INSURANCE DIVISION – HEALTHCHOICE DISABILITY PLAN

317:155-1-1. Purpose

All terms of the HealthChoice Disability plan shall be set forth in handbooks and administrative procedures. These shall describe program and coverage eligibility, what constitutes disability, maximum length of coverage, maximum and minimum benefits for short-term disability and long-term disability, the calculation of disability income benefits, and the suspension or termination of benefits.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 75. FEDERALLY QUALIFIED HEALTH CENTERS

317:30-5-660.3. Health Center enrollment requirements for specialty behavioral health services

~~(a)~~ For the provision of behavioral health related case management services and psychosocial rehabilitation services, Health Centers must contract as an outpatient behavioral health agency and meet the requirements found at OAC 317:30-5-241.3 and 317:30-5-241.6.

~~(b) Health Centers which provide substance use treatment services must also be certified by the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS)~~

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 1. PHYSICIANS

317:30-5-2. General coverage by category

(a) **Adults**. Payment for adults is made to physicians for medical and surgical services within the scope of the Oklahoma Health Care Authority's (OHCA) SoonerCare program, provided the services are reasonable and necessary for the diagnosis and treatment of illness or injury, or to improve the functioning of a malformed body member. Coverage of certain services must be based on a determination made by the OHCA's medical consultant in individual circumstances.

(1) Coverage includes, but is not limited to, the following medically necessary services:

(A) Inpatient hospital visits for all SoonerCare covered stays. All inpatient services are subject to post-payment review by the OHCA, or its designated agent.

(B) Inpatient psychotherapy by a physician.

(C) Inpatient psychological testing by a physician.

(D) One (1) inpatient visit per day, per physician.

(E) Certain surgical procedures performed in a Medicare certified free-standing ambulatory surgery center (ASC) or a Medicare certified hospital that offers outpatient surgical services.

(F) Therapeutic radiology or chemotherapy on an outpatient basis without limitation to the number of treatments per month for members with proven malignancies.

(G) Physician services on an outpatient basis include:

(i) A maximum of four (4) visits per member per month, including primary care or specialty, with the exception of SoonerCare Choice members.

(ii) Additional visits are allowed per month for treatment related to emergency medical conditions and family planning services.

(H) Direct physician services in a nursing facility.

(i) A maximum of two (2) nursing facility visits per month are allowed; and if the visit (s) is for psychiatric services, it must be provided by a psychiatrist or a physician with appropriate behavioral health training.

(ii) To receive payment for a second nursing facility visit in a month denied by Medicare for a Medicare/SoonerCare member, attach the explanation of Medicare benefits (EOMB) showing denial and mark "carrier denied coverage."

(I) Diagnostic x-ray and laboratory services.

(J) Mammography screening and additional follow-up mammograms as per current guidelines.

(K) Obstetrical care.

(L) Pacemakers and prostheses inserted during the course of a surgical procedure.

(M) Prior authorized examinations for the purpose of determining medical eligibility for programs administered by OHCA. A copy of the authorization, Oklahoma Department of Human Services (OKDHS) form 08MA016E, Authorization for Examination and Billing, must accompany the claim.

(N) If a physician renders direct care to a member on the same day as a dialysis treatment, payment is allowed for a separately identifiable service unrelated to the dialysis.
(O) Family planning includes sterilization procedures for legally competent members twenty-one (21) years of age and over who voluntarily request such a procedure and execute the federally mandated consent form with his/her physician. A copy of the consent form must be attached to the claim form. Separate payment is allowed for the insertion and/or implantation of contraceptive devices during an office visit. Certain family planning products may be obtained through the Vendor Drug Program. Reversal of sterilization procedures for the purposes of conception is not allowed. Reversal of sterilization procedures are allowed when medically indicated and substantiating documentation is attached to the claim.
(P) Genetic counseling.
(Q) Laboratory testing.
(R) Payment for ultrasounds for pregnant women as specified in Oklahoma Administrative Code (OAC) 317:30-5-22.
(S) Payment to the attending physician in a teaching medical facility for compensable services when the physician signs as claimant and renders personal and identifiable services to the member in conformity with federal regulations.
(T) Payment to the attending physician for the services of a currently Oklahoma licensed physician in training when the following conditions are met:

(i) Attending physician performs chart review and signs off on the billed encounter;
(ii) Attending physician is present in the clinic/or hospital setting and available for consultation; and
(iii) Documentation of written policy and applicable training of physicians in the training program regarding when to seek the consultation of the attending physician.

(U) Payment for services rendered by medical residents in an outpatient academic setting when the following conditions are met:

(i) The resident has obtained a medical license or a special license for training from the appropriate regulatory state medical board; and
(ii) Has the appropriate contract on file with the OHCA to render services within the scope of their licensure.

(V) The payment to a physician for medically directing the services of a certified registered nurse anesthetist (CRNA) or for the direct supervision of the services of an anesthesiologist assistant (AA) is limited. The maximum allowable fee for the services of both providers combined is limited to the maximum allowable had the service been performed solely by the anesthesiologist.
(W) Screening and follow up pap smears as per current guidelines.
(X) Medically necessary organ and tissue transplantation services for children and adults are covered services based upon the conditions listed in (i)-(v) of this subparagraph:

(i) All transplantation services, except kidney and cornea, must be prior authorized;
(ii) All transplant procedures are reviewed and prior authorization is based upon appropriate medical criteria;
(iii) All organ transplants must be performed at a Medicare-approved transplantation center;

(iv) 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

(v) Donor search and procurement services are covered for transplants consistent with the methods used by the Medicare program for organ acquisition costs.

(Y) Donor expenses incurred for complications are covered only if they are directly and immediately attributable to the donation procedure. Donor expenses that occur after the ninety (90) day global reimbursement period must be submitted to the OHCA for review.

(Z) Total parenteral nutritional (TPN) therapy for identified diagnoses and when prior authorized.

(AA) Ventilator equipment.

(BB) Home dialysis equipment and supplies.

(CC) Ambulatory services for treatment of members with tuberculosis (TB). This includes, but is not limited to, physician visits, outpatient hospital services, rural health clinic visits and prescriptions. Drugs prescribed for the treatment of TB beyond the prescriptions covered under SoonerCare require prior authorization by the University of Oklahoma College of Pharmacy Help Desk using form "Petition for TB Related Therapy." Ambulatory services to members infected with TB are not limited to the scope of the SoonerCare program, but require prior authorization when the scope is exceeded.

(DD) Smoking and tobacco use cessation counseling for treatment of members using tobacco.

(i) Smoking and tobacco use cessation counseling consists of the 5As:

(I) Asking the member to describe their smoking use;

(II) Advising the member to quit;

(III) Assessing the willingness of the member to quit;

(IV) Assisting the member with referrals and plans to quit; and

(V) Arranging for follow-up.

(ii) Up to eight (8) sessions are covered per year per individual.

(iii) Smoking and tobacco use cessation counseling is a covered service when performed by physicians, physician assistants (PA), advanced registered nurse practitioners (ARNP), certified nurse midwives (CNM), dentists, Oklahoma State Health Department (OSDH) and Federally Qualified Health Center (FQHC) nursing staff, and maternal/child health licensed clinical social worker trained as a certified tobacco treatment specialist (CTTS). It is reimbursed in addition to any other appropriate global payments for obstetrical care, primary care provider (PCP) care coordination payments, evaluation and management codes, or other appropriate services rendered. It must be a significant, separately identifiable service, unique from any other service provided on the same day.

(iv) Chart documentation must include a separate note that addresses the 5A's and office note signature along with the member specific information addressed in the five (5) steps and the time spent by the practitioner performing the counseling. Anything under three (3) minutes is considered part of a routine visit and not separately billable.

(EE) Immunizations as specified by the Advisory Committee on Immunization Practices (ACIP) guidelines.

(FF) Genetic testing and other molecular pathology services are covered when medically necessary. Genetic testing may be considered medically necessary when the following conditions are met:

(i) The member displays clinical features of a suspected genetic condition, is at direct risk of inheriting the genetic condition in question (e.g., a causative familial variant has been identified) or has been diagnosed with a condition where identification of specific genetic changes will impact treatment or management; and

(ii) Clinical studies published in peer-reviewed literature have established strong evidence that the result of the test will positively impact the clinical decision-making or clinical outcome for the member; and

(iii) The testing method is proven to be scientifically valid for the identification of a specific genetically-linked inheritable disease or clinically important molecular marker; and

(iv) A medical geneticist, physician, or licensed genetic counselor provides documentation that supports the recommendation for testing based on a review of risk factors, clinical scenario, and family history.

(GG) Behavioral Health Integration Services. For full guidelines, please refer to www.okhca.org/mau.

(2) General coverage exclusions include, but is not limited to, the following:

(A) Inpatient admission for diagnostic studies that could be performed on an outpatient basis.

(B) Services or any expense incurred for cosmetic surgery.

(C) Services of two (2) physicians for the same type of service to the same member on the same day, except when supplemental skills are required and different specialties are involved.

(D) Routine eye examinations for the sole purpose of prescribing glasses or visual aids, determination of refractive state, treatment of refractive errors or purchase of lenses, frames or visual aids.

(E) Pre-operative care within twenty-four (24) hours of the day of admission for surgery and routine post-operative care as defined under the global surgery guidelines promulgated by Current Procedural Terminology (CPT) and the Centers for Medicare and Medicaid Services (CMS).

(F) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.

(G) Sterilization of members who are under twenty-one (21) years of age, mentally incompetent, or institutionalized or reversal of sterilization procedures for the purposes of conception.

(H) Non-therapeutic hysterectomies.

(I) Medical services considered experimental or investigational. For more information regarding experimental or investigational including clinical trials, see OAC 317:30-3-57.1.

(J) Payment for more than four (4) outpatient visits per member (home or office) per month, except visits in connection with family planning, services related to emergency medical conditions, or primary care services provided to SoonerCare Choice members.

(K) Payment for more than two (2) nursing facility visits per month.

(L) More than one (1) inpatient visit per day per physician.

(M) Physician services which are administrative in nature and not a direct service to the member including such items as quality assurance, utilization review, treatment staffing, tumor board review or multidisciplinary opinion, dictation, and similar functions.
(N) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.
(O) Payment for the services of social workers, licensed family counselors, registered nurses or other ancillary staff, except as specifically set out in OHCA rules.
(P) Induced abortions, except when certified in writing by a physician that the abortion was necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, or that the pregnancy is the result of an act of rape or incest. (Refer to OAC 317:30-5-6 or 317:30-5-50).
(Q) Speech and hearing services.
(R) Mileage.
(S) A routine hospital visit on the date of discharge unless the member expired.
(T) Direct payment to perfusionist as this is considered part of the hospital reimbursement.
(U) Inpatient chemical dependency treatment.
(V) Fertility treatment.
(W) Payment for removal of benign skin lesions.

(b) **Children**. Payment is made to physicians for medical and surgical services for members under the age of twenty-one (21) within the scope of the SoonerCare program, provided the services are medically necessary for the diagnosis and treatment of illness or injury, or to improve the functioning of a malformed body member. Medical and surgical services for children are comparable to those listed for adults. For services rendered to a minor child, the child's parent or court-appointed legal guardian must provide written authorization prior to the service being rendered, unless there is an explicit state or federal exception to this requirement. In addition to those services listed for adults, the following services are covered for children.

(1) **Pre-authorization of inpatient psychiatric services**. All inpatient psychiatric services for members under twenty-one (21) years of age must be prior authorized by an agency designated by the OHCA. All psychiatric services are prior authorized for an approved length of stay. Non-authorized inpatient psychiatric services are not SoonerCare compensable.

(A) All inpatient psychiatric services are authorized based on the medical necessity criteria as described in OAC 317:30-5-95.25, 317:30-5-95.27 and 317:30-5-95.29.
(B) For out of state placements, refer to OAC 317:30-3-89 through 317:30-3-92.

(2) **General Acute inpatient service limitations**. All general Acute inpatient hospital services for members under the age of twenty-one (21) are not limited. All inpatient care must be medically necessary.

(3) **Procedures for requesting extensions for inpatient services**. The physician and/or facility must provide necessary justification to enable OHCA, or its designated agent, to make a determination of medical necessity and appropriateness of treatment options. Extension requests for psychiatric admissions must be submitted to the OHCA or its designated agent. Extension requests must contain the appropriate documentation validating the need for continued treatment in accordance with the medical necessity criteria described in OAC 317:30-5-95.26, 317:30-5-95.28 and 317:30-5-95.30. Requests must be made prior to the expiration of the approved inpatient stay. All decisions of OHCA or its designated agent are

final.

(4) **Utilization control requirements for psychiatric beds.** Utilization control requirements for inpatient psychiatric services for members under twenty-one (21) years of age apply to all hospitals and residential psychiatric treatment facilities.

(5) **Early and periodic screening diagnosis and treatment (EPSDT) program.** Payment is made to eligible providers for EPDST of members under age twenty-one (21). These services include medical, dental, vision, hearing and other necessary health care. Refer to OAC 317:30-3-65.2 through 317:30-3-65.12 for specific guidelines.

(6) **Reporting suspected abuse and/or 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 OKDHS 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.

(7) **General exclusions.** The following are excluded from coverage for members under the age of twenty-one (21):

(A) Inpatient admission for diagnostic studies that could be performed on an outpatient basis.

(B) Services or any expense incurred for cosmetic surgery unless the physician certifies the procedure emotionally necessary.

(C) Services of two (2) physicians for the same type of service to the same member on the same day, except when supplemental skills are required and different specialties are involved.

(D) Pre-operative care within twenty-four (24) hours of the day of admission for surgery and routine post-operative care as defined under the global surgery guidelines promulgated by CPT and CMS.

(E) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.

(F) Sterilization of members who are under twenty-one (21) years of age, mentally incompetent, or institutionalized or reversal of sterilization procedures for the purposes of conception.

(G) Non-therapeutic hysterectomies.

(H) Medical services considered experimental or investigational. For more information regarding experimental or investigational including clinical trials, see OAC 317:30-3-57.1.

(I) More than one (1) inpatient visit per day per physician.

(J) Induced abortions, except when certified in writing by a physician that the abortion was necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, or that the pregnancy is the result of an act of rape or incest. (Refer to OAC 317:30-5-6 or 317:30-5-50).

(K) Physician services which are administrative in nature and not a direct service to the

member including such items as quality assurance, utilization review, treatment staffing, tumor board review or multidisciplinary opinion, dictation, and similar functions.

(L) Payment for the services of social workers, licensed family counselors, registered nurses or other ancillary staff, except as specifically set out in OHCA rules.

(M) Direct payment to perfusionist as this is considered part of the hospital reimbursement.

(N) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.

(O) Mileage.

(P) A routine hospital visit on date of discharge unless the member expired.

(c) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the OHCA allowable for comparable services. Claims filed with Medicare Part B should automatically cross over to OHCA. The EOMB reflects a message that the claim was referred to SoonerCare. If such a message is not present, a claim for coinsurance and deductible must be filed with the OHCA within ninety (90) days of the date of Medicare payment and within one (1) year of the date of service in order to be considered timely filed.

(1) In certain circumstances, some claims do not automatically "cross over." Providers must file a claim for coinsurance and/or deductible to SoonerCare within ninety (90) days of the Medicare payment and within one (1) year from the date of service.

(2) If payment was denied by Medicare Part B and the service is a SoonerCare covered service, mark the claim "denied by Medicare" and attach the EOMB showing the reason for the denial.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 62. PRIVATE DUTY NURSING

317:30-5-558. Private duty nursing (PDN) coverage limitations

The following provisions apply to all PDN services and provide coverage limitations:

(1) All services must be prior authorized to receive payment from the Oklahoma Health Care Authority (OHCA). Prior authorization means authorization in advance of services provided in accordance with Oklahoma Administrative Code (OAC) 317:30-3-31 and 317:30-5-560.1;

(2) A treatment plan must be completed by an eligible PDN provider before requesting prior authorization and must be updated at least annually and signed by the physician [medical doctor (MD), or doctor of osteopathy, (DO)], a physician assistant (PA), or advanced practice registered nurse (APRN)];

(3) An assessment by an OHCA care management nurse is required prior to the authorization for services. The assessment will be conducted by the OHCA through one (1) of the following:

(A) ~~Telephone~~**Telephone.** Audio-only telephonic communication;

(B) ~~Virtually~~**Virtually.** Virtual visits are the standard method of assessment. This is a means to use virtual technology to collect medical and other forms of health data for the purposes of assessment and recommendation; or

(C) ~~Face-to-face;~~**Face-to-face.** In person face-to-face assessments are completed when determined by OHCA to be the most appropriate assessment method. A face-to-face assessment is not completed at the parent or caregiver's request.

(4) Care in excess of the designated hours per ~~day~~week granted in the prior authorization is not SoonerCare compensable. Prior-authorized but unused service hours cannot be ~~"banked," "saved," or otherwise "accumulated"~~accumulated for use at a future date or time. If such hours or services are provided, they are not SoonerCare compensable.

(5) Any medically necessary PDN care provided outside of the home must be counted in and cannot exceed the number of hours requested on the treatment plan and approved by OHCA.

(6) PDN services do not include office time or administrative time in providing the service. The time billed is for direct nursing services only.

(7) Staff must be engaged in purposeful activity that directly benefits the member receiving services. Staff must be physically able and mentally alert to carry out the duties of the job. At no time will OHCA compensate an organization for nursing staff time when sleeping.

(8) OHCA will not approve PDN services if all health and safety issues cannot be met in the setting in which services are provided.

(9) A provider must not misrepresent or omit facts in a treatment plan.

(10) It is outside the scope of coverage to deliver care in a manner outside of the treatment plan or to deliver units over the authorized units of care.

(11) PDN is not authorized in excess of 112 hours per week, not exceeding sixteen (16) hours per day. There may be approval for additional hours for a period not to exceed thirty (30) days, if:

(A) The member has an acute episode that would otherwise require hospitalization or immediately following a hospital stay; or

(B) The primary caregiver is temporarily and involuntarily unable to provide care.

(C) The OHCA has discretion and the final authority to approve or deny any additional PDN hours and will take into consideration that the additional hours are not to be a substitute for institutionalized care.

(12) Family and/or caregivers and/or guardians (hereinafter, "caregivers") are required to provide some of the nursing care to the member without compensation. PDN services shall not be provided solely to allow the member's caregiver to work or go to school, nor solely to allow respite for the caregiver.

(13) PDN services will not be approved for overnight trips away from the member's primary residence that are unrelated to medically necessary treatment or medical care.

(A) For a member to receive Medicaid-reimbursable PDN services on an overnight trip that is related to medically necessary treatment or medical care, all provisions of this Part must be met. If said trip occurs out of state, OAC 317:30-3-89 through 317:30-3-92 must also be met.

(B) In instances in which the member's family is temporarily absent due to vacations, any additional PDN hours must be paid for by the family, or provided by other trained family members without SoonerCare reimbursement.

(14) PDN services will not be approved when services are reimbursed or reimbursable by other insurance, other governmental programs, or Medicaid program services that the member receives or is eligible to receive. For example, if a member receives Medicaid-reimbursable PDN services pursuant to an Individualized Education Program (IEP) in a public school, then those PDN school hours will be counted in the member's daily allotment of PDN services.

317:30-5-559. How Private Duty Nursing (PDN) services are authorized

PDN services may be initiated after completion of the following steps:

(1) A treatment plan for the patient has been created by an eligible PDN provider per Oklahoma Administrative Code (OAC) 317:30-5-560;

(2) A prior authorization request is submitted with the appropriate Oklahoma Health Care Authority (OHCA) required data elements and the treatment plan;

(3) An assessment (telephonic, virtual, or face-to-face) has been conducted by an OHCA care management nurse, per OAC 317:30-5-558 (3); and

(4) An OHCA physician, or his or her designee, has determined the medical necessity of the service, including but not limited to, scoring the member's needs on the OHCA PDN assessment.

317:30-5-560. Treatment plan

(a) An eligible organization must create a treatment plan for the member as part of the authorization process for private duty nursing (PDN) services. The initial treatment plan must be signed by the member's attending physician [medical doctor (MD), or doctor of osteopathy, (DO)], a physician assistant (PA), or advanced practice registered nurse (APRN).

(b) The treatment plan must include all of the following:

(1) Diagnosis;

(2) Prognosis;

(3) Anticipated length of treatment;

(4) Number of PDN requested hours per ~~day~~week;

(5) Assessment needs and frequency (e.g., vital signs, glucose checks, neuro checks,

respiratory);
(6) Medication method of administration and frequency;
(7) Age-appropriate feeding requirements (diet, method and frequency);
(8) Respiratory needs;
(9) Mobility requirements including need for turning and positioning, and the potential for skin breakdown;
(10) Developmental deficits;
(11) Casting, orthotics, therapies;
(12) Age-appropriate elimination needs;
(13) Seizure activity and precautions;
(14) Age-appropriate sleep patterns;
(15) Disorientation and/or combative issues;
(16) Age-appropriate wound care and/or personal care;
(17) Communication issues;
(18) Social support needs;
(19) Name, skill level, and availability of all caregivers; and
(20) Other pertinent nursing needs such as dialysis, isolation.

317:30-5-560.1. Prior authorization requirements

(a) Authorizations are provided for a maximum period of six (6) months.
(b) Authorizations require:
(1) A treatment plan for the member;
(2) An assessment (telephonic, virtual, or face-to-face) has been conducted by an Oklahoma Health Care Authority (OHCA) care management nurse, per Oklahoma Administrative Code (OAC) 317:30-5-558 (2); and
(3) An OHCA physician, or his or her designee, to determine medical necessity including use of the OHCA Private Duty Nursing (PDN) assessment.
(c) The number of hours authorized may differ from the hours requested on the treatment plan based on the review by an OHCA physician.
(d) If the member's condition necessitates a change in the treatment plan, the provider must request a new prior authorization.
(e) Changes in the treatment plan may necessitate another assessment (telephonic, virtual, or face-to-face) by an OHCA care management nurse.

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

SUBCHAPTER 23. LIVING CHOICE PROGRAM

317:35-23-2. Eligibility criteria

Adults with disabilities or long-term illnesses, members with intellectual disabilities and members with physical disabilities are eligible to transition into the community through the Living Choice program if they meet all of the criteria in paragraphs (1) through (7) of this subsection.

(1) He/she must be at least nineteen (19) years of age.

(2) He/she must reside in a nursing facility, skilled nursing facility, ~~or a~~ qualified long term care facility, or a public or private Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) for at least sixty (60) consecutive days prior to the proposed transition date. ~~If any portion of the sixty (60) days includes time in a skilled nursing facility, those days cannot be counted toward the sixty (60) day requirement, if the member received Medicare post-hospital extended care rehabilitative services.~~

(3) He/she must have at least one (1) day of Medicaid paid long-term care services prior to transition.

(4) If transitioning from an out of state institution, he/she must be SoonerCare eligible.

(5) He/she requires at least the same level of care that necessitated admission to the institution.

(6) He/she must reside in a qualified residence after leaving the institution. A qualified residence is defined in (A) through (C) of this paragraph.

(A) a home owned or leased by the individual or the individual's family member;

(B) an apartment with an individual lease, with a locking entrance/exit, and which includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control; and

(C) a residence, in a community-based residential setting, in which no more than four (4) unrelated individuals reside.

(7) His/her needs can be met by the Living Choice program while living in the community.

(8) He/she must not be a resident of a nursing facility or ICF/IID in lieu of incarceration.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 34. SECURE BEHAVIORAL HEALTH TRANSPORTATION

317:30-5-347. Definitions

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

"Member/eligible member" means any person eligible for SoonerCare and individuals considered to be Medicare/SoonerCare dual eligible.

"Nearest appropriate facility" means a medical facility that is generally equipped and legally permitted to provide the needed care for the illness or injury involved that is the closest in geographical proximity to the member's pickup location.

"OAC" means Oklahoma Administrative Code.

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

"O.S." means Oklahoma Statutes.

"Qualified Transportation Service Provider" or **"QTSP"** means an ODMHSAS-contracted transportation provider for members requiring transportation to a treatment facility for the purpose of examination, emergency detention, protective custody, or inpatient services in accordance with 43A O.S. § 1-110.

317:30-5-348. Program overview

(a) ODMHSAS-contracted Qualified Transportation Service Providers (QTSPs) are required to transport SoonerCare members reasonably believed to be experiencing a behavioral health crisis to and from designated sites/facilities for the purpose of examination, emergency detention, protective custody, or inpatient services in accordance with 43A O.S. § 1-110.

(b) SoonerCare members being transported shall be afforded all rights and privileges guaranteed by the laws and Constitution of the State of Oklahoma and the United States of America. SoonerCare members have the right to be transported in a way that protects their dignity and safety.

(c) Mechanical restraints may only be used in the transportation of members when needed in accordance with 43A O.S. § 1-110 and as defined in the QTSP's contract with ODMHSAS.

317:30-5-349. Program eligibility and covered services

(a) SoonerCare members, both children and adults, are eligible for services when medically necessary.

(b) A member must be reasonably believed to be experiencing a behavioral health crisis as evidenced by extreme emotional distress that includes, but is not limited to, an acute episode of mental illness and/or suicidal thoughts and/or behavior that may occur with substance use and other disorders.

(c) Secure behavioral health transportation may be provided when medically necessary for the following:

(1) Transportation to a facility arranged by individuals authorized by ODMHSAS, including but not limited to, hospitals and other mental health facilities;

(2) Facility-to-facility transports; and

(3) Transport of a member seeking voluntary admission to a facility.

(d) Members must be transported to the nearest appropriate facility.
(e) Out-of-state transports are allowable when medically necessary and may require prior approval or authorization by ODMHSAS.

317:30-5-350. Service requirements

(a) **Eligible providers.** Service providers must be ODMHSAS-contracted Qualified Transportation Service Providers (QTSPs) and meet the Uniform Transportation Standards for QTSPs described in this Section.

(b) **Driver requirements.** Drivers must:

(1) Be twenty-one (21) years of age or older;

(2) Hold a valid driver's license issued by the State of Oklahoma;

(3) Undergo a criminal background check and not have been convicted of or received a deferred or probated sentence related to any felony crime, a crime involving moral turpitude or a crime of domestic violence; and not have any criminal charges pending in ay court in the State of Oklahoma, another state, in tribal court or pursuant to the United States Code;

(4) Be able to ensure that SoonerCare members who are transported are protected by harm and injuries due to abuse, self-abuse, neglect, sexual incidents, serious injuries and other sources of immediate danger;

(5) Be able to provide emergency care or have an established plan to access emergency care;

(6) Be trained in effective communication skills with persons with mental illness, consumer rights, CPR/First Aid, and confidentiality as prescribed by ODMHSAS prior to completing transports;

(7) Be able to recognize and plan for problematic behaviors in a therapeutic and safe manner and complete a 16-hour Therapeutic Options Course or similar curriculum approved by ODMHSAS prior to completing transports; and

(8) Be familiar with the statutes and standards related to transporting members.

(c) **Vehicle requirements.** Vehicles must:

(1) Be well maintained and in good mechanical condition;

(2) Have the following equipment operational:

(A) Air conditioner;

(B) Heater; and

(C) Chemical-type fire extinguisher, of at least a one-quart capacity, located in the same compartment of the vehicle as the driver.

(3) Have a safety partition between the driver's area and passenger's area;

(4) Have safety locks to prevent a member from exiting a car that is in motion;

(5) Be equipped with, either in the car or on the driver, a two-way radio or cellular telephone that is operational during the entire period of transport; and

(6) If transporting members in wheelchairs, be equipped with the following:

(A) An electrical or hydraulically operated lift mechanism or a ramp with a non-skid surface;

(B) A means of securing a wheelchair to the inside of the vehicle to prevent any lateral, forward, backward, or vertical motion of the wheelchair within the vehicle;

(C) A rear-view mirror that enables the driver to view any passenger in a wheelchair; and

(D) A door at the rear of the vehicle for an emergency exit.

317:30-5-351. Authorization and reimbursement

(a) Secure behavioral health transportation does not require a prior authorization, with the exception of out-of-state transports, which may require prior approval or authorization by ODMHSAS.
(b) Secure behavioral health transportation is reimbursed per 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 5. PHARMACIES

317:30-5-78. Reimbursement

(a) **Reimbursement.** Reimbursement for pharmacy claims is based on the sum of the ingredient cost plus a professional dispensing fee for brand and generic drugs dispensed by a retail community pharmacy or for a member residing in a long term care facility.

(b) **Ingredient Cost.** Ingredient cost is determined by one of the following methods:

(1) **Maximum Allowable Cost.** The State Maximum Allowable Cost (SMAC) is established for certain products which have a Food and Drug Administration (FDA) approved generic equivalent. The SMAC will be calculated using prices from pharmaceutical wholesalers who supply these products to pharmacy providers in Oklahoma. Pharmacies may challenge a specific product's SMAC price by providing information from their wholesaler(s) to certify a net cost higher than the calculated SMAC price and that there is not another product available to them which is generically equivalent to the higher priced product.

(2) **Actual Acquisition Cost.** The Actual Acquisition Cost (AAC) means the cost of a particular drug product to the pharmacy based on a review of invoices or the Wholesale Acquisition Cost (WAC), whichever is lower. The National Average Drug Acquisition Cost (NADAC) is based on a review of invoices and published by Centers for Medicare and Medicaid Services (CMS) and will be used in the determination of AAC.

(3) **Specialty Pharmaceutical Allowable Cost.** Reimbursement for specialty drugs not typically dispensed by a retail community pharmacy and dispensed primarily by delivery, including clotting factor for hemophilia, shall be set as a Specialty Pharmaceutical Allowable Cost (SPAC). The Medicare Part B allowed charge~~, defined as Average Sales Price (ASP) plus 6%,~~ WAC, and NADAC when available, will be considered in setting the SPAC rate. For the purpose of this section, a drug may be classified as a specialty drug when it has one or more of the following characteristics:

(A) Covered by Medicare Part B;
(B) "5i drug" B Injected, infused, instilled, inhaled, or implanted;
(C) Cost greater than $1,000.00 per claim;
(D) Licensed by the FDA under a Biological License Application;
(E) Special storage, shipping, or handling requirements;
(F) Available only through a limited distribution network; and/or
(G) Does not have a NADAC price from CMS.

(4) **Exceptions.** Some exceptions apply to the above ingredient cost methods:

(A) Physician administered drugs shall be priced based on a formula equivalent to the Medicare Part B allowed charge~~, defined as ASP plus 6%~~. If a price equivalent to the Medicare Part B allowed charge cannot be determined, a purchase invoice may be supplied by the provider and will be considered in setting the reimbursement.

(B) I/T/U pharmacies shall be reimbursed at the OMB encounter rate as a per member per facility per day fee regardless of the number of prescriptions filled on that day. I/T/U pharmacies should not split prescriptions into quantities less than a one month supply for

maintenance medications. For this purpose a maintenance medication is one that the member uses consistently month to month.

(C) Pharmacies other than I/T/U facilities that acquire drugs via the Federal Supply Schedule (FSS) or at nominal price outside the 340B program or FSS shall notify OHCA and submit claims at their actual invoice price plus a professional dispensing fee.

(c) **Professional dispensing fee.** The professional dispensing fee for prescribed medication is established by review of surveys. A recommendation is made by the State Plan Amendment Rate Committee and presented to the Oklahoma Health Care Authority Board for their approval. There may be more than one level or type of dispensing fee if approved by the OHCA Board and CMS. A contracted pharmacy agrees to participate in any survey conducted by the OHCA with regard to dispensing fees. The pharmacy shall furnish all necessary information to determine the cost of dispensing drug products. Failure to participate may result in administrative sanctions by the OHCA which may include but are not limited to a reduction in the dispensing fee.

(d) **Reimbursement for prescription claims.** Prescription claims will be reimbursed using the lower of the following calculation methods:

(1) the lower of Actual Acquisition Cost (AAC), State Maximum Allowable Cost (SMAC), or Specialty Pharmaceutical Allowable Cost (SPAC) plus a professional dispensing fee, or

(2) usual and customary charge to the general public. The pharmacy is responsible to determine its usual and customary charge to the general public and submit it to OHCA on each pharmacy claim. The OHCA may conduct periodic reviews within its audit guidelines to verify the pharmacy's usual and customary charge to the general public and the pharmacy agrees to make available to the OHCA's reviewers prescription and pricing records deemed necessary by the reviewers. The OHCA defines general public as the patient group accounting for the largest number of non-SoonerCare prescriptions from the individual pharmacy, but does not include patients who purchase or receive their prescriptions through other third-party payers. If a pharmacy offers discount prices to a portion of its customers (i.e. -10% discount to senior citizens), these lower prices would be excluded from the usual and customary calculations unless the patients receiving the favorable prices represent more than 50% of the pharmacy's prescription volume. The usual and customary charge will be a single price which includes both the product price and the dispensing fee. For routine usual and customary reviews, the pharmacy may provide prescription records for non-SoonerCare customers in a manner which does not identify the customer by name so long as the customer's identity may be determined later if a subsequent audit is initiated. The OHCA will provide the pharmacy notice of its intent to conduct a review of usual and customary charges at least ten days in advance of its planned date of review.

(e) **Payment of Claims.** In order for an eligible provider to be paid for filling a prescription drug, the pharmacy must complete all of the following:

(1) have an existing provider agreement with OHCA,

(2) submit the claim in a format acceptable to OHCA,

(3) have a prior authorization before filling the prescription, if a prior authorization is necessary,

(4) have a proper brand name certification for the drug, if necessary, and

(5) include the usual and customary charges to the general public as well as the actual acquisition cost and professional dispensing fee.

(f) **Claims.** Prescription reimbursement may be made only for individuals who are eligible for coverage at the time a prescription is filled. Member eligibility information may be accessed by

swiping a SoonerCare identification card through a commercial card swipe machine which is connected to the eligibility database or via the Point of Sale (POS) system when a prescription claim is submitted for payment. Persons who do not contract with commercial vendors can use the Member Eligibility Verification System (EVS) at no additional cost.

PART 5. MEDICAL SUPPLIERS

317:30-5-218. Reimbursement

(a) **Medical supplies, equipment and appliances.**

~~(1)~~ Reimbursement for medical supplies, equipment, and appliances will be made using an amount derived from the lesser of the Oklahoma Health Care Authority (OHCA) maximum allowable fee or the provider's usual and customary charge. The maximum allowable fee is the maximum amount that the OHCA will pay a provider for an allowable procedure. When a code is not assigned a maximum allowable fee for a unit of service, a fee will be established.

~~(2)~~(1) The fee schedule will be reviewed annually. Adjustments to the fee schedule may be possible at any time based on efficiency, budget considerations, federal regulations, and quality of care as determined by the OHCA.

~~(3)~~(2) Payment for medical supplies, equipment, and appliances will be calculated using the rate methodologies found in the Oklahoma Medicaid State Plan.

~~(4)~~(3) Payment is not made for medical supplies, equipment, and appliances that are not deemed as medically necessary or considered over-the-counter.

~~(5)~~(4) OHCA does not reimburse medical supplies, equipment, and appliances providers separately for services that are included as part of the payment for another treatment program. For example, all items required during inpatient stays are paid through the inpatient payment structure.

~~(6)~~(5) Medical supplies, equipment, and appliance products purchased at a pharmacy are paid the equivalent to the Medicare Part B~~, average sales price (ASP) + six percent (6%)~~ allowed charge. When ~~ASP~~the Medicare Part B allowed charge is not available, an equivalent price is calculated using ASP or wholesale acquisition cost (WAC). If no Medicare, ASP, or WAC pricing is available, then the price will be calculated based on invoice cost.

(b) **Manually-priced medical equipment and supplies.** There may be instances when manual pricing is required. When it is, the following pricing methods will be used:

(1) **Invoice pricing.** Reimbursement is at the provider's documented manufacturer's suggested retail price (MSRP) minus thirty percent (30%) or at the provider's invoice cost plus thirty percent (30%), whichever is the lesser of the two.

(2) **Fair market pricing.** OHCA may establish a fair market price through claims review and analysis. For a list of medical equipment and supplies that are fair market-priced, refer to the OHCA website at www.okhca.org for the fair market value list (Selected medical supplies, equipment, and appliance items priced at fair market price).

(c) **Oxygen equipment and supplies.** ~~(1)~~ Payment for stationary oxygen systems (liquid oxygen systems, gaseous oxygen systems, and oxygen concentrators) is based on continuous rental, i.e., a continuous monthly payment that is made as long as it is medically necessary. The rental payment includes all contents and supplies, e.g., regulators, tubing, masks, etc. Portable oxygen systems are considered continuous rental. Ownership of the equipment remains with the supplier.

~~(2)~~(1) 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. In addition, the provider/supplier will not be reimbursed for mileage.
~~(3)~~(2) Payment for oxygen and oxygen equipment and supplies will not exceed the Medicare fee for the same procedure code.
~~(4)~~(3) For residents in a long-term care facility, durable medical equipment products, including oxygen, are included in the facility's per diem rate.

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

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING EMERGENCY RULES ARE CONSIDERED PROMULGATED AND EFFECTIVE UPON APPROVAL BY THE GOVERNOR AS SET FORTH IN 75 O.S., SECTION 253(F):

SUBCHAPTER 1. GENERAL PROVISIONS

317:35-1-2. Definitions

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

"Acute Care Hospital" means an institution that meets the requirements defined in Section (§) 440.10 of Title 42 of the Code of Federal Regulations (C.F.R.) and:

(A) Is maintained primarily for the care and treatment of patients with disorders other than mental diseases;

(B) Is formally licensed or formally approved as a hospital by an officially designated authority for state standard setting; and

(C) Meets the requirements for participation in Medicare as a hospital.

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

"ADvantage Administration (AA)" means the Oklahoma Department of Human Services (OKDHS) which performs certain administrative functions related to the ADvantage Waiver.

"Aged" means an individual whose age is established as sixty-five (65) years or older.

"Agency partner" means an agency or organization contracted with the OHCA that will assist those applying for services.

"Aid to Families with Dependent Children (AFDC)" means the group of low-income families with children described in Section 1931 of the Social Security Act. The Personal Responsibility and Work Opportunity Act of 1996 established the new eligibility group of low-income families with children and linked eligibility income and resource standards and methodologies and the requirement for deprivation for the new group to the State plan for AFDC in effect on July 16, 1996. Oklahoma has elected to be less restrictive for all SoonerCare members related to AFDC. Children covered under Section 1931 are related to the children's group, and adults covered under Section 1931 are related to the parent and caretaker relative group. The Modified Adjusted Gross Income (MAGI) methodology is used to determine eligibility for these groups.

"Alien" is synonymous with the word "noncitizen" and means an individual who does not have United States citizenship and is not a United States national.

"Area nurse" means a registered nurse in the OKDHS Aging Services Division, designated according to geographic areas who evaluates the Uniform Comprehensive Assessment Tool (UCAT) and determines medical eligibility for Personal Care, ADvantage Waiver, and Nursing Facility services. The area nurse also approves care plan and service plan implementation for Personal Care services.

"Area nurse designee" means a registered nurse selected by the area nurse who evaluates the UCAT and determines medical eligibility for Personal Care, ADvantage Waiver, and Nursing

Facility services.

"Authority" means the OHCA.

"Blind" means an individual who has central visual acuity of 20/200 or less in the better eye with the use of a correcting lens.

"Board" means the OHCA Board.

"Buy-in" means the procedure whereby the OHCA pays the member's Medicare premium.

(A) **"Part A Buy-in"** means the procedure whereby the OHCA pays the Medicare Part A premium for individuals determined eligible as Qualified Medicare Beneficiaries Plus (QMBP) who are enrolled in Part A and are not eligible for premium free enrollment as explained under Medicare Part A. This also includes individuals determined to be eligible as Qualified Disabled and Working Individuals (QDWI).

(B) **"Part B Buy-in"** means the procedure whereby the OHCA pays the Medicare Part B premium for categorically needy individuals who are eligible for Part B Medicare. This includes individuals who receive TANF or the State Supplemental Payment to the Aged, Blind or Disabled, and those determined to be Qualified Medicare Beneficiary Plus (QMBP), Specified Low Income Medicare Beneficiaries (SLMB) or Qualifying Individual-1 (QI-1). Also included are individuals who continue to be categorically needy under the PICKLE amendment and those who retain eligibility after becoming employed.

"Caretaker relative" means a person other than the biological or adoptive parent with whom the child resides who meets the specified degree of relationship within the fifth degree of kinship.

"Case management" means the activities performed for members to assist them in accessing services, advocacy and problem solving related to service delivery.

"Categorically needy" means that income and, when applicable, resources are within the standards for the category to which the individual is related.

"Categorically related" or **"related"** means the individual meets basic eligibility requirements for an eligibility group.

"Certification period" means the period of eligibility extending from the effective date of certification to the date of termination of eligibility or the date of the next periodic redetermination of eligibility.

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

"Continuous eligibility" means uninterrupted eligibility for the extent of the certification period regardless of any changes in circumstances, unless:

(A) The child turns age nineteen (19);

(B) The child dies;

(C) The child is no longer an Oklahoma resident;

(D) The child becomes incarcerated (per OAC 317:35-6-45 the eligibility is suspended for the duration of the incarceration period for individuals under the age of twenty-one (21) except for periods of time that inpatient services are provided per OAC 317:35-5-26);

(E) The adult parent or caretaker relative on the case requests that the medical benefits are closed;

(F) The state has erred in the eligibility determination;

(G) The child or the adult parent or caretaker relative on the case has committed fraud or perjury in order to become eligible; or

(H) The child becomes categorically related to either the pregnancy eligibility group or

the former foster care eligibility groups, thereby receiving eligibility based on such category, which is not considered an interruption in continuous eligibility.

"County" means the Oklahoma OKDHS' office or offices located in each county within the State.

"Custody" means the custodial status, as reported by OKDHS.

"Deductible/Coinsurance" means the payment that must be made by or on behalf of an individual eligible for Medicare before Medicare payment is made. The coinsurance is that part of the allowable medical expense not met by Medicare, which must be paid by or on behalf of an individual after the deductible has been met.

(A) For Medicare Part A (Hospital Insurance), the deductible relates to benefits for inpatient services while the patient is in a hospital or nursing facility. After the deductible is met, Medicare pays the remainder of the allowable cost.

(B) For Medicare Part B (Medical Insurance), the deductible is an annual payment that must be made before Medicare payment for medical services. After the deductible is met, Medicare pays eighty percent (80%) of the allowable charge. The remaining twenty percent (20%) is the coinsurance.

"Disabled" means an individual who is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death, or which has lasted (or can be expected to last) for a continuous period of not less than twelve (12) months.

"Disabled child" means for purposes of Medicaid Recovery a child of any age who is blind, or permanently and totally disabled according to standards set by the Social Security Administration.

"Estate" means all real and personal property and other assets included in the member's estate as defined in Title 58 of the Oklahoma Statutes.

"Expansion adult" means an individual defined by 42 Code of Federal Regulations (C.F.R.) § 435.119 who is age nineteen (19) or older and under sixty-five (65), at or below 133 percent of the federal poverty level (FPL), and who are not related to the aged, blind, or disabled.

"Gatekeeping" means the performance of a comprehensive assessment by the OKDHS nurse utilizing the UCAT for the determination of medical eligibility, care plan development, and the determination of Level of Care for Personal Care, ADvantage Waiver and Nursing Facility services.

"Ineligible Spouse" means an individual who is not eligible for Supplemental Security Income (SSI) but is the husband or wife of someone who is receiving SSI.

"Lawfully present" means a noncitizen in the United States who is considered to be in lawful immigration status or class.

"Lawfully residing" means the individual is lawfully present in the United States and also meets Medicaid residency requirements.

"Local office" means the Oklahoma OKDHS' office or offices located in each county within the State.

"LOCEU" means the Oklahoma Health Care Authority's Level of Care Evaluation Unit.

"MAGI eligibility group" means an eligibility group whose financial eligibility is determined through the Modified Adjusted Gross Income (MAGI) methodology. The groups subject to MAGI are defined in 42 C.F.R. _ 436.603 and listed in OAC 317:35-6-1.

"Modified Adjusted Gross Income (MAGI)" means the financial eligibility determination methodology established by the Patient Protection and Affordable Care Act (PPACA) in 2009.

"Medicare" means the federally funded health insurance program also known as Title XVIII

of the Social Security Act. It consists of four (4) separate programs. Part A is Hospital Insurance, Part B is Medical Insurance, Part C is Medicare Advantage Plans, and Part D is Prescription Drug Coverage.

(A) **"Part A Medicare"** means Hospital Insurance that covers services for inpatient services while the patient is in a hospital or nursing facility. Premium free enrollment is provided for all persons receiving Old Age, Survivors, and Disability Insurance (OASDI) or Railroad Retirement income who are age sixty-five (65) or older and for those under age sixty-five (65) who have been receiving disability benefits under these programs for at least twenty-four (24) months.

(i) Persons with end-stage renal disease who require dialysis treatment or a kidney transplant may also be covered.

(ii) Those who do not receive OASDI or Railroad Retirement income must be age sixty-five (65) or over and pay a large premium for this coverage. Under Authority rules, these individuals are not required to enroll for Part A to be eligible for SoonerCare benefits as categorically needy. They must, however, enroll for Medicare Part B. Individuals eligible as a QMBP or as a QDWI under Medicaid are required to enroll for Medicare Part A. The Authority will pay Part A premiums for QMBP individuals who do not qualify for premium free Part A and for all QDWI's.

(B) **"Part B Medicare"** means Supplemental Medical Insurance that covers physician and related medical services other than inpatient or nursing facility care. Individuals eligible to enroll in Medicare Part B are required to do so under OHCA policy. A monthly premium is required to keep this coverage in effect.

"Minor child" means a child under the age of eighteen (18).

"Noncitizen" is synonymous with the word "alien" and means an individual who does not have United States citizenship and is not a United States national.

"Nursing Care" for the purpose of Medicaid Recovery is care received in a nursing facility, an intermediate care facility for individuals with intellectual disabilities (ICF/IIDs) or other medical institution providing nursing and convalescent care, on a continuing basis, by professional personnel who are responsible to the institution for professional medical services.

"OCSS" means the OKDHS' Oklahoma Child Support Services (formerly Child Support Enforcement Division).

"OHCA" means the Oklahoma Health Care Authority.

"OHCA Eligibility Unit" means the group within the OHCA that assists with the eligibility determination process.

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

"OKDHS nurse" means a registered nurse in the OKDHS Aging Services Division who meets the certification requirements for UCAT Assessor and case manager, and who conducts the uniform assessment of individuals utilizing the UCAT for the purpose of medical eligibility determination. The OKDHS nurse also develops care plans and service plans for Personal Care services based on the UCAT.

"Qualified Disabled and Working Individual (QDWI)" means individuals who have lost their Title II OASDI benefits due to excess earnings but have been allowed to retain Medicare coverage.

"Qualified Medicare Beneficiary Plus (QMBP)" means certain aged, blind or disabled individuals who may or may not be enrolled in Medicare Part A, meet the Medicaid QMBP income and resource standards and meet all other Medicaid eligibility requirements.

"Qualifying Individual" means certain aged, blind or disabled individuals who are enrolled in Medicare Part A, meet the Medicaid Qualifying Individual income and resource standards and meet all other Medicaid eligibility requirements.

"Qualifying Individual-1" means a Qualified Individual who meets the Qualifying Individual-1 income and resource standards.

"Reasonably compatible" means that there is no significant discrepancy between information declared by a member or applicant and other information available to the agency. More specific policies and procedures for determining whether a declaration is reasonably compatible are detailed in Oklahoma's Verification Plan.

"Recipient lock-in" means when a member is restricted to one primary physician and/or one pharmacy. It occurs when the OHCA determines that a SoonerCare member has used multiple physicians and/or pharmacies in an excessive manner over a twelve (12) month period.

"Scope" means the covered medical services for which payment is made to providers on behalf of eligible individuals. The OHCA Provider Manual (OAC 317:30) contains information on covered medical services.

"Specified Low Income Medicare Beneficiaries (SLMB)" means individuals who, except for income, meet all of the eligibility requirements for QMBP eligibility and are enrolled in Medicare Part A.

"TEFRA" means the Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97-248). TEFRA provides coverage to certain disabled children living in the home who would qualify for SoonerCare if residents of nursing facilities, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs), or inpatient acute care hospital stays are expected to last not less than sixty (60) days.

"Worker" means the OHCA or OKDHS worker responsible for assisting in eligibility determinations.

SUBCHAPTER 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~~Temporary Assistance for Needy Families (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, except for children who are eligible for twelve months continuous coverage; 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 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 Oklahoma residence; or

(B) Expires.

(4) A newborn child cannot be deemed eligible when the mother's only coverage was presumptive eligibility, and continued eligibility was not established.

317:35-6-60.1 Changes in circumstances

(a) **Reporting changes.** Members are required to report changes in their circumstances within ~~10~~ten (10) days of the date the member is aware of the change.

(b) **Agency action on changes in circumstances**. When the agency responsible for determining eligibility for the member becomes aware of a change in the member's circumstances, the agency will promptly redetermine eligibility for all household members whose eligibility is affected by the change.

(c) **Changes reported by third parties.** When the agency receives information regarding a change in the member's circumstances from a third party, such as the Oklahoma Employment Security Commission (OESC) or the Social Security Administration (SSA), the agency will determine whether the information received is reasonably compatible with the most recent information provided by the member.

(1) If the information received is reasonably compatible with the information provided by the member, the agency will use the information provided by the member for determinations and redeterminations of eligibility.

(2) If the information received is not reasonably compatible with the information provided by the member, the agency will determine whether the information received will have an effect on the eligibility of any member of the household.

(A) If the information received has no effect on the eligibility of any member of the household, including the benefit package the member is enrolled in, the agency will take no action.

(B) If the information received has an effect on the eligibility of a member of the household, the agency will request more information from the member, including, but not limited to, an explanation of the discrepancy or verification documenting the correct information regarding the factor of eligibility affected by the information received from a third party.

(C) The agency will give the member proper notice of at least 10 days to respond to the agency's request for information.

(D) If the member does not cooperate in resolving the discrepancy within the timeframe established by the notice, benefits will be terminated.

~~(d) **Exception January to March, 2014.** During the period January to March, 2014, redeterminations due to changes in circumstances will be processed, but the effective date of any termination action taken as a result of changes in household composition or income for individuals in MAGI eligibility groups will be April 1, 2014, or later.~~

(d) **Changes in a continuous eligibility period for children.** During a continuous eligibility period for children, a member must report:

(1) A change of address for the child; or

(2) If a certified child leaves the home, is institutionalized, or dies.

317:35-6-61. Redetermination of eligibility for persons receiving SoonerCare

(a) A periodic redetermination of eligibility for SoonerCare is required for all members. The

redetermination is made prior to the end of the initial certification period and each ~~12~~twelve (12) months thereafter. A deemed newborn is eligible through the last day of the month the newborn child attains the age of one year, without regard to eligibility of other household members in the case.

(b) Effective January 1, 2014, when the agency has sufficient information available electronically to redetermine eligibility, eligibility will be redetermined on that basis and a notice will be sent to the household explaining the action taken by the agency. The member is responsible for notifying the agency if any information used to redetermine eligibility is incorrect. If the agency does not have sufficient information to redetermine eligibility, the agency will send notice to that effect, and the member is responsible for providing the necessary information to redetermine eligibility.

(c) A member's case is closed if he/she does not return the form(s) and any verification necessary for redetermination timely. If the member submits the form(s) and verification necessary for redetermination within ~~90~~ninety (90) days after closure of the case, benefits are reopened effective the date of the closure, provided the member is eligible and benefits were closed because the redetermination process was not completed.

~~(d) Periodic redeterminations scheduled for January to March, 2014 will be rescheduled for April, 2014.~~

(d) Effective January 1, 2024, a child who meets the criteria for continuous eligibility shall remain eligible for SoonerCare, until the earlier of:

(1) Twelve (12) months from the effective date of the child's most recent certification period; or

(2) The child's nineteenth (19^{th}) birthday.

317:35-7-16. Special application procedures for children in OKDHS custody

The rules in this section apply when determining eligibility for health benefits for children who are reported by OKDHS as being in custody.

(1) When a child placed in custody as reported by OKDHS remains in the parent's home and there is not an active medical case:

~~(A) The~~the OKDHS child welfare specialist advises the family ~~that an application for medical services may be made at the local OKDHS office.~~of available medical resources and refers the parent(s) to SoonerCare to apply for medical assistance. Application for children receiving Supplemental Security Income must be made in the local OKDHS office.

~~(B) The OKDHS Family Support Services (FSS) worker is responsible for processing the SC-1, SoonerCare Health Benefits application or FSS-1, Comprehensive Application and Review, whichever is appropriate.~~

(2) When a child placed in custody as reported by OKDHS has an active case and a change in placement is made to a home or facility outside the parent's home:

(A) The OKDHS child welfare specialist ~~completes Form CWS-KIDS-4, Eligibility Determination, and forwards it to the OKDHS custody specialist advising of this change, including the date the child was placed outside the home~~enters the child's removal information into the Child Abuse and Neglect Information System (KIDS) Removal screen, which generates an assignment to the custody specialist for Title XIX medical benefits. This referral is made within five working days of the placement.

(B) The OKDHS custody specialist makes the appropriate change to remove the child from the family case and opens a child only case the next effective date.

(3) When a child in custody as reported by OKDHS is placed outside the home and there is not an active case, the OKDHS child welfare specialist ~~is responsible for completing and forwarding the CWS-KIDS-4, Eligibility Determination,~~enters the child's removal information into the Child Abuse and Neglect Information System (KIDS) Removal screen, which generates an assignment to the OKDHS custody specialist. This referral is made~~The CWS-KIDS-4 must be sent~~ within five working days of removal from the home. The date of application is the date the child is placed in custody. The OKDHS custody specialist is responsible for processing the application.

(4) When a child in custody as reported by OKDHS placed outside the home is later returned to the home but remains in custody:

(A) The OKDHS child welfare specialist advises~~forwards Form K-13 to~~ the OKDHS custody specialist ~~advising of~~ the change in placement. The OKDHS child welfare specialist advises the family ~~that a Medicaid application may be made at the local OKDHS office for medical benefits to continue, if the family meets eligibility criteria~~of available medical resources and refers the parent(s) to SoonerCare to apply for medical assistance. Application for children receiving Supplemental Security Income must be made in the local OKDHS office.

(B) ~~The OKDHS custody specialist is responsible for sending a SC-1 to the family so the child's Medicaid eligibility can be redetermined. If the family does not return the completed SC-1, the OKDHS custody specialist closes the child's Medicaid case.~~The child remains continuously eligible for the remainder of the certification period, as defined at OAC 317:35-1-2, pursuant to 42 U.S.C. 1396a(e)(12).

(5) When a child in custody as reported by OKDHS and living in an out of home placement attains age 18, he/she may still be eligible for medical benefits until the age of 21 under the Foster Care Independence Act if his/her income is below the standard on OKDHS Appendix C-1, Schedule 1.A. The individual must complete a new application and have eligibility redetermined in accordance with OAC 317:35-6.

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 3. GENERAL MEDICAL PROGRAM INFORMATION

317:30-3-62. ~~Serious reportable events - never events~~ Provider Preventable Conditions

~~(a) **Definitions.** The following words and terms, when used in this Section, have the following meaning, unless the context clearly indicates otherwise.~~

~~(1) **"Surgical and other invasive procedures"** are defined as operative procedures in which skin or mucous membranes and connective tissues are incised or an instrument is introduced through a natural body orifice. Invasive procedures include a range of procedures from minimally invasive dermatological procedures (biopsy, excision, and deep cryotherapy for malignant lesions) to extensive multi-organ transplantation. They include all procedures described by the codes in the surgery section of the Current Procedural Terminology (CPT) and other invasive procedures such as percutaneous transluminal angioplasty and cardiac catheterization. They include minimally invasive procedures involving biopsies or placement of probes or catheters requiring the entry into a body cavity through a needle or trocar. They do not include use of instruments such as otoscopes for examinations or very minor procedures such as drawing blood.~~

~~(2) A surgical or other invasive procedure is considered to be the wrong procedure if it is not consistent with the correctly documented informed consent for that member.~~

~~(3) A surgical or other invasive procedure is considered to have been performed on the wrong body part if it is not consistent with the correctly documented informed consent for that member including surgery on the right body part, but on the wrong location on the body; for example, left versus right (appendages and/or organs), or at the wrong level (spine).~~

~~(4) A surgical or other invasive procedure is considered to have been performed on the wrong member if that procedure is not consistent with the correctly documented informed consent for that member.~~

~~(b) **Coverage.** The Oklahoma Health Care Authority (OHCA) will no longer cover a particular surgical or other invasive procedure to treat a particular medical condition when the practitioner erroneously performs (1) a different procedure altogether; (2) the correct procedure but on the wrong body part; or (3) the correct procedure but on the wrong member. SoonerCare will not cover hospitalizations or any services related to these non-covered procedures. All services provided in the operating room when an error occurs are considered related and therefore not covered. All providers in the operating room when the error occurs, who could bill individually for their services, are also not eligible for payment. All related services provided during the same hospitalization in which the error occurred are not covered. A provider cannot shift financial liability or responsibility for the non-covered services to the member if the OHCA has determined that the service is related to one of the above erroneous surgical procedures.~~

~~(c) **Billing.** For inpatient claims, hospitals are required to bill two claims when the erroneous surgery is reported, one claim with covered services or procedures unrelated to the erroneous surgery, the other claim with the non-covered services or procedures as a no-payment claim. For outpatient and practitioner claims, providers are required to append the applicable HCPCS modifiers to all lines related to the erroneous surgery. Claim lines submitted with one of the~~

~~applicable HCPCS modifiers will be line-item denied.~~

~~(d) **Related claims.** Once a claim for the erroneous surgery(s) has been received, OHCA may review member history for related claims as appropriate. Incoming claims for the identified member may be reviewed for an 18-month period from the date of the surgical error. If such claims are identified to be related to the erroneous surgical procedure(s), OHCA may take appropriate action to deny such claims and recover any overpayments on claims already processed.~~

~~(e) **Dually eligible members.** SoonerCare will not act as a secondary payer for Medicare non-payment of the aforementioned erroneous surgery(s).~~

~~(f) **Hospital acquired conditions.** SoonerCare will not reimburse the extra cost of treating certain categories of conditions that occur while a member is in the hospital. See OAC 317:30-3-63 for specific information regarding hospital acquired conditions.~~

(a) **Definitions.** The following words and terms, when used in this Section, have the following meaning, unless the context clearly indicates otherwise.

(1) "**Health care-acquired conditions (HCAC)**" means a condition occurring in any inpatient hospital setting, (identified as a hospital acquired condition by federal regulation and Medicare; other than deep vein thrombosis/pulmonary embolism as related to a total knee replacement or hip replacement surgery in pediatric and obstetric patients.) Medicare's list of hospital acquired conditions is also available at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Hospital-Acquired_Conditions.html.

(2) **"National Quality Forum (NQF)"** means the independent, nonpartisan organization tasked with devising a national strategy to set standards for quality improvement and reporting in the healthcare industry.

(3) "**Other provider preventable conditions (OPPC)**" means the list of serious reportable events in health care as identified by this Section and published by the NQF.

(4) "**Present on admission (POA) indicator"** means a status code the hospital uses on an inpatient claim that indicates if a condition was present at the time the order for inpatient admission occurs.

(5) "**Provider preventable condition (PPC)**" means a condition that meets the definition of a "health care-acquired condition" or an "other provider-preventable condition" as defined in this Section.

(b) **Health care-acquired conditions (HCAC)**

(1) **Payment policy**. In accordance with 42 C.F.R § 447.26, the Oklahoma Health Care Authority (OHCA) will not reimburse health care professionals and inpatient hospitals for the increased incremental cost of inpatient care services that result when a member is harmed by one (1) of the HCACs listed below.

(A) Foreign object retained after surgery;
(B) Air embolism;
(C) Blood incompatibility;
(D) Pressure ulcer stages III & IV;
(E) Falls and trauma; including:
(i) Fracture;
(ii) Dislocation;
(iii) Intracranial injury;
(iv) Crushing injury;
(v) Burn;
(vi) Electric shock;

(F) Catheter-associated urinary tract infection;
(G) Vascular catheter-associated infection;
(H) Manifestations of poor glycemic control; including:
(i) Diabetic ketoacidosis;
(ii) Nonketotic hyperosmolar coma;
(iii) Hypoglycemic coma;
(iv) Secondary diabetes with ketoacidosis;
(v) Secondary diabetes with hyperosmolarity;
(I) Surgical site infection following:
(i) Coronary artery bypass graft-mediastinitis;
(ii) Bariatric surgery; including:
(I) Laparoscopic gastric bypass;
(II) Gastroenterostomy;
(III) Laparoscopic gastric restrictive surgery;
(iii) Orthopedic procedures; including:
(I) Spine;
(II) Neck;
(III) Shoulder;
(IV) Elbow;
(iv) Cardiac implantable electronic device (CIED)
(J) Deep vein thrombosis and pulmonary embolism following:
(i) Total knee replacement with exceptions for pediatric and/or obstetric cases; or
(ii) Hip replacement with exceptions for pediatric and/or obstetric cases.
(K) Iatrogenic pneumothorax with venous catheterization

(2) **Billing.** Hospitals paid under the diagnosis related grouping (DRG) methodology are required to submit a POA indicator for the principal diagnosis code and every secondary diagnosis code for all discharges. A valid POA indicator is required on all inpatient hospital claims. Claims with no valid POA indicator will be denied. For all claims involving inpatient admissions, OHCA will group diagnoses into the proper DRG using the POA indicator. If a provider in either a fee-for-service or managed care delivery system receives SoonerCare reimbursement for the increased incremental cost of inpatient care services that result when a member is harmed by the HCACs identified in (b)(1) (A)-(K), the provider shall reimburse those costs to the Agency or Contracted Entity.

(3) **Dually eligible members.** SoonerCare will not act as a secondary payer for Medicare non-payment of HCACs.

(c) **Other provider preventable condition (OPPC)**

(1) **Payment policy.** In accordance with 42 C.F.R § 447.26, the Agency will not reimburse health care professionals and inpatient hospitals for care related to the treatment of consequences of an OPPC when the condition:

(A) Is identified in the Oklahoma Medicaid State Plan;
(B) Has been found by the State, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines;
(C) Is within the control of the hospital;
(D) Has a negative consequence for the member;
(E) Is auditable; and

(F) Is included on the list of serious reportable events in health care by the National Quality Forum (NQF). Providers are responsible for keeping abreast of any changes to the list of serious reportable events identified by the NQF. The list of serious reportable events in health care, as of the publishing of this rule, includes surgical or invasive procedure events:

(i) Surgical or other invasive procedure performed on the wrong site;

(ii) Surgical or other invasive procedure performed on the wrong patient;

(iii) Wrong surgical or other invasive procedure performed on a patient;

(2) **Billing.** For inpatient claims, hospitals are required to bill two (2) claims when the erroneous surgery is reported, one (1) claim with covered services or procedures unrelated to the erroneous surgery, the other claim with the non-covered services or procedures as a no-payment claim. For outpatient and practitioner claims, providers are required to append the applicable Healthcare Common Procedure Coding System (HCPCS) modifiers to all lines related to the erroneous surgery. Claim lines submitted with one (1) of the applicable HCPCS modifiers will be line-item denied. If a provider in either a fee-for-service or managed care delivery system receives SoonerCare reimbursement for patient care or treatment directly related to an identifiable provider-preventable condition that was not present when the individual initiated treatment with that provider, the provider shall reimburse those costs to the Agency or Contracted Entity.

(3) **Related claims.** Once a claim for the erroneous surgery(s) has been received, OHCA may review member history for related claims as appropriate. Incoming claims for the identified member may be reviewed for an eighteen-month (18-month) period from the date of the surgical error. If such claims are identified to be related to the erroneous surgical procedure(s), OHCA may take appropriate action to deny such claims and recover any overpayments on claims already processed.

(4) **Dually eligible members.** SoonerCare will not act as a secondary payer for Medicare non-payment of OPPCs.

(d) **Reporting.** Title 42 of the Code of Federal Regulations, Sections 447, 434 and 438 require providers, in both fee-for-service and managed care delivery systems, to report all PPCs that are associated with claims for SoonerCare payment or with courses of treatment furnished to a SoonerCare member for which Medicaid payment would otherwise be available. The report shall be made to the OHCA regardless of whether the provider seeks SoonerCare reimbursement for services to treat the PPCs. The Agency report form is available for download at https://oklahoma.gov/ohca. Providers must report the following information to the OHCA within 10 days of the occurrence of the event:

(1) Member name and member ID number.

(2) A description of the event.

(3) Dates of services and occurrence of the event.

(4) Attending physician(s).

(5) Facility.

(e) **Liability.** A provider cannot shift financial liability or responsibility for the non-covered services and treatment to the member if the OHCA has determined that the service is related to a PPC.

317:30-3-63. Hospital acquired conditions [REVOKED]

~~(a) **Coverage.** The Oklahoma Health Care Authority (OHCA) will no longer reimburse the extra~~

~~cost of treating certain categories of conditions that occur while a member is in the hospital. For discharges, hospitals will not receive additional payment for cases in which one of the selected conditions was not present on admission. The claim will be grouped to a DRG as if the diagnosis was not present on the claim. The selected conditions that OHCA recognizes are those conditions identified as non-payable by Medicare. OHCA may revise through addition or deletion the selected conditions at any time during the fiscal year. The following is a complete list of the hospital acquired conditions (HACs) currently recognized by OHCA:~~

~~(1) Foreign Object Retained After Surgery~~
~~(2) Air Embolism~~
~~(3) Blood Incompatibility~~
~~(4) Pressure Ulcer Stages III & IV~~
~~(5) Falls and Trauma~~
~~(A) Fracture~~
~~(B) Dislocation~~
~~(C) Intracranial Injury~~
~~(D) Crushing Injury~~
~~(E) Burn~~
~~(F) Electric Shock~~
~~(6) Catheter-Associated Urinary Tract Infection~~
~~(7) Vascular Catheter-Associated Infection~~
~~(8) Manifestations of Poor Glycemic Control~~
~~(A) Diabetic Ketoacidosis~~
~~(B) Nonketotic Hyperosmolar Coma~~
~~(C) Hypoglycemic Coma~~
~~(D) Secondary Diabetes with Ketoacidosis~~
~~(E) Secondary Diabetes with Hyperosmolarity~~
~~(9) Surgical Site Infection Following:~~
~~(A) Coronary Artery Bypass Graft- Mediastinitis~~
~~(B) Bariatric Surgery~~
~~(i) Laparoscopic Gastric Bypass~~
~~(ii) Gastroenterostomy~~
~~(iii) Laparoscopic Gastric Restrictive Surgery~~
~~(C) Orthopedic Procedures~~
~~(i) Spine~~
~~(ii) Neck~~
~~(iii) Shoulder~~
~~(iv) Elbow~~
~~(10) Deep Vein Thrombosis and Pulmonary Embolism~~
~~(A) Total Knee Replacement~~
~~(B) Hip Replacement~~

~~(b) **Billing.** Hospitals paid under the diagnosis related grouping (DRG) methodology are required to submit a present on admission (POA) indicator for the principal diagnosis code and every secondary diagnosis code for all discharges. A valid POA indicator is required on all inpatient hospital claims. Claims with no valid POA indicator will be denied. For all claims involving inpatient admissions, OHCA will group diagnoses into the proper DRG using the POA indicator.~~
~~(c) **Dually eligible members.** SoonerCare will not act as a secondary payer for Medicare non-~~

~~payment of the aforementioned hospital acquired conditions.~~

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

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

317:35-18-4. Provider regulations

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

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

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

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

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

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

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

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

317:35-18-5. Eligibility criteria

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

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

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

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

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

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

317:35-18-8. Enrollment

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

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

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

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

(2) The participant is involuntarily disenrolled.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(B) All efforts to remedy the situation.

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

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

~~or~~

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

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

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

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

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

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

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

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

(1) A justification summary for involuntary disenrollment;

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

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

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

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

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

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

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

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

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

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

(f) Involuntary disenrollment procedures for PACE organizations.

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

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

access the appeal process.

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

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

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

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

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

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

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

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

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

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

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

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

(A) Disenrollment form;

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

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

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

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

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

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 58. NON-HOSPITAL BASED HOSPICE

317:30-5-531. Coverage ~~for adults~~

(a) **Definition.** **"Hospice care"** means 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.

(b) **Requirements.**

(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.

(c) **Eligibility.** Coverage for hospice services is provided to Medicaid eligible ~~expansion adults only~~members.

~~(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)~~(1) 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. The certification must be completed by the member's attending physician or the Medical Director of an Interdisciplinary Group. Nurse practitioners serving as the attending physician may not certify the terminal illness; however, nurse practitioners may re-certify the terminal illness.

~~(3)~~(2) 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.

(d) **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.

(e) **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.

(f) **Service election.**

(1) For Medicaid eligible adults, ~~The~~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) For Medicaid eligible children, hospice services are available without forgoing any other service to which the member is entitled under SoonerCare for curative treatment of the terminal illness.

~~(2)~~(3) 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. Hospice providers are not responsible for curative treatments for members that elect such services while on hospice.

(g) **Service revocation.**

(1) Hospice care services may be revoked by the member, family, 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~~any 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.

(h) **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.

(i) **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.

(j) **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%~~ninety-five percent (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.** The following reimbursement methodology applies to hospice:

(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.

317:30-5-532. Coverage for children [REVOKED]

~~Hospice is palliative and/or comfort care 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 months or less. A hospice program offers palliative and supportive care to meet the special needs arising~~

~~out of the physical, emotional and spiritual stresses which are experienced during the final stages of illness and death. Hospice services must be related to the palliation and management of the member's illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills.~~

~~(1) Payment is made for home based hospice services for terminally ill individuals with a life expectancy of six months or less when the member and/or family has elected hospice benefits. Hospice services are available to eligible members without forgoing any other service to which the member is entitled under SoonerCare for curative treatment of the terminal illness. Once the member has elected hospice care, the hospice medical team assumes responsibility for the member's medical care for the terminal illness in the home environment. Hospice providers are not responsible for curative treatments for members that elect such services while on hospice. Hospice care includes nursing care, physician services, medical equipment and supplies, drugs for symptom control and pain relief, home health aide and personal care, physical, occupational and/or speech therapy, medical social services, dietary counseling and grief and bereavement counseling to the member and/or family. Services must be prior authorized.~~

~~(2) Hospice care is available for two 90-day periods and an unlimited number of 60-day periods during the remainder of the member's lifetime. Beginning January 1, 2011, a hospice physician or nurse practitioner must have a face-to-face encounter with the member to determine if the member's terminal illness necessitates continuing hospice care services. The encounter must take place prior to the 180th day recertification and each subsequent recertification thereafter; and attests that such visit took place. The member and/or the family may voluntarily terminate hospice services. Hospice services must be reasonable and necessary for the palliation or management of a terminal illness or related conditions. A certification that the individual is terminally ill must be completed by the member's attending physician or the Medical Director of an Interdisciplinary Group. Nurse practitioners serving as the attending physician may not certify the terminal illness; however, effective January 1, 2011, nurse practitioners may re-certify the terminal illness.~~

~~(3) Services must be prior authorized. A written plan of care must be established before services are provided. The plan of care should be submitted with the prior authorization request.~~

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-24. Third party liability

As the Medicaid Agency, the Oklahoma Health Care Authority (OHCA) is the payer of last resort, with few exceptions. When other resources are available, those resources must first be utilized. Exceptions to this policy are those receiving medical treatment through Indian Health Services, eligible students on an Individualized Education Program (IEP) or Individual Family Service Plan (IFSP) receiving school-based services and those eligible for the Crime Victims Compensation Act. Guidance for third party liability under the Insure Oklahoma program is found in Oklahoma Administrative Code (OAC) 317:45, Insure Oklahoma.

(1) If a member has coverage by an absent parent's insurance program or any other policy holder, that insurance resource must be used prior to filing a SoonerCare claim. This includes Health Maintenance Organizations (HMO), Preferred Provider Organizations (PPO) and any other insuring arrangements that provide a member access to healthcare. Members must comply with all requirements of their primary insurance as well as SoonerCare requirements in order to take advantage of both coverages. For example, a member must comply with the network restrictions of both the primary and SoonerCare plans ~~as well as prior authorization requirements~~. If the member does not comply with the requirements of the primary plan, he/she will be responsible for the charges incurred. ~~Denials by private insurance companies because the member did not secure a preauthorization or use a participating provider is not a sufficient reason for SoonerCare to make payment~~The tate's authorization that an item or service is as covered under the state plan, or a waiver of such plan, shall meet the prior authorization requirements of the primary insurer. If the provider is aware of private insurance or liability, a claim must first be filed with that source. When private insurance information is known to the OHCA, the eligibility verification system will reflect that information. If payment is denied by the primary insurance, except as stated above, the provider must attach the Explanation of Benefits (EOB), stating the reason for the denial, to the claim submitted to the Fiscal Agent. When payment is received from another source, that payment amount must be reflected on the claim form.

(2) It is possible that other resources are available but are unknown to OHCA. Providers will routinely question SoonerCare members to determine whether any other resources are available. In some instances, coverage may not be obvious, for example, the member may be covered by a policy on which he/she is not the subscriber (e.g., a child whose absent parent maintains medical and hospital coverage).

(3) If the provider receives payment from another source after OHCA has made payment, it is necessary that the provider reimburse OHCA for the SoonerCare payment. The provider may retain the primary insurance payment, if any, that represents payment for services that are not covered services under SoonerCare. By accepting the OHCA's payment, the provider agrees to accept it as payment in full and, therefore, cannot retain any portion of other resource money as payment for reduced charges on covered services. Other than SoonerCare copayments, a provider cannot bill a member for any unpaid portion of the bill or for a claim that is not paid

because of provider administrative error. If, after reimbursing OHCA and retaining a portion of the other payment in satisfaction of any non-covered services there is money remaining, it must be refunded to the member.

(4) If a member is covered by a private health insurance policy or plan, he/she is required to inform medical providers of the coverage, including:

(A) provision of applicable policy numbers;

(B) assignment payments to medical providers;

(C) provision of information to OHCA of any coverage changes; and

(D) release of money received from a health insurance plan to the provider if the provider has not already received payment or to the OHCA if the provider has already been paid by the OHCA.

(5) Members are responsible for notifying their providers of the intent to make application for SoonerCare coverage and of any retroactive eligibility determinations. Members may be responsible for any financial liability if they fail to notify the provider of the eligibility determinations and as a result, the provider is unable to secure payment from OHCA.

(6) Members must present evidence of any other health insurance coverage to a medical provider each time services are requested. Members may be responsible for any financial liability if they fail to furnish the necessary information before the receipt of services and as a result, the provider is unable to secure payment from OHCA.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 3. HOSPITALS

317:30-5-50. Abortions

~~(a) Payment is made only for abortions in those instances where the abortion is necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed, or where the pregnancy is the result of an act of rape or incest. SoonerCare coverage for abortions to terminate pregnancies that are the result of rape or incest are considered to be medically necessary services and federal financial participation is available specifically for these services.~~

~~(1) For abortions necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, the physician must complete the Certification for Medicaid Funded Abortion and certify in writing that the abortion is being performed due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed. The patient's name and address must be included in the certification and the certification must be signed and dated by the physician. The certification must be attached to the claim.~~

~~(2) For abortions in cases of rape or incest, there are two requirements for the payment of a claim. First, the physician must fully complete the Certification for Medicaid Funded Abortion. Second, the patient must have made a police report or counselor's report of the rape or incest. In cases where an official report of the rape or incest is not available, the physician must certify in writing and provide documentation that in his or her professional opinion, the patient was unable, for physical or psychological reasons, to comply with the requirement. The statement explains the reason the rape or incest was not reported. The patient's name and address must be included in the certification and the certification must be signed and dated by the physician and the patient. In cases where a physician provides certification and documentation of a patient's inability to file a report, the Oklahoma Health Care Authority (OHCA) will perform a prepayment review of all records to ensure there is sufficient documentation to support the physician's certification.~~

~~(b) The OHCA performs a look-behind procedure for abortion claims paid from SoonerCare funds. This procedure will require that this Agency obtain the complete medical records for abortions paid under SoonerCare. On a post payment basis, this Authority will obtain the complete medical records on all claims paid for abortions.~~

~~(c) Claims for spontaneous abortions, including Dilation and Curettage do not require certification. The following situations also do not require certification:~~

~~(1) If the physician has not induced the abortion, counseled or otherwise collaborated in inducing the abortion, and~~

~~(2) If the process has irreversibly commenced at the point of the physician's medical intervention.~~

~~(d) Claims for the diagnosis incomplete abortion require medical review. The appropriate diagnosis codes should be used indicating spontaneous abortion, etc.; otherwise the procedure will be denied.~~

(a) Payment of abortion related services is made only in those instances where there is no detectable heartbeat of the fetus, or if, in reasonable medical judgment, the SoonerCare member has a complicating condition that necessitates termination of the pregnancy to avert serious risk of substantial and irreversible physical impairment of a major bodily function, not including psychological or emotional conditions, or death.

(b) For abortions necessary to avert death or irreversible physical impairment of a major bodily function, the physician, must complete the Certification for Medicaid Funded Abortion and certify in writing that the abortion is being performed to avert death or irreversible physical impairment of a major bodily function. The patient's name and address must be included in the certification and the certification must be signed and dated by the physician. The certification must be attached to the claim.

(c) Prior to, or post payment, OHCA may perform a review of abortion related services. These reviews will require that the Agency obtain the applicable medical records.

(d) Claims for services related to fetal demise, including dilation and curettage, do not require the Certification for Medicaid Funded Abortion.

(e) The appropriate diagnosis codes should be used; otherwise, the procedure(s) will be denied.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 115. PHARMACISTS

317:30-5-1225. Eligible Providers

Eligible Providers shall:

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

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

317:30-5-1226. Covered Services

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

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

317:30-5-1227. Reimbursement

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

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

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

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

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

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

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

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

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

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

(3) Services of advanced practice nurses (APNs), physician assistants (PAs), certified nurse midwives (CNMs), or specialized advanced practice nurse practitioners;

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

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

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

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 69. CERTIFIED REGISTERED NURSE ANESTHETISTS

317:30-5-607. Billing instructions

The CRNA is responsible for entering the correct anesthesia procedure code on the appropriate claim form. Anesthesia codes from the Physicians' Current Procedural Terminology or Medicare assigned codes should be used.

(1) Payment is made only for the major procedure during an operative session.

(2) All anesthesia procedure codes must have a modifier. Without the modifier, the claim will be denied. Payment to the CRNA is ~~limited to 80%~~made at 100% of the physician allowable for anesthesia services ~~without medical direction~~in collaboration with a physician licensed in this state using modifier QZ and 50% of the physician allowable when services are provided under the medical direction of an anesthesiologist using modifier QX.

(3) Certain codes in the Medicine section of the CPT are used to identify extraordinary anesthesia services. Additional payment can be made when applicable for extremes of age, total body hypothermia and controlled hypertension.

(4) All other qualifying circumstances, i.e., physical status, emergency, etc., have been structured into the total allowable for the procedure.

(5) Hypothermia total body or regional is not covered unless medical necessity is documented and approved through review by the Authority's Medical Consultants.

(6) Payment for placement of central venous catheter, injection of anesthesia substance or similar procedures will be made only when the procedure is distinctly separate from the anesthesia procedure.

317:30-5-611. Payment methodology

Payment to the CRNA is limited to 80%made at 100% of the physician allowable for anesthesia services performed ~~without medical direction~~in collaboration with a physician licensed in this state and 50% of the physician allowable when services are provided under the medical direction of a licensed physician.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 9. LONG TERM CARE FACILITIES

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

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

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

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

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

(2) The resident must be medically dependent on a ventilator for life support six (6) hours per day, seven (7) days per week.

(3) The resident has a tracheostomy.

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

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

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

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

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

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

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

(4) The resident sees a pulmonologist as needed and a respiratory therapist at least once every other week, with a respiratory therapist available on call twenty four (24) hours a day.

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

(1) The resident has a Brief Interview for Mental Status (BIMS) Interview score between zero and twelve (0-12) (moderately to severely impaired).

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

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

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

(5) The resident is unable to suction themselves.

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

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

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

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

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

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

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

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

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 30. APPLIED BEHAVIORAL ANALYSIS (ABA) SERVICES

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

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

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

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

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

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

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

(A) A licensed physical therapist;

(B) A licensed occupational therapist;

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

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

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

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

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

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

(1) A BCBA shall:

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

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

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

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

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

(5) All contracted providers must reside in the state of Oklahoma, or within 50 miles of the Oklahoma border as per OAC 317:30-3-89 through 92.

(6) All staff providing ABA services must be contracted with the OHCA.

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

(a) **Treatment plan**. The treatment plan is developed by a BCBA or a licensed psychologist from the clinical assessment, and if applicable, the Functional Behavior Assessment (FBA). The treatment plan shall:

(1) Be person-centered and individualized;
(2) Delineate the baseline levels of target behaviors;
(3) Specify long-term and short-term objectives that are defined in observable, measurable behavioral terms;
(4) Specify criteria that will be used to determine achievement of objectives;
(5) ~~Include assessment(s) and treatment protocols for addressing each of the target behaviors such as including antecedent and consequence interventions, and teaching of replacement skills specific to the function of the identified maladaptive behaviors;~~ Clearly relate to the identified maladaptive behavior and/or should include functional goals and those related to

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(D) Consequence analysis; and

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

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

(3) Assessments must be completed by the BCBA.

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

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

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

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

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

(A) Date;

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

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

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

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

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

(G) Progress made toward goals and objectives;

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

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

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

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

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

(iii) The signature of consent of:

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

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

(iv) All signatures:

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

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

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

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

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

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

(A) Pediatric neurologist or neurologist;

(B) Developmental pediatrician;

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

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

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

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

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

(4) The member is medically stable and does not require twenty-four (24) hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for individuals with intellectual disabilities (ICF/IID).

(5) The member exhibits functional limitations that interfere with participation in daily life and activities that are specific to the core deficits of ASD as outlined in the DSM.

~~(5)~~(6) The member exhibits atypical or disruptive behavior within the most recent thirty (30) calendar days that significantly interferes with daily functioning and activities when applicable. Such atypical or disruptive behavior may include, but is not limited to:

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

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

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

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

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

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

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

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

(b) Frequency and duration.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

317:30-5-314. Prior authorization, service limitations, and exclusions to treatment

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

(1) The criteria should include a comprehensive behavioral assessment, FBA, ~~and other supporting assessment(s)~~BSP (if applicable), treatment plan, and the OHCA initial prior authorization template outlining the maladaptive behaviors or core deficits consistent with the diagnosis of ASD and its associated comorbidities. Additional assessments that may be submitted include the: Stress Index for Parents of Adolescents (SIPA); Assessment of Basic Language and Learning (ABLLS-R); Assessment, Evaluation, and Programming System (AEPS); Verbal Behavior Milestone Assessment and Placement Program (VB-MAPP); and Personalized System of Instruction (PSI.) In addition to completing the initial request form, providers ~~will be~~are required to submit documentation that ~~will consist~~consists of the following:

(A) Information about relevant medical status, prior assessment results, response to prior treatment, and other relevant information gathered from review of records and past assessments.
(B) Information gathered from interview of family and/or caregivers, rating scales, and social validity measures to assess perceptions of the client's skill deficits and behavioral excesses, and the extent to which these deficits impede the daily life of the member and the family.
(C) Direct assessment and observation, including any data related to the identified ~~problem~~maladaptive behavior or core deficits. Clinical history from past trauma should be included, if applicable. The analysis of such data serves as the primary basis for identifying pretreatment levels of functioning, developing, and adapting treatment protocols, and evaluating response to treatment and progress towards goals.
(D) Documentation of interviews with parent(s)/caregiver(s) to further identify and define lack of adaptive behaviors and presence of maladaptive behaviors or core deficits.
(E) Length of time that the child/youth has received ABA services as well as previous ABA provider(s).

~~(D)~~(F) Functional assessment of problem behavior that includes antecedent factors, skill deficits, and consequences contributing to the problem behavior. The treatment plan should address all three (3) areas, including antecedent interventions, teaching replacement skills, and modification of consequences. Other supporting assessments may be additionally submitted for review.

(G) All treatment plans should be signed and dated by the parent(s)/guardian(s) and child/youth, if applicable.

(H) The OHCA initial prior authorization form must be filled out completely or the request will be considered as incomplete.

(2) The prior authorization request for ABA treatment will be time limited ~~for up to thirty (30) hours per week~~ unless ~~other hours are~~ deemed medically necessary and authorized through a prior authorization request and must:

(A) Be a one-on-one encounter (face-to-face between the member and ABA provider) except in the case of family adaptive treatment guidance;

(B) Be child-centered and based upon individualized goals that are strengths-specific, family-focused, and community-based;

(C) Be culturally competent and the least intrusive as possible;

(D) Clearly define in measurable and objective terms the intervention plan so it can address specific target behaviors. The intervention plan should be clearly linked to the identified deficits interfering with the child's participation in daily life activities, and if applicable also related to the identified function of the maladaptive behavior and include antecedent interventions, replacement skills to be taught, and modification of consequences. Additional goals may be identified that are related to the core deficits of ASD and are prioritized based on current research and social significance for the ~~individual~~member.

(E) Record the frequency, rate, symptom intensity/duration, or other objective measures of baseline levels;

(F) Set quantifiable criteria for progress;

(G) Establish and record behavioral intervention techniques that are appropriate to the identified target and/or maladaptive behaviors. The detailed treatment plan utilizes reinforcement and other behavioral principles and excludes the use of methods or techniques that lack consensus about their effectiveness based on evidence in peer-reviewed publications;

(H) Specify strategies for generalization of learned skills beyond the clinical settings such as in the home ~~or other~~, clinic, community, or other natural settings;

(I) Document ~~planning~~plan for transition through the continuum of interventions, services, and settings, as well as discharge criteria. Treatment (behavioral training) will be individualized, and documentation will support the identified skill deficits and atypical or disruptive behavior.

(J) Document the daily schedule by hour and the staff with credentials that will perform each service. If there is a change in staff, identify this in the extension review.

~~(J)~~(K) Include parent(s)/legal guardian(s) in behavioral training techniques so that they can practice additional hours of intervention on their own. The treatment plan is expected to achieve the parent(s)/legal guardian(s) ability to successfully reinforce the established plan of care and support generalization of skills in the home and community settings.

Frequency of parental involvement will be determined by the treatment provider and listed on the treatment plan;

~~(K)~~(L) Document parent(s)/legal guardian(s) participation in the training of behavioral techniques in the member's medical record. Parent(s)/legal guardian(s)' participation is critical to the generalization of treatment goals to the member's environment. It is expected that child/youth and parent(s)/guardian(s) attend at least eighty-five percent (85%) of treatment each review period, unless due to sickness or other unforeseen circumstances that may occur, to be documented this in the prior authorization request form; and

~~(L)~~(M) Ensure that recommended ABA services do not duplicate, or replicate services received in a member's primary academic education setting or provided within an Individualized Education Program (IEP), Individualized Service Plan (ISP), or any other individual plan of care. Documentation may be requested by the OHCA to support coordination of services with other providers and to prevent overlap and duplication of services including those in school settings.

(N) Identify if member is receiving additional therapies such as occupational therapy (OT), physical therapy (PT), or speech therapy and the timeframes in which this occurs, in relation to ABA services.

(b) **Service Limitations.**

(1) **Settings.** The following limitations apply to where ABA services are provided:

(A) ABA services are not allowed in a daycare setting or school setting, without OHCA approval. If approved, it will be time-limited to three (3) months or less. The BCBA shall create and submit a treatment plan that identifies the goals outlined to assist school staff with the members without ABA staff being present throughout the school year.

(B) The treatment plan should show a titration of services to school paraprofessionals/staff through the duration of the prior authorization.

(C) If the child/youth is transitioning into a private school, where IEPs are not legally required, then services will be time-limited to three (3) months or less. The BCBA should create and submit an FBA, treatment plan, or BSP, along with the prior authorization request that identifies the goals to match the setting and a specific plan to fade direct support.

(D) ABA treatment may be rendered via in-person service delivery, telehealth, or a hybrid of in-person and telehealth. The modality selected for delivery of ABA services must be clearly defined in the prior authorization template and treatment plan. If services will be provided via telehealth, the ABA provider must provide the justification of how treatment will be beneficial to the member and parents(s)/guardian(s) when rendered this way.

(E) Documentation of services must be maintained, to include: service rendered, location at which service was rendered, and that service was provided via telehealth. Documentation of services must also follow all other SoonerCare documentation requirements.

(2) **Coverage.** Services are limited to the following:

(A) Providers may only concurrently bill RBT and supervision hours when the following criteria is outlined in the prior authorization request:

(i) The BCBA or licensed psychologist met with the member and/or parent or guardian and directed the RBT through one (1) or more of the following:

(I) Monitoring treatment integrity to ensure satisfactory implementation of

treatment protocols;
(II) Directing RBT staff and/or caregivers in the implementation of new or revised treatment protocols;
(III) Selection and development of treatment goals, protocols, and data collection systems;
(IV) Collaboration with family members and other stakeholders;
(V) Creating materials, gathering materials;
(VI) Reviewing data to adjust treatment protocols; and/or
(VII) Development and oversight of transition and discharge planning.

(B) The BCBA or licensed psychologist used behavior training in session as appropriate in supervision of the RBT staff and/or caregivers. Behavioral skills training consists of providing instructions, modeling, rehearsal, and feedback between provider and member.
(C) The functional behavior assessment is reimbursed per authorized units provided by the BCBA, not to exceed thirty-two (32) units (eight (8) hours).
(D) RBT and supervision codes may be reimbursed for ABA individual treatment.
(E) Parent training may be reimbursed for ABA parent/caregiver/family education and training services. This service must be completed by the BCBA or BCaBA and cannot be completed by the RBT.
(F) ABA is not allowed to be billed concurrently during any other therapies (i.e., OT, PT speech, etc.).
(G) ABA hours approved for one CPT code cannot be used in place of another.
(H) All ABA services should be billed under the rendering provider that performed the services.

(3) **Exclusions to Treatment.** The following services are non-covered benefits of Oklahoma Medicaid:

(A) ABA addressing academic goals.
(B) ABA addressing goals only related to performative social norms that do not significantly impact health, safety, or independence.
(C) Treatment other than at the maintenance or consultative level not expected to result in improvements in the child/youth's level of functioning.
(D) Services that do not require the supervision of or specific skills and judgement of a BCBA to perform.
(E) Services that do not meet accepted standards of practice for specific and effective treatment of ASD.
(F) Services in the school/daycare setting as a shadow, aide, or to provide general support to the child/youth.
(G) ABA evaluation or intervention services provided by a clinic or agency owned or partially owned by the child/youth's responsible adult (e.g., biological, adoptive, or foster parent(s), guardian(s), court-appointed managing conservator(s), or other family member(s) by birth or marriage).
(H) ABA evaluation or intervention services provided directly by the child/youth's responsible adult (e.g., biological, adoptive, or foster parent(s), guardian(s), court-appointed managing conservator(s), other family member(s) by birth or marriage).
(I) Experimental or investigational treatment.
(J) Services or items not generally accepted as effective and/or not within the normal course and duration of treatment.

(K) Services for the caregiver or provider convenience, for example, as respite care or limiting treatment to a setting chosen by provider for convenience.
(L) ABA authorized for toilet learning/toilet training, OT, or speech therapy.

317:30-5-315. ABA extension requests

Extension requests for ABA services must be submitted to the OHCA or its designated agent.
(1) Documentation Requirements. Extension requests must contain the appropriate documentation validating the need for continued treatment and establish and/or document the following:

~~(1)~~(A) Eligibility criteria in OAC 317:30-5-313;
~~(2)~~(B) The frequency of the target behavior has diminished since last review, or if not, there has been modification of the treatment or additional assessments have been conducted;
(C) The daily schedule and staff with credentials that will be performing each service;
(D) Identified positive reinforces and negative reinforcers of targeted behaviors;
(E) A summary of progress towards goals as related to the core deficits and maladaptive behavior identified in the treatment plan;
(F) Updated assessments as appropriate, including an updated, FBA and BIP, updated treatment plan that clearly outlines progress towards goals and any new goals, the OHCA extension prior authorization template outlining the maladaptive behaviors or core deficits consistent with the diagnosis of ASD and its associated comorbidities;

~~(3) A functional analysis shall be completed by the provider when no measurable progress has occurred, or it may be requested by the OHCA. The functional analysis should record the member's serious maladaptive target behavioral symptom(s) and precipitants, and document the modifications of the current treatment plan to address progress, as well as make a determination of the function a particular maladaptive behavior serves for the member in the environmental context;~~
~~(4) Appropriate consultations from other staff or experts have occurred (to optimize psychiatric medications and medical treatments to include but not limited to psychiatric consults, pediatric evaluation for other conditions, etc.) and interventions have been changed, including the number of hours per week of service or setting (higher level of care);~~
~~(5) The OHCA may suggest appropriate consultation from other staff or experts during the process of prior authorization;~~
~~(6) Parent(s)/legal guardian(s) have received re-training on these changed approaches; and~~
~~(7) The treatment plan documents a gradual tapering of higher intensities of intervention and transitioning to supports from other sources (i.e., schools) as progress allows.~~

(2) To receive an increase in RBT hours on the first extension request, parent training by the BCBA or BCaBA must be provided at minimum of an hour (1) per week for three (3) months. Start and stop times must be included in the prior authorization request;
(3) Further extension request for an increase in RBT hours will require that parent training has been provided for two (2) hours/week for three (3) months. Start and stop times must be included in the prior authorization request;
(4) Include parent(s)/legal guardian(s) in behavioral training techniques so that they can practice additional hours of intervention on their own. The treatment plan is expected to achieve the parent(s)/legal guardian(s) ability to successfully reinforce the established plan of care and support generalization of skills in the home and community settings. Frequency of

parental involvement will be determined by the treatment provider and listed on the treatment plan;
(5) Document parent(s)/legal guardian(s) participation in the training of behavioral techniques. Parent(s)/legal guardian(s)' participation is critical to the generalization of treatment goals to the member's environment.
(6) Absence or less than two (2) hours per month of appropriate parent training/involvement documented in the record will result in a reduction of hours and possibly denial of services;
(7) The OHCA extension prior authorization form must be filled out completely, or the request will be considered as incomplete. A summary of the supported documentation must be included in the prior authorization request;
(8) If problem behavior is persistent outside of clinic, please identify the treatment goals/techniques to address these behaviors in the community, home, or other natural environment;
(9) Document appropriate consultations from other staff or experts have occurred (to optimize psychiatric medications and medical treatments to include but not limited to psychiatric consults, pediatric evaluation for other conditions, etc.) and interventions have been changed, including the number of hours per week of service or setting (higher level of care);
(10) The OHCA may suggest appropriate consultation from other staff or experts during the process of prior authorizations;
(11) Identify if member is receiving additional therapies such as occupational therapy (OT), physical therapy (PT), speech therapy, or otherwise and the timeframes in which this occurs, in relation to ABA services;
(12) Extension request may only be submitted seven (7) calendar days prior to the end date of the most recent request. Late submissions may result in a technical denial and loss of days.

317:30-5-316. Reimbursement methodology

SoonerCare shall provide reimbursement for ABA services in accordance with the Medicaid State Plan.

(1) Payment shall only be made to SoonerCare-contracted groups or qualified individual providers who are currently licensed and in good standing. Payment is not made to under supervision ABA practitioners/paraprofessionals, including but not limited to, BCaBAs and RBTs.
(2) Reimbursement for covered ABA procedure codes is for direct service time. Pre and post work for the session are not reimbursed separately. Separate reimbursement for treatment planning, note documentation, report writing, or updating of charts and data sheet is prohibited (other than what is allowable under the functional behavioral assessment procedure code).
~~(2)~~(3) Reimbursement for ABA services is only made on a fee-for-services basis. The maximum allowable fee for a unit of service has been determined by OHCA to be a reasonable fee, consistent with efficiency, economy, and quality of care. ~~Payment for covered services is the lower of the provider's actual billed charges, consistent with the provider's usual and customary charge to the general public for the service, or the maximum allowable per unit of service.~~
~~(3)~~(4) Reimbursement shall only be made for services that have been prior authorized by OHCA or its designee; and performed on an individualized basis and not in a group setting except for family adaptive behavior treatment guidance by a qualified ABA provider ~~(~~outlined in OAC 317:30-5-311~~)~~.

~~(4) Providers may only concurrently bill current Procedural Terminology (CPT) codes when they outline in the prior authorization the following criteria:~~

~~(A) The BCBA or licensed psychologist met with the member and/or parent or guardian and directed the RBT through one (1) or more of the following:~~

~~(i) Monitoring treatment integrity to ensure satisfactory implementation of treatment protocols;~~

~~(ii) Directing RBT staff and/or caregivers in the implementation of new or revised treatment protocols;~~

~~(iii) Selection and development of treatment goals, protocols, and data collection systems;~~

~~(iv) Collaboration with family members and other stakeholders;~~

~~(v) Creating materials, gathering materials;~~

~~(vi) Reviewing data to make adjustments to treatment protocols; and/or~~

~~(vii) Development and oversight of transition and discharge planning.~~

~~(B) The BCBA or licensed psychologist used behavior training in session as appropriate in supervision of the RBT staff and/or caregivers. Behavioral skills training consists of providing instructions, modeling, rehearsal, and feedback between provider and member.~~

(5) Reimbursement for ABA services shall not be made to or for services rendered by a parent, legal guardian, or other legally responsible person.

(6) Services rendered via telehealth must be billed using the appropriate modifier.

(7) Reimbursement is in accordance with the prior authorization and coverage limitation requirements within OAC 317:30-5-314.

317:30-5-317. Restraint, Seclusion and Serious Occurrence Reporting Requirements

Physical restraint is not appropriate during any service provided to SoonerCare clients under the Autism Services benefit except in emergency instances of threat of physical harm to the child/youth or others around them. If restraint is used, it may only occur under the following circumstances and according to the processes outlined below.

(1) Physical restraint may only be implemented by a person trained in the type of restraint being implemented. The training must be documented in the personnel file.

(2) Restraint must be limited to the use of such reasonable force as is necessary to address the emergency.

(3) Restraint must be discontinued at the point at which the emergency no longer exists.

(4) Restraint must be implemented in such a way as to protect the health and safety of the child/youth and others.

(5) Restraint must not deprive the child/youth of basic human necessities.

(6) Documentation must be kept of the up-to-date training for all staff members involved and of each incident that resulted in restraint.

(7) Documentation must be kept identifying the reason, start time/end time, the staff signature, and credentials of who performed the restraint, and date.

(8) A phone call to the parent or guardian must be reported immediately if an injury occurs and documented in the record.

(9) In the event of death or serious injury (i.e., bruising, scratches, etc.), the OHCA critical incident reporting form must be submitted to OHCA no later than 5:00 p.m. Central time the

following business day.

317:30-5-318. Service Quality Review

(a) A Service Quality Review (SQR, may be requested by OHCA or it's designated agent).
(b) The OHCA will designate the members of the SQR team. The SQR team will consist of one (1) to three (3) team members and will be comprised of LBHPs or registered nurses.
(c) The SQR will include, but not be limited to, review of facility and clinical record documentation, staff training, and qualifications. The clinical record review may consist of records of members currently at the facility as well as records of members for which claims have been filed with OHCA for Applied Behavior Analysis. The SQR includes validation of compliance with policy, which must be met for the services to be compensable.
(d) Following the SQR, the SQR team will report its findings in writing to the facility. A copy of the final report will be sent to the Program Integrity, and if applicable any licensing agencies.
(e) Deficiencies identified during the SQR may result in full or partial recoupment of paid claims. The determination of whether to assess full or partial recoupment shall be at the discretion of the OHCA based on the severity of the deficiencies.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 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 the first ninety (90) days of treatment.

(6) **"Phase II"** means the second ninety (90) days of treatment.

(7) **"Phase III"** means the third ninety (90) days of treatment.

(8) **"Phase IV"** means the last ninety (90) days of the first year of treatment.

(9) **"Phase V"** means the phase of treatment for members who have been receiving continuous treatment for more than one (1) year.

(10) **"Phase VI"** means the phase of treatment for members who 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)(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. Refusal of members to participate in treatment services as prescribed in 317:30-5-241.7(f)(1) through 317:30-5-241.7(f)(5) shall not preclude them from receiving medications from the OTP. The OTP shall document refusal of treatment services in the clinical record. 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. 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. Available services shall include, but not be limited to, therapy, rehabilitation, case management, and peer recovery support services.

(3) During phase III, phase IV and phase V, the member shall participate in at least one (1) treatment session per month. 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, 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 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 21. OUTPATIENT BEHAVIORAL HEALTH SERVICES

317:30-5-241.1 Screening, assessment and service plan

All providers must comply with the requirements as set forth in this Section.

(1) **Screening.**

(A) **Definition.** Screening is for the purpose of determining whether the member meets basic medical necessity and need for further behavioral health (BH) assessment and possible treatment services.

(B) **Qualified professional.** Screenings can be performed by any credentialed staff members as listed under OAC 317:30-5-240.3.

(C) **Target population and limitations.** Screening is compensable on behalf of a member who is seeking services for the first time from the contracted agency. This service is not compensable if the member has previously received or is currently receiving services from the agency, unless there has been a gap in service of more than six (6) months. To qualify for reimbursement, the screening tools used must be evidence-based or otherwise approved by Oklahoma Health Care Authority (OHCA) and Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) and appropriate for the age and/or developmental stage of the member.

(2) **Assessment.**

(A) **Definition.** Gathering and assessment of historical and current bio-psycho-social information which includes face-to-face contact with the person and/or the person's family or other person(s) resulting in a written summary report, diagnosis and recommendations. All agencies must assess the medical necessity of each individual to determine the appropriate level of care.

(B) **Qualified practitioners.** This service is performed by a licensed behavioral health professional (LBHP) or licensure candidate.

(C) **Target population and limitations.** The BH assessment is compensable on behalf of a member who is seeking services for the first time from the contracted agency. This service is not compensable if the member has previously received or is currently receiving services from the agency, unless there has been a gap in service of more than six (6) months and it has been more than one (1) year since the previous assessment.

(D) **Documentation requirements.** The assessment must include all elements and tools required by the OHCA. In the case of children under the age of eighteen (18), it is performed with the direct, active face-to-face participation of the parent or guardian. The child's level of participation is based on age, developmental and clinical appropriateness. The assessment must include at least one DSM diagnosis from the most recent DSM edition or diagnostic impression. The information in the assessment must contain but is not limited to the following:

(i) Behavioral, including substance use, abuse, and dependence;

(ii) Emotional, including issues related to past or current trauma;

(iii) Physical;

(iv) Social and recreational;
(v) Vocational;
(vi) Date of the assessment sessions as well as start and stop times; and
(vii) Signature of parent or guardian participating in face-to-face assessment. Signatures are required for members over the age of fourteen (14). Signature and credentials of the practitioner who performed the face-to-face behavioral assessment. The signatures may be included in a signature page applicable to both the assessment and treatment plan if the signature page clearly indicates that the signatories consent and approve of both.

(3) **Behavioral Health Services Plan Development.**

(A) **Definition.** The Behavioral Health Service Plan is developed based on information obtained in the assessment and includes the evaluation of all pertinent information by the practitioners and the member, including a discharge plan. It is a process whereby an individualized plan is developed that addresses the member's strengths, functional assets, weaknesses or liabilities, treatment goals, objectives and methodologies that are specific and time limited, and defines the services to be performed by the practitioners and others who comprise the treatment team. Behavioral Health Service Plan Development is performed with the direct active participation of the member and a member support person or advocate if requested by the member. In the case of children under the age of eighteen (18), it is performed with the participation of the parent or guardian and the child as age and developmentally appropriate, and must address school and educational concerns and assisting the family in caring for the child in the least restrictive level of care. For adults, it is focused on recovery and achieving maximum community interaction and involvement including goals for employment, independent living, volunteer work, or training. A Service Plan Development, Low Complexity is required every six (6) months and must include an update to the bio-psychosocial assessment and re-evaluation of diagnosis.

(B) **Qualified practitioners.** This service is performed by an LBHP or licensure candidate.

(C) **Time requirements.** Service Plan updates must be conducted face-to-face and are required every six (6) months during active treatment. However, updates can be conducted whenever it is clinically needed as determined by the qualified practitioner and member, but are only compensable twice in one (1) year.

(D) **Documentation requirements.** Comprehensive and integrated service plan content must address the following:

(i) member strengths, needs, abilities, and preferences (SNAP);
(ii) identified presenting challenges, problems, needs and diagnosis;
(iii) specific goals for the member;
(iv) objectives that are specific, attainable, realistic, and time-limited;
(v) each type of service and estimated frequency to be received;
(vi) the practitioner(s) name and credentials that will be providing and responsible for each service;
(vii) any needed referrals for service;
(viii) specific discharge criteria;
(ix) description of the member's involvement in, and responses to, the service plan, and his/her signature and date;

(x) service plans are not valid until all signatures are present [signatures are required from the member, if fourteen (14) or over], the parent/guardian [if younger than eighteen (18) or otherwise applicable], and the primary LBHP or licensure candidate. The signatures may be included in a signature page applicable to both the assessment and treatment plan if the signature page clearly indicates that the signatories consent and approve of both; and

(xi) all changes in a service plan must be documented in either a scheduled six (6) month service plan update (low complexity) or within the existing service plan through an amendment until time for the update (low complexity). Any changes to the existing service plan must, prior to implementation, be signed and dated by the member [if fourteen (14) or over], the parent/guardian [if younger than eighteen (18) or otherwise applicable], and the lead LBHP or licensure candidate.

(xii) Amendment of an existing service plan to revise or add goals, objectives, service provider, service type, and service frequency, may be completed prior to the scheduled six (6) month review/update. A plan amendment must be documented through an addendum to the service plan, dated and signed prior to the implementation, by the member [if fourteen (14) or over], the parent/guardian [if younger than eighteen (18) or otherwise applicable], and the lead LBHP or licensure candidate. A temporary change of service provider may be documented in the progress note for the service provided, rather than an amendment.

(xiii) Behavioral health service plan development, low complexity, must address the following:

(I) update to the bio-psychosocial assessment, re-evaluation of diagnosis service plan goals and/ or objectives;

(II) progress, or lack of, on previous service plan goals and/or objectives;

(III) a statement documenting a review of the current service plan and an explanation if no changes are to be made to the service plan;

(IV) change in goals and/or objectives (including target dates) based upon member's progress or identification of new need, challenges and problems;

(V) change in frequency and/or type of services provided;

(VI) change in practitioner(s) who will be responsible for providing services on the plan;

(VII) change in discharge criteria;

(VIII) description of the member's involvement in, and responses to, the service plan, and his/her signature and date; and

(IX) service plan updates (low complexity) are not valid until all signatures are present. The required signatures are: from the member [if fourteen (14) or over], the parent/guardian [if younger than eighteen (18) or otherwise applicable], and the primary LBHP or licensure candidate.

(E) **Service limitations:**

(i) Behavioral Health Service Plan Development, Moderate Complexity (i.e., pre-admission procedure code group) is limited to one (1) per member, per provider, unless more than one (1) year has passed between services, in which case, one can be requested and performed, if authorized by OHCA or its designated agent.

(ii) Behavioral Health Service Plan Development, Low Complexity: Service Plan updates are required every six (6) months during active treatment. Updates, however,

can be conducted whenever clinically needed as determined by the provider and member, but are only reimbursable twice in one (1) year. The date of service is when the service plan is complete and the date the last required signature is obtained. Services should always be age, developmentally, and clinically appropriate.

(4) **Assessment/Evaluation testing.**

(A) **Definition.** Assessment/Evaluation testing is provided by a clinician utilizing tests selected from currently accepted assessment test batteries. Test results must be reflected in the Service Plan. The medical record must clearly document the need for the testing and what the testing is expected to achieve.

(B) **Qualified practitioners.** Assessment/Evaluation testing will be provided by a psychologist, certified psychometrist, psychological technician of a psychologist, an LBHP or licensure candidate. For assessments conducted in a school setting, the Oklahoma State Department of Education (OSDE) requires that a licensed supervisor sign the assessment. Each qualified professional must have a current contract with the OHCA.

(C) **Documentation requirements.** All psychological services must be documented in the member's record. All assessment, testing, and treatment services/units billed must include the following:

(i) date;

(ii) start and stop time for each session/unit billed and physical location where service was provided;

(iii) signature of the provider;

(iv) credentials of provider;

(v) specific problem(s), goals and/or objectives addressed;

(vi) methods used to address problem(s), goals and objectives;

(vii) progress made toward goals and objectives;

(viii) patient response to the session or intervention; and

(ix) any new problem(s), goals and/or objectives identified during the session.

(D) **Service Limitations.** Testing for a child younger than three (3) must be medically necessary and meet established child [zero (0) to thirty-six (36) months of age] criteria as set forth in the Prior Authorization Manual. Evaluation and testing is clinically appropriate and allowable when an accurate diagnosis and determination of treatment needs is needed. ~~Eight (8)~~Ten (10) hours/units of testing per patient over the age of three (3), per provider is allowed every twelve (12) months. There may be instances when further testing is appropriate based on established medical necessity criteria found 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 actual testing, interpretation, scoring, and reporting are performed. A maximum of twelve (12) hours of therapy and testing, per day per rendering provider are allowed. A child who is being treated in an acute inpatient setting can receive separate psychological services by a physician or psychologist as the inpatient per diem is for "non-physician" services only. A child receiving residential level treatment in either a therapeutic foster care home, or group home may not receive additional individual, group or family counseling or psychological testing unless allowed by the OHCA or its designated agent. Psychologists employed in state and federal agencies, who are not permitted to engage in private practice, cannot be reimbursed for services as an individually contracted provider. For assessment conducted in a school

setting the OSDE requires that a licensed supervisor sign the assessment. For individuals who qualify for Part B of Medicare, payment is made utilizing the SoonerCare allowable for comparable services. Payment is made to physicians, LBHPs or psychologists with a license to practice in the state where the services is performed or to practitioners who have completed education requirements and are under current board approved supervision to become licensed.

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 Code of Code of Federal Regulations 431.10.

(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~~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 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~~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 can include up to eight (8) individuals for members ~~18-20~~eighteen through twenty (18-20) years of age. Group therapy must be provided for the benefit of the member four (4) 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~~Ten (10) hours/units of testing per patient (over the age of three), per provider is allowed every ~~12~~twelve (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 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) sessions/units of therapy and testing services per day per provider are allowed. A maximum of ~~thirty five~~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.

(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 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~~eighteen (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 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.

317:30-5-281. Coverage by Category

(a) **Outpatient Behavioral Health Services.** Outpatient behavioral health services are covered as set forth in this Section, and when provided in accordance with a documented individualized service plan and/or 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 (6) 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 431.10.

(b) **Adults.** Outpatient behavioral health coverage for adults rendered by a LBHP 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) **Children.** Coverage for children includes the following services:

(1) Bio-psycho-social and level of care assessments.

(A) 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.

(B) Assessments for children's level of care determination of medical necessity must follow a specified assessment process through OHCA or their designated agent. Only one assessment is allowable per provider per member. If there has been a break in service over a six (6) month period, or the assessment is conducted for the purpose of determining a child's need for inpatient psychiatric admission, then an additional unit can be 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. Individual 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 LBHP. 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 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 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 an 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) for ages four (4) up to eighteen (18). Groups with 18-20 year olds can include eight (8) individuals. Group therapy must be provided for the benefit of the member as a specifically identified component of an individual treatment plan. Multi-family group therapy size is limited to eight (8) family units.

(5) Assessment/evaluation and testing is provided by a psychologist, certified psychometrist, 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 (8)~~Ten (10) hours/units of testing per patient over the age of three (3), per provider is allowed every twelve (12) months. There may be instances when further testing is appropriate based on established medical necessity criteria found 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. Test results must be reflected in the service plan or medical record. The service plan must clearly document the need for the testing and what the testing is expected to achieve. Testing units must be billed on the date the testing, interpretation, scoring, and/or reporting was performed and supported by documentation.

(6) Crisis intervention services for the purpose of stabilization and hospitalization diversion as clinically appropriate.

(7) Payment for therapy services provided by a LBHP to any one member is limited to four (4) sessions/units per month. A maximum of twelve (12) sessions/units of therapy and testing services per day per provider are allowed. A maximum of 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.

(8) 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 testing unless allowed by the OHCA or their designated agent.

(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 must have a separate contract with this Authority to provide services under this program. All services are specified in the individual's plan of care.

(e) **Individuals eligible for Part B of Medicare**. Payment is made utilizing the Medicaid allowable for comparable services.

(f) **Nursing Facilities.** Services provided to members residing in nursing facilities may not be billed to SoonerCare**.**

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 9. LONG-TERM CARE FACILITIES

317:30-5-122. Levels of care

(a) This rule sets forth the criteria used to determine whether an individual who is seeking SoonerCare payment for long term care services needs services at the level of Skilled Nursing Facility, or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). The criteria set forth in this Section must be used when determining level of care for individuals seeking SoonerCare coverage of either facility-based institutional long term care services or Home and Community Based Services (HCBS) Waivers.

(b) The level of care provided by a long term care facility or through a HCBS Waiver is based on the nature of the person's needs and the care, services, and treatment required from appropriately qualified personnel. The level of care review is a determination of an individual's physical, mental, and social/emotional status to determine the appropriate level of care required. In addition to level of care requirements, other applicable eligibility criteria must be met.

(1) **Skilled Nursing facility.** Payment is made for the Part A coinsurance and deductible for Medicare covered skilled nursing facility care for dually eligible, categorically needy individuals.

(2) **Nursing Facility.** Care provided by a nursing facility to members who require professional nursing supervision and a maximum amount of nonprofessional nursing care due to physical conditions or a combination of physical and mental conditions.

(3) **Intermediate Care Facility for Individuals with Intellectual Disabilities.** Care for persons with intellectual disabilities or related conditions to provide health and/or habilitative services in a protected residential setting. To qualify for ICF/IID level of care, persons must have substantial functional limitations in three or more of the following areas of major life activity:

(A) **Self-care**. The individual requires assistance, training, or supervision to eat, dress, groom, bathe, or use the toilet.

(B) **Understanding and use of language**. The individual lacks functional communication skills, requires the use of assistive devices to communicate, does not demonstrate an understanding of requests, or is unable to follow two-step instructions.

(C) **Learning**. The individual has a valid diagnosis of intellectual disability as defined in the Diagnostic and Statistical Manual of Mental Disorders. When the individual is seeking SoonerCare coverage of Oklahoma Human Services Developmental Disabilities Services HCBS Waivers they must be:

(i) determined by the Social Security Administration (SSA) to have a disability and a diagnosis of intellectual disability; or

(ii) Be determined by the Oklahoma Health Care Authority (OHCA) Level of Care Evaluation Unit (LOCEU) to have a disability and a diagnosis of intellectual disability per SSA guidelines or a diagnosis of global developmental delay when accompanied by a Full-Scale Intelligence Quotient less than or equal to 70, plus or

minus five, when under six (6) years of age as defined in the Diagnostic and Statistical Manual of Mental Disorders.

(D) **Mobility**. The individual requires the use of assistive devices to be mobile and cannot physically self-evacuate from a building during an emergency without assistive device.

(E) **Self-direction**. The individual is seven (7) years old or older and significantly at risk in making age appropriate decisions or an adult who is unable to provide informed consent for medical care, personal safety, or for legal, financial, habilitative, or residential issues, and/or has been declared legally incompetent. The individual is a danger to himself or others without supervision.

(F) **Capacity for independent living**. The individual who is seven (7) years old or older and is unable to locate and use a telephone, cross the street safely, or understand that it is unsafe to accept rides, food, or money from strangers. Or an adult who lacks basic skills in the areas of shopping, preparing food, housekeeping, or paying bills.

PART 43. AGENCY COMPANION, SPECIALIZED FOSTER CARE, DAILY LIVING SUPPORTS, GROUP HOMES, EXTENSIVE RESIDENTIAL SUPPORTS, AND COMMUNITY TRANSITION SERVICES

317:30-5-422. Description of services

Residential supports include:

(1) agency companion services ~~(ACS)~~ per Oklahoma Administrative Code (OAC)317:40-5;

(2) specialized foster care ~~(SFC)~~ per OAC 317:40-5;

(3) daily living supports ~~(DLS)~~:

(A) Community Waiver per OAC 317:40-5-150; and

(B) Homeward Bound Waiver per OAC 317:40-5-153;

(4) group home services provided per OAC 317:40-5-152; ~~and~~

(5) extensive residential supports per OAC 317:40-5-154; and

~~(5)~~(6) community transition services (CTS).

(A) Minimum qualifications. The provider must enter into contractual agreements with the Oklahoma Health Care Authority (OHCA) to provide ACS, habilitation training specialist ~~(HTS)~~ services, or DLS, in addition to a contract to provide CTS.

(B) Description of services. CTS is a one-time setup expense for members transitioning from an intermediate care facility for individuals with intellectual disabilities ~~(ICF/IID)~~ or provider-operated residential setting to the member's own home or apartment. The cost per member of CTS cannot exceed limitations set forth by OHCA. The member's name must be on the lease, deed or rental agreement. CTS:

(i) are furnished only when the member is unable to meet such expense and must be documented in the member's Individual Plan (IP);

(ii) include security deposits, essential furnishings, such as major appliances, dining ~~table/chairs,~~tables and chairs, bedroom set, sofa, chair, window coverings, kitchen ~~pots/pans,~~pots and pans, dishes, eating utensils, ~~bed/bath~~bed and bath linens, kitchen dish ~~towel/potholders,~~towels and potholders, a one month supply of laundry/cleaning products, and setup fees or deposits for initiating utility service, including phone, electricity, gas, and water. CTS also includes moving expenses, ~~services/items~~services and items necessary for the member's health and safety, such

as pest eradication, allergen control, a one-time cleaning prior to occupancy, flashlight, smoke detector, carbon monoxide detector, first aid kit, fire extinguisher, and a tempering valve or other anti-scald device when determined by the Personal Support Team necessary to ensure the member's safety; and

(iii) ~~does~~do not include:

(I) recreational items, such as television, cable, satellite, internet, video cassette recorder (VCR), digital video disc (DVD) player, compact disc (CD) player, MP3 player, gaming system, cell phone or computer used primarily as a diversion or recreation;

(II) monthly rental or mortgage expenses;

(III) food;

(IV) personal hygiene items;

(V) disposable items, such as paper ~~plates/napkins,~~plates and napkins, plastic utensils, disposable food storage bags, aluminum foil, and plastic wrap;

(VI) items that are considered decorative, such as rugs, pictures, bread box, canisters, or a clock;

(VII) any item not considered an essential, one-time expense; or

(VIII) regular ongoing utility charges;

(iv) prior approval for exceptions ~~and/or~~and questions regarding eligible items ~~and/or~~and expenditures are directed to the programs manager for community transition services at ~~DHS DDS state office;~~Oklahoma Human Services Developmental Disabilities Services State Office;

~~(v) authorizations are issued for the date a member transitions;~~

~~(vi)~~(v) may only be authorized for members approved for the Community Waiver; and

~~(vii)~~(vi) may not be authorized for items purchased more than ~~30~~thirty (30) calendar days after the date of transition.

PART 51. HABILITATION SERVICES

317:30-5-482. Description of services

Habilitation services include the services identified in (1) through (15) of this Section. Habilitation services providers must have an applicable agreement with the Oklahoma Health Care Authority (OHCA) to provide Developmental Disabilities Services (DDS) through Home and Community-Based Services (HCBS).

(1) **Dental services.** Dental services are provided per Oklahoma Administrative Code (OAC) 317:40-5-112.

(A) **Minimum qualifications.** Dental services providers must have non-restrictive licensure by the Oklahoma State Board of Dentistry to practice dentistry in Oklahoma.

(B) **Description of services.** Dental services include services for maintenance or improvement of dental health as well as relief of pain and infection. These services may include:

(i) Oral examinations;

(ii) Medically necessary images;

(iii) Prophylaxis;

(iv) Fluoride application;

(v) Development of a sequenced treatment plan that prioritizes:

(I) Pain elimination;

(II) Adequate oral hygiene; and

(III) Restoring or improving ability to chew;

(vi) Routine training of member or primary caregiver regarding oral hygiene; and

(vii) Preventive, restorative, replacement, and repair services to achieve or restore functionality provided after appropriate review when applicable, per OAC 317:40-5-112.

(C) **Coverage limitations.** Dental service coverage is specified in the member's Individual Plan (IP) in accordance with applicable Waiver limits. Cosmetic dental services are not authorized.

(2) **Nutrition services**. Nutrition Services are provided, per OAC 317:40-5-102.

(3) **Occupational therapy services.**

(A) **Minimum qualifications.** Occupational therapists and occupational therapy assistants have current, non-restrictive licensure by the Oklahoma Board of Medical Licensure and Supervision. Occupational therapy assistants are supervised by occupational therapists, per OAC 317:30-5-295 (b) (1).

(B) **Service description.** Occupational therapy services include evaluation, treatment, and consultation in leisure management, daily living skills, sensory motor, perceptual motor, mealtime assistance, assistive technology, positioning, and mobility. Occupational therapy services may include occupational therapy assistants, within the limits of the occupational therapist's practice.

(i) Services are:

(I) Intended to help the member achieve greater independence to reside and participate in the community; and

(II) Rendered in any community setting as specified in the member's IP. The IP includes a practitioner's prescription.

(ii) For this Section's purposes, a practitioner means medical and osteopathic physicians, physician assistants, and other licensed health care professionals with prescriptive authority to order occupational therapy services in accordance with the rules and regulations governing the SoonerCare program.

(iii) Service provision includes a written report or record documentation in the member's record, as required.

(C) **Coverage limitations.** For compensable services, payment is made to the individual occupational therapist for direct services or for services provided by a qualified occupational therapist assistant within the occupational therapist's employment. Payment is made in fifteen-minute (15-minute) units, with a limit of four hundred and eighty (480) units per Plan of Care (POC) year. Payment is not allowed solely for written reports or record documentation.

(4) **Physical therapy services.**

(A) **Minimum qualifications.** Physical therapists and physical therapist assistants must have current, non-restrictive licensure with the Oklahoma Board of Medical Licensure and Supervision. The physical therapist supervises the physical therapist assistant, per OAC 317:30-5-290.1 (b) (1).

(B) **Service description.** Physical therapy services include evaluation, treatment, and consultation in locomotion or mobility skeletal and muscular conditioning, assistive

technology, and positioning to maximize the member's mobility and skeletal/muscular well-being. Physical therapy services may include physical therapist assistants, within the limits of the physical therapist's practice.

(i) Services are intended to help the member achieve greater independence to reside and participate in the community. Services are provided in any community setting as specified in the member's IP. The IP includes a practitioner's prescription. For this Section's purposes, practitioners are defined as licensed medical and osteopathic physicians and physician assistants in accordance with the rules and regulations covering the OHCA SoonerCare program.

(ii) Service provision includes a written report or record documentation in the member's record, as required.

(C) **Coverage limitations.** For compensable services, payment is to individual physical therapists for direct services or for services provided by a qualified physical therapist assistant within the physical therapist's employment. Payment is made in fifteen-minute (15-minute) units with a limit of four hundred and eighty (480) units per POC. Payment is not allowed solely for written reports or record documentation.

(5) **Psychological services.**

(A) **Minimum qualifications.** Qualification to provide psychological services requires current, non-restrictive licensure as a psychologist by the Oklahoma State Board of Examiners of Psychologists, or by the licensing board in the state where the service is provided. Psychological technicians who have completed all board certification and training requirements may provide services under a licensed psychologist's supervision.

(B) **Service description.** Psychological services include evaluation, psychotherapy, consultation, and behavioral treatment. Service is provided in any community setting as specified in the member's IP. The provider develops, implements, evaluates, and revises the Protective Intervention Protocol (PIP) corresponding to the relevant outcomes identified in the member's IP.

(i) Services are:

(I) Intended to maximize a member's psychological and behavioral well-being; and

(II) Provided in individual and group formats, with a six-person maximum.

(ii) Service approval is based on assessed needs per OAC 340:100-5-51.

(C) **Coverage limitations.**

(i) Payment is made in fifteen (15) minute units. A minimum of fifteen (15) minutes for each individual and group encounter is required.

(ii) Psychological services are authorized for a period, not to exceed twelve (12) months.

(I) Initial authorization does not exceed one hundred and ninety-two (192) units, forty-eight (48) service hours.

(II) Authorizations may not exceed two hundred and eighty-eight (288) units per POC year unless the DDS Behavior Support Services director or designee makes an exception.

(III) No more than twelve (12) hours of services, forty-eight (48) units, may be billed for PIP preparation. Any clinical document is prepared within sixty (60) calendar days of the request. Further, if the document is not prepared, payments are suspended until the requested document is provided.

(IV) When revising a PIP to accommodate recommendations of a required committee review, the provider may bill for only one (1) revision. The time for preparing the revision is clearly documented and does not exceed four (4) hours.

(6) **Psychiatric services.**

(A) **Minimum qualifications.** Qualification as a psychiatric services provider requires a current, non-restrictive license to practice medicine in Oklahoma. Certification by the American Board of Psychiatry and Neurology or satisfactory completion of an approved residency program in psychiatry is required.

(B) **Service description.** Psychiatric services include outpatient evaluation, psychotherapy, medication and prescription management and consultation, and are provided to eligible members. Services are provided in the community setting specified in the member's IP.

(i) Services are intended to contribute to the member's psychological well-being.

(ii) A minimum of thirty (30) minutes for encounter and record documentation is required.

(C) **Coverage limitations.** A unit is thirty (30) minutes, with a limit of two hundred (200) units, per POC year.

(7) **Speech-language pathology services.**

(A) **Minimum qualifications.** Qualification as a speech-language pathology services provider requires current, non-restrictive licensure as a speech-language pathologist, speech-language pathology assistant, or speech-language pathology clinical fellow, by the Oklahoma Board of Examiners for Speech-Language Pathology and Audiology, per OAC 317:30-5-675.

(B) **Service description.** Speech therapy includes evaluation, treatment, and consultation in communication, oral motor activities, and/or feeding activities provided to eligible members. Services are intended to maximize the member's community living skills and may be provided in the community setting specified in the member's IP.

(i) The IP includes a practitioner's prescription. For this Section's purposes, practitioners are defined as licensed medical and osteopathic physicians, physician assistants, and other licensed professionals with prescriptive authority to order speech or language services or both in accordance with rules and regulations covering the OHCA SoonerCare program.

(ii) A minimum of fifteen (15) minutes for encounter and record documentation is required.

(C) **Coverage limitations.** A unit is fifteen (15) minutes, with a limit of two hundred and eighty-eight (288) units, per POC. Payment is not allowed solely for written reports or record documentation.

(8) **Habilitation training specialist (HTS) services.**

(A) **Minimum qualifications.** Providers complete Oklahoma Human Services (OKDHS) DDS-sanctioned training curriculum. Residential habilitation providers:

(i) Are at least eighteen (18) years of age or older;

(ii) Are specifically trained to meet members' unique needs;

(iii) Have not been convicted of, pled guilty to, or pled nolo contendere to misdemeanor assault and battery, or a felony, per Section (§) 1025.2 of Title 56 of the Oklahoma Statutes (56 O.S. § 1025.2) unless a waiver is granted, per 56 O.S. §1025.2; and

(iv) Receive supervision and oversight from contracted-agency staff with a minimum of four (4) years of any combination of college-level education or full-time equivalent experience in serving persons with disabilities.

(B) **Service description.** HTS services include services to support the member's self-care, daily living, and adaptive and leisure skills needed to reside successfully in the community. Services are provided in community-based settings in a manner that contributes to the member's independence, self-sufficiency, community inclusion, and well-being.

(i) Payment is not made for~~:~~ routine care and supervision family normally provides.

~~(I) Routine care and supervision family normally provides; or~~

~~(II) Services furnished to a member by a person who is legally responsible, per OAC 340:100-3-33.2~~.

(ii) Family members who provide HTS services meet the same standards as providers who are unrelated to the member. Legally responsible individuals, per OAC 340:100-3-33.2, may provide HTS for extraordinary care as determined by the Oklahoma Choice Assessment completed annually by DDS staff. HTS staff residing in the same household as the member may not provide services in excess of forty (40) hours per week. Members who require HTS services for more than forty (40) hours per week use staff members who do not reside in the household, and who are employed by the member's chosen provider agency, to deliver the balance of necessary support staff hours. Exceptions may be authorized, when needed, for members who receive services through the Homeward Bound Waiver.

(iii) Payment does not include room and board or maintenance, upkeep, or improvement of the member's or family's residence.

(iv) For members who also receive intensive personal supports (IPS), the member's IP clearly specifies the role of the HTS and person providing IPS to ensure there is no service duplication.

(v) Review and approval by the DDS plan of care reviewer is required.

(vi) Pre-authorized HTS services accomplish the same objectives as other HTS services, but are limited to situations where the HTS provider is unable to obtain required professional and administrative oversight from an OHCA-approved oversight agency. For pre-authorized HTS services, the service:

(I) Provider receives DDS area staff oversight; and

(II) Is pre-approved by the DDS director or his or her designee.

(C) **Coverage limitations.** HTS services are authorized per OAC 317:40-5-110, 317:40-5-111, 317:40-7-13, and 340:100-3-33.1.

(i) A unit is fifteen (15) minutes.

(ii) Individual HTS service providers are limited to a maximum of forty (40) hours per week regardless of the number of members served.

(iii) More than one (1) HTS may provide care to a member on the same day.

(iv) Payment cannot be made for services provided by two (2) or more HTSs to the same member during the same hours of a day.

(v) An HTS may receive reimbursement for providing services to only one (1) member at any given time. This does not preclude services from being provided in a group setting where services are shared among group members.

(vi) HTS providers may not perform any job duties associated with other

employment including on-call duties, at the same time they are providing HTS services.

(9) **Remote Supports (RS).** RS is provided per OAC 317:40-4-4.

(10) **Self Directed HTS (SD HTS).** SD HTS are provided per OAC 317:40-9-1.

(11) **Self Directed Goods and Services (SD GS).** SD GS are provided per OAC 317:40-9-1.

(12) **Audiology services.**

(A) **Minimum qualifications.** Audiologists have licensure as an audiologist by the Oklahoma Board of Examiners for Speech Pathology and Audiology per OAC 317:30-5-675 (d) (1).

(B) **Service description.** Audiology services include individual evaluation, treatment, and consultation in hearing to eligible members. Services are intended to maximize the member's auditory receptive abilities.

(i) The member's IP includes a practitioner's prescription. For this Section's purposes, practitioners are defined as licensed medical and osteopathic physicians, and physician assistants in accordance with OAC 317:30-5-1 covering the OHCA SoonerCare program.

(ii) A minimum of fifteen (15) minutes for encounter and record documentation is required.

(C) **Coverage limitations.** Audiology services are provided in accordance with the member's IP.

(13) **Prevocational services.**

(A) **Minimum qualifications.** Prevocational services providers:

(i) Are eighteen (18) years of age or older;

(ii) Complete OKDHS DDS-sanctioned training curriculum;

(iii) Are not convicted of, pled guilty to, or pled nolo contendere to misdemeanor assault and battery, or a felony per 56 O.S. § 1025.2, unless a waiver is granted per 56 O.S. § 1025.2; and

(iv) Receive supervision and oversight from a person with a minimum of four (4) years of any combination of college-level education or full-time equivalent experience in serving persons with disabilities.

(B) **Service description.** Prevocational services are not available to persons who can be served under a program funded per Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (IDEA) per Section 1401 et seq. of Title 20 of the United States Code.

(i) Prevocational services are learning and work experiences where the member can develop general, non-job, task-specific strengths that contribute to employability in paid employment in integrated community settings.

(ii) Activities include teaching concepts such as communicating effectively with supervisors, co-workers, and customers, attendance, task completion, problem solving, and safety. These activities are associated with building skills necessary to perform work.

(iii) Pre-vocational services are delivered to further habilitation goals that lead to greater opportunities for competitive, integrated employment. All prevocational services are reflected in the member's IP. Documentation is maintained in the record of each member receiving this service, noting the service is not otherwise available

through a program funded under the Rehabilitation Act of 1973 or IDEA.

(iv) Services include:

(I) Center-based prevocational services, per OAC 317:40-7-6;

(II) Community-based prevocational services per, OAC 317:40-7-5;

(III) Enhanced community-based prevocational services per, OAC 317:40-7-12; and

(IV) Supplemental supports, as specified in OAC 317:40-7-13.

(C) **Coverage limitations.** A unit of center-based or community-based prevocational services is one (1) hour and payment is based on the number of hours the member participates in the service. All prevocational services and supported-employment services combined may not exceed the annual costs set forth in OKDHS Appendix D-26, Developmental Disabilities Services Rates Schedule. The services that may not be provided to the same member at the same time as prevocational services are:

(i) HTS;

(ii) IPS;

(iii) Adult Day Health;

(iv) Daily Living Supports (DLS);

(v) Homemaker; or

(vi) Therapy services, such as occupational therapy; physical therapy; nutrition, speech, or psychological services; family counseling; or family training, except to allow the therapist to assess the individual's needs at the workplace or to provide staff training, per OAC 317:40-7-6.

(14) **Supported employment.**

(A) **Minimum qualifications.** Supported employment providers:

(i) Are eighteen (18) years of age or older;

(ii) Complete the OKDHS DDS-sanctioned training curriculum;

(iii) Are not convicted of, pled guilty to, or pled nolo contendere to misdemeanor assault and battery, or a felony, per 56 O.S. § 1025.2 unless a waiver is granted, per 56 O.S. § 1025.5; and

(iv) Receive supervision and oversight from a person with a minimum of four (4) years of any combination of college-level education or full-time equivalent experience in serving persons with disabilities.

(B) **Services description.** For members receiving HCBS Waiver services, supported employment is conducted in various settings, particularly worksites where persons without disabilities are employed, and includes activities that are outcome based and needed to sustain paid work, including supervision and training. The supported employment outcome is sustained paid employment at or above minimum wage, but not less than the customary wage and benefit level the employer pays for the same or similar work individuals without disabilities perform. The paid employment occurs in an integrated setting in the general workforce in a job that meets personal and career goals.

(i) When supported-employment services are provided at a worksite where persons without disabilities are employed, payment:

(I) Is made for the adaptations, supervision, and training members require as a result of their disabilities; and

(II) Does not include payment for the supervisory activities rendered as a normal part of the business setting.

(ii) Services include:

(I) Job coaching per OAC 317:40-7-7;

(II) Enhanced job coaching per OAC 317:40-7-12;

(III) Employment training specialist services per OAC 317:40-7-8; and

(IV) Stabilization per OAC 317:40-7-11.

(iii) Supported-employment services furnished under HCBS Waivers are not available under a program funded by the Rehabilitation Act of 1973 or IDEA.

(iv) Documentation that the service is not otherwise available under a program funded by the Rehabilitation Act of 1973 or IDEA is maintained in each member's record.

(v) Federal financial participation may not be claimed for incentive payment subsidies or unrelated vocational training expenses, such as:

(I) Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;

(II) Payments passed through to users of supported-employment programs; or

(III) Payments for vocational training not directly related to a member's supported-employment program.

(C) **Coverage limitations.** A unit is fifteen (15) minutes and payment is made per OAC 317:40-7-1 through 317:40-7-21. All prevocational services and supported-employment services combined cannot exceed $27,000, per POC year. The DDS case manager assists the member to identify other alternatives to meet identified needs above the limit. The services that may not be provided to the same member, at the same time as supported-employment services are:

(i) HTS;

(ii) IPS;

(iii) Adult Day Health;

(iv) DLS;

(v) Homemaker; or

(vi) Therapy services, such as occupational therapy; physical therapy; nutrition, speech, or psychological services, family counseling, or family training, except to allow the therapist to assess the individual's needs at the workplace or to provide staff training.

(15) **IPS.**

(A) **Minimum qualifications.** IPS provider agencies must have a current provider agreement with OHCA and OKDHS DDS. Providers:

(i) Are eighteen (18) years of age or older;

(ii) Complete OKDHS DDS-sanctioned training curriculum;

(iii) Are not convicted of, pled guilty to, or pled nolo contendere to misdemeanor assault and battery, or a felony, per 56 O.S. § 1025.2 unless a waiver is granted, per 56 O.S. § 1025.2;

(iv) Receive supervision and oversight from a person with a minimum of four (4) years of any combination of college-level education or full-time equivalent experience in serving persons with disabilities; and

(v) Receive oversight regarding specific methods to be used with the member to meet the member's complex behavioral or health support needs.

(B) **Service description.**

(i) IPS:

(I) Are support services provided to members who need an enhanced level of direct support in order to successfully reside in a community-based setting; and (II) Build on the support level HTS or DLS staff provides by utilizing a second staff person on duty to provide assistance and training in self-care, daily living, and recreational and habilitation activities.

(ii) The member's IP clearly specifies the role of HTS and the person providing IPS to ensure there is no service duplication.

(iii) The DDS POC reviewer is required to review and approve services.

(C) **Coverage limitations.** IPS are limited to twenty-four (24) hours per day and are included in the member's IP, per OAC 317:40-5-151 and 317:40-5-153.

(16) **Adult day health.**

(A) **Minimum qualifications.** Adult day health provider agencies:

(i) Meet licensing requirements, per 63 O.S. § 1-873 *et seq*. and comply with OAC 310:605; and

(ii) Are approved by the OKDHS DDS director and have a valid OHCA contract for adult day health.

(B) **Service description.** Adult day health provide assistance with retaining or improving the member's self-help ability adaptive and socialization skills, including the opportunity to interact with peers in order to promote a maximum level of independence and function. Services are provided in a non-residential setting away from the home or facility where the member resides.

(C) **Coverage limitations.** adult day health is furnished four (4) or more hours per day on a regularly scheduled basis, for one (1) or more days per week. A unit is fifteen (15) minutes for up to a maximum of eight (8) hours daily. All services are authorized in the member's IP.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 40. DEVELOPMENTAL DISABILITIES SERVICES

SUBCHAPTER 1. GENERAL PROVISIONS

317:40-1-1. Home and Community-Based Services (HCBS) Waivers for persons with intellectual disabilities or certain persons with related conditions

(a) **Applicability.** This Section applies to services funded through Medicaid HCBS Waivers per Oklahoma Administrative Code (OAC) 317:35-9-5 and Section 1915(c) of the Social Security Act. Specific Waivers are the In-Home Supports Waiver (IHSW) for Adults, IHSW for Children, Community Waiver, and Homeward Bound Waiver.

(b) **Program provisions.** Each individual requesting services provided through an HCBS Waiver and his or her family or guardian, are responsible for:

(1) Accessing with ~~the~~ Oklahoma ~~Department of~~ Human Services (OKDHS) staff assistance, all benefits available under Oklahoma's Medicaid State Plan or other payment sources prior to accessing funding for those same services under an HCBS Waiver program;

(2) Cooperating in the determination of medical and financial eligibility including prompt reporting of changes in income or resources;

(3) Choosing between services provided through an HCBS Waiver or institutional care; and

(4) Reporting any changes in address or other contact information to OKDHS within thirty (30) calendar days.

(c) **Waiver eligibility.** To be eligible for Waiver services, an applicant must meet the criteria established in (1) of this Subsection and the criteria for one (1) of the Waivers established in (1) through (8) of this Subsection.

(1) **HCBS Waiver services.** Services provided through an HCBS Waiver are available to Oklahoma residents meeting SoonerCare (Medicaid) eligibility requirements established by law, regulatory authority, and policy within funding available through state or federal resources. To be eligible and receive services funded through any of the Waivers listed in (a) of this Section, an applicant must meet conditions, per OAC 317:35-9-5. The applicant:

(A) Must be determined financially eligible for SoonerCare, per OAC 317:35-9-68;

(B) May not simultaneously be enrolled in any other Medicaid Waiver program or receiving services in an institution including a hospital, rehabilitation facility, mental health facility, nursing facility, or residential care home per Section (') 1-820 of Title 63 of the Oklahoma Statutes (O.S.), or Intermediate Care facility for individuals with intellectual disabilities (ICF/IID);

(C) May not be receiving Developmental Disabilities Services (DDS) state-funded services, such as the Family Support Assistance Payment, Respite Voucher Program, sheltered workshop services, community integrated employment services, or assisted living without Waiver supports, per OAC 340:100-5-22.2; and

(D) Must also meet other Waiver-specific eligibility criteria.

(2) **In-Home Supports Waivers (IHSW).** To be eligible for services funded through the IHSW, an applicant must:

(A) Meet all criteria listed in (c) of this Section; and

(B) Be determined by the Social Security Administration (SSA) to have a disability and a diagnosis of intellectual disability; or

(C) Be determined by the Oklahoma Health Care Authority (OHCA) Level of Care

Evaluation Unit (LOCEU) to have a disability and a diagnosis of intellectual disability per SSA guidelines or a diagnosis of global developmental delay when accompanied by a Full-Scale Intelligence Quotient (FSIQ) less than or equal to seventy (70), plus or minus five (5), when under six (6) years of age as defined in the Diagnostic and Statistical Manual of Mental Disorders ~~by the Oklahoma Health Care Authority (OHCA) Level of Care Evaluation Unit (LOCEU)~~; and

(D) Be three (3) years of age or older;

(E) Be determined by the OHCA LOCEU to meet the ICF/IID Institutional Level of Care requirements, per OAC 317:30-5-122; and

(F) Reside in:

(i) A family member's or friend's home;

(ii) His or her own home;

(iii) An OKDHS Child Welfare Services (CWS) foster home; or

(iv) A CWS group home; and

(vii) Have critical support needs that can be met through a combination of non-paid, non-Waiver, and SoonerCare (Medicaid) resources available to the individual; and HCBS Waiver resources within the annual per capita Waiver limit, agreed on between the State of Oklahoma and the Centers for Medicare and Medicaid Services (CMS).

(3) **Community Waiver.** To be eligible for services funded through the Community Waiver, the applicant must:

(A) Meet all criteria listed in (c) of this Section;

(B) Be determined by the SSA to have a disability and a diagnosis of intellectual disability; or

(C) Have an intellectual ~~disability as defined in the Diagnostic and Statistical Manual of Mental Disorders~~per SSA guidelines or a related condition by DDS and be covered under the State's alternative disposition plan, adopted under Section 1919(e)(7)(E) of the Social Security Act; or

(D) Be determined by the OHCA LOCEU to have a disability and a diagnosis of intellectual disability per SSA guidelines or a diagnosis of global developmental delay when accompanied by an FSIQ less than or equal to seventy (70), plus or minus five (5), when under six (6) years of age as defined in the Diagnostic and Statistical Manual of Mental Disorders ~~or the OHCA LOCEU~~; and

(E) Be three (3) years of age or older; and

(F) Be determined by the OHCA LOCEU, to meet ICF/IID Institutional Level of Care requirements, per OAC 317:30-5-122; and

(G) Have critical support needs that can be met by the Community Waiver and cannot be met by IHSW services or other service alternatives, as determined by the DDS director or designee.

(4) **Homeward Bound Waiver.** To be eligible for services funded through the Homeward Bound Waiver, the applicant must:

(A) Be certified by the United States District Court for the Northern District of Oklahoma as a member of the plaintiff class in *Homeward Bound et al. v. The Hissom Memorial Center*, Case No. 85-C-437-E;

(B) Meet all criteria for HCBS Waiver services listed in (c) of this Section; and

(C) Be determined by SSA to have a disability and a diagnosis of intellectual disability; or

(D) Have an intellectual disability as defined in the Diagnostic and Statistical Manual of Mental Disorders or a related condition, per OAC 317:35-9-45 as determined by DDS, and to be covered under the State's alternative disposition plan adopted under Section 1919(e)(7)(E) of the Social Security Act; or

(E) Have a disability as defined in the Diagnostic and Statistical Manual of Mental Disorders by the OHCA/LOCEU; and

(F) Meet ICF/IID Institutional Level of Care requirements, per OAC 317:30-5-122, as determined by the OHCA LOCEU.

(5) **Evaluations and information.** Applicants desiring services through any of the Waivers listed in (a) of this Section participates in diagnostic evaluations and provides information necessary to determine HCBS Waiver services eligibility, including:

(A) A psychological evaluation, by a licensed psychologist that includes:

(i) A full-scale, functional and/or adaptive assessment; and

(ii) A statement of age of onset of the disability; and (iii) Intelligence testing that yields a full-scale, intelligence quotient.

(I) Intelligence testing results obtained at sixteen (16) years of age and older are considered valid of the current status, provided they are compatible with current behavior. Intelligence testing results obtained between seven to sixteen (7 to 16) years of age are considered current for four (4) years when the full-scale intelligence quotient is less than forty (40) and for two (2) years when the intelligence quotient is forty (40) or above.

(II) When an applicant is approved for an HCBS waiver with a diagnosis of global developmental delay, a new psychological evaluation must be conducted and submitted after the child reaches six (6) years of age. Re-evaluation occurs at the beginning of the plan of care year following the child's sixth (6^{th}) birthday, at which time, a diagnosis of Intellectual Disability must be confirmed to continue waiver services.

~~(II)~~(III) DDS may require a current psychological evaluation when a significant change of condition, disability, or psychological status is noted;

(B) A social service summary, current within twelve (12) months of the requested approval date that includes a developmental history; and

(C) A medical evaluation, current within one (1) calendar year of the requested approval date; and

(D) A completed Form LTC-300, ICF/IID Level of Care Assessment; and

(E) Proof of disability per SSA guidelines. When a disability determination is not made by SSA, OHCA LOCEU may make a disability determination using SSA guidelines.

(6) **Eligibility determination.** OHCA reviews the diagnostic reports listed in (2) of this subsection and makes an eligibility determination for DDS HCBS Waivers.

(7) **State's alternative disposition plan.** For individuals who are determined to have an intellectual disability or a related condition by DDS per the State's alternative disposition plan adopted under Section 1919(e)(7)(E) of the Social Security Act, DDS reviews the diagnostic reports listed in (2) of this subsection and, on behalf of OHCA, makes a determination of eligibility for DDS HCBS Waiver services and ICF/IID level of care.

(8) **Member's choice.** A determination of need for ICF/IID Institutional Level of Care does

not limit the opportunities of the person receiving services to participate in community services. Individuals are assured of the opportunity to exercise informed choice in the selection of services.

(d) **Request list.** When state DDS resources are unavailable to add individuals to services funded through an HCBS Waiver, persons are placed on a statewide Request for Waiver Services List.

(1) The Request for Waiver Services List is maintained in chronological order, based on the date of receipt of a written request for services on Form 06MP001E, Request for Developmental Disabilities Services. The applicant must submit the required documentation, per Form 06MP001E, Request for Developmental Disabilities Services, for initial consideration of potential eligibility. Active United States Armed Forces personnel, who have a pending HCBS Waiver application in another state for an immediate family member, may be placed on the list with the date they applied in the other state. The person's name is added to the list when he or she provides proof of application date from the other state.

(2) The Request for Waiver Services List for persons requesting services provided through an HCBS Waiver is administered by DDS uniformly throughout the state.

(3) An individual applicant is removed from the Request for Waiver Services List, when he or she:

(A) Is found to be ineligible for services;

(B) Cannot be located by OKDHS;

(C) Does not provide OKDHS-requested information or fails to respond;

(D) Is not an Oklahoma resident at the requested Waiver approval date; or

(E) Declines an offer of Waiver services.

(4) An applicant removed from the Request for Waiver Services List, because he or she could not be located, may submit a written request to be reinstated to the list. The applicant is returned to the same chronological place on the Request for Waiver Services List, provided he or she was on the list prior to January 1, 2015.

(e) **Applications.** When resources are sufficient for initiation of HCBS Waiver services, DDS ensures action regarding a request for services occurs within forty-five (45) calendar days. When action is not taken within the required forty-five (45) calendar days, the applicant may seek resolution, per OAC 340:2-5-61.

(1) Applicants are allowed sixty (60) calendar days to provide information requested by DDS to determine eligibility for services.

(2) When requested information is not provided within sixty (60) calendar days, the applicant is notified that the request was denied, and he or she is removed from the Request for Waiver Services List.

(f) **Admission protocol.** Initiation of services funded through an HCBS Waiver occurs in chronological order from the Request for Waiver Services List, per (d) of this Section based on the date of DDS receipt of a completed request for services, as a result of the informed choice of the person requesting services or the individual acting on the member's behalf, and upon determination of eligibility, per (c) of this Section. Exceptions to the chronological requirement may be made, when:

(1) An emergency situation exists in which the health or safety of the person needing services or of others is endangered and there is no other resolution to the emergency. An emergency exists, when:

(A) The person is unable to care for himself or herself and:

(i) the person's caretaker, 43A O.S. § 10-103:

(I) Is hospitalized;
(II) Moved into a nursing facility;
(III) Is permanently incapacitated; or
(IV) Died; and

(ii) There is no caretaker to provide needed care to the individual; or

(iii) An eligible person is living at a homeless shelter or on the street;

(B) OKDHS finds the person needs protective services due to ongoing physical, sexual, or emotional abuse or neglect in his or her present living situation, resulting in serious jeopardy to the person's health or safety;

(C) The behavior or condition of the person needing services is such that others in the home are at risk of being seriously harmed by the person. For example, when the person is routinely physically assaultive to the caretaker or others living in the home and sufficient supervision cannot be provided to ensure the safety of those in the home or community; or

(D) The person's medical, psychiatric, or behavioral challenges are such that the person is seriously injuring or harming himself or herself, or is in imminent danger of doing so.

(2) The Legislature appropriated special funds with which to serve a specific group or a specific class of individuals, per HCBS Waiver provisions;

(3) Waiver services may be required for people who transition to the community from a public ICF/IID or children in OKDHS custody receiving services from OKDHS. Under some circumstances Waiver services related to accessibility may be authorized in advance of transition, but may not be billed until the day the member leaves the ICF/IID and enters the Waiver; or

(4) Individuals subject to the provisions of Public Law 100-203 residing in nursing facilities for at least 30-continuous months prior to January 1, 1989, and are determined by Preadmission Screening and Resident Review (PASRR) evaluation conducted per Title 42 Section 483.100 of the Federal Code of Regulations to have an intellectual disability or a related condition, who are covered under the State's alternative disposition plan adopted under Section 1919(e)(7)(E) of the Social Security Act, and choose to receive services funded through the Community or Homeward Bound Waiver.

(g) **Movement between DDS HCBS Waiver programs.** A person's movement from services funded through one (1) DDS-administered HCBS Waiver to services funded through another DDS-administered HCBS Waiver is explained in this subsection.

(1) When a member receiving services funded through the IHSW for children becomes eighteen (18) years of age, services through the IHSW for adults becomes effective.

(2) Change to services funded through the Community Waiver from services funded through the IHSW occurs only when:

(A) A member has critical health and safety support needs that cannot be met by IHSW services, non-Waiver services, or other resources as determined by the DDS director or designee; and

(B) Funding is available, per OAC 317:35-9-5.

(3) Change to services funded through the IHSW from services funded through the Community Waiver may only occur when a member's history of annual service utilization was within the IHSW per capita allowance.

(4) When a member served through the Community Waiver has support needs that can be met within the per capita Waiver allowance of the applicable IHSW and through a combination of non-Waiver resources, the individual may choose to receive services through the IHSW.

(h) **Continued eligibility for HCBS Waiver services.** Eligibility for members receiving services provided through the HCBS Waiver is re-determined by the OHCA LOCEU when a determination of disability was not made by the Social Security Administration. The OHCA LOCEU determines categorical relationship to the SoonerCare disabled category according to Social Security Administration guidelines. OHCA LOCEU also approves the level of care, per OAC 317:30-5-122, and confirms a diagnosis of intellectual disability per ~~the Diagnostic and Statistical Manual of Mental Disorders~~SSA guidelines.

(1) DDS may require a new psychological evaluation and re-determination of eligibility at any time when a significant change of condition, disability, or psychological status is noted.

(2) Annual review of eligibility requires a medical evaluation that is current within one year of the requested approval date. The medical evaluation must be submitted by the member or the individual acting on his or her behalf thirty (30) calendar days prior to the Plan of Care expiration.

(i) **HCBS Waiver services case closure.** Services provided through an HCBS Waiver are terminated, when:

(1) A member or the individual acting on the member's behalf chooses to no longer receive Waiver services;

(2) A member is incarcerated;

(3) A member is financially ineligible to receive Waiver services;

(4) A member is determined by SSA to no longer have a disability qualifying the individual for services under these Waivers;

(5) A member is determined by the OHCA LOCEU to no longer be eligible;

(6) A member moves out of state or the custodial parent or guardian of a member who is a minor moves out of state;

(7) A member is admitted to a nursing facility, ICF/IID, residential care facility, hospital, rehabilitation facility, or mental health facility for more than thirty (30) consecutive calendar days;

(8) The guardian of a member who is a minor or adjudicated adult fails to cooperate during the annual review process, per OAC 340:100-5-50 through 340:100-5-58;

(9) The guardian of a member who is a minor or adjudicated adult fails to cooperate in the implementation of the OKDHS rule or service delivery in a manner that places the health or welfare of the member at risk, after efforts to remedy the situation through Adult Protective Services or Child Protective Services were not effective;

(10) The member is determined to no longer be SoonerCare eligible;

(11) There is sufficient evidence the member or the individual acting on the member's behalf engaged in fraud or misrepresentation, failed to use resources as agreed on in the Individual Plan, or knowingly misused public funds associated with these services;

(12) The member or the individual acting on the member's behalf either cannot be located, did not respond, or did not allow case management to complete plan development or monitoring activities as required, per OAC 340:100-3-27, and the member or the individual acting on the member's behalf:

(A) Does not respond to the notice of intent to terminate; or

(B) The response prohibits the case manager from being able to complete plan development or monitoring activities as required, per OAC 340:100-3-27;

(13) The member or the individual acting on the member's behalf fails to cooperate with the case manager to implement a Fair Hearing decision;

(14) It is determined services provided through an HCBS Waiver are no longer necessary to meet the member's needs and professional documentation provides assurance the member's health, safety, and welfare can be maintained without Waiver supports;

(15) The member or the individual acting on the member's behalf fails to cooperate with service delivery;

(16) A family member, the individual acting on the member's behalf, other individual in the member's household, or persons who routinely visit, pose a threat of harm or injury to provider staff or official OKDHS representatives; or

(17) A member no longer receives a minimum of one (1) Waiver service per month and DDS is unable to monitor the member on a monthly basis.

(j) **Reinstatement of services.** Waiver services are reinstated when:

(1) The situation resulting in case closure of a Hissom class member is resolved;

(2) A member is incarcerated for ninety (90) calendar days or less;

(3) A member is admitted to a nursing facility, ICF/IID, residential care facility, hospital, rehabilitation facility, or mental health facility for ninety (90) calendar days or less; or

(4) A member's SoonerCare eligibility is re-established within ninety (90) calendar days of the SoonerCare ineligibility date.

SUBCHAPTER 5. MEMBER SERVICES

PART 11. OTHER COMMUNITY RESIDENTIAL SUPPORTS

317:40-5-155 Extensive residential supports (ERS) [NEW]

(a) **Introduction.** ERS are provided by an agency, approved by Developmental Disabilities Services (DDS), that has a valid Oklahoma Health Care Authority contract for the service.

(1) ERS provide up to twenty-four (24) hours per day of direct support services, including the provision of more than one staff when the needs of the member indicate additional supports are required.

(2) ERS provides a level of supervision necessary to keep the member safe in the home and in the community and to assist the member with obtaining desired outcomes identified in the member's Individual Plan (Plan).

(b) **Provider approval criteria**. Prospective providers of ERS must demonstrate a history of effective services and supports to persons with challenging behaviors per OAC 340:100-5-57(c), emotional challenges or community protection needs. Provider approval requires review of historical information, when available, from DDS Quality Assurance Unit and Residential Unit. The DDS director or designee must approve the location of the home prior to the implementation of services. Each prospective provider submits written documentation of:

(1) a history of services to persons who present challenging behaviors, emotional challenges, or community protection needs, including:

(A) past experience;

(B) number of persons served;

(C) provider's perspective on the greatest challenges in serving persons eligible for ERS services; and

(D) provider's philosophy for service provision;

(2) financial viability through fiscal information when requested, including the anticipated budget related to the rate for ERS services;

(3) service provision plans, including:

(A) anticipated number of homes;

(B) location;

(C) gender to be served;

(D) population to be served; and

(E) availability of psychological, psychiatric, vocational and educational services in the proposed location;

(4) plans for staffing and program coordination; and

(5) staff qualifications, including any additional training provided.

(c) **Services provided.** Services and supports are based on person-centered principles and practices and consistent with OAC 317:40-1-3. The service includes but is not limited to:

(1) program supervision and oversight, which includes:

(A) 24-hour availability of response staff to:

(i) meet schedules or unpredictable needs in a way that promotes maximum dignity and independence; and

(ii) provide supervision, safety and security consistent with the program described in the member's Plan; and

(B) staff who are available to respond to a crisis to:

(i) help ensure safety; and

(ii) assist the member to self-regulate to help prevent placement disruption;

(2) behavioral support, which includes supporting the member in being a valued member of the community. Challenging interactions may include but are not limited to:

(A) physical or verbal aggression;

(B) sexually unsafe behaviors or actions;

(C) victimizing other people or animals;

(D) property destruction;

(E) self-harm;

(F) suicidal ideations or attempts; and

(G) stealing or other illegal behavior;

(3) activities of daily living, which includes instruction, hands-on support, supervision, modeling or prompting to:

(A) eat;

(B) bathe;

(C) dress;

(D) toilet;

(E) complete personal hygiene;

(F) transfer;

(G) complete housework;

(H) manage money;

(I) engage in community safety;

(J) participate in recreation;

(K) engage in socialization;
(L) manage health;
(M) manage medication; or
(N) attend school and other community-based educational opportunities;
(4) coordinating overall safety and supports in the home;
(5) self-advocacy training and support, which includes, but is not limited to:
(A) training and assistance in supported decision making;
(B) accessing needed services;
(C) asking for help;
(D) recognizing and reporting abuse, neglect, mistreatment, or exploitation of self,
(E) responsibility for one's own actions; and
(F) participation in all meetings;
(6) development of communication skills;
(7) assistance with:
(A) emergency planning;
(B) safety planning;
(C) fire, weather and disaster drills; and
(D) crisis intervention;
(8) community access support to enhance the abilities and skills necessary for the member to access typical activities and functions of community life.
(A) Accessing the community includes providing a wide variety of opportunities which may include:
(i) development of social, communication and other skills needed to successfully participate in the desired communities;
(ii) facilitating and building natural relationships in the desired communities;
(iii) participating in community education experiences or training;
(iv) participating in volunteer activities the member finds interesting and desirable;
(v) exploring and understanding available public transportation options; and
(vi) participating in pre-employment and employment activities;
(B) Services are conducted in a variety of settings in which members interact with individuals without disabilities. Services may include:
(i) social skill development;
(ii) adaptive skill development; and
(iii) personnel to accompany and support the member in community settings; and
(9) implementation of recommended and approved follow-up counseling, behavioral, or other therapeutic interventions;
(10) implementation of services delivered under the direction of a licensed or certified professional in that discipline including, but not limited to:
(A) family training;
(B) psychological services;
(C) counseling services;
(D) physical therapy;
(E) occupational therapy; and
(F) speech therapy;
(11) medical and health care services that are integral to meeting the daily needs of the member, which include, but are not limited to:

(A) routine administration of medications; and
(B) tending to the medical needs of members;
(12) the provision of staff training per Oklahoma Administrative Code (OAC) 340:100-3-38.14, to meet the specific needs of the member; and
(13) assisting the member in obtaining services and supplies.

(d) **Eligibility.** ERS are provided to members who:
(1) have challenging behaviors, emotional challenges, or community protection needs and require additional supports to enable them to reside successfully in community settings. These services are designed to assist members to acquire, retain and improve the self-help, socialization, and adaptive skills necessary to remain in the community;
(2) have needs that cannot be met in other traditional community settings;
(3) participate in the DDS Community Waiver, per OAC 317:40-1-1;
(4) need community residential services outside the family home;
(5) do not receive:
(A) home-and community-based services options per OAC 340:100-5-22.1;
(B) group home services per OAC 317:40-5-152;
(C) habilitation training specialist per OAC 317:40-5-110;
(D) respite care per OAC 317:30-5-517;
(E) homemaker per OAC 317:30-5-535; and
(F) intensive personal supports per OAC 317:40-5-151; and
(6) are eighteen (18) years of age or older, unless approved by the DDS director or designee.

(e) **Service requirements.** ERS must be:
(1) included in the member's Plan per OAC 340:100-5-51, including a description of the type(s) and intensity of supervision and assistance that must be provided to the member;
(2) authorized in the member's Plan of Care (POC);
(3) provided by the contracted provider agency chosen by the member or guardian;
(4) delivered per OAC 340:100-5-22.1; and
(5) provided directly to the member.

(f) **Home Requirements.** ERS are provided to eligible members living outside the family's home in a home:
(1) licensed by Oklahoma Human Services (OKDHS) Child Care Services when the member is a child in custody of OKDHS, Child Welfare Services; or
(2) leased or owned by the member receiving services.

(g) **Responsibilities of provider agencies.** Each agency providing ERS ensures:
(1) ongoing supports are available as needed when the member is out of the home visiting family and friends, or hospitalized for psychiatric or medical care;
(2) compliance with all applicable DDS policy found at OAC 340:100; and
(3) that trained staff are available to the member as described in the Plan.
(4) a trainer of a nationally recognized person-centered planning program approved by DDS is employed as a member of the provider’s leadership team or is contracted with the provider.
(5) A background investigation is conducted on staff per OAC 340:100-3-39.
(6) staff identified to work with children complete a Federal Bureau of Investigation (FBI) national criminal history search, which is based on the staff's fingerprints.

(h) **ERS claims.** No more than one unit of ERS per day may be billed.
(1) The provider agency claims one unit of service for each day during which the member receives ERS. A day is defined as the period between 12:00 a.m. and 11:59 p.m.

(2) Claims must not be based on budgeted amounts.

(3) When a member changes provider agencies, only the outgoing service provider agency claims for the day that the member moves.

(i) **Therapeutic leave.** ERS provides for therapeutic leave payments to enable the provider agency to retain direct support staff.

(1) Therapeutic leave is claimed when the member does not receive ERS services for 24-consecutive hours from 12:00 a.m. to 11:59 p.m. because of:

(A) a visit with family or friends without direct support staff;

(B) vacation without direct support staff; or

(C) hospitalization, whether direct support staff are present or not. ERS staff may be present with the member in the hospital as approved by the member's Personal Support Team (Team) in the Plan but are not responsible for the care of the patient.

(2) Therapeutic Leave must be authorized and documented in the POC.

(3) A member may receive therapeutic leave for no more than fourteen (14) consecutive days per event, not to exceed sixty (60) calendar days per POC year.

(4) The payment for a day of therapeutic leave is the same amount as the per diem rate for ERS.

(5) To promote continuity of staffing in the member's absence, the provider agency pays the staff member the salary that he or she would have earned if the member was not on therapeutic leave or provides the staff member a temporary, alternative work opportunity.

(j) **Transition.** Teams plan for a service recipient's transition to appropriate services when it is determined ERS is no longer necessary.

(1) Within six months of the service recipient's admission to ERS, the Team develops measurable, reasonable criteria for the service recipient's transition to a less restrictive environment that are:

(A) based on findings of the risk assessment completed by the Team per OAC 340:100-5-56.

(B) included in a written plan submitted to designated DDS State Office staff; and

(C) reviewed at least annually by the Team.

(2) All transitions from ERS must be approved by designated DDS State Office staff. DDS State Office staff may adjust the transition date when necessary.

(k) **DDS-initiated transition.** The DDS director or designee may initiate the transition process for a member receiving ERS who can be effectively served in another residential environment.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 3. HOSPITALS

317:30-5-42.7. Emergency department (ED) care/services

Emergency department care must:

(1) Be provided in a hospital with a designated emergency department; and

(2) Provide direct patient care, including patient assessment, monitoring, and treatment by hospital medical personnel such as physicians, nurses, or lab and x-ray technicians.

(A) Medical records must document the emergency diagnosis and the extent of direct patient care.

(B) Emergency department care does not include unattended waiting time.

(C) Emergency services are covered for a medical emergency. This means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such 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:

(i) Placing the physical or mental health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or continuation of severe pain;

(ii) serious impairment to bodily functions; serious dysfunction of any bodily organ or part; or death.

(D) Labor and delivery is a medical emergency, if it meets this definition.

(3) Prescheduled services are not considered an emergency.

(4) Services provided as follow-up to initial emergency care are not considered emergency services.

(5) Include provision of emergency opioid antagonist upon discharge as per state law.

317:30-5-47. Reimbursement for inpatient hospital services

Reimbursement will be made for inpatient hospital services in the following manner:

(1) Covered inpatient services provided to eligible SoonerCare members admitted to in-state acute care and critical access hospitals will be reimbursed the lesser of the billed charges or the Diagnosis Related Group (DRG) amount. In addition to the billed charges or DRG payment, whichever is less, an outlier payment may be made to the hospital for very high-cost stays. Additional outlier payment is applicable if either the amount billed by the hospital or DRG payment, whichever applies, is less than a threshold amount of the hospital cost. Each inpatient hospital claim is tested to determine whether the claim qualified for a cost outlier payment. Payment is equal to a percentage of the cost after the threshold is met.

(2) The lesser of the billed charges or DRG amount and outlier, if applicable, represent full reimbursement for all non-physician services provided during the inpatient stay. Payment includes but is not limited to:

(A) Laboratory services;

(B) Prosthetic devices, including pacemakers, lenses, artificial joints, cochlear implants, implantable pumps;
(C) Technical component on radiology services;
(D) Transportation, including ambulance, to and from another facility to receive specialized diagnostic and therapeutic services;
(E) Pre-admission diagnostic testing performed within seventy-two (72) hours of admission; and
(F) Organ transplants.

(3) Charges for services or supplies deemed not medically necessary and/or not separately billable may be recouped upon post payment review of outlier payments.

(4) Hospitals may submit a claim for payment only upon the final discharge of the patient or upon completion of a transfer of the patient to another hospital.

(5) Covered inpatient services provided to eligible members of the SoonerCare program, when treated in out-of-state hospitals will be reimbursed in the same manner as in-state hospitals. Refer to OAC 317:30-3-90 and 317:30-3-91.

(6) Cases which indicate transfer from one (1) acute care hospital to another will be monitored under a retrospective utilization review policy to help ensure that payment is not made for inappropriate transfers.

(7) The transferring hospital will be paid the lesser of the calculated transfer fee or the DRG base payment amount for a non-transfer.

(8) If the transferring or discharge hospital or unit is exempt from the DRG, that hospital or unit will be reimbursed according to the method of payment applicable to the particular facility or units.

(9) Covered inpatient services provided in out-of-state specialty hospitals may be reimbursed at a negotiated rate not to exceed one-hundred percent (100%) of the cost to provide the service. Negotiation of rates will only be allowed when the OHCA determines that the specialty hospital or specialty unit provides a unique (non-experimental) service required by SoonerCare members and the provider will not accept the DRG payment rate. Prior authorization is required.

(10) New providers entering the SoonerCare program will be assigned a peer group and will be reimbursed at the peer group base rate for the DRG payment methodology or the statewide median rate for per diem methods.

(11) All inpatient services are reimbursed per the methodology described in this Section and/or as approved under the Oklahoma Medicaid State Plan.

(12) For high-investment drugs, refer to OAC 317:30-5-47.6.

(13) Separate reimbursement may be obtained for provision of two (2) doses of emergency opioid antagonist upon discharge as per state law.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 112. PUBLIC HEALTH CLINIC SERVICES

317:30-5-1154. County health department (CHD) and city-county health department (CCHD) services/limitations

CHD/CCHD service limitations are:

(1) Child-guidance services (refer to Oklahoma Administrative Code (OAC) 317:30-5-1023).

(2) Dental services (refer to OAC 317:30-3-65.4(7) for specific coverage).

(3) Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services, including blood lead testing and follow-up services (refer to OAC 317:30-3-65 through 317:30-3-65.12 for specific coverage).

(4) Environmental investigations.

(5) Family planning and SoonerPlan family planning services (refer to OAC 317:30-5-12 for specific coverage guidelines).

(6) Immunizations (adult and child).

(7) Blood lead testing (refer to OAC 317:30-3-65.4 for specific coverage).

(8) Newborn hearing screening.

(9) Newborn metabolic screening.

(10) Maternity services (refer to OAC 317:30-5-22 for specific coverage).

(11) Public health nursing services.

(12) Tuberculosis case management and directly observed therapy.

(13) Laboratory services.

(14) Targeted case management.

(15) Community health services.

317:30-5-1162. Community Health Services

(a) **Overview.** Community Health Services are a preventive health service to prevent disease, disability and other health conditions or their progression; to prolong life; and/or to promote physical and mental health and efficiency. Community Health Services are furnished by community health workers (CHW). CHWs are trusted members of a community who help address chronic conditions, preventive health care needs, and health-related social needs.

(b) **Settings.** Community Health Services:

(1) Must be performed at the main clinic site or satellite clinic or mobile clinic site that is open to the public.

(2) Only when an eligible individual does not reside in a permanent dwelling or does not have a fixed home or mailing address can services be provided outside of the clinic, satellite clinic, or mobile clinic.

(c) **Covered Services.** Community Health Services include:

(1) Health education and coaching, in individual or group settings, consistent with established or recognized healthcare standards, to promote beneficiaries' awareness of and engagement in health care and other related services as well as chronic disease self-management methods;

including care planning, setting goals, and creating action plans to address barriers to engaging in care and/or self-management of chronic conditions;

(2) Screening and assessment to uncover the need for services;

(3) Health system navigation and health-related social resource coordination to assist beneficiaries with access to appropriate health care and other related community resources; care coordination services include engaging with beneficiaries and interdisciplinary care teams as a part of a team-based, person-centered approach to support and advocate for physical and mental health including during time-limited episodes of instability.

(d) **Member Eligibility.** In order to receive CHW services, a beneficiary must have services ordered by a physician or other licensed practitioner and must have at least one of the following:

(1) Diagnosis of one or more chronic health conditions including behavioral health conditions;

(2) Self-reported/suspected or documented unmet health-related social need;

(3) Received a screening; and/or

(4) Pregnancy.

(e) **Provider Eligibility.** In order to provide CHW services, an individual shall, in addition to the requirements set forth in 317:30-5-1152:

(1) Be at least eighteen (18) years of age, a legal United States resident, and a resident of Oklahoma;

(2) Be contracted with the State Medicaid Agency or its designee;

(3) Pass a background check;

(4) Obtain a certificate of completion of a C3 core competency-based Community Health Worker training offered by the Oklahoma State Department of Health, Tulsa City County Health Department, and/or Oklahoma City County Health Department; or have two thousand (2,000) documented hours of paid, volunteer, or lived experience;

(5) Have lived experience that aligns with the community being served; and

(6) Work and bill under a licensed provider.

(f) **Limitations.** The following limits exist for community health services.

(1) Individuals may not receive more than two (2) hours or four (4) units per member per day.

(2) Monthly service limits are not to exceed twelve (12) hours or twenty-four (24) units.

(3) Hour limits are constant, regardless of whether services are administered in an individual or group setting.

(4) A visit may consist of multiple units of service on the same date; the time for units of service is added together and rounded up only once per visit.

OPERATIONAL METRICS

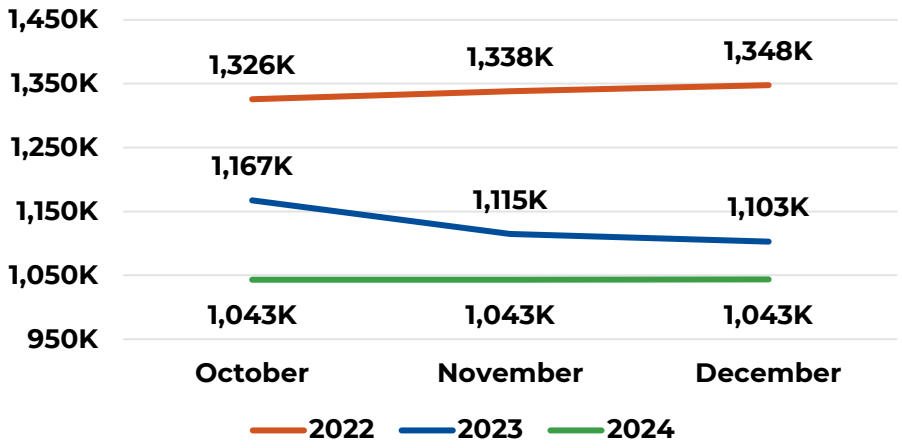
January 2025 Board Meeting

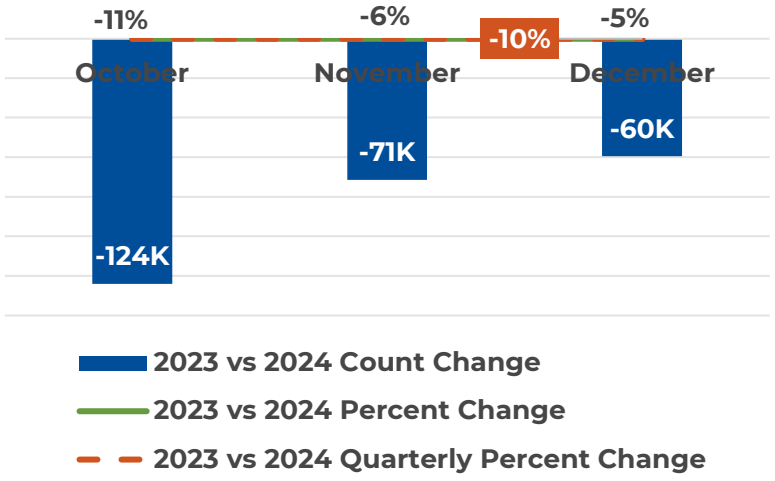
OKLAHOMA HEALTH CARE AUTHORITY

4345 N. LINCOLN BLVD. | OKHCA.ORG |

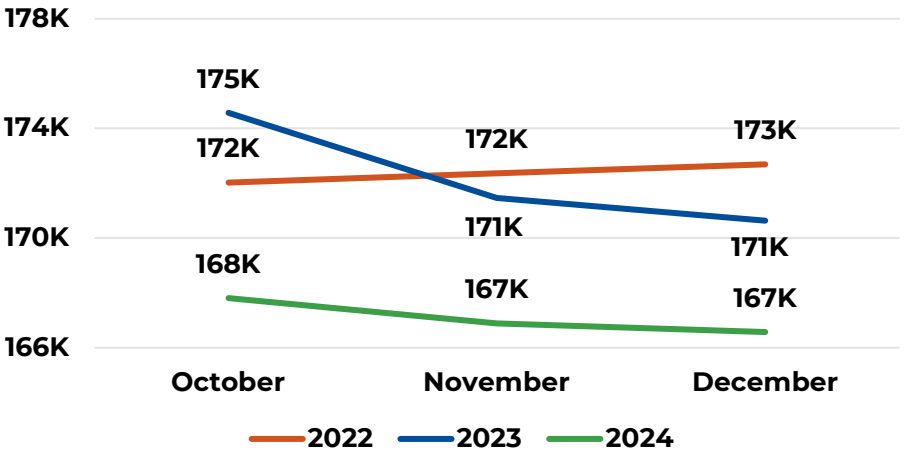
Enrollment & Utilization

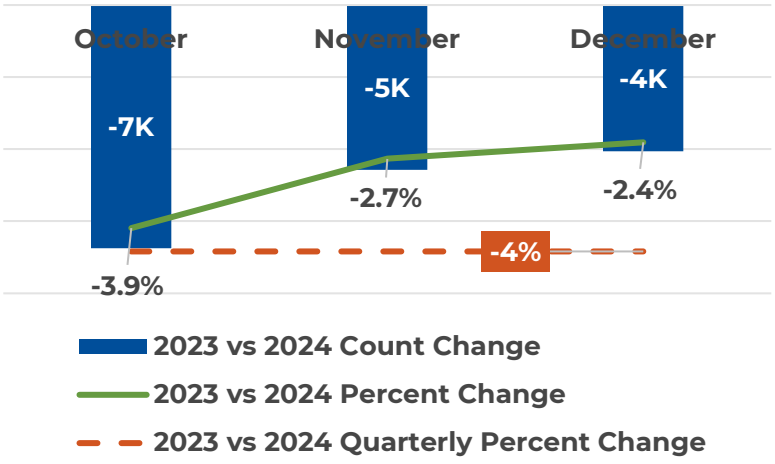
Total Enrolled Members





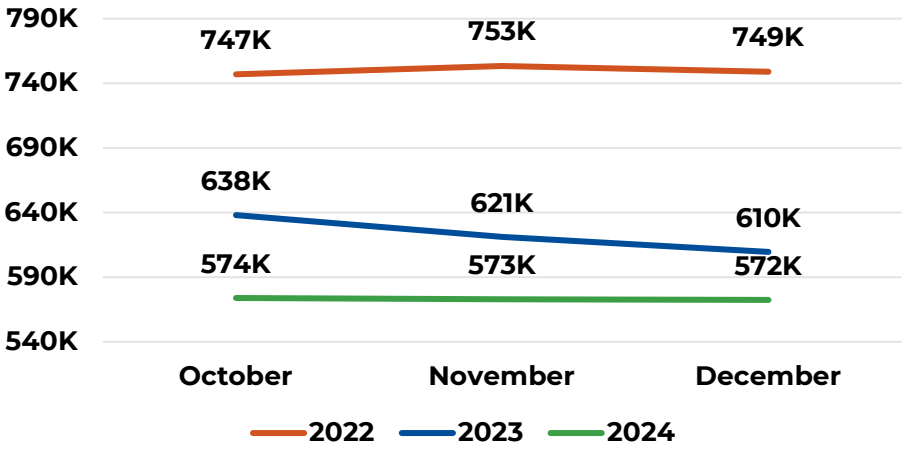
Aged/Blind/Disabled Enrolled

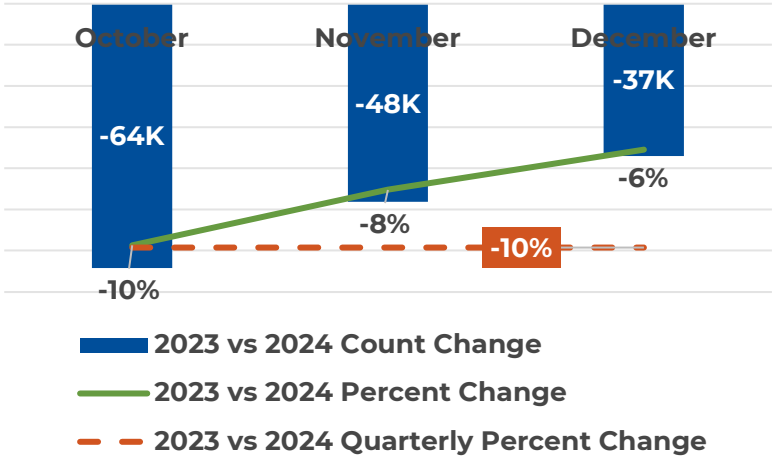




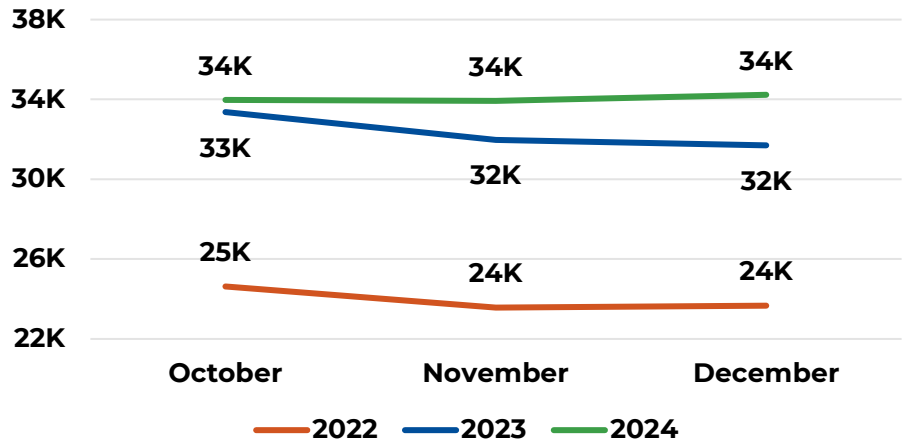
Enrollment & Utilization (Cont.)

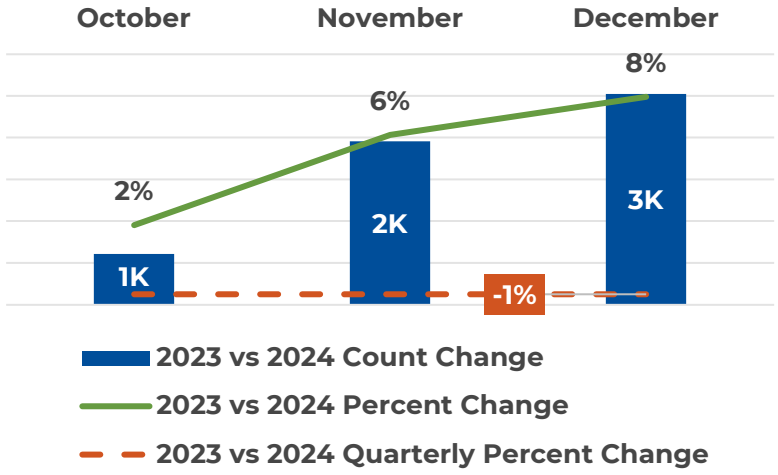
Children & Parent/Caretaker Enrolled





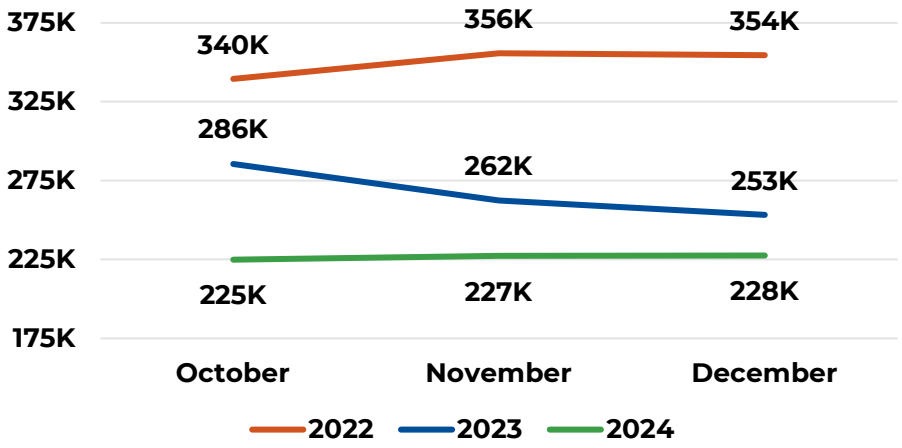
Pregnant (Full Scope) Enrolled

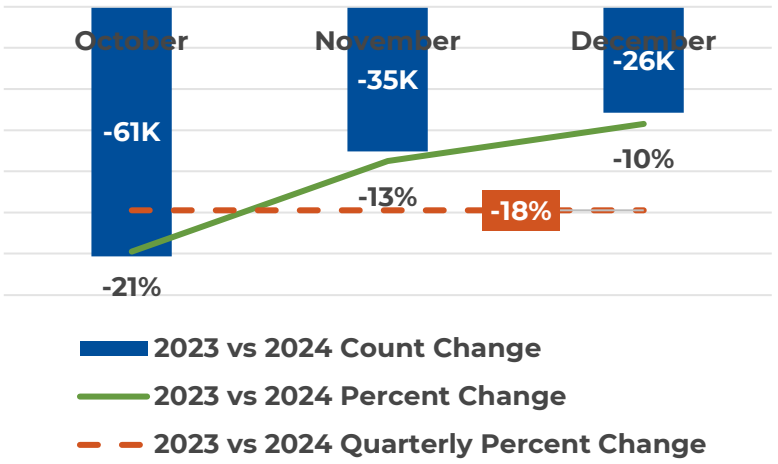




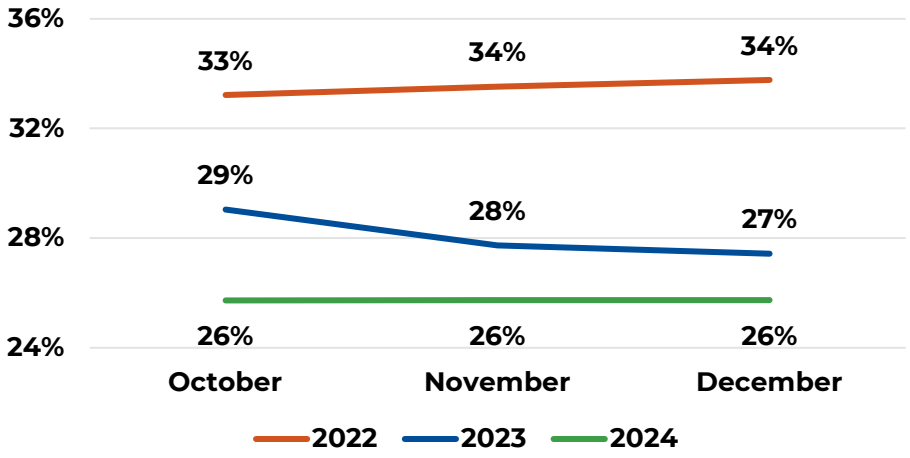
Enrollment & Utilization (Cont.)

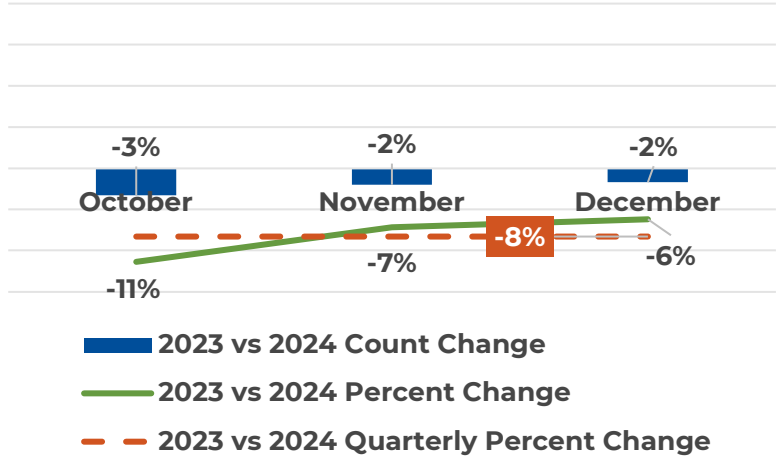
Expansion Enrolled





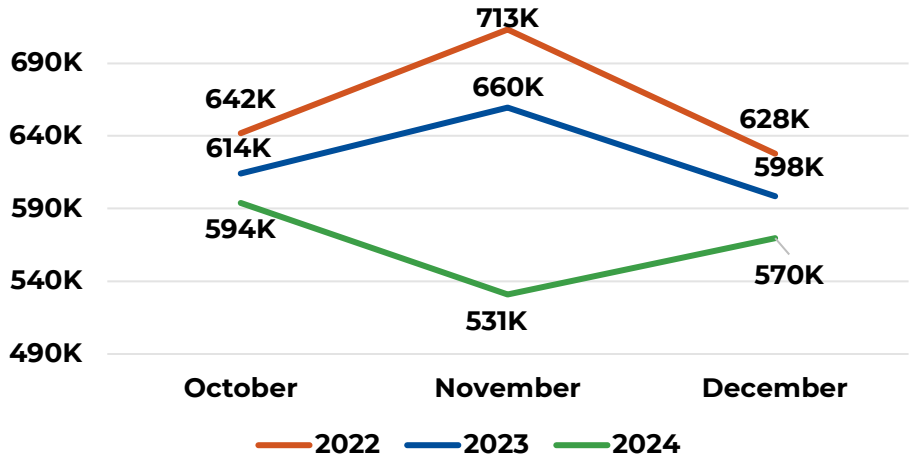
Percent of OK Population Enrolled

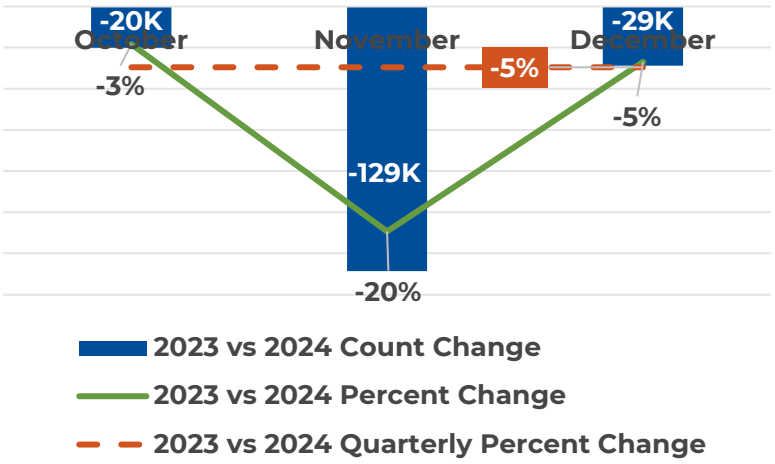




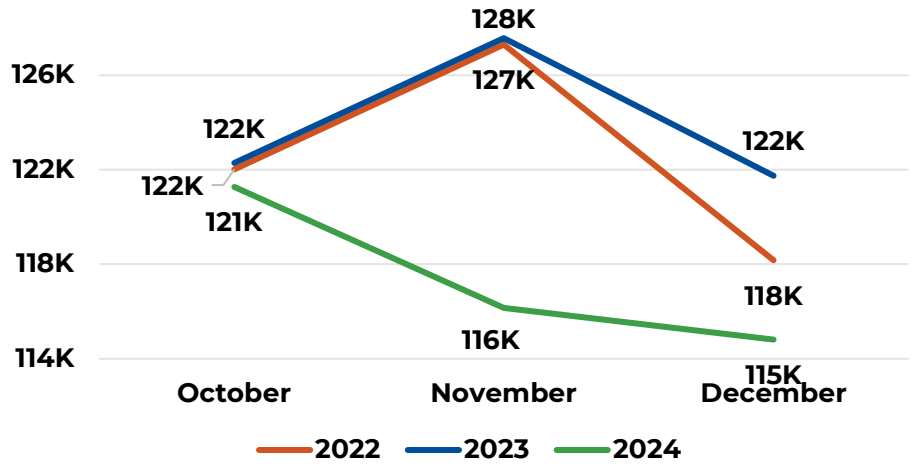
Enrollment & Utilization (Cont.)

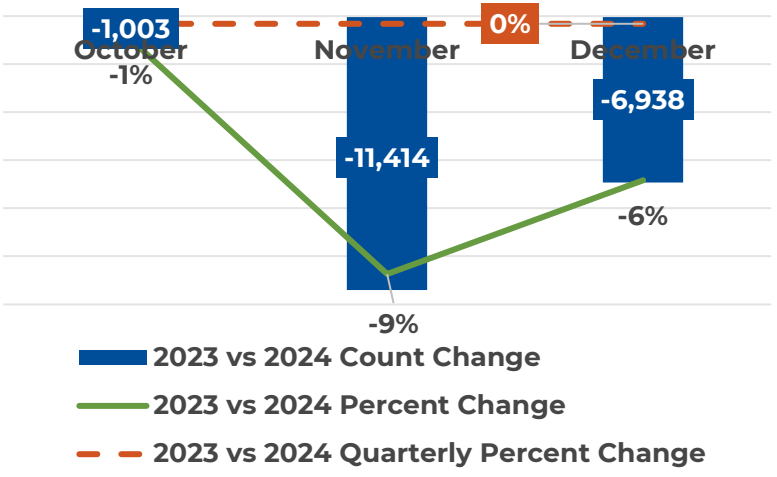
Total Members Utilization





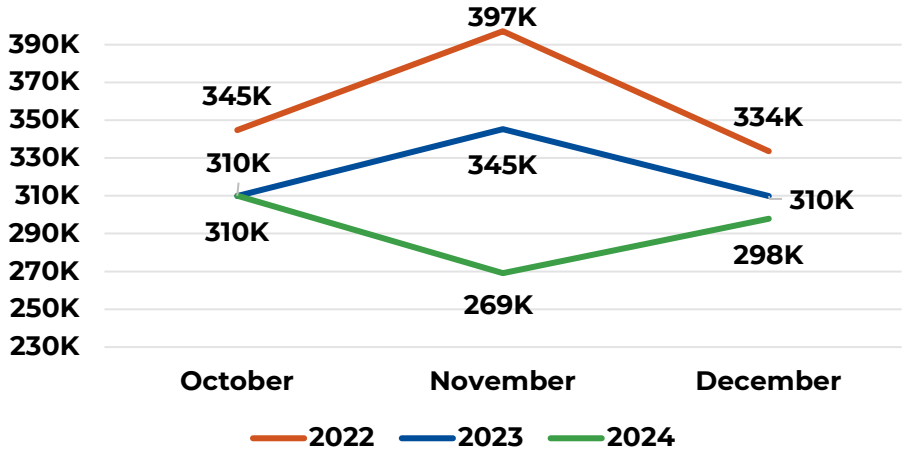
Aged/Blind/Disabled Utilization

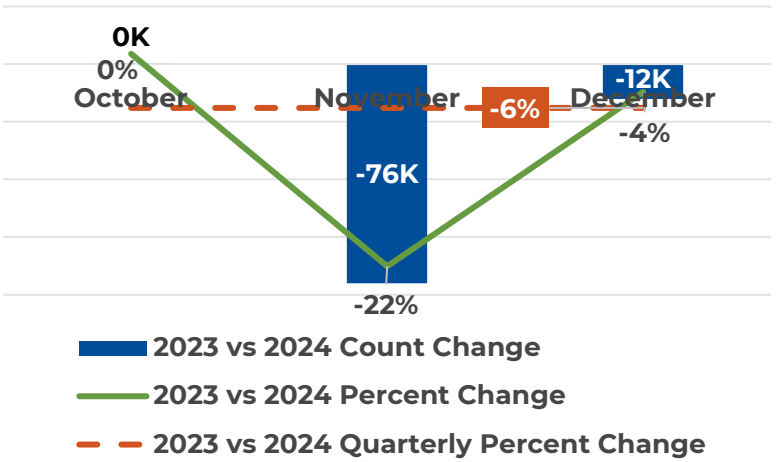




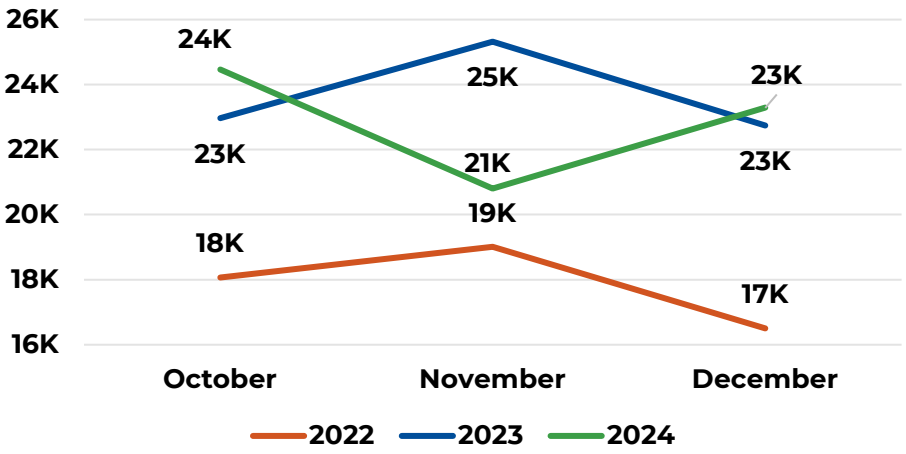
Enrollment & Utilization (Cont.)

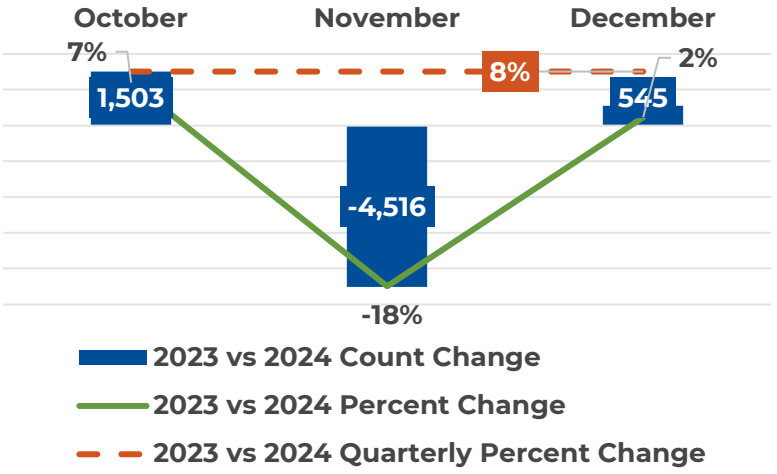
Children & Parent/Caretaker Utilization





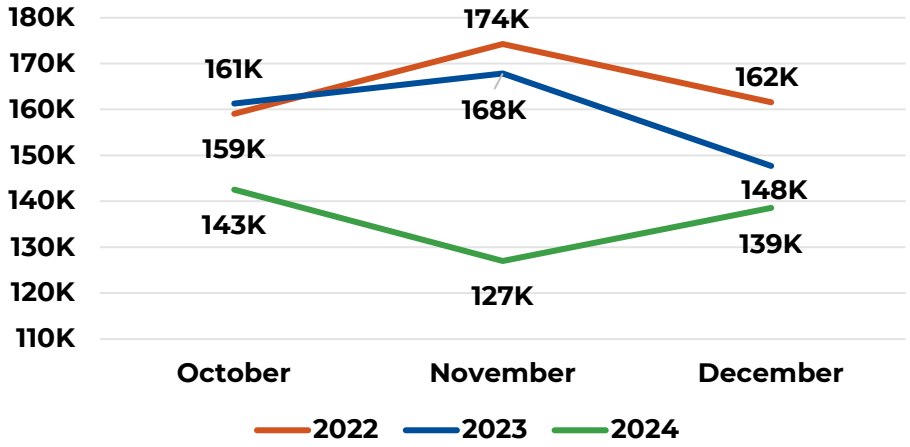
Pregnant (Full Scope) Utilization

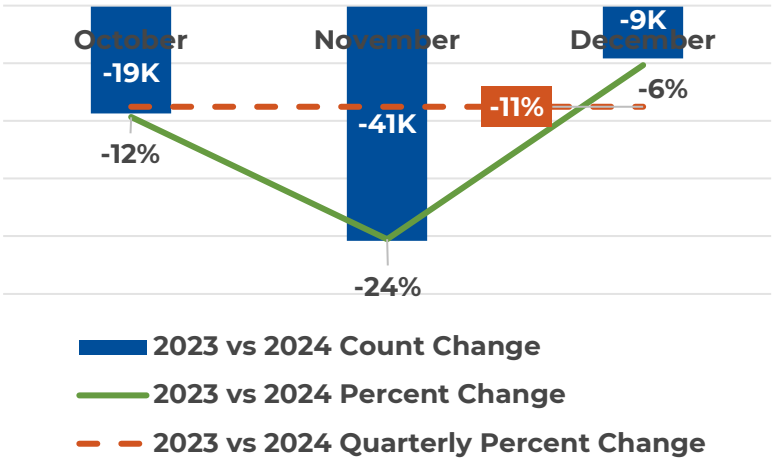




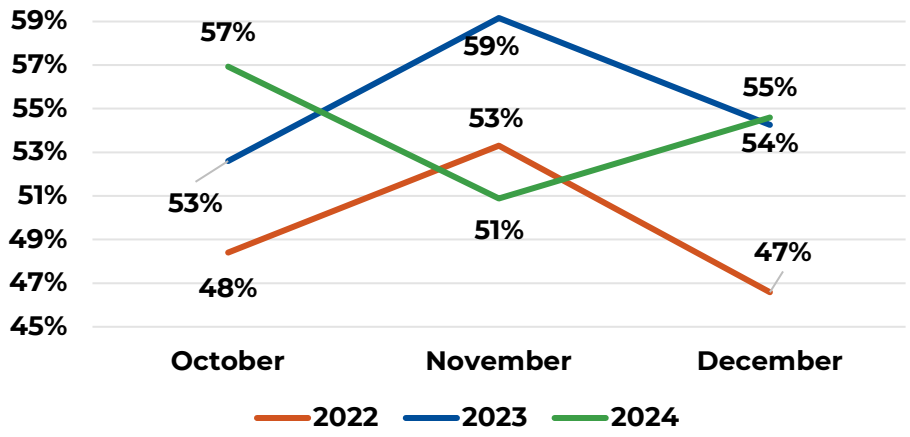
Enrollment & Utilization (Cont.)

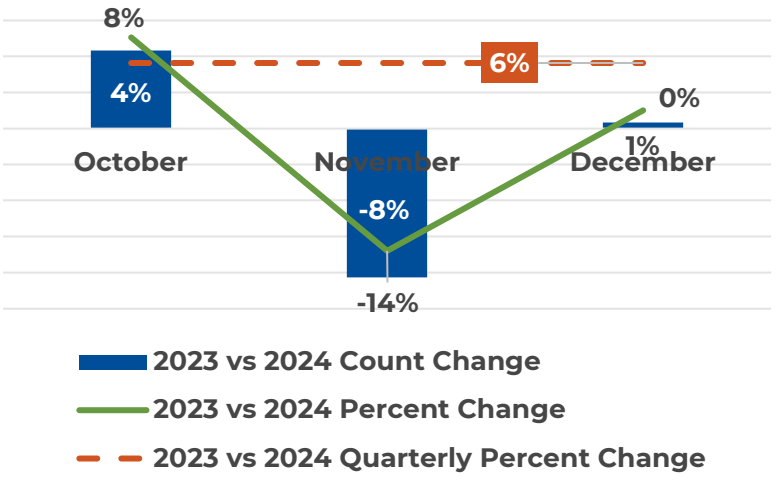
Expansion Utilization





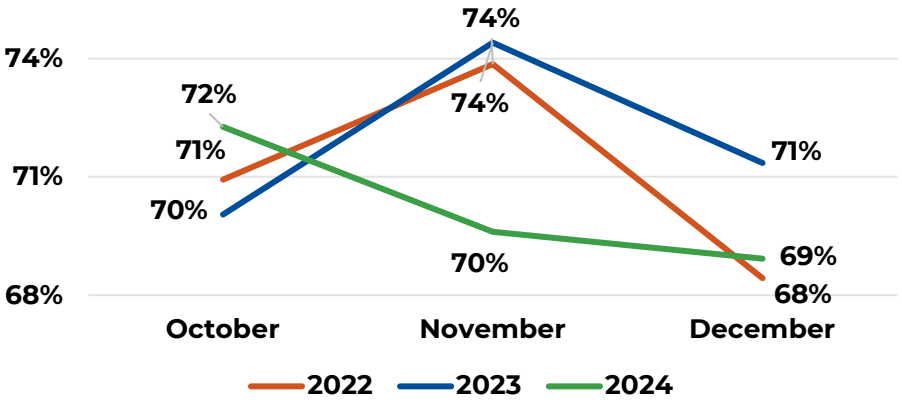
Percent of Total Enrolled Members Utilization

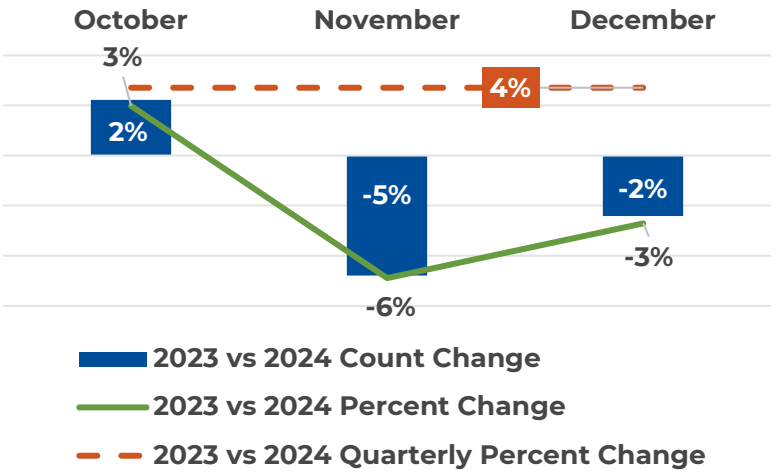




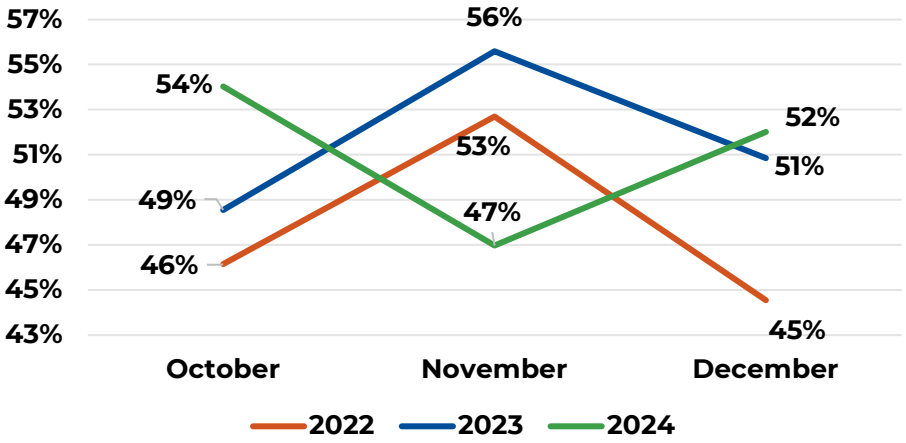
Enrollment & Utilization (Cont.)

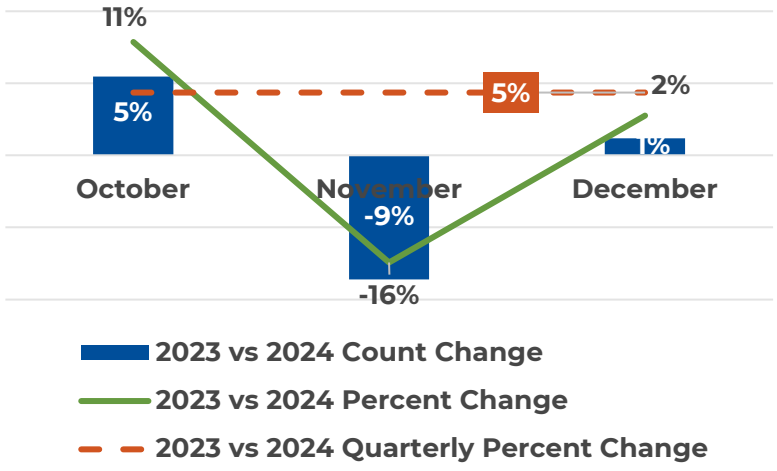
Percent of Aged/Blind/Disabled Enrolled Members Utilization





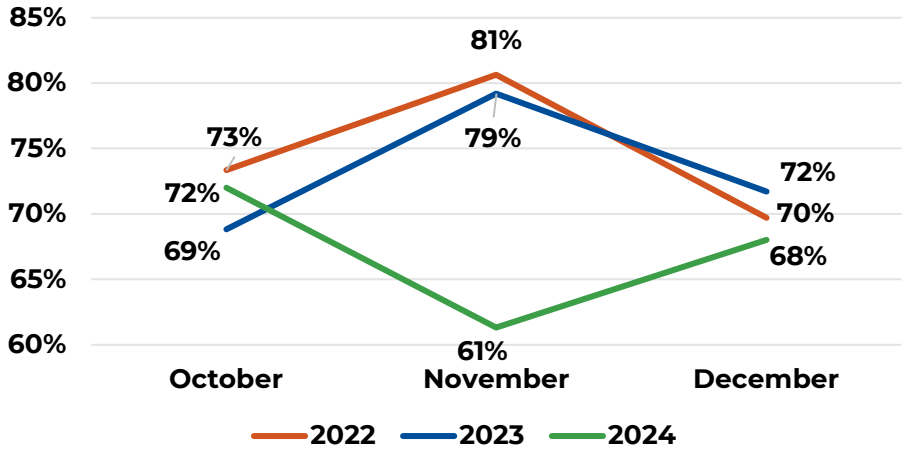
Percent of Children & Parent/Caretaker Enrolled Members Utilization

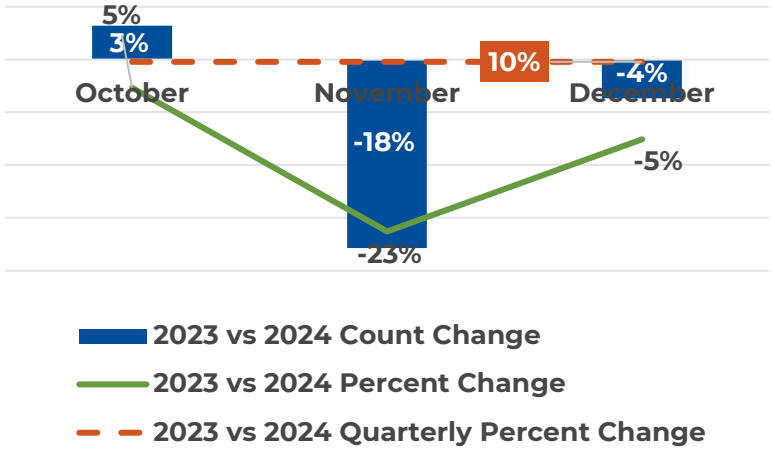




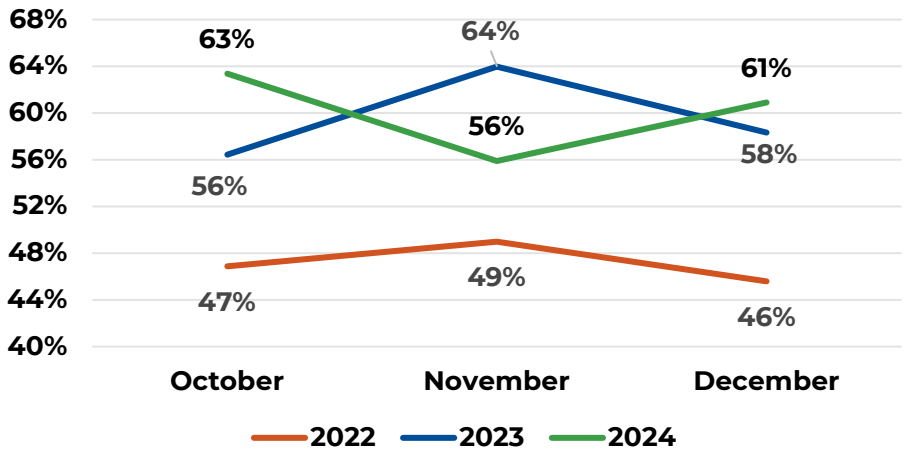
Enrollment & Utilization (Cont.)

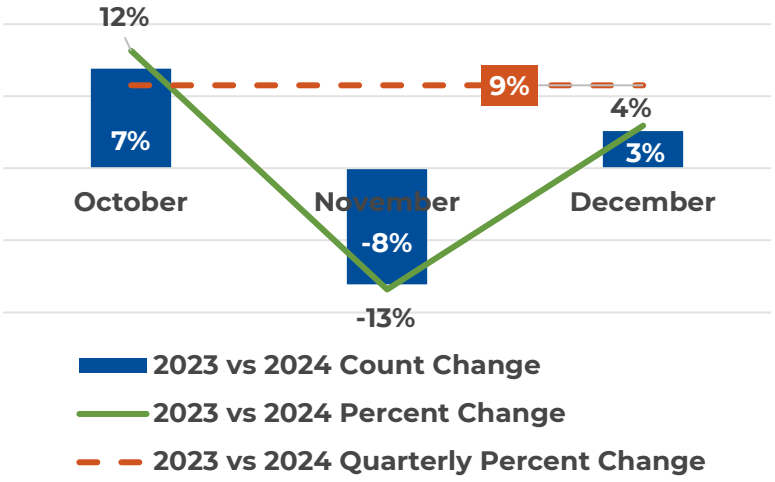
Percent of Pregnant (Full Scope) Enrolled Members Utilization





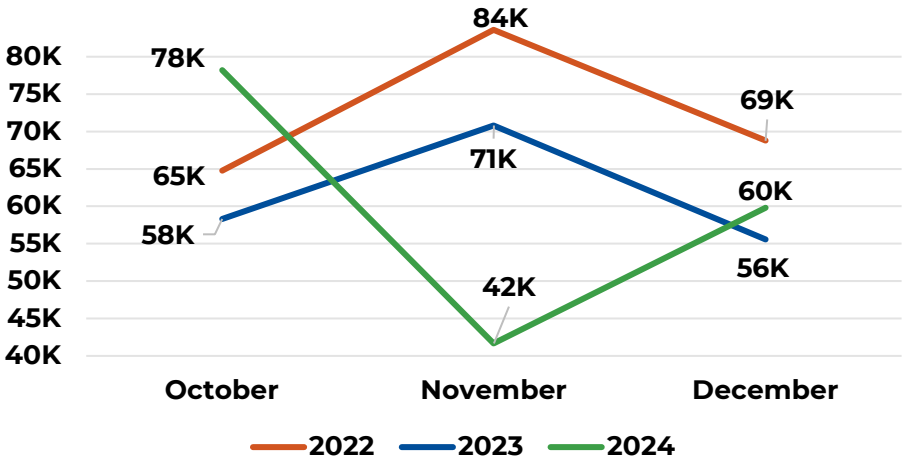
Percent of Expansion Enrolled Members Utilization

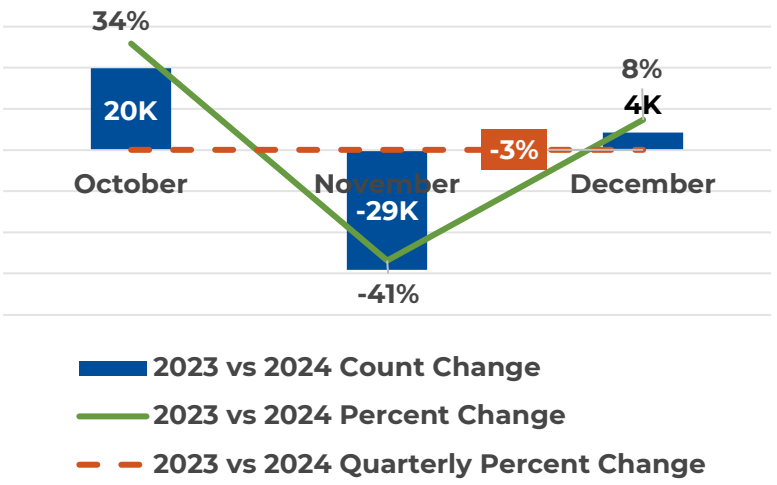




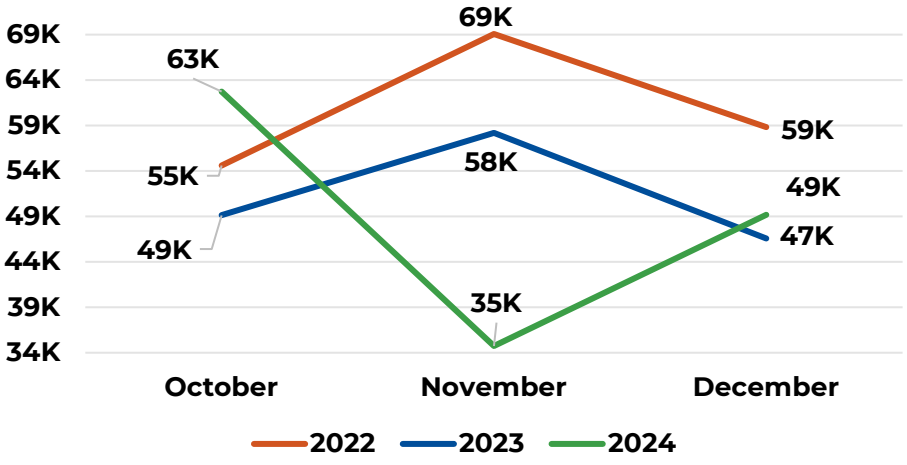
Utilization

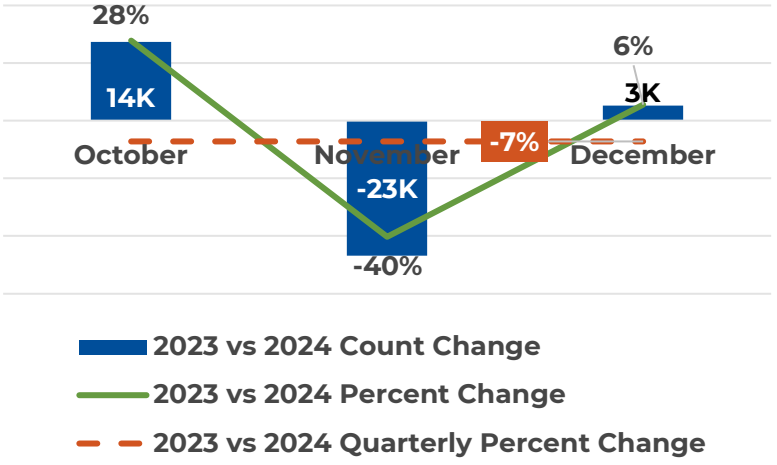
Emergency Department Visits (Claims)





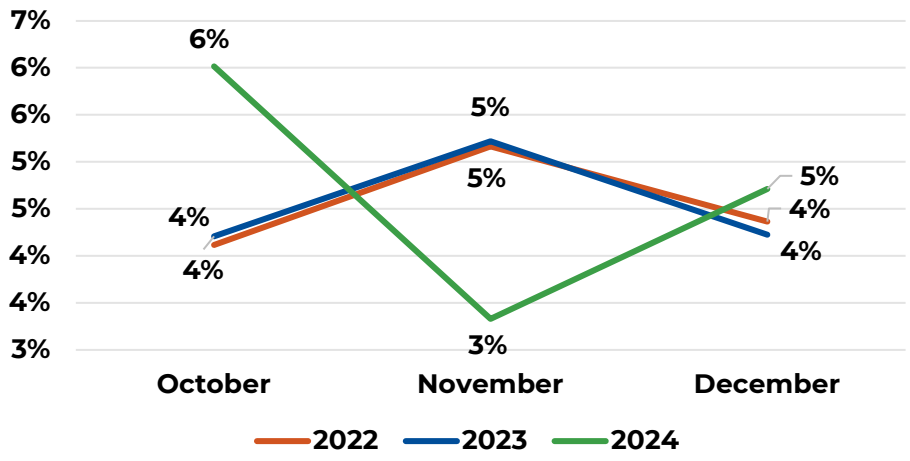
Members Utilizing Emergency Department

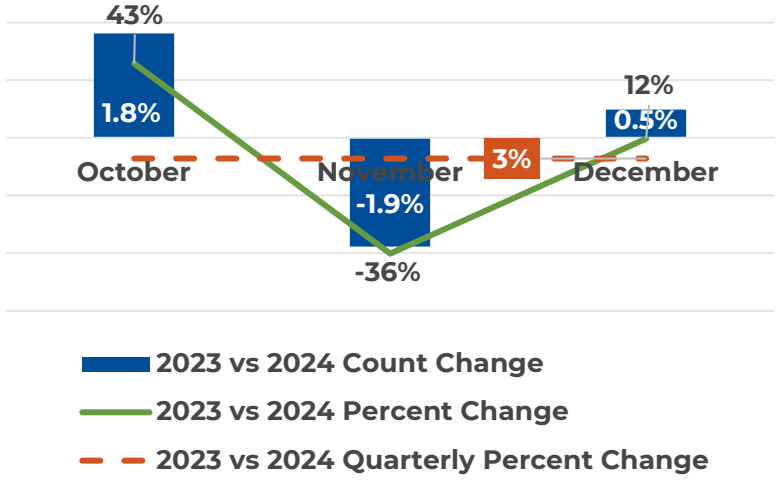




Utilization (Cont.)

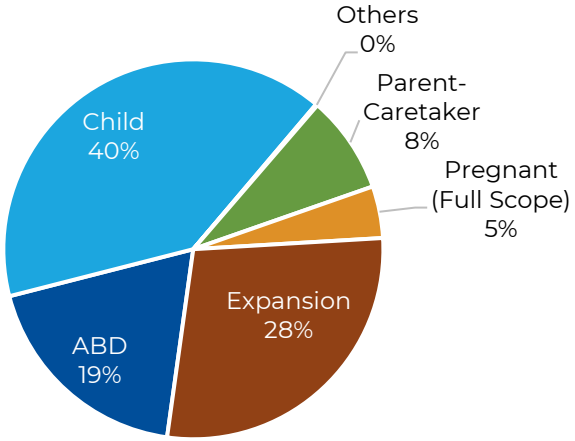
Percent Total Enrolled Using ED



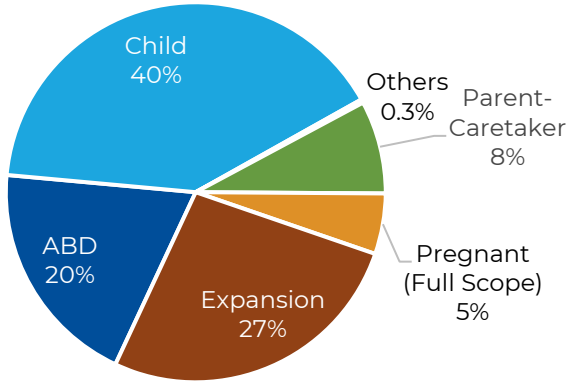


Members Utilizing Emergency Department By Qualifying Group

Q2 2024

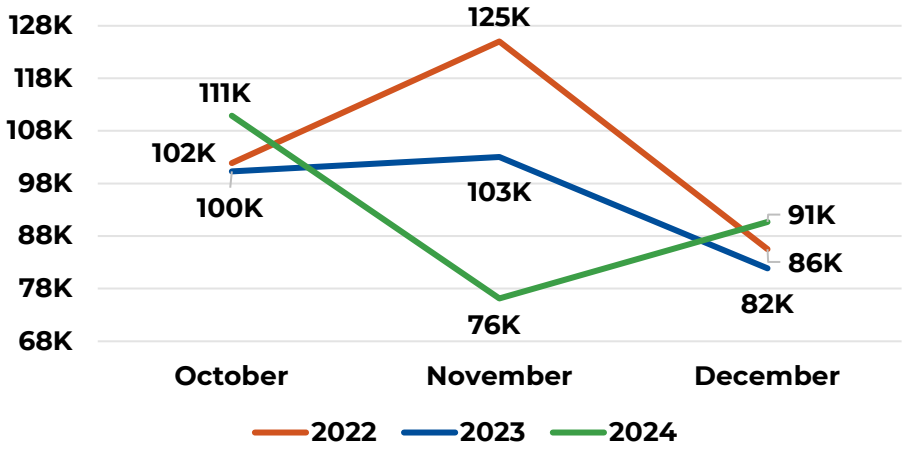


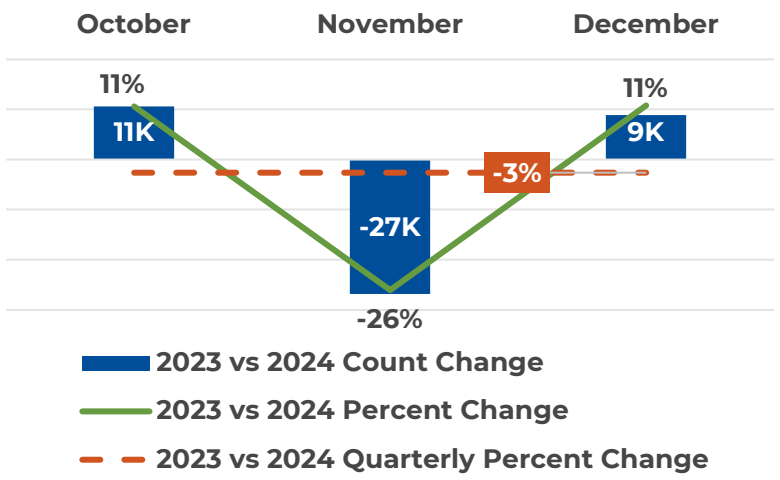
Q2 2025



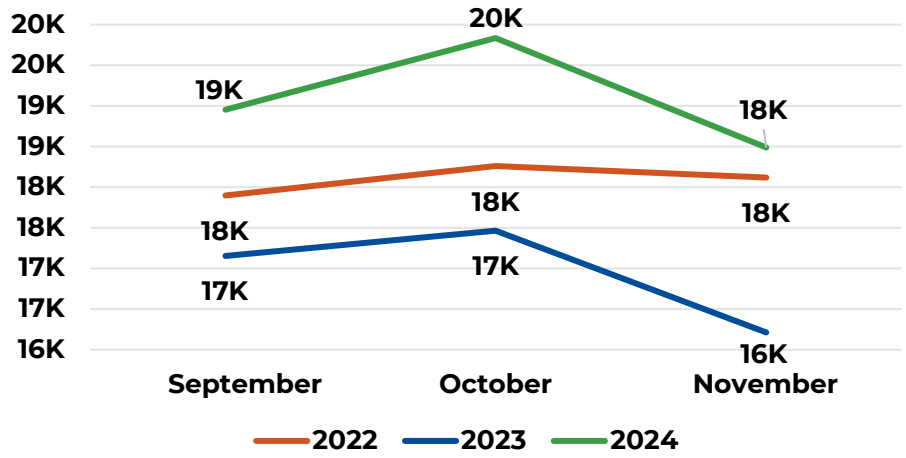
Utilization (Cont.)

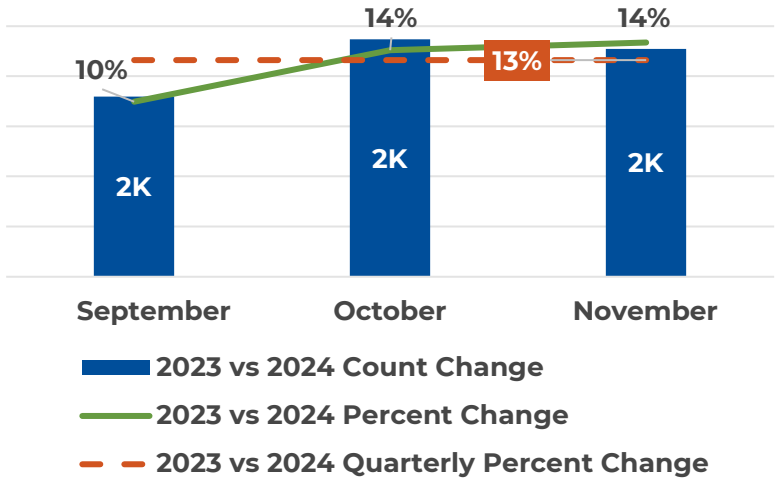
Telemedicine - Total Visits





Members With Opioid Claims

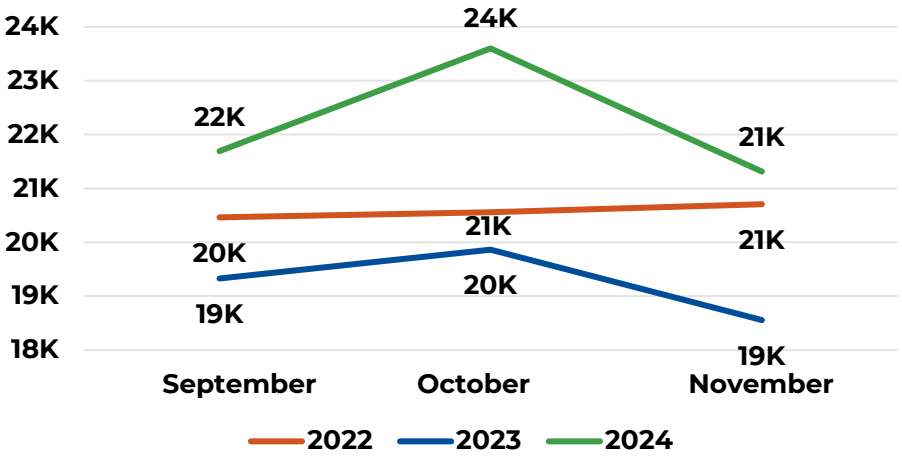


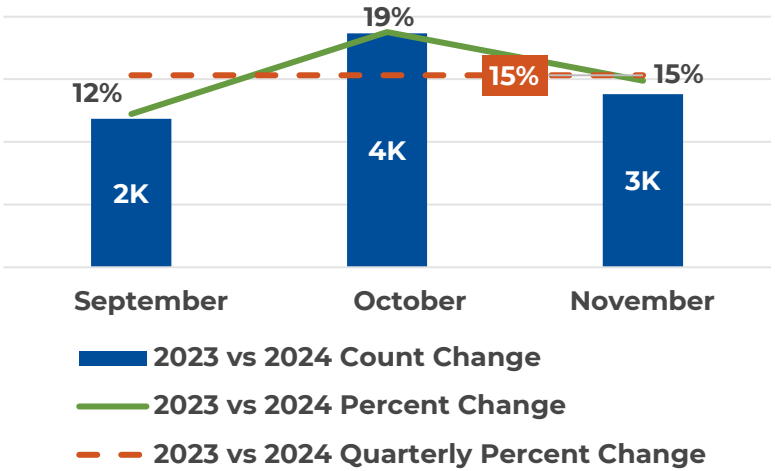


Utilization (Cont.)

Members With Opioid Claims By Qualifying Group

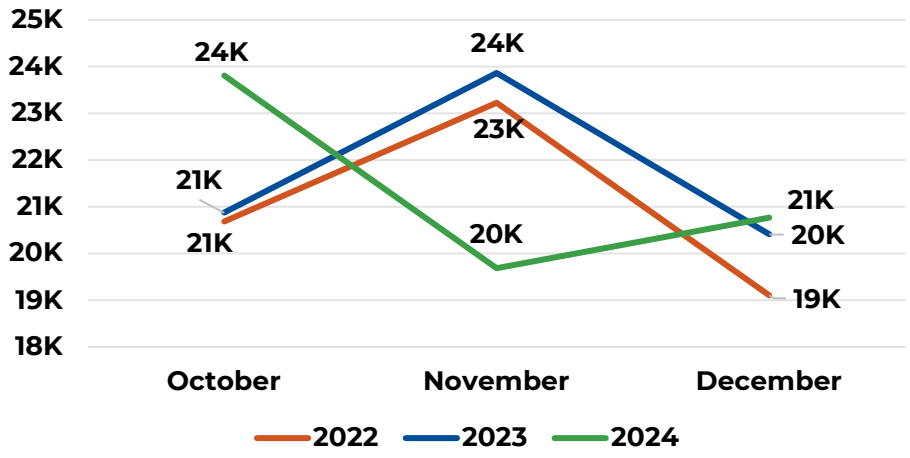
Total Opioid Claims

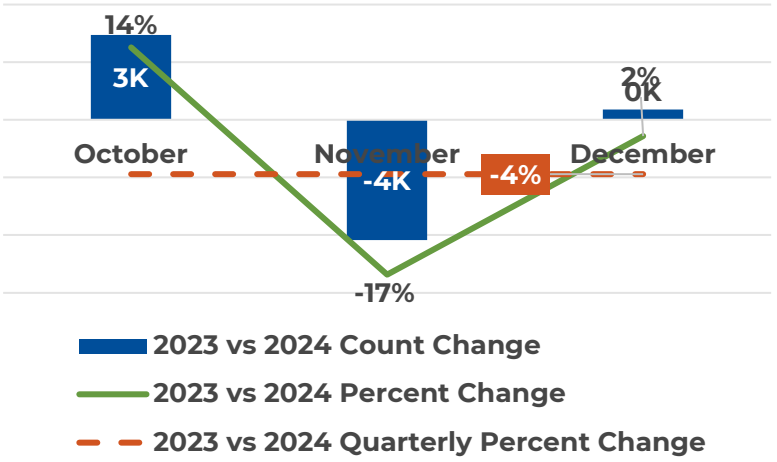




Utilization (Cont.)

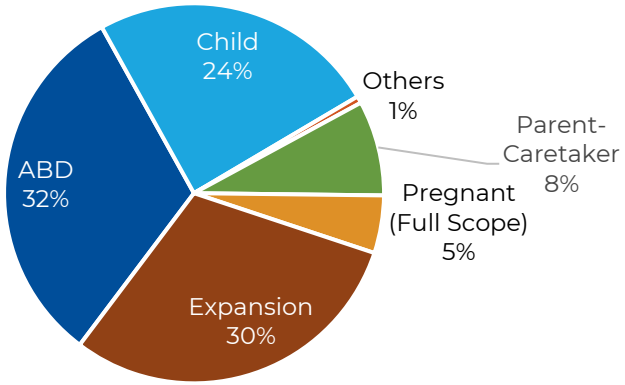
Out of State Services (Non Border County) - Total Members Utilization



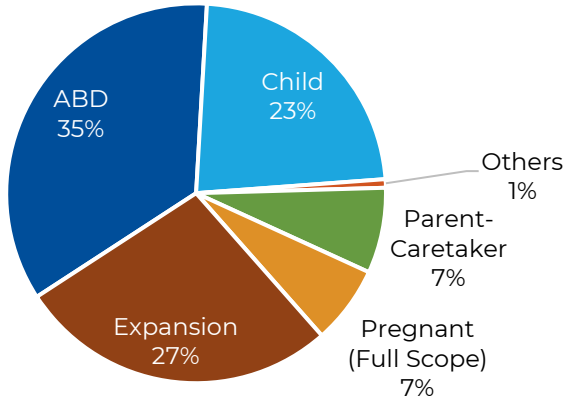


Out of State Services (Non Border County) - Total Members Utilization By Qualifying Group

Q2 2024

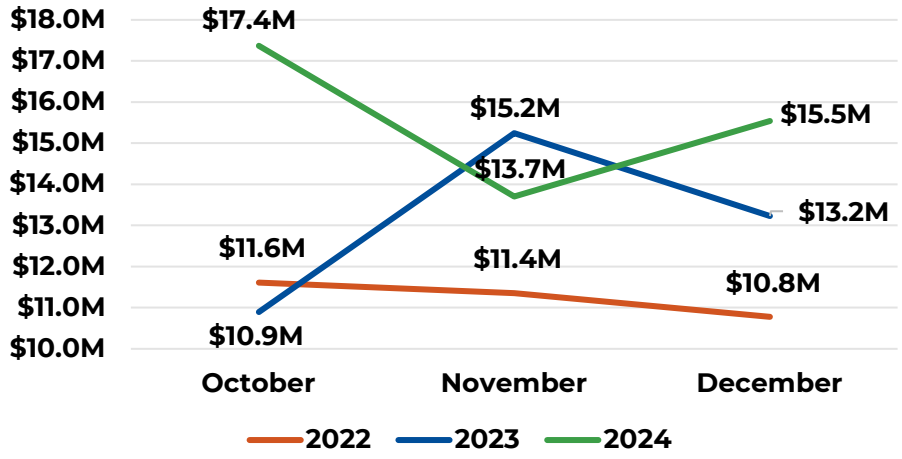


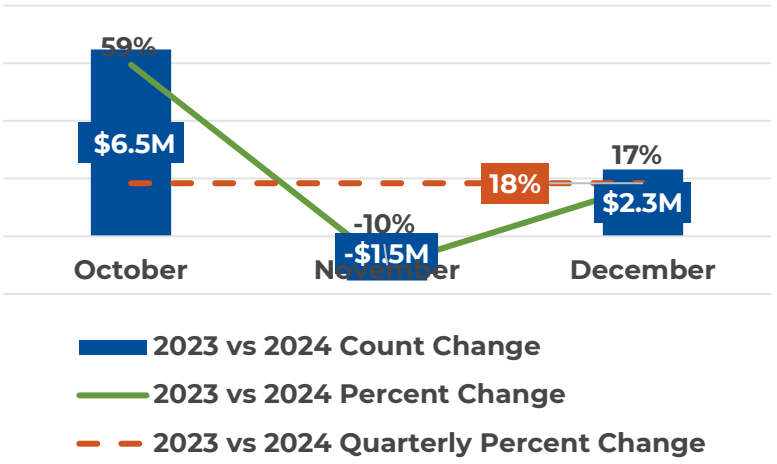
Q2 2025



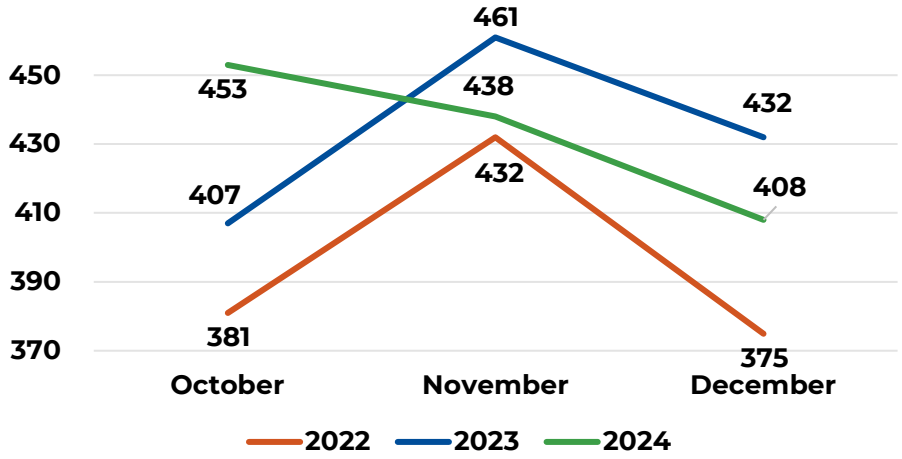
Utilization (Cont.)

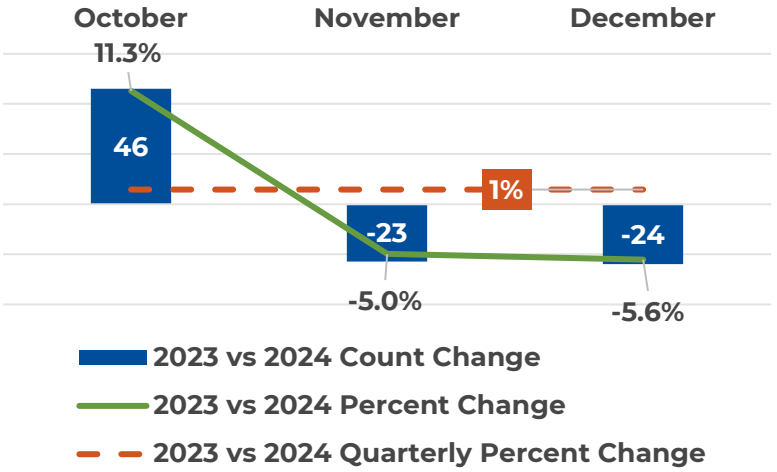
Out of State Services (Non Border County) - Total Reimbursements





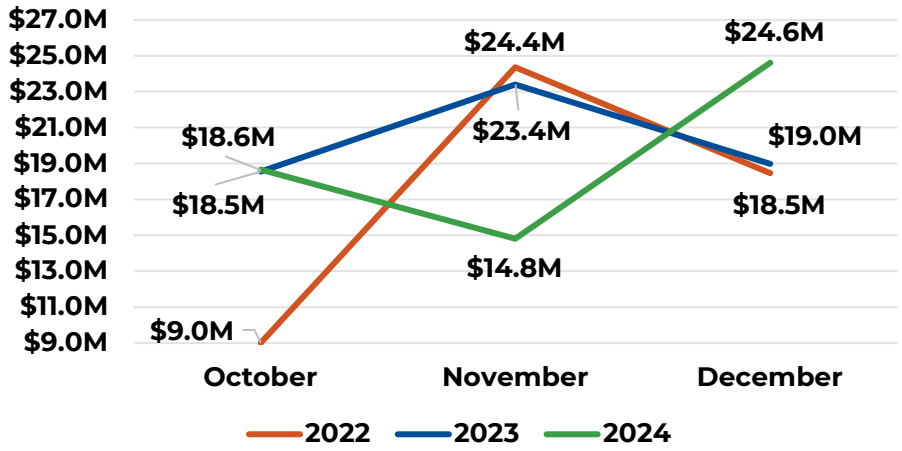
Out of State Services (Non Border County) - Total Active Billing Providers

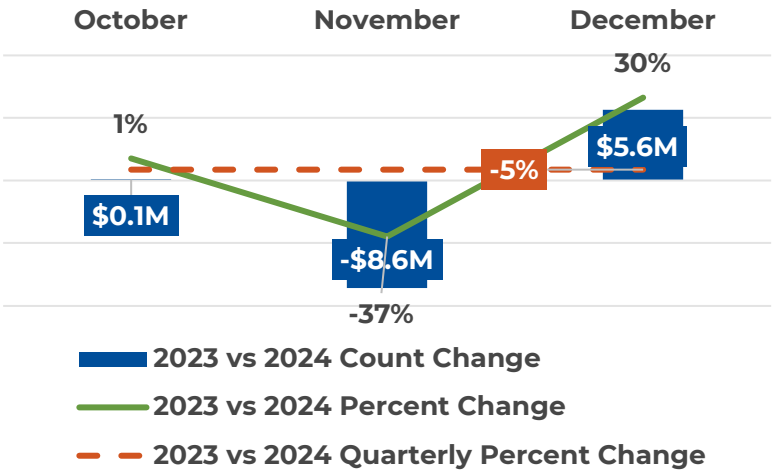




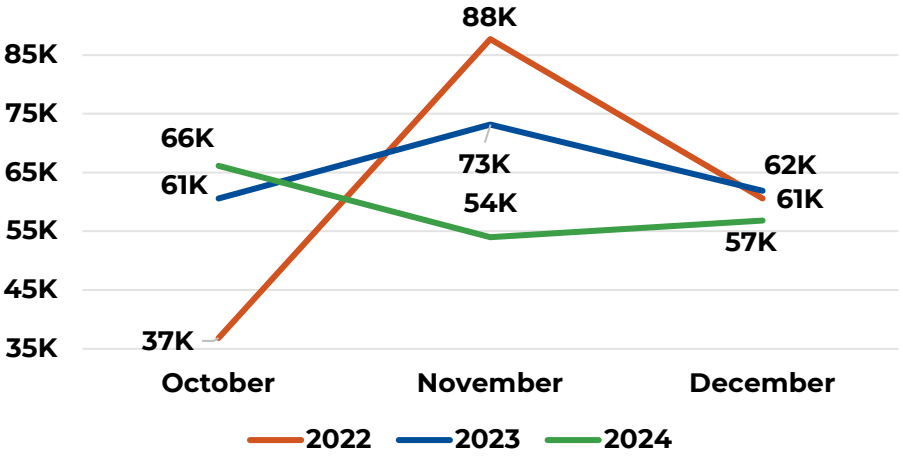
Utilization (Cont.)

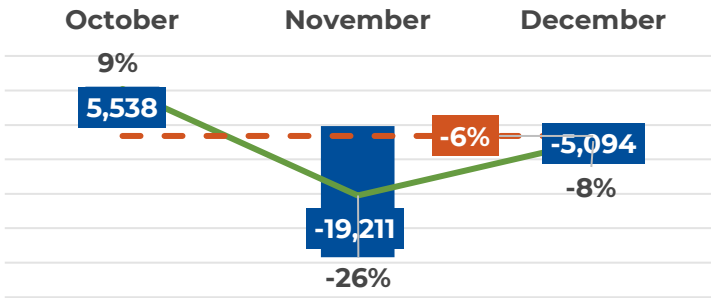
Dental Claims





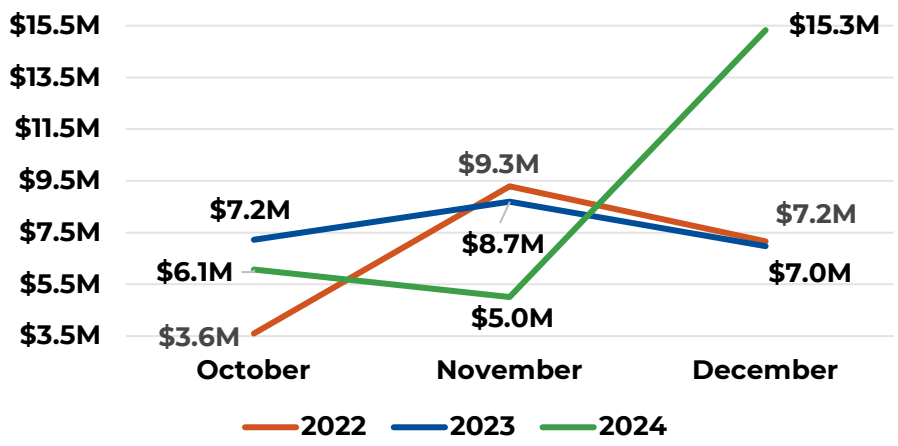
Total Members with Dental Claims

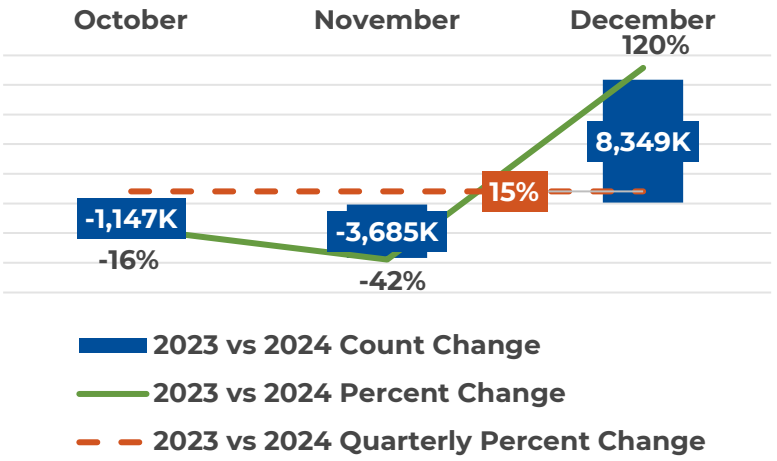




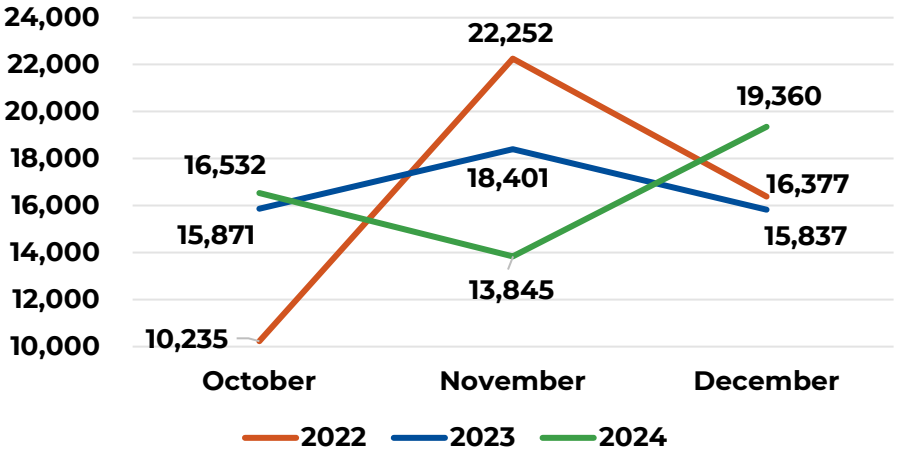
Utilization (Cont.)

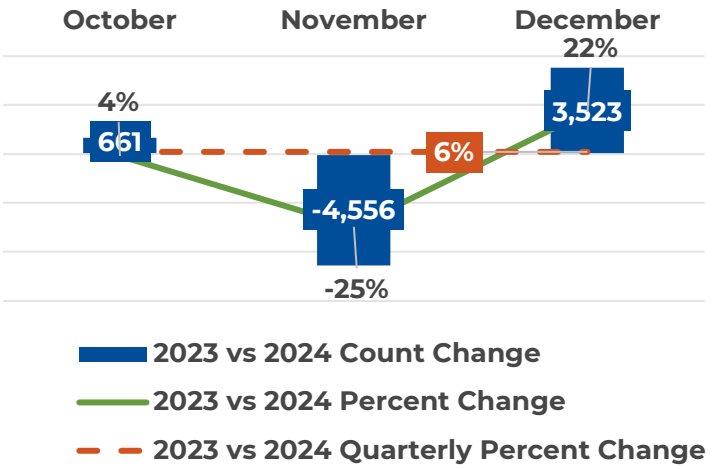
Adult (21 & Over) Dental Claims





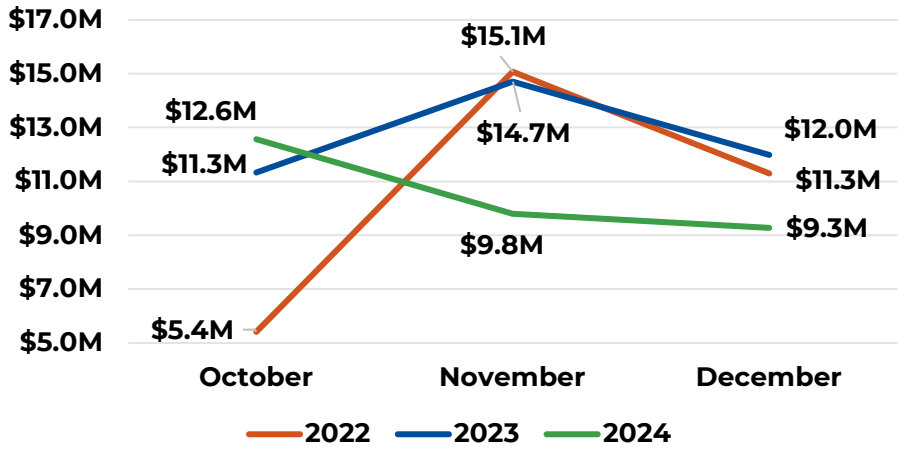
Adults (21 & Over) with Dental Claims

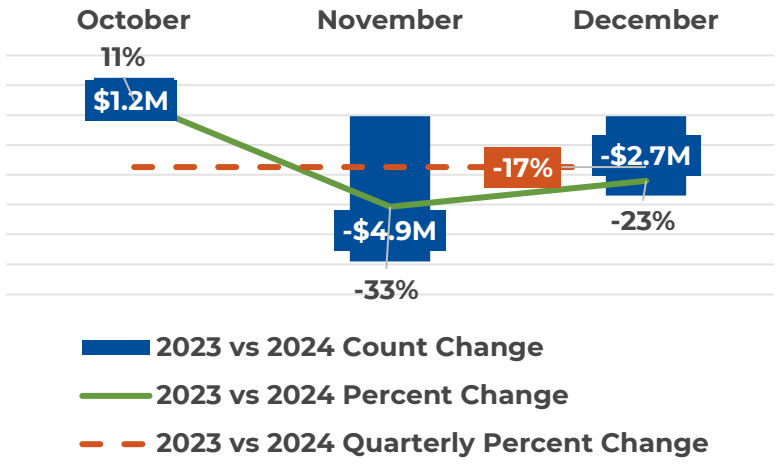




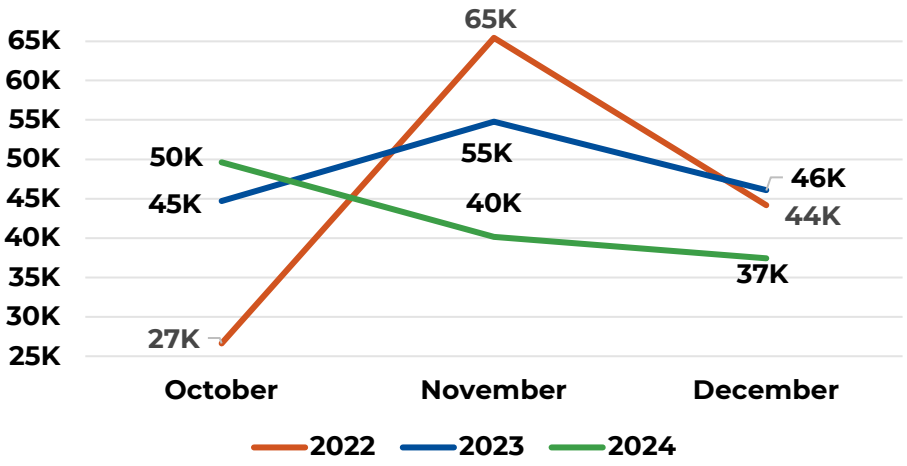
Utilization (Cont.)

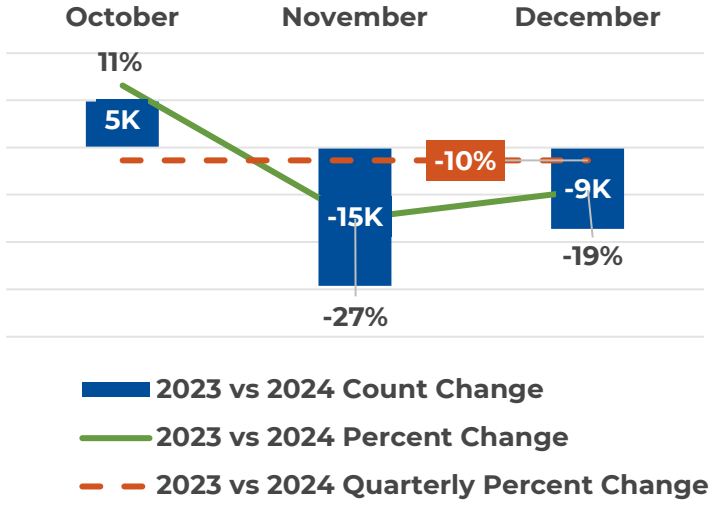
Children (Under 21) Dental Claims





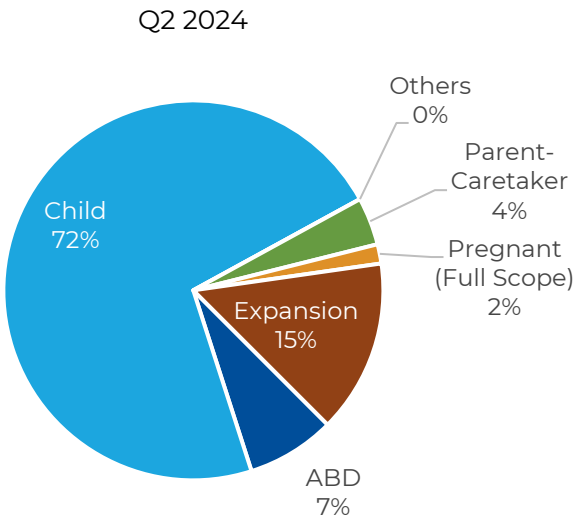
Children (Under 21) with Dental Claims

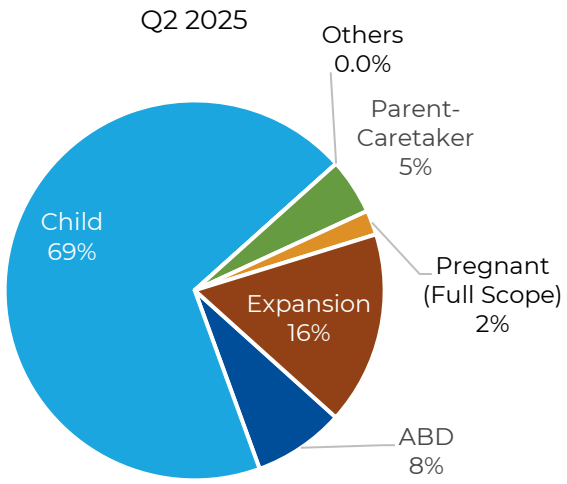




Utilization (Cont.)

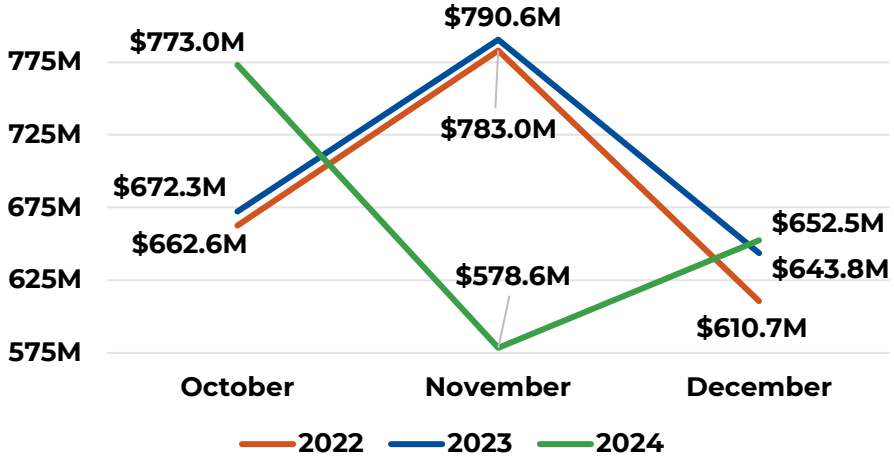
Members With Dental Claims By Qualifying Group

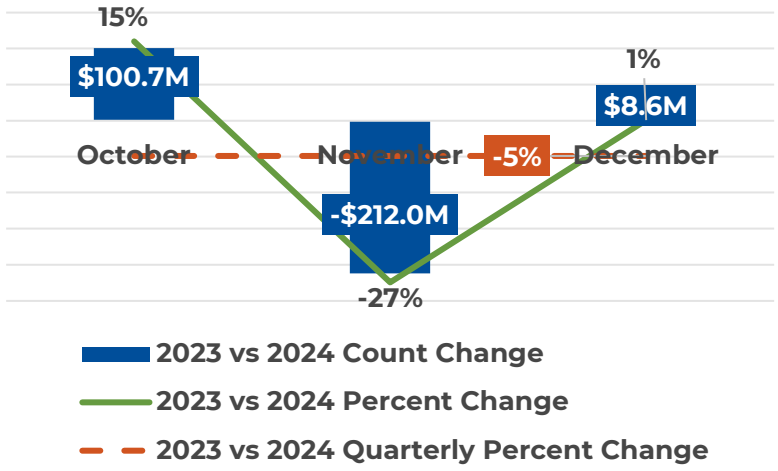




Financials

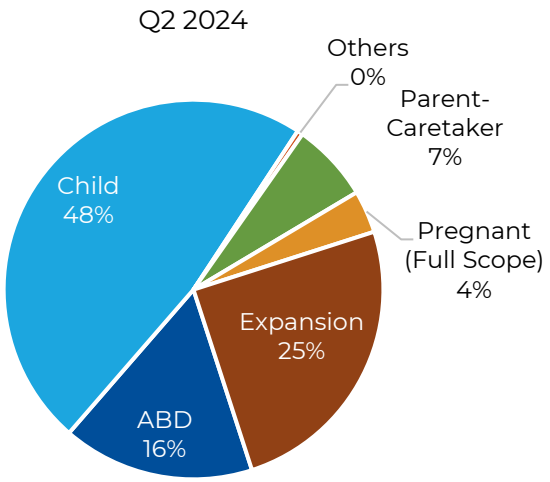
Total Agency Expenditures

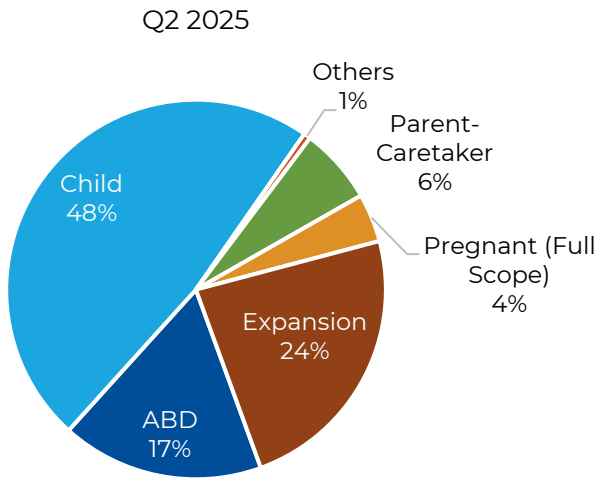




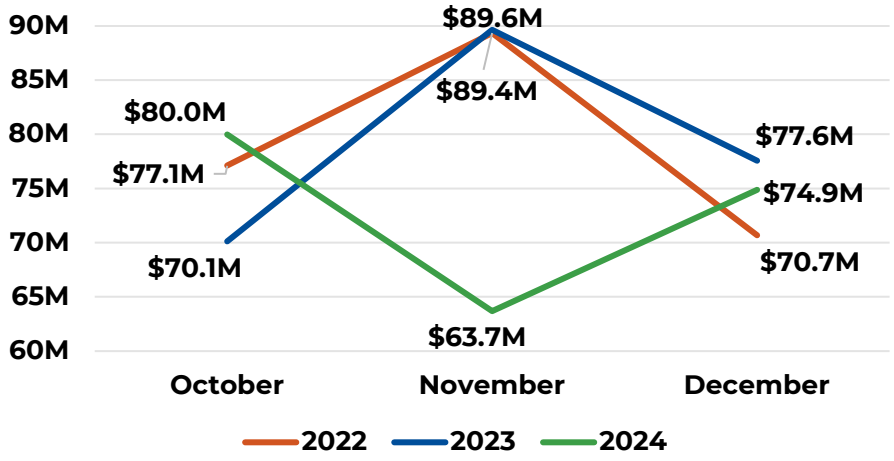
Financials (Cont.)

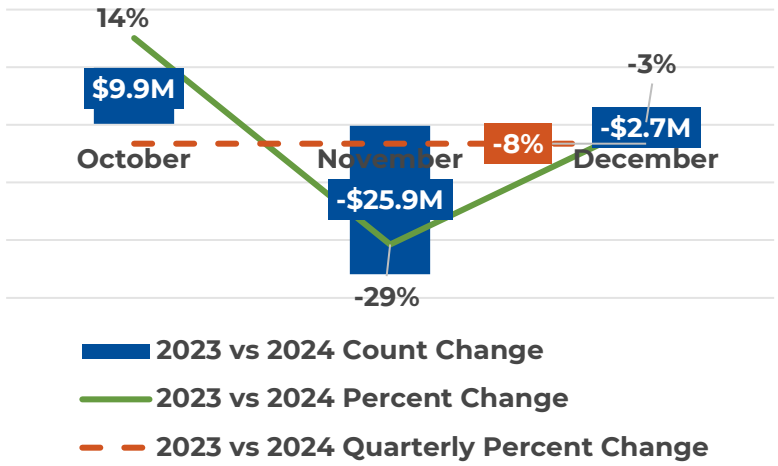
Total Agency Members Utilization by Qualifying Group





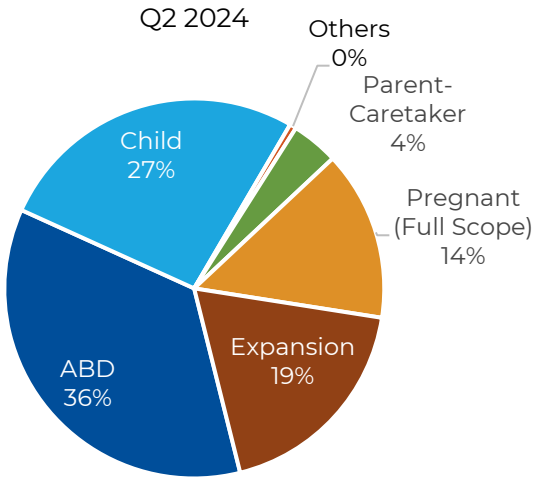
Inpatient Services Expenditures

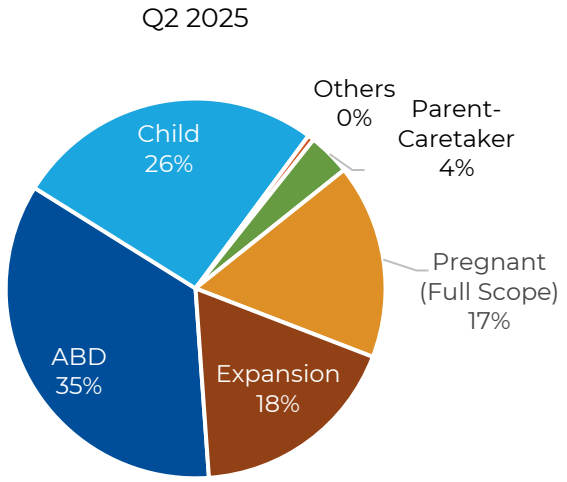




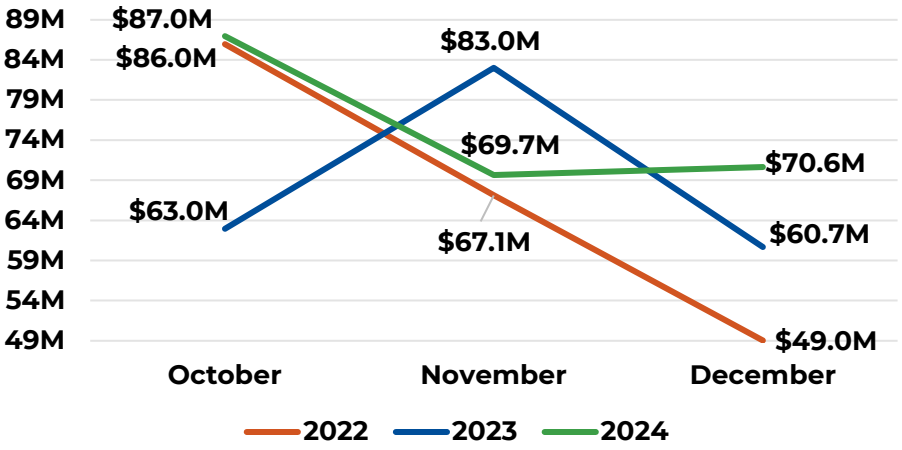
Financials (Cont.)

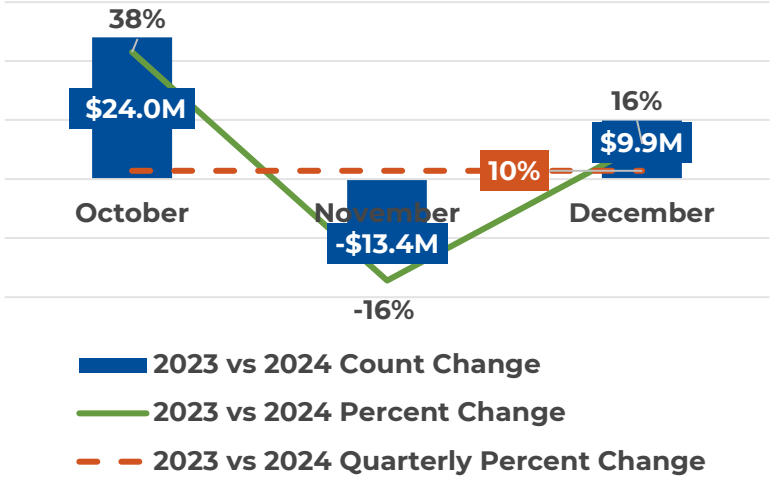
Inpatient Services Members Utilization by Qualifying Group





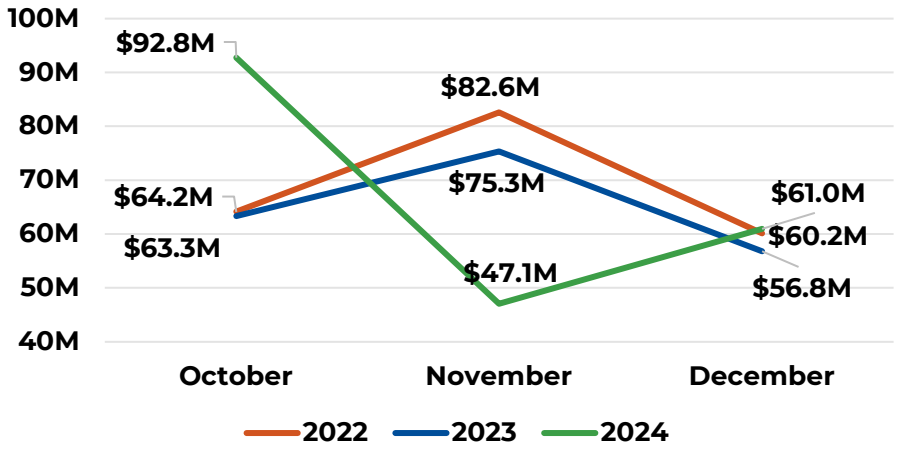
Nursing Facility Expenditures

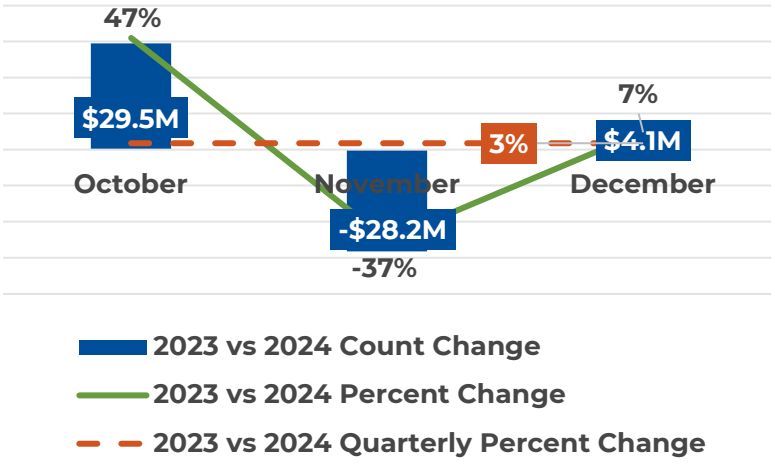




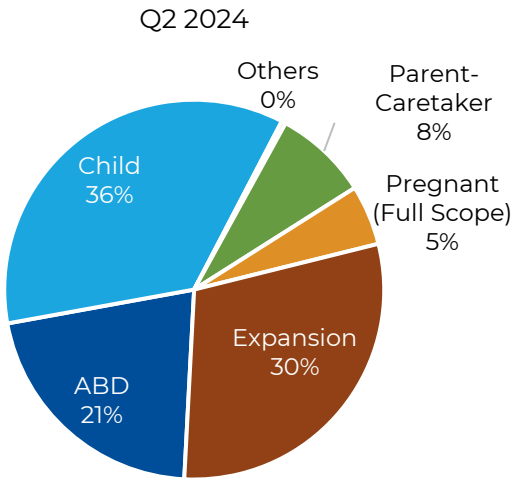
Financials (Cont.)

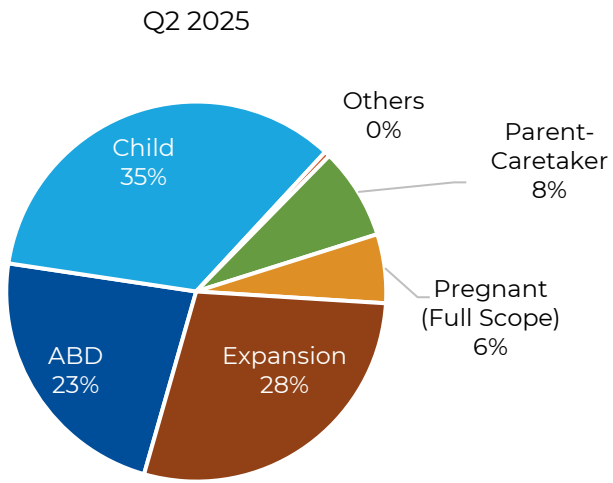
Outpatient Hospital Expenditures





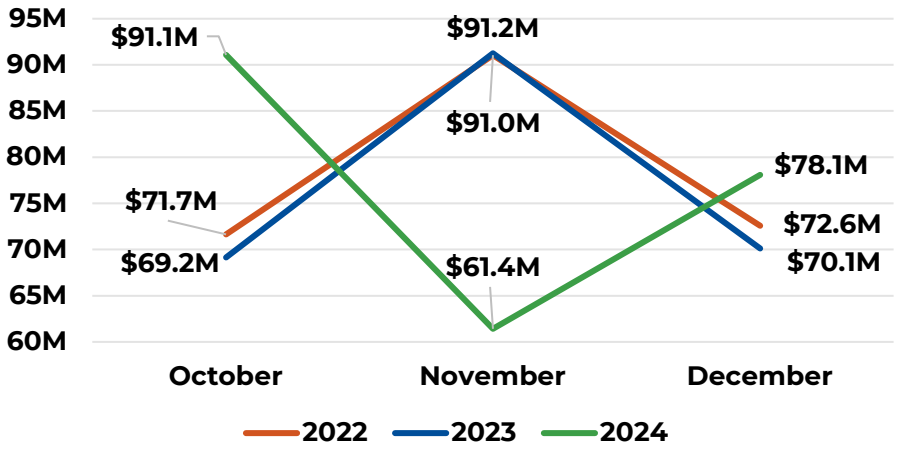
Outpatient Hospital Members Utilization by Qualifying Group

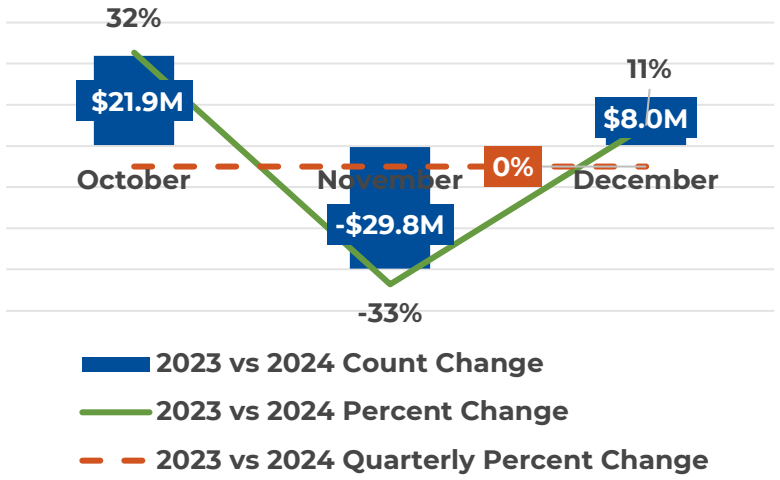




Financials (Cont.)

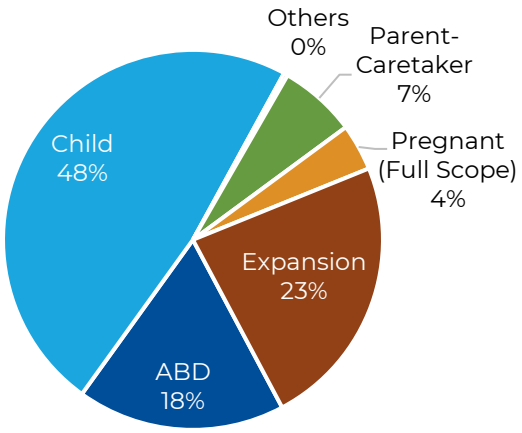
Physician Expenditures



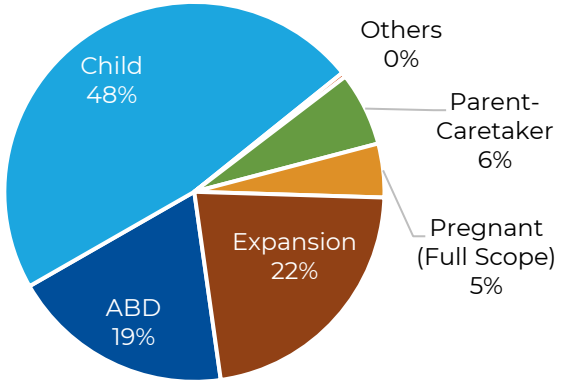


Physician Members Utilization By Qualifying Group

Q2 2024

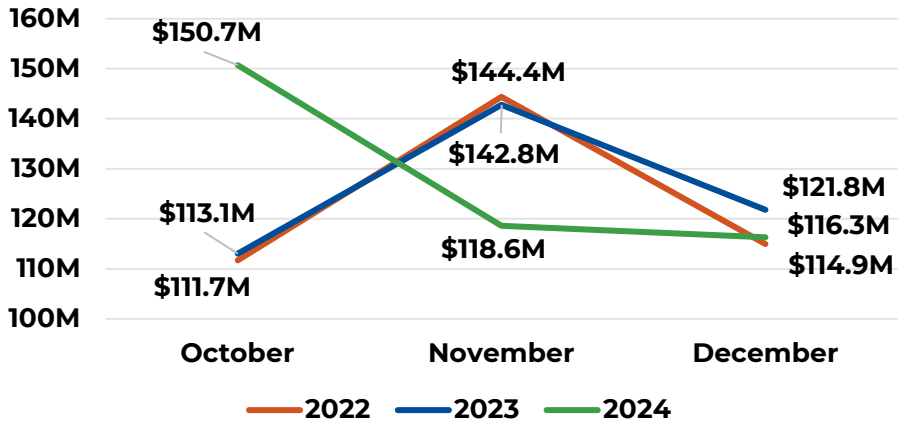


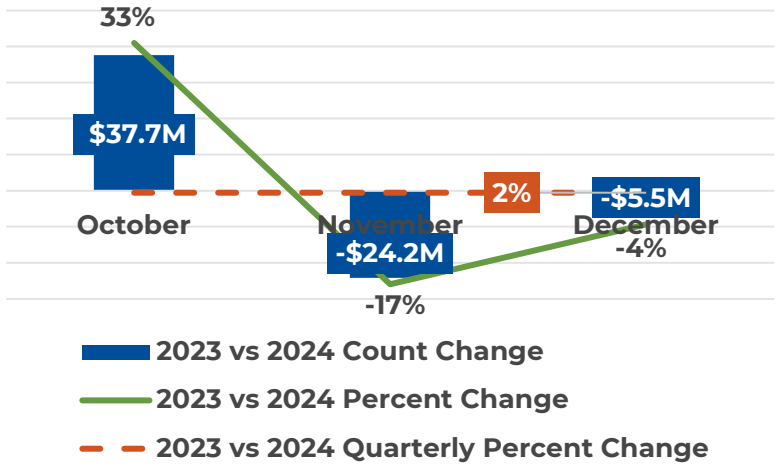
Q2 2025



Financials (Cont.)

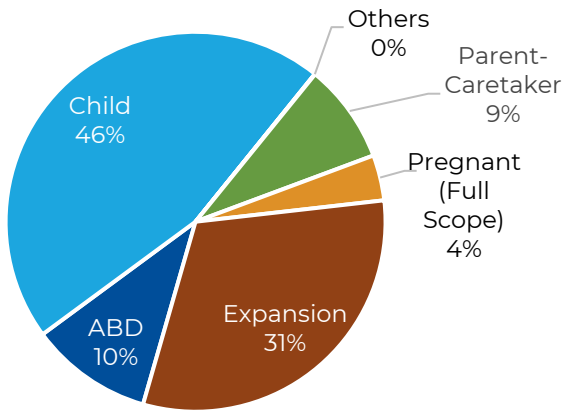
Prescribed Drugs Expenditures



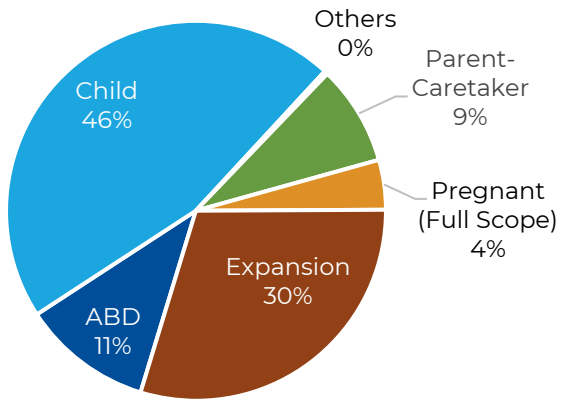


Prescribed Drugs Members Utilization By Qualifying Group

Q2 2024

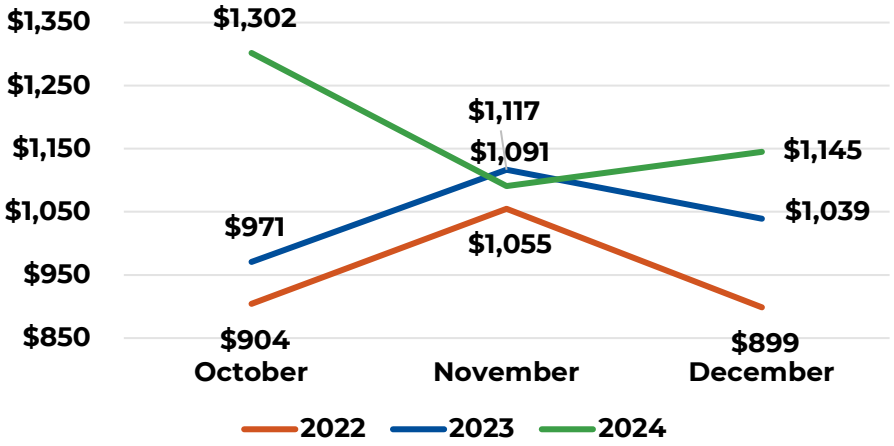


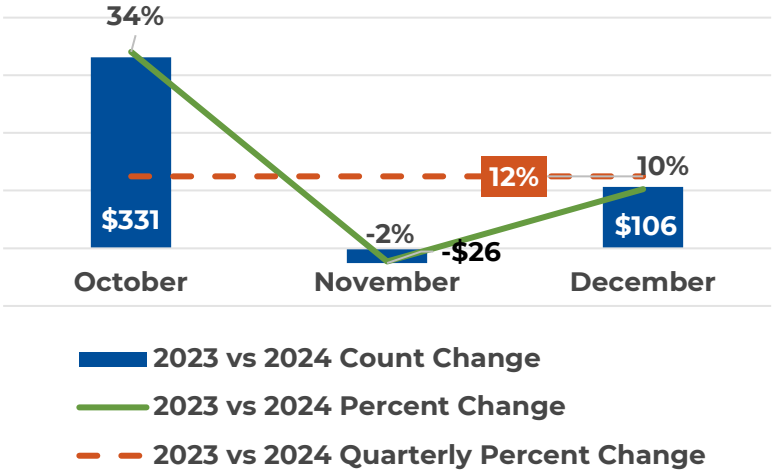
Q2 2025



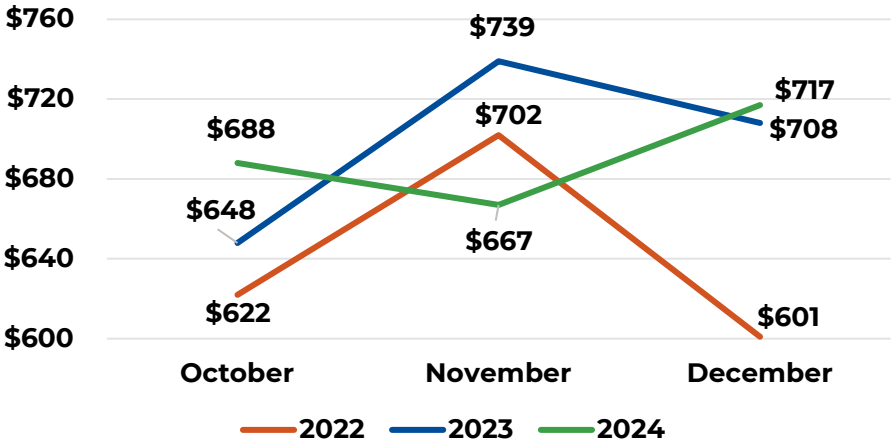
Financials (Cont.)

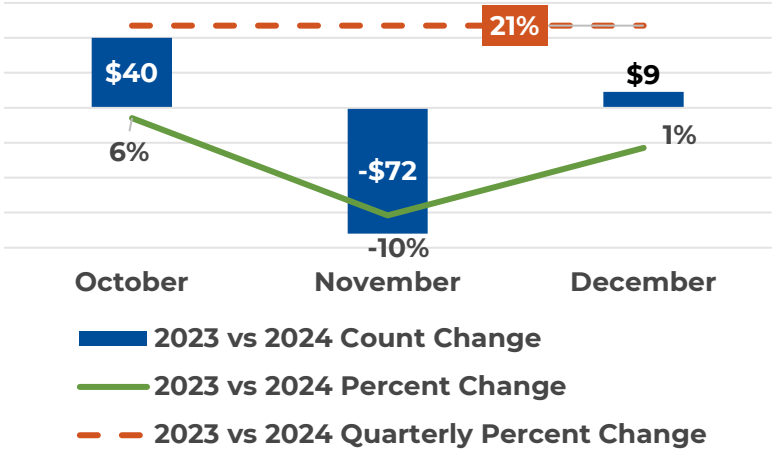
Average Per Total Member Served





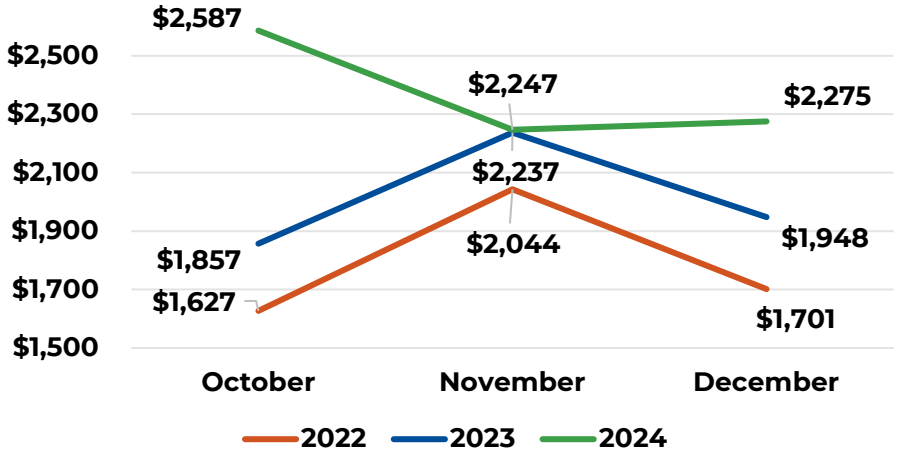
Average Per Child (Under 21) Member Served

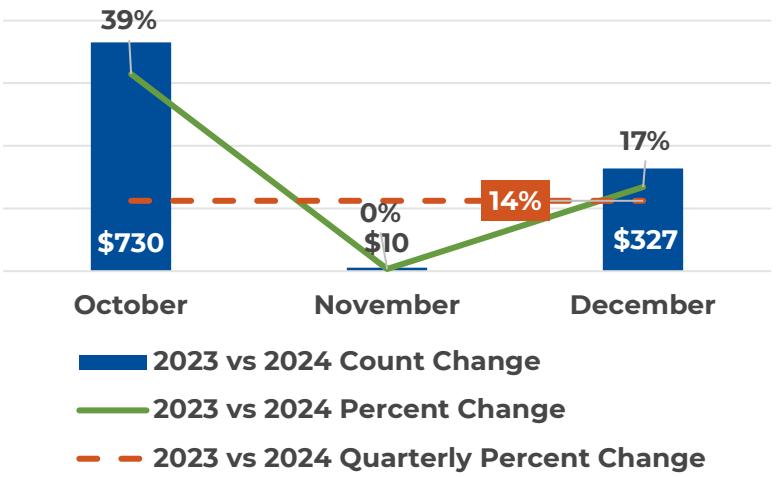




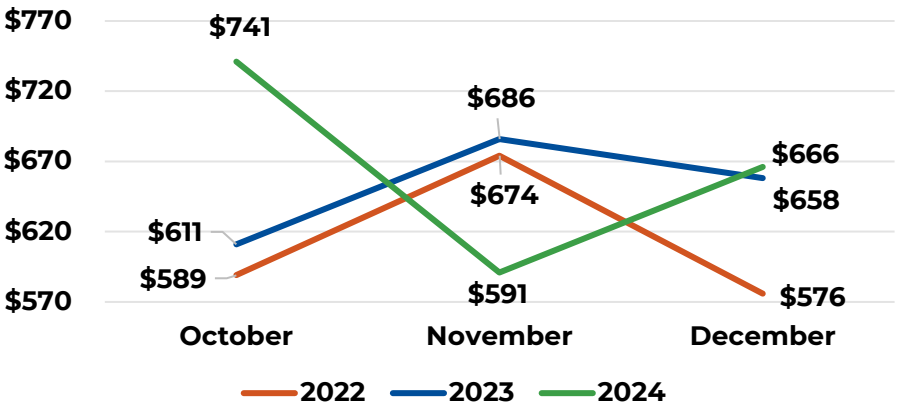
Financials (Cont.)

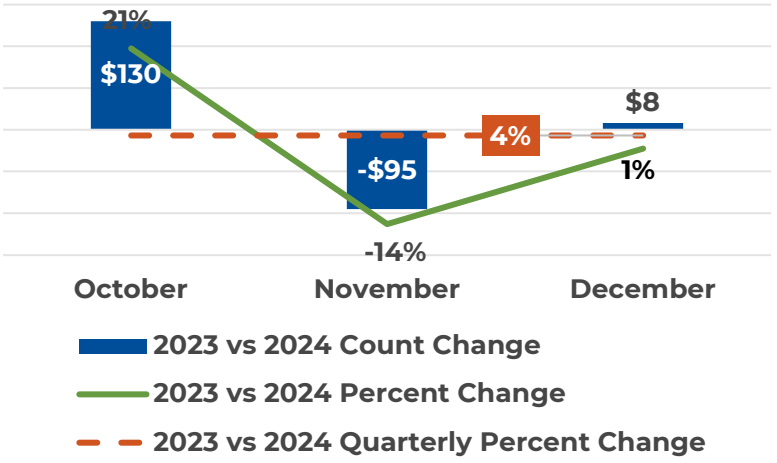
Average Per Aged/Blind/Disabled Member Served





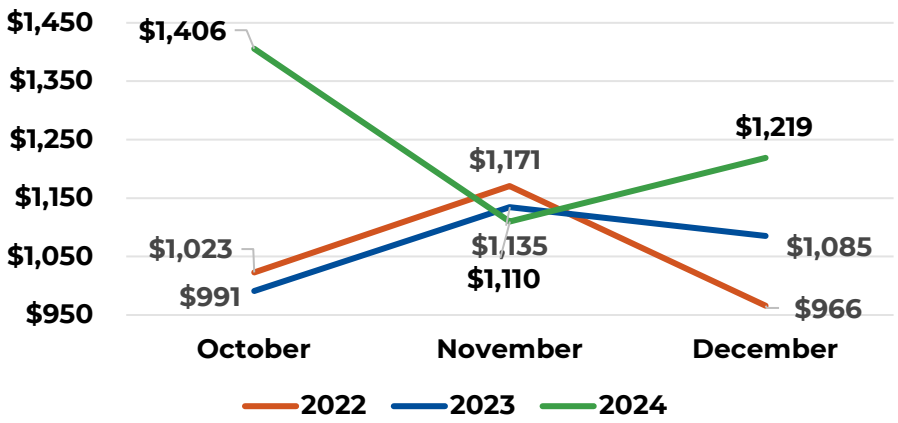
Average Per Children & Parent/Caretaker Member Served

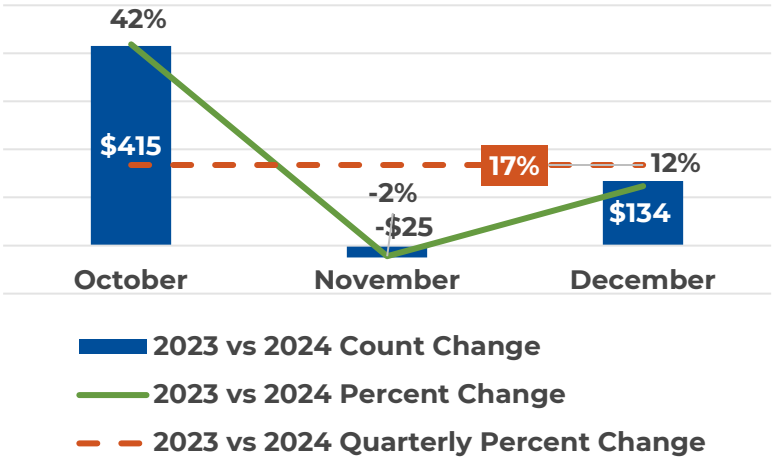




Financials (Cont.)

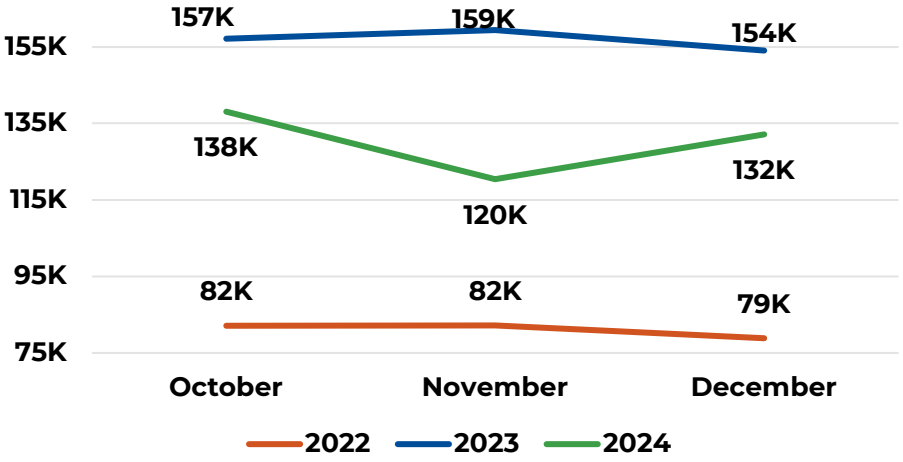
Average Per Expansion Member Served (Effective July 2021)

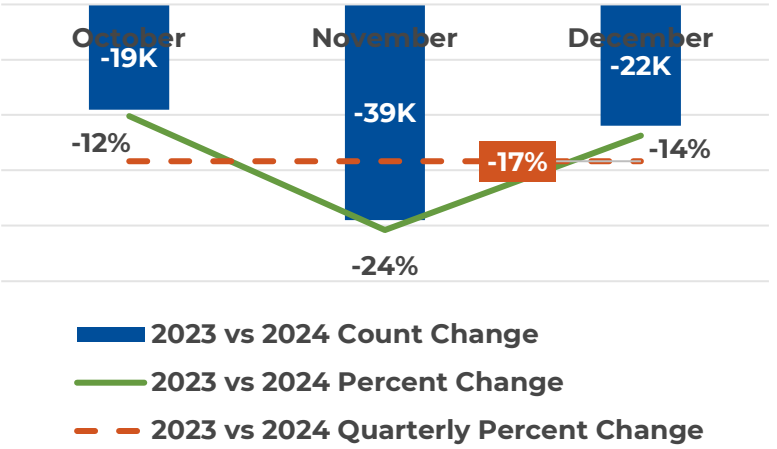




Call Center

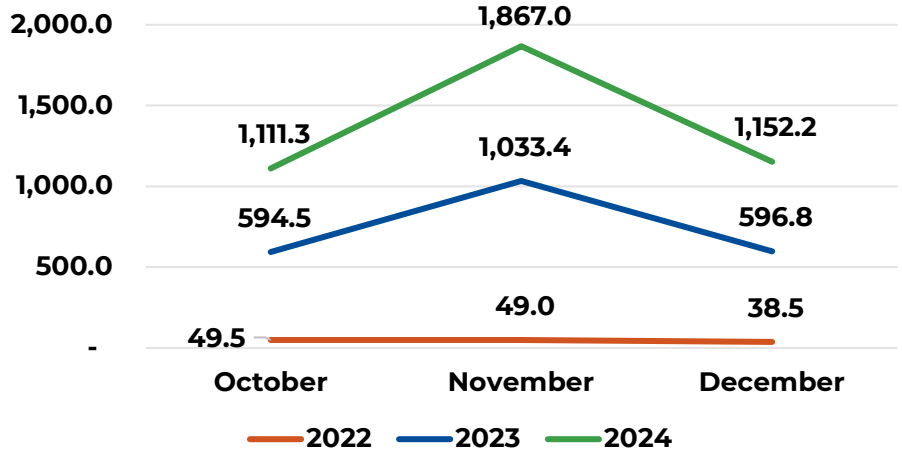
Call Center - Member Calls Answered

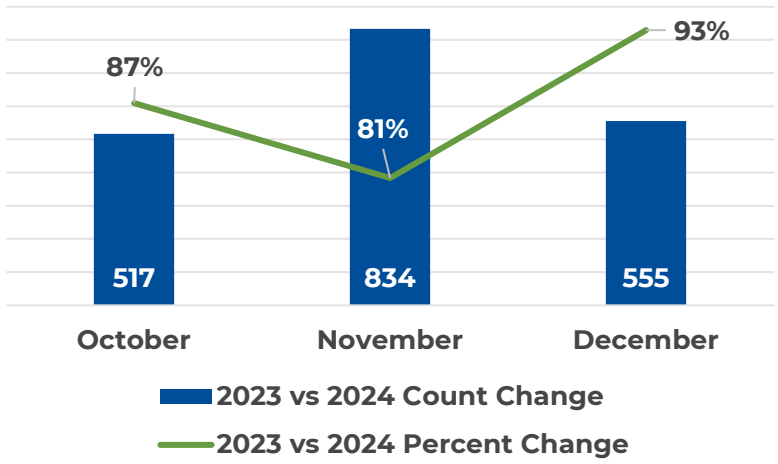




Call Center (Cont.)

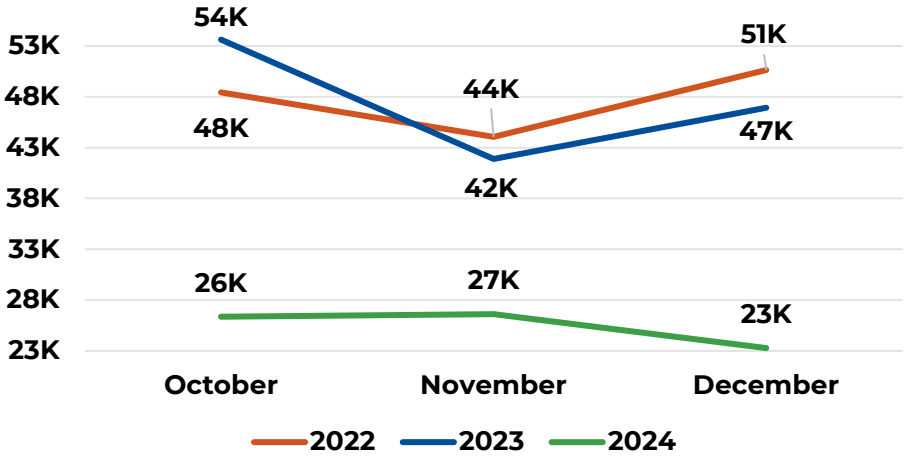
Call Center - Average Wait Time (In Seconds)

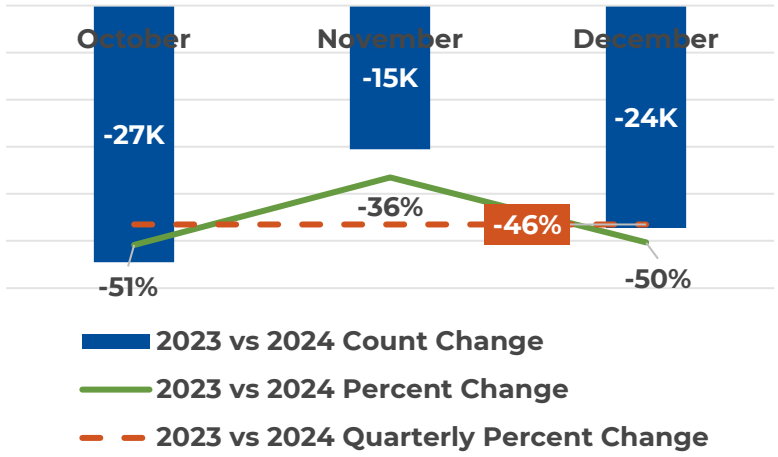




Prior Authorization

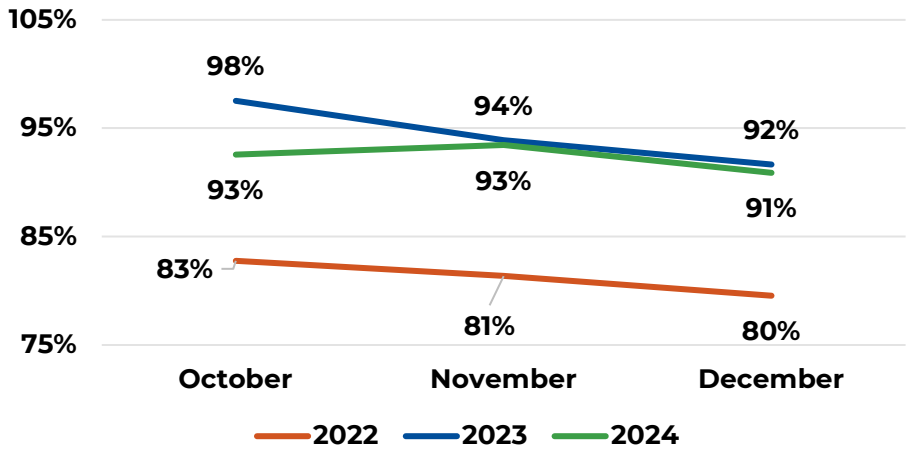
Prior Authorization - Total Combined - Total Completed PA Volume

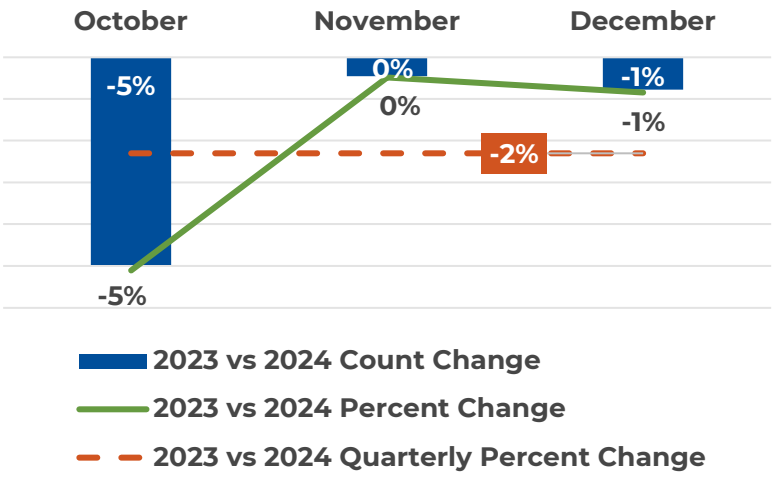




Prior Authorization (Cont.)

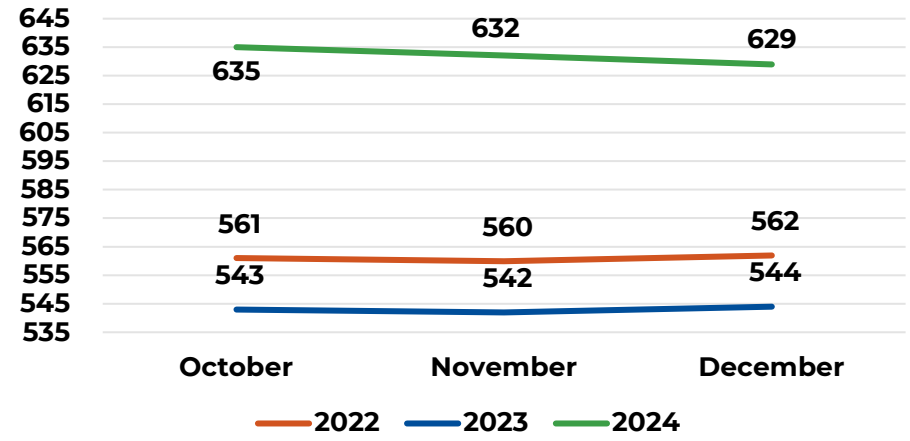
Prior Authorization - Total Combined - Total Percent Completed 0-6 Days

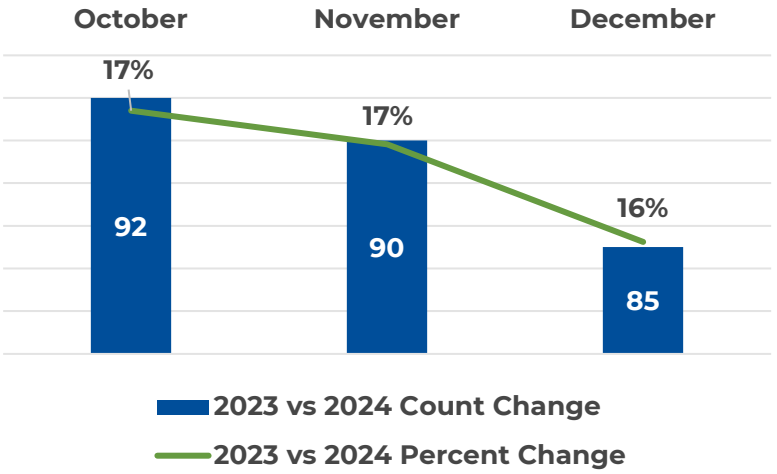




Agency Stats & Provider Network

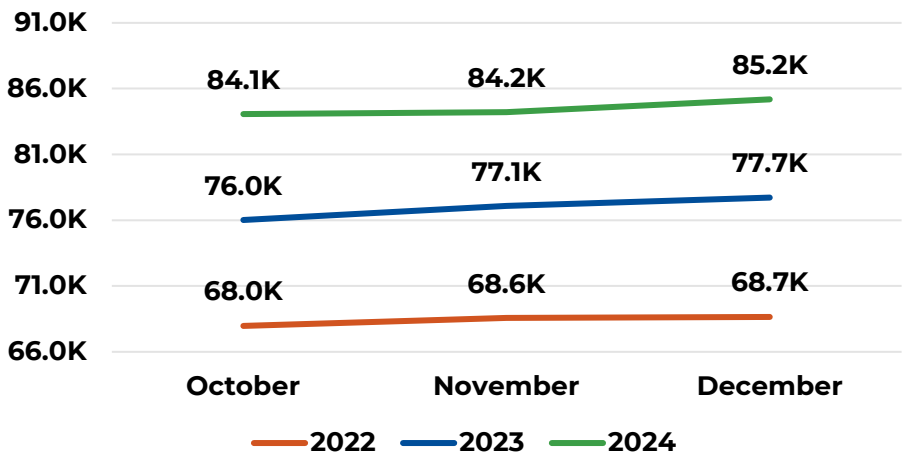
OHCA Admin - Number of FTEs

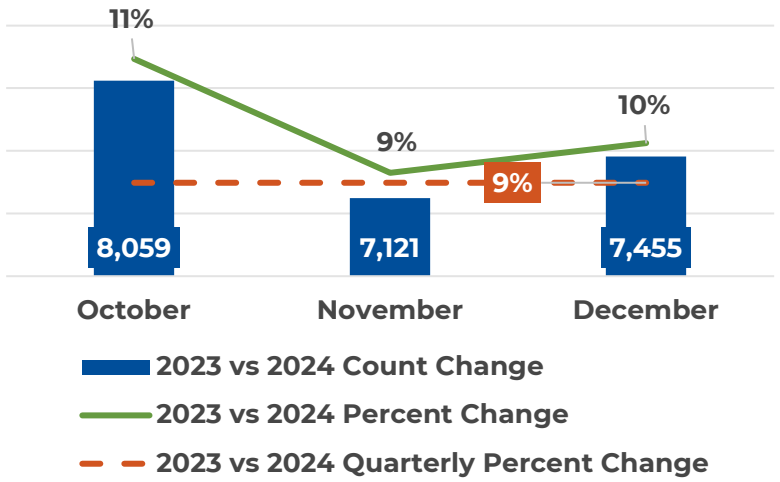




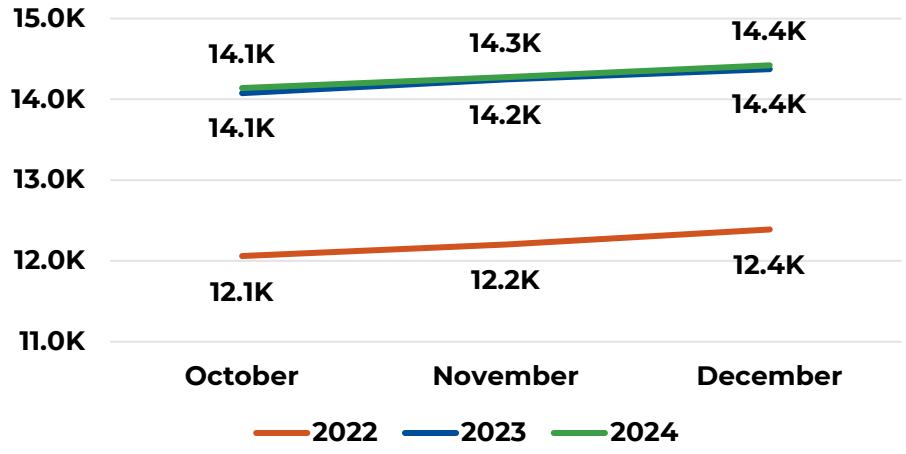
Agency Stats & Provider Network (Cont.)

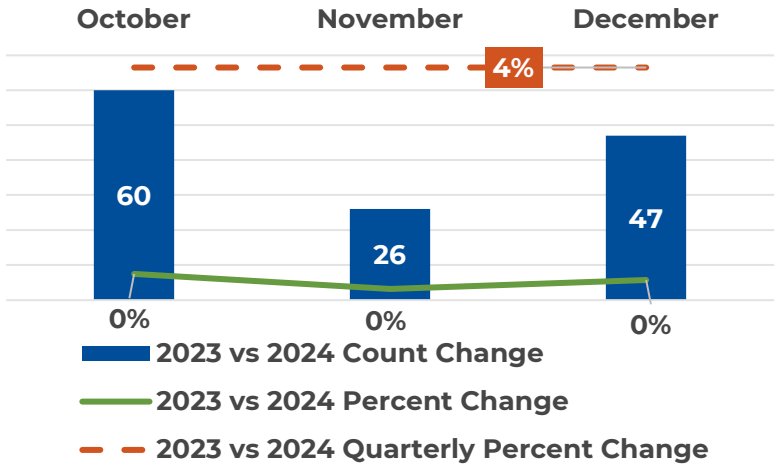
Total Providers





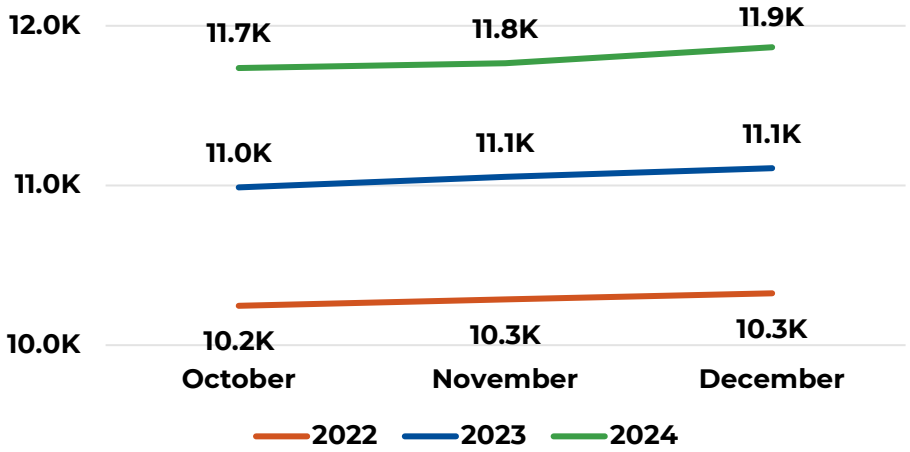
Mental Health Providers (In-State Only)

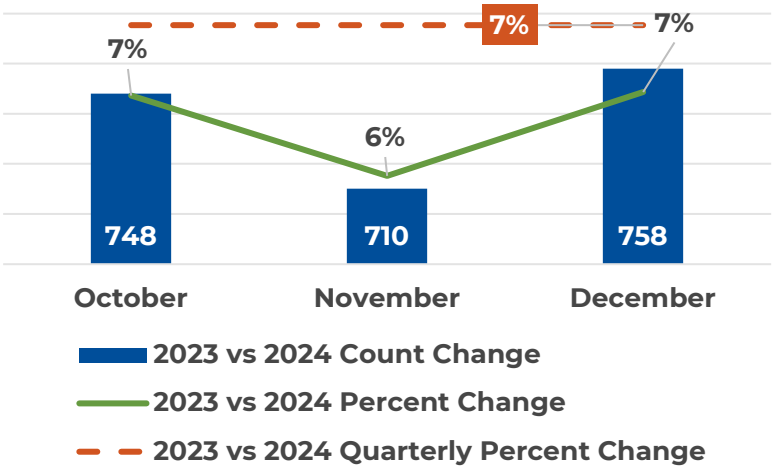




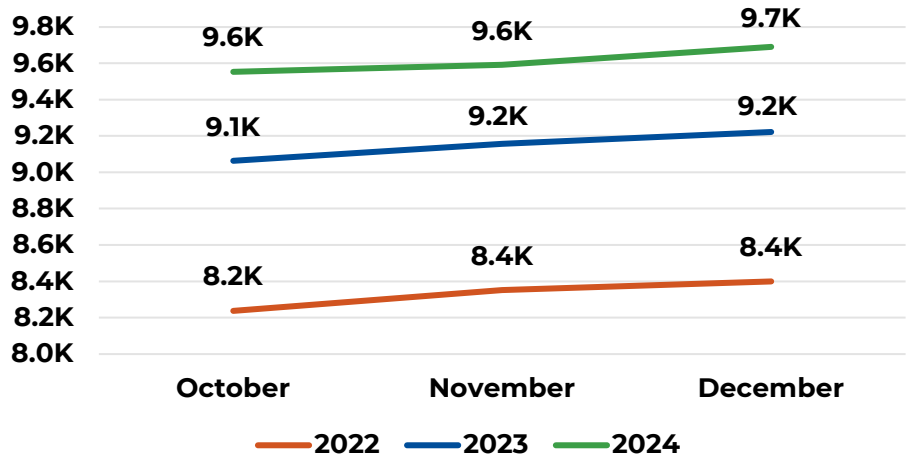
Agency Stats & Provider Network (Cont.)

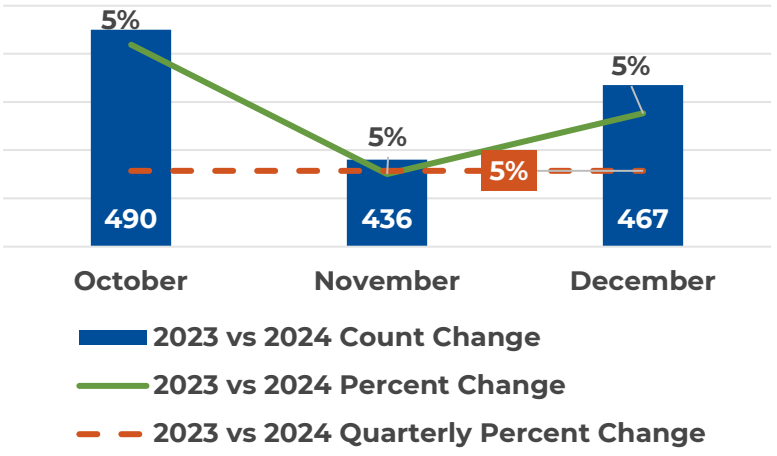
Physicians (In-State Only)





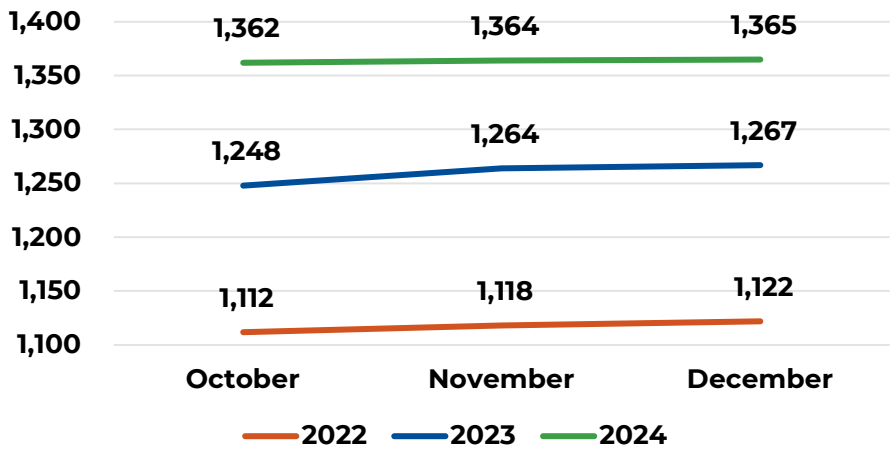
Primary Care Providers (In-State Only)

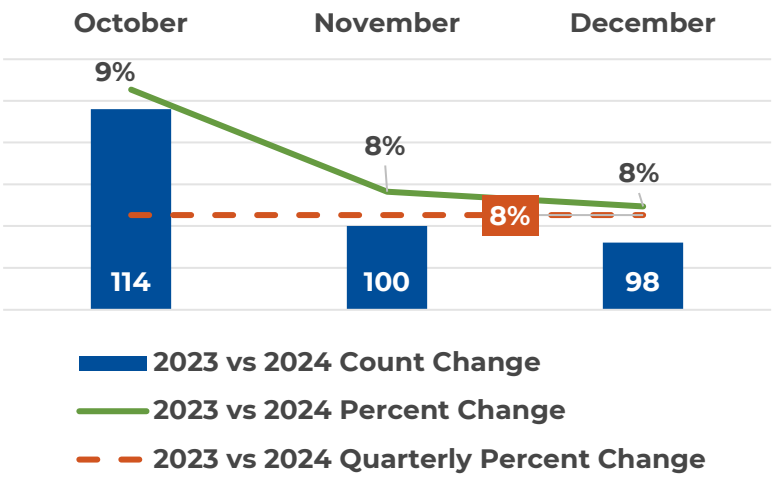




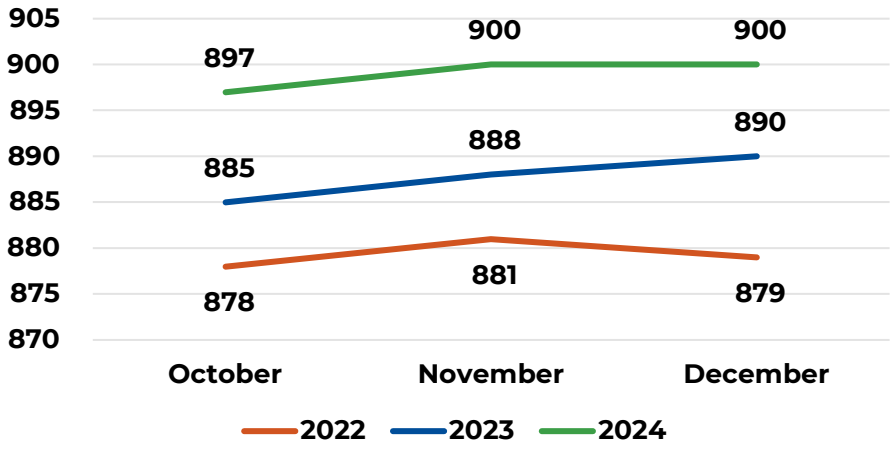
Agency Stats & Provider Network (Cont.)

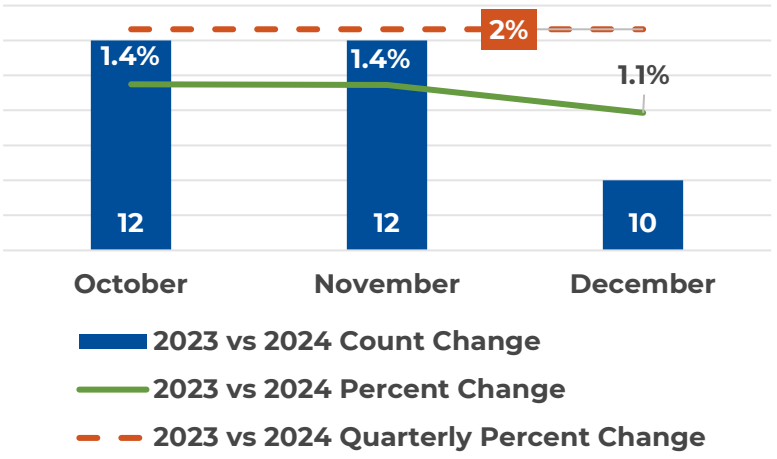
Dentists (In-State Only)





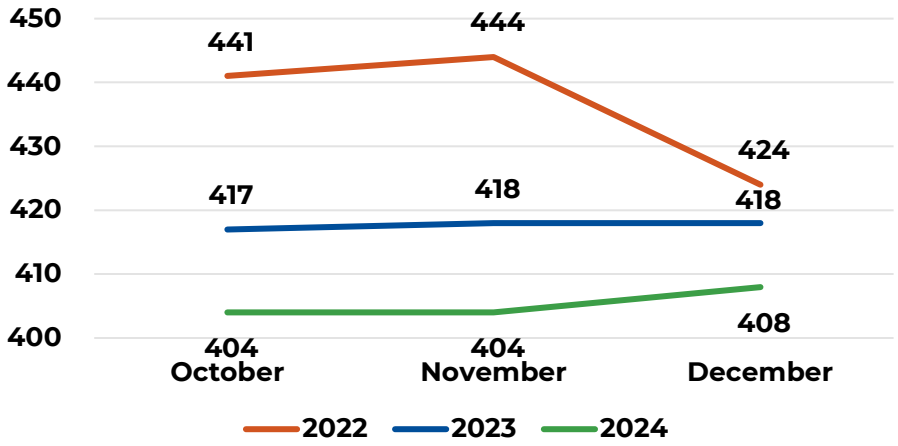
Pharmacy (In-State Only)

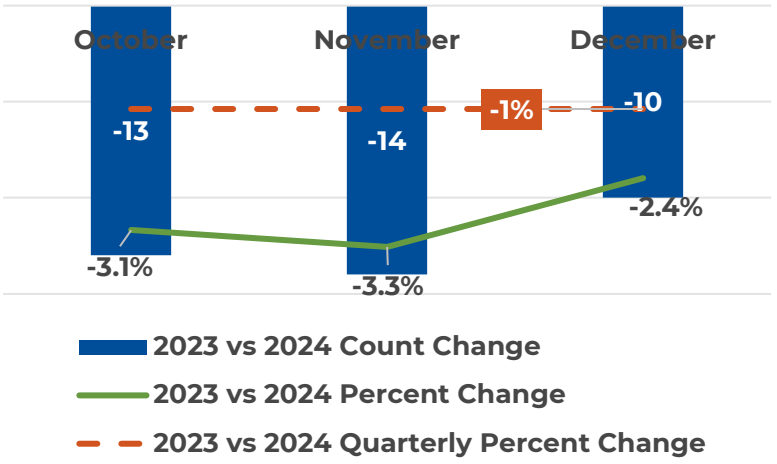




Agency Stats & Provider Network (Cont.)

Extended Care Facilities (In-State Only)





Hospitals (In-State Only)