OKLAHOMA HEALTH CARE AUTHORITY
REGULAR BOARD MEETING
January 21, 2026, 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_RGm01Ws_S4GaF0CHTV9Bfw
Telephone: 1-669-216-1590 Webinar ID: 161 898 6243

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

1. Call to Order / Determination of Quorum……...Marc Nuttle, Chair

2. Discussion and Vote on the November 10, 2025, OHCA Board Meeting Minutes……..….Marc Nuttle, Chair

3. State Medicaid Director Update (Attachment A)……..Melissa Miller, State Medicaid Director

4. Discussion of Report from the Pharmacy……..……Jeffrey Cruzan, MD
   Advisory Committee and Possible Action Regarding Chair, Pharmacy Advisory Committee
   Drug Utilization Review Board Recommendation:

   a) Discussion and Possible Vote on Recommendations Made by the Drug Utilization Review Board Pursuant to 63 O.S. § 5030.1, § 5030.3 To Add the Following Drugs to the Utilization and Scope Prior Authorization Program under OAC 317:30-5-77.2(e) (Attachment "B"):

Item:	Drug Name:	Used For:
i.	Eliquis® (Apixaban) Tablet for Oral Suspension Eliquis® Sprinkle (Apixaban)	Venous Thromboembolism (VTE)
ii.	Boruzu® (Bortezomib) Lynozyfic™ (Linvoseltamab-gcpt)	Multiple Myeloma (MM)
iii.	Bilprevda® (Denosumab-nxxp) Bomyntra® (Denosumab-bnht) Osenvelt® (Denosumab-bmwo)	Prevention of Skeletal-related events in patients with bone metastases from solid tumors and patients with MM Giant Cell Tumor of the Bone (GCTB) Hypercalcemia of Malignancy (HoM)
iv.	Forzinity™ (Elamipretide)	Barth Syndrome (BS)
v.	Harliku™ (Nitisinone) Orfadin® (Nitisinone) Nityr® (Nitisinone) Sephience™ (Sepiapterin)	Alkaptonuria (AKU) AKU and Hereditary Tyrosinemia type I (HT-1) AKU and HT-1 Phenylketonuria (PKU)
vi.	Brinsupri™ (Brensocatib)	Non-Cystic Fibrosis Bronchiectasis (NCFB)
vii.	Anzupgo® (Delgocitinib 2% Cream)	Chronic Hand Eczema (CHE)
viii.	Rhapsido® (Remibrutinib)	Chronic Spontaneous Uticaria (CSU)
ix.	Omlyclo (omalizumab-igec)	Immuneglobulin E-Mediated Asthma

		(IgE-MA) CSU Immuneglobulin E-Medicated Food Allergy (IgE-MFA) Nasal Polyps

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

    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. Behavioral Health Transportation Rates

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

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

        i. APA WF # 25-04A&B Hospice for HCBS
        ii. APA WF # 25-07 Health Information Exchange Cleanup
        iii. APA WF # 25-11 Dental Policy Revisions
        iv. APA WF # 25-10 Residential Behavioral Management Services
        v. APA WF # 25-13 Secure Behavioral Health Transportation
        vi. APA WF # 25-17 Outpatient Behavioral Health Agency Services
        vii. APA WF # 25-18 Inpatient Psychiatric Accrediting Bodies
        viii. APA WF # 25-21 Pharmacists' Policy Revisions
        ix. APA WF # 25-22 Elective Sterilization Clarification
        x. APA WF # 25-19 Medically Fragile Change of Agency
        xi. APA WF # 25-23 Sports Physical Clarification
        xii. APA WF # 25-24 PACE Two-Way Agreement
        xiii. APA WF # 25-25 Opioid Overdose Reversal Agent
        xiv. APA WF # 25-26 Lactation Consultant Revisions
        xv. APA WF # 25-27 Determination of Qualifying Categorical Relationships
        xvi. APA WF # 25-28A&B Developmental Disabilities Services Revisions
        xvii. Chapter 150: Employees Group Insurance Division

The following PERMANENT rules were previously adopted by the board under EMERGENCY rulemaking

        xviii. APA WF # 25-01 Functional Family Therapy
        xix. APA WF # 25-02 ADvantage Waiver Revisions
        xx. APA WF # 25-03 SoonerSelect Auto-Assignment
        xxi. APA WF # 25-05 Ancillary Services
        xxii. APA WF # 25-06 Rapid Whole Genome Sequencing
        xxiii. APA WF # 25-08 Birthing Centers and Licensed Midwives
        xxiv. APA WF # 25-09 RHC and FQHC Policy Revisions
        xxv. APA WF # 25-12 Four Walls Clinic Services
        xxvi. APA WF # 25-14 Paid Family Caregiver Program
        xxvii. APA WF # 25-15 340B Drug Discount Program

The following EMERGENCY and PERMANENT rules were not previously adopted and are new to the board. The Agency is requesting emergency rules be effective upon the Governor's signature, with concurrent adoption of

permanent rules.

xxviii. APA WF # 26-01 Removal of Physician Limit Caps
xxix. APA WF # 26-02 Telehealth Originating Site Reimbursement

7. Chief Executive Officer Report……..…..……..Clay Bullard, Chief Executive Officer

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

NEXT BOARD MEETING
March 25, 2026, at 2:00PM
Oklahoma Health Care Authority
4345 N. Lincoln Blvd
Oklahoma City, OK 73105

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MINUTES OF AMENDED BOARD MEETING
OF THE HEALTH CARE AUTHORITY BOARD
November 10, 2025
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 November 7, 2025, at 9:002:00 p.m. Advance public meeting notice was provided to the Oklahoma Secretary of State. In addition to the posting of statutory public notice, the agency placed its agenda on its website on November 5, 2025, at 3:53 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 Cruzan, Member Jolley, Member Leland

BOARD MEMBER ABSENT: Member Corbett, Member Kennedy

ITEM 2 / PUBLIC COMMENT
Chairman Nuttle, OHCA Board Chairman

The following members of the public signed up to speak publicly during the November 10, 2025, board meeting.

Dr. Angela Hawkins, Chair, Oklahoma Section of the American College of Obstetricians and Gynecologists
Cori Loomis, Attorney, McAfee & Taft, representing the Oklahoma State Medical Association

ITEM 3 / DISCUSSION AND POSSIBLE VOTE ON THE SEPTEMBER 30, 2025, OHCA BOARD MEETING MINUTES
Chairman Nuttle, OHCA Board Chairman

MOTION: Member Jolley moved for approval of the September 30, 2025, board meeting minutes, as published. The motion was seconded by Member Christ.

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

BOARD MEMBER ABSENT: Member Corbett, Member Kennedy

Chairman Nuttle reminded the board that they can challenge a Chair ruling, if they so wish. He added that the board can request legal opinions if there is a debate on a rule or an issue

ITEM 4 / CHIEF EXECUTIVE OFFICER REPORT
Clay Bullard, Chief Executive Officer

CEO Bullard provided a brief overview of his background.

CEO Bullard highlighted the Trust & Transparency key principle, stating that the agency will expound on what has been done in the past, including overly communicating everything that the staff are doing. The goal is to re-establish and gain trust with every stakeholder in the process.

Key Program Initiatives: CEO Bullard stated that there are a lot of things coming up in HR1, including work requirements and other things that will require an enormous amount of planning software. Steve Miller and his team are driving those changes to be able to make sure that everything is ready when that time comes. He added that member eligibility will be a major factor moving forward, which funnels into the entire landscape of HR1. The Department of Health did submit the application to CMS last week. If approved, the grant will be awarded on December 31, 2025, or sooner. CEO Bullard stated that the Finance team is preparing the budget for the upcoming legislative session. He added that it will be one of the largest ask this agency has ever had of the legislature. He added that a lot of that is related to HR1 and Rural Health Transformation, simply because part of that program requires each state to have sustainability. The sustainability of those programs falls back on OHCA. CEO Bullard highlighted Josh Richards, CFO, and his team for their work on the budget.

Key Administrative Initiatives: CEO Bullard introduced Josh Anderson as OHCA's Chief of Staff, and Melissa Miller as OHCA's State Medicaid Director and Deputy Chief of Staff. Strategically, they both come from agencies which interlink

and overlap with OHCA. He added that he has met with agency staff, other state agency leadership, legislators, stakeholders, and associations in preparations for what OHCA is doing in January.

Chairman Nuttle asked when the board can expect to have the amended budget. CEO Bullard stated that the amended budget will not be available until January. Chairman Nuttle asked Vice-Chairman Yaffe when the legislature will see the budget. Vice-Chairman Yaffe stated that the legislature sees the budget before the end of the year. Chairman Nuttle added that the AG opinion referenced that as a policy board, the board must review the budget before it is finalized to the legislature. Member Jolley added that the AG opinion also references, not just the budget, but any business plan that has to be presented by January to the legislature. He added that in the years as an OHCA board member, he has not seen a business plan from a state agency. Chairman Nuttle stated that he is unsure if the Governor has decided on the Rural Health Transformation plan yet. He added that he would take it under his authority to talk to the Governor about how he would like to incorporate that into a business plan. CEO Bullard added that the budget outlines an operational plan line by line, so the plan would be funneled directly into the budget that will be submitted. That is already developed and he added that he would be happy to share that with the board.

Member Case asked CEO Bullard to explain about SNAP and how it relates to OHCA. CEO Bullard stated that SNAP does not relate to OHCA; however, some of OHCA's members are affected by SNAP, so it is more of an oversight, meaning that they are in that program, but it is not directly through OHCA's funding or processes.

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

ITEM 5 / DISCUSSION OF REPORT FROM THE PHARMACY ADVISORY COMMITTEE

Dr. Jeff Cruzan, Pharmacy Committee Member

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 "B")

Item:	Drug Name:	Used For:
i.	Zevaskyn™ (Prademagene Zamikeracel)	Recessive Dystrophic Epidermolysis Bullous (RDEB)
ii.	Zunveyl® (Denzfalantamine)	Alzheimer's Type Dementia (AD)
iii.	Blujepa (Gepotidacin) Emblaveo™ (Aztreopam/Avibactam) Likmez™ (Metronidazole Oral Suspension) Metronidazole 125mg Tablet Metronidazole 375mg Capsule	Various Infections
iv.	Proctofoam® HC (Hydrocortisone/Pramoxine 1%/1% Rectal Foam)	Inflammatory and pruritic (itching) manifestations of corticosteroid-responsive dermatoses of the anal region. 10,946 members with hemorrhoid diagnosis
v.	Ryoncil® (Remestemcel-L-rknd)	Acute Graft Versus Host Disease (aGVHD)

vi.	Datroway® (Datopotamab Deruxtecan-dlnk) Itovebi™ (Inavolisib)	Breast Cancer (BC and Non-Small Cell Lung Cancer (NSCLC) Breast Cancer
vii.	Encelto™ (Revakinagene Taroretcel-lwey)	Macular Telangiectasia (MacTel)
viii.	Fosrenol® (Lanthanum Carbonate) 750mg and 1,000mg Oral Powder Packet	Hyperphosphatemia (DP)
ix.	Alyftrek™ (Vanzacaftor/Tezacaftor/ Deutivicaftor)	Cystic Fibrosis (CF)
x.	Attruby™ (Acoramidis)	Cardiomyopathy of Variant Transthyretin-Mediated Amyloidosis (ATTR-CM)
xi.	Photrexa®/ Photrexa® Viscous (Riboflavin 5'-Phosphate)	Keratoconus (KC) and Corneal Ectastia (CE)

MOTION: Member Case moved for approval of item 5a.i-xi as published. The motion was seconded by Member Jolley.

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

BOARD MEMBER ABSENT: Member Corbett, Member Kennedy

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

ITEM 6 / DISCUSSION OF REPORT FROM THE COMPLIANCE ADVISORY COMMITTEE
Conner Mulvaney, Deputy General Counsel

a) Discussion and Possible Vote regarding the Authority's ability to withstand the procurement decision made by the CEO based on the Authority's budget and available funds pursuant to 63 O.S. Section 5006(A)(2) under OAC 317:10-1-16. (Attachment "C")

i. EGID Member Navigation and Advocacy Services Contract Renewal (HealthChoice App)
ii. Provision of Telemedicine Contract Renewal (Telemedicine Management)
iii. Technology Services for Health Information Exchange Extension
iv. Health Information Technology – Member Jolley asked for clarification regarding the federal match, as this contract states that there is no federal match for this contract; however, the next page states that there is the potential to receive federal funding based off of specific criteria. Is it that there is no federal match for this contract, or is it that there is an undetermined federal match? Mr. Mulvaney stated that undetermined would be correct. With this contract, it was previously a sole source which do not receive federal matches; however, if OHCA competitively bids a contract, which is what OHCA is doing through statewide, OHCA will receive a federal match.

MOTION: Member Jolley moved to approve item 6a.i-iv as published. The motion was seconded by Member Case.

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

BOARD MEMBER ABSENT: Member Corbett, Member Kennedy

For more detailed information, see Attached "C" of the board packet.

ITEM 7 / DISCUSSION OF REPORT OF THE ADMINISTRATIVE RULES ADVISORY COMMITTEE AND POSSIBLE ACTION
Tanya Case, Chair, Administrative Rules Advisory Committee

Vice-Chairman Yaffe presented the following emergency rules.

a) Discussion and Possible Vote on Recommended Rulemaking Pursuant to Article I of the Administrative Procedures Act and in accordance with 75 O.S. § 253. OHCA Requests the Adoption of the Following Emergency Rules (see Attachment "D")

Member Case stated that Emergency adoption is necessary to achieve timely compliance, as rules taken through the permanent rulemaking process do not become effective until November 2026. There was no action taken by the Administrative Rules Advisory Committee because there was no quorum due to abstentions. Therefore, this rule will be presented by Chairman Nuttle after the second rule is presented for consideration.

i. APA WF # 25-16 Provider Attestation Revisions – Chairman Nuttle clarified how this will work. First, this issue emanated from the board in an executive order, so it was delegated as a task to the Rules Committee. What is in the board packet is the carryover rules that were drafted and amended, stricken, added, and deleted by the Rules Committee; however, the committee could not make a recommendation on those drafts. Chairman Nuttle, as Chair, stated that he will call, or make a motion that the board adopts this rule. If there are any recusals, this would be the time to do so. Member Cruzan stated that he has been advised by counsel to recuse himself from the vote. Vice-Chairman asked what the outcome would be in terms of implementation of the executive order and the attestation requirement. Mr. Gillett stated the agency can still implement the executive order even without passage of the rule. He added that from a risk management perspective, it is good for the agency to have the passage of a rule, but it can implement the executive order.

Member Jolley provided the following statement: The Governor and Executive Order 2025-16 seeks to protect the unborn by ensuring that no provider is receiving payments of Oklahoma taxpayer dollars while simultaneously engaging in a practice that violates the tenants of Oklahoma's statutorily adopted values, that being elective abortion, and for his desire to align Oklahoma's agencies with Oklahoma's statutory values, I stand in solidarity with the Governor on that point. However, the Oklahoma Constitution places legislative power with my appointing authority, the Oklahoma Senate, and her esteem co-equal, the House of Representatives. Over the years, there have been numerous instances where an executive order of the Governor has been subject to review by the courts and the Attorney General's office for determination of validity. In each of those instances, unless there has been a specific prescription by the legislature with a specific statutory power to issue an executive order, no foundation for the Governor to issue an executive order directing any agency to perform a non-delegated function has been found. In today's era, where the federal power of executive order has been broadly exercised by Presidents of both political parties, largely required because of the growing political ineptiveness of Congresses over the last three decades. It is just natural for us to assume that executive orders require strict adherence by executive branch agencies, such as the Oklahoma Health Care Authority. In fact, in our last meeting, a statement was made that we were required to comply with the order. From my research and understanding, that's just simply not true. Oklahoma's Constitution invests zero powers to the Governor to issue an executive order; while Article 6, section 8 of the Constitution provides the Governor, "shall cause the laws of the state to be faithfully executed", and Title 74, sections 1-6 also provide general powers to the Governor. Neither the Oklahoma Constitution nor any statute grant the Governor general power to issue executive orders. In 1933, the Oklahoma Supreme Court found clearly the Governor has no authority to issue an order, proclamation, or decree having the force of law as, "lawmaking power of the state being vested exclusively elsewhere". Upon reading the executive order seeking to find a statutory reference that allows for the Governor to issue this order, the Governor relies on 63 Oklahoma Statute Section 1-741.3. When referencing that section of law and the executive order, a plain and substantive difference arises between the laws passed by the legislative body and the scope of Executive Order 2025-16. Title 63, section 1-741.3 was added in 2011 by the Oklahoma Legislature under Senate Bill 547 by my friend and colleague, Senator Anthony Sykes. I voted in favor of Senate Bill 547 when it came before the Senate in March of that year. The language in Senate Bill 547 provides in relevant part that, "no health plan including health insurance, contracts, plans, or policies shall provide coverage for elective abortions except by optional separate supplemental coverage for elective abortions for which there must be paid a separate premium". Saying that the Oklahoma Health Care Authority operates as a health plan for those who are uninsured and meet income limitations. I believe the Governor's executive order properly includes the OHCA Medicaid program. OHCA is unable to charge premiums to our members, and as such, if abortion procedures were to become legal again, in Oklahoma, we should not allow for any coverage for elective abortions for OHCA members. The Governor's executive order goes past the statutory constructs by not just saying Oklahoma tax dollars shall not be paid to providers for performing elective abortion-related procedures, which is something now illegal in Oklahoma, but the Health Care Authority and all other state agencies shall cease making any

payments to any individual or entity directly affiliated with a physician, medical practice, or other organization providing abortion facilities or services in the procurement of abortion services. This goes significantly past refusing to pay for a procedure to a new policy prohibiting any individuals performing any abortion-related procedure from being eligible to participate in the State Medicaid program. While Oklahoma's criminal laws in Title 21 of Oklahoma Statutes establishes that engaging in abortion, except in limited exceptions, is a felony. There is also no provision, to my knowledge, in Oklahoma's criminal statute saying that payment to a medical provider for a non-abortion-related procedure is also a criminal act if that provider also engaged in a disallowed and illegal abortion procedure. It's my firm opinion that the new policies attempting to be enacted by way of this executive order could very well be adopted by the legislature with statutory modifications in the future, and upon that date, I would gladly support inclusion of a rule based on a duly passed legislative statute. However, I believe it could be considered legal error for this board which is granted specific statutory authority to govern the policies of this agency to align our agency's permanent rules based upon an executive order that uses an undelegated exercise of authority instead of a statute passed through the legislative branch upon which Oklahoma's Constitutional Authority is vested. I'm certain that members of the executive branch and the proponents of this policy change will take issue with my interpretation of this and also believe my judgment in this matter may be in error, although my research into relevant statute and judicial opinion has not yet provided me with contradictory evidence. Accordingly, if the others on this board find themselves in agreement with my judgment, I would be happy to move this board as the independently appointed policy-making board, seek the opinion either of a court of competent jurisdiction through declaratory judgment, or the opinion of the Attorney General, that my interpretation is either correct or in error. And accordingly, Mr. Chairman, I would move that the board seek opinion from the Attorney General as to whether the board is compelled to abide by the directives, each of the directives, in Executive Order 2025-16. I believe the motion to table is a prior motion, and would be in order at this time, and I would make that motion.

Chairman Nuttle did not recognize the motion at the table. He added that the board could pick it up as a separate motion, if the current motion on the table fails. Member Jolley respected the Chairman's comment but suggested that the Chairman's ruling is contradictory to the purpose of the motion. Chairman Nuttle stated that if the consensus is to seek Attorney General opinion, it ought to be a separate motion. He added that his concern of not taking action leave providers in limbo on what they're to do for what could take another 90-days or four months. Vice-Chairman Yaffe stated that this board does not have the authority to say up or down whether this executive order is legal or not. He added that this is an issue that deals with clarity of contracting with our provider community. This deals with separation of power issues with the Executive branch and the Legislative branch, and potentially the Judicial branch. Vice-Chairman Yaffe encouraged the board to vote the current motion down Member Jolley's Attorney General opinion request. He also encouraged OHCA to work with the Governor to ask for an extension on the attestation until clarity is received from the courts or the Attorney General. Chairman Nuttle stated that, assuming the current vote fails, he will accept a motion to seek Attorney General opinion. CEO Bullard did not have a problem with that, and stated that he will go back to the Governor to seek an extension.

MOTION:	Chairman Nuttle motioned to approve the emergency rule listed in item 7a.i, as amended. The motion was seconded by Member Leland.
FOR THE MOTION:	Chairman Nuttle, Member Leland
AGAINST THE MOTION:	Vice-Chairman Yaffe, Member Case, Member Jolley
BOARD MEMBER ABSTAIN:	Member Christ
BOARD MEMBER RECUSAL:	Member Cruzan
BOARD MEMBER ABSENT:	Member Corbett, Member Kennedy
MOTION:	Member Jolley motioned to seek an opinion as a board, from the Attorney General as to whether the board is compelled to abide by each of the directions in Executive Order 2025-16. The motion was seconded by Member Cruzan.

Chairman Nuttle asked what action should be taken while waiting on the opinion. Member Jolley stated that it seems to him like the appropriate stance for the board to take would be to hold abeyance on, until the board has a directive, any action on implementation of the executive order until the board has clear direction as to whether the executive order and the specific parts thereof which include the dates by which attestation is have been achieved. If the board is required to implement it, then an attestation, after the board has acted, should be done. Chairman Nuttle asked what our authority is to enforce or not enforce the order. Mr. Gillett stated that it's a directive to the state agency and the staff. He added that he does not think the board has the authority to not enforce the executive order, or to order the agency not to enforce the

order from the Governor. Member Jolley stated that there is an Attorney General opinion in this state that says quite the contrary, that the staff is responsible for executing the day-to-day operations of the agency, but this board, under statute, and as clarified by Attorney General opinion, is solely responsible for policy and governance.

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

BOARD MEMBER ABSENT: Member Corbett, Member Kennedy

MOTION: Vice-Chairman Yaffe motioned to pass a resolution to request Chairman Nuttle and CEO Bullard to engage with the Governor to seek clarification on Executive Order 2025-16 and also to work with the Governor to postpone enforcement of the attestation requirement until such time as rules have been passed by this board. The motion was seconded by Member Cruzan.

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

BOARD MEMBER ABSENT: Member Corbett, Member Kennedy

ii. APA WF # 25-15 340B Program Revisions

MOTION: Vice-Chairman Yaffe motioned to approve the declaration of compelling public interest for the promulgation of the emergency rules in item 7a.ii. The motion was seconded by Member Jolley.

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

BOARD MEMBER ABSENT: Member Corbett, Member Kennedy

MOTION: Member Jolley moved to approve the emergency rule listed in item 7a.ii, as published. The motion was seconded by Vice-Chairman Yaffe.

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

BOARD MEMBER ABSENT: Member Corbett, Member Kennedy

ITEM 8 / DISCUSSION AND POSSIBLE ACTION OF THE ELECTION OF THE OHCA 2025 BOARD OFFICERS
Marc Nuttle, OHCA Board Chairman

MOTION: Member Cruzan moved to retain Mr. Nuttle as Chairman of the Health Care Authority Board. The motion was seconded by Member Jolley.

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

BOARD MEMBER ABSENT: Member Corbett, Member Kennedy

MOTION: Member Cruzan moved to retain Mr. Yaffe as Vice-Chairman of the Health Care Authority Board. The motion was seconded by Member Case.

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

BOARD MEMBER ABSENT: Member Corbett, Member Kennedy

ITEM 9 / DISCUSSION AND POSSIBLE ACTION OF THE OHCA BOARD MEETING DATES AND TIMES FOR CALENDAR YEAR 2026
Marc Nuttle, OHCA Board Chairman

MOTION:	Member Jolley moved to approve the proposed 2026 meeting dates and times, as published. The motion was seconded by Member Cruzan.
FOR THE MOTION:	Chairman Nuttle, Vice-Chairman Yaffe, Member Case, Member Christ, Member Cruzan, Member Jolley, Member Leland
BOARD MEMBER ABSENT:	Member Corbett, Member Kennedy

ITEM 8 / ADJOURNMENT
Marc Nuttle, OHCA Board Chairman

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

Meeting adjourned at 11:00 a.m., 11/10/2025.

NEXT BOARD MEETING
January 21, 2026
Oklahoma Health Care Authority
4345 N. Lincoln Blvd
Oklahoma City, OK 73105

Martina Ordonez
Board Secretary

Minutes Approved: _____

*Initials:*_____

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MEDICAID DIRECTOR UPDATE

January 21, 2026

RURAL HEALTH TRANSFORMATION H.R.1

RURAL HEALTH TRANSFORMATION

- RHT is federal funding to support rural access, infrastructure, and care delivery transformation across the State.
- OSDH as designated administrator
- $50 billion distributed over 5 years
  - 50% of funding distributed equally across all states with approved applications
    - Baseline funding for all states who apply is $100M per year
  - 50% of funding distributed based on various factors regarding the rural nature of the state

OKLAHOMA AWARD AMOUNT

- Oklahoma's 2026 Award Amount: $223.5 million for FFY26
- Five-year program
- Full application available here: oklahoma.gov/health/rhtp

Oklahoma Rural Health Transformation Program

OKLAHOMA'S RHT INITIATIVES

- Innovating Care Model
  - Bringing care closer to home through telehealth, transportation, and local infrastructure
- Moving Upstream
  - Promoting wellness and prevention
- Growing the Next-Gen of Rural Talent
  - Attracting and retaining rural workforce
- Facilitating Regional Collaboration
  - Shared resources
- Shifting to Value
  - Supporting transition to value-based care
- Building Health Data Utility
  - Investing in technology that improves data sharing

OHCA MANAGED INITIATIVES

EHR Expansion

- Extends EHR coverage to unconnected rural facilities
- Assessment to determine target facilities

HIE Expansion

- Extends HIE coverage to unconnected rural facilities

Data and Analytics

- Roadmap for expanded functionality of HIE integration

OHCA MANAGED INITIATIVES

Community Health Worker

- Expand current coverage in county health departments to rural hospitals
- Recruit/train/hire/compensate 30 Community Health Workers

Community Care Portal

- Expand FindHelp closed-loop referral system extension to Critical Access Hospitals, emergency departments, county health departments

Programs for All inclusive Care for the Elderly (PACE) Expansion

- Currently 4 total/2 urban, 2 rural
- Recruit additional rural locations (3-6)

OHCA MANAGED INITIATIVES

Remote Patient Monitoring for Maternal Health (TMAH add-in)

- Funds used for specialized continuous glucose monitoring equipment, blood pressure cuffs, and technology for remote patient monitoring

Practice Enablement

- Supports practices to participate in value-based arrangements/business practice transformation

PCP Clinical Extension Model

- Supports practices in managing high-risk patients and coordinating care

OTHER INITIATIVES

- Transportation Expansion
- Rural Relocation Incentives
- Wellness Hub Microgrants
- BH Integration in Primary Care

NEXT STEPS

- Budget finalization
- RFP/Procurement
- Stakeholder Meetings
- Ongoing federal reporting/evaluation

RHT RELATED POLICY INITIATIVES

- Telehealth site origination fee
  - Supports RHT investment in equipment/connectivity for ongoing telehealth utilization costs in facilities

- Removal of physician visit limits
  - Supports initiatives focused on access to primary and preventive care

H.R.1 – IMPORTANT DATES

H.R.1 POLICY MILESTONES- ELIGIBILITY

- **Immigrant Eligibility Changes** October 1, 2026
  - Estimated 6,000 refuges will lose coverage
- **Community/Work Engagement** December 31, 2026
  - Estimated 123k screened; 78k to provide documentation
- **6-Month Redeterminations** December 31, 2026
  - For non-tribal expansion adults and Insure Oklahoma; estimated 183k
- **Retroactive Coverage Limit** January 1, 2027
  - Limits retroactive coverage from 90 days (current practice) to 1 month for expansion adults; 2 months for other eligibility categories

H.R.1 POLICY MILESTONES- FINANCIAL

Provider Tax Cap

- Reductions begin for hospital tax in FFY2032 (4% to 3.5%)

State Directed Payment Caps

- Reductions to SHOPP (10% per year) begin in SFY2029

Cost Sharing Changes October 1, 2028

- Up to $35 per services for individuals with incomes between 100-138% of federal poverty level
- Certain services required to have no cost sharing (eg, primary care, behavioral health)

OTHER FEDERAL ITEMS

- BALANCE/GENEROUS Pharmacy Models from CMS
- New CMS Office of Rural Health Transformation

PROGRAMMATIC UPDATES

TRANSFORMING MATERNAL HEALTH (TMAH)

- One of 15 states selected for the ten-year demonstration focused on maternal health improvement
- Model focuses on access to care, quality improvement, and whole-person perinatal care for Medicaid and CHIP enrollees
- Oklahoma's participation is limited to a defined test region, including select counties and targeted North Tulsa ZIP codes
- Remote monitoring for hypertension and diabetes is supported through the Rural Health Transformation (RHT) initiative, as TMaH funds were not approved for this component

FOOD IS MEDICINE

- **Legislation:** SB 806 directs OHCA to seek federal approval to support nutrition-related interventions
- **Two CEs** have initiated early-stage Food is Medicine efforts (FreshRx) as plan-level activities, outside the Medicaid State Plan
- OHCA has engaged **CMS** for technical assistance; CMS is actively reviewing options and developing guidance and resources to support states exploring this approach
- **What's next**: OHCA will continue discussions with CMS to assess feasible authorities, informed by CE activity and federal developments

MAC CHANGES

MAC CHANGES

- Both state (63 O.S. § 5009.2) and federal (42 CFR 431.12) requirements have recently been updated related to the MAC. Key changes include:
  - MCE/plan association representative
  - Required proportion of MAC must be MATF members
  - Term limits
  - Non-voting members
  - Hybrid options
- OHCA is updating MAC structure, by-laws, and processes to align with updated requirements and ensure continued compliance.

OKLAHOMA
Health Care Authority

GET IN TOUCH

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MySoonerCare.org

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Oklahoma Health Care Authority Board Meeting – Drug Summary

Drug Utilization Review Board Meetings –November 12, 2025, and December 10, 2025

Vote Item	Drug	Used for	Cost*	Notes
1	Eliquis® (Apixaban) Tablet for Oral Suspension Eliquis® Sprinkle (Apixaban)	• **Venous Thromboembolism (VTE):** VTE is a blood clot that blocks the flow of blood through the veins. 237 members with VTE	• $7,272 per year *Budget impact estimate: $14,544 per year* • $3,636 per year *Budget impact estimate: $145,440 per year*	• No PA for children 10 years and younger for both products. Adolescents and adults can use regular tablets without a PA.
2	Boruzu® (Bortezomib) Lynozyfic™ (Linvoseltamab-gcpt))	• **Multiple Myeloma (MM):** MM is a cancer that forms in a type of white blood cell called a plasma cell. Healthy plasma cells help fight infections by making proteins called antibodies. Antibodies find and attack germs. *246 members with MM*	• $47,593 per course of treatment *Budget impact estimate: none* • $322,420 per 6 months *Budget impact estimate: $967,260 per year*	• Other cheaper therapies required first[¥] • Not first line[±]
3	Bilprevda® (Denosumab-nxxp) Bomyntra® (Denosumab-bnht)	• **Prevention of skeletal-related events in patients with bone metastases from solid tumors and patients with MM** such as fractures, spinal compression, and surgery to bone. *2.035 members with solid tumors and 246 members with MM*	• $21,944 per year *Budget impact estimate: none* • $43,501 per year *Budget impact estimate: none*	• Other cheaper therapies required first[¥] • Other cheaper therapies required first[¥]

	Osenvelt® (Denosumab-bmwo)	**Giant Cell Tumor of the Bone (GCTB):** GCTB is one of the most common benign bone tumors, predominantly occurring in young adults aged 20 to 40 with a high recurrence rate and the potential for aggressive behavior. **Hypercalcemia of Malignancy (HoM):** HoM is a common finding typically found in patients with advanced stage cancers. HoM usually presents with markedly elevated calcium levels. The major systems affected by hypercalcemia include neuropsychiatric, gastrointestinal, and renal. *3,896 members with hypercalcemia*	• $42,604 per year *Budget impact estimate: none*	• Other cheaper therapies required first¥
4	Forzinity™ (Elamipretide)**	• **Barth Syndrome (BS):** BS is a metabolic and neuromuscular genetic disorder, occurring almost exclusively in males, that primarily affects the heart, immune system, muscles, and growth leading to severe health issues. *5 members with diagnosis in claims history*	• $793,569 per year *Budget impact estimate: $1,587,138 per year*	• No other treatments available
5	Harliku™ (Nitisinone)	• **Alkaptonuria (AKU):** AKU is a rare genetic inborn error of protein metabolism. It is the result of the deficiency of an enzyme leading to the accumulation of homogentisic acid in connective tissue and to severe deformity of joints, spine, and organ dysfunction. *No diagnosis code for AKU. Estimating no members*	• $534,636 per year *Budget impact estimate: none*	• Other cheaper therapies required first¥

	Orfadin® (Nitisinone)	• **AKU and Hereditary Tyrosinemia type 1 (HT-1):** HT-1 is a rare autosomal recessive genetic metabolic disorder characterized by lack of an enzyme which is needed for the final break down of the amino acid tyrosine. Failure to properly break down tyrosine leads to abnormal accumulation of tyrosine and its metabolites in the liver, potentially resulting in severe liver disease. Tyrosine may also accumulate in the kidneys and central nervous system. *No diagnosis code for HT-1. Estimating no members*	• $26,157 per year *Budget impact estimate: none*	• Generics available
	Nityr® (Nitisinone)	• **AKU and HT-1**	• $32.144 per year *Budget impact estimate: none*	• Generics available
	Sephience™ (Sepiapterin)	• **Phenylketonuria (PKU):** PKU is a rare inherited disorder that causes an amino acid called phenylalanine to build up in the body. Without the enzyme necessary to break down phenylalanine, a dangerous buildup can develop when a person with PKU eats foods that contain protein or eats aspartame, an artificial sweetener. This can eventually lead	• $810,000 per year *Budget impact estimate: $4,050,000 per year*	• Other cheaper therapies required first[¥]

		to serious health problems. *45 members with PKU*		
6	Brinsupri™ (Brensocatib)	• **Non-Cystic Fibrosis Bronchiectasis (NCFB):** NCFP is a heterogeneous group of pulmonary diseases characterised by irreversibly damaged and dilated bronchi. It has a variety of causes and a broad spectrum of clinical presentations, ranging from asymptomatic radiological changes detected incidentally to chronic sputum production and recurrent exacerbations. In NCFB airway architectural changes lead to mucus accumulation, chronic airway infection and persistent neutrophilic inflammation and causes further airway damage. *629 members with NCFB*	• $87,998 per year *Budget impact estimate: $439,990 per year*	• No other FDA approved treatments
7	Anzupgo® (Delgocitinib 2% Cream)	• **Chronic Hand Eczema (CHE):** CHE is a common and challenging skin condition, characterized by persistent hand dermatitis which lasts over 3 months or recurs at least twice a year. This condition is often multifactorial, involving genetic predispositions, environmental factors and triggers, such as irritants and allergens. *No diagnosis code for CHE. Estimating 43,500 members might have CHE*	• $23,832 per year *Budget impact estimate: $238,320 per year*	• Other cheaper therapies required first[¥]

8	Rhapsido® (Remibrutinib)	• **Chronic Spontaneous Uticaria (CSU):** CSU is defined by the presence of hives daily or almost daily for at least six weeks with no identifiable external trigger. *3,195 members with CSU*	• $54,252 per year *Budget impact estimate: $1,627,560 per year*	• Other cheaper therapies required first[¥]
9	Omlyclo (omalizumab-igec)	• **Immuneglobulin E-Mediated Asthma (IgE-MA**): IgE-MA is a common type of allergic asthma where the immune system produces an antibody called Immunoglobulin E (IgE). In this condition, the immune system misidentifies harmless substances, such as pollen or dust mites, as threats. This error triggers a defensive response that leads to asthma symptoms. Allergic asthma accounts for approximately two-thirds of all asthma cases. *78 members using Xolair (omalizumab)* • **CSU** • **Immuneglobulin E-Mediated Food Allergy (IgE-MFA):** IgE-MFA is defined as an adverse immunologic response to a food. IgE-M reactions to foods are associated with a broad range of signs and symptoms that may involve any of the following body systems: the skin, gastrointestinal tract, respiratory tract, and cardiovascular system. IgE-mediated food allergy is a leading	• N/A *Budget Impact: none*	• Not available in the market yet

		cause of anaphylaxis. *78 members using Xolair (omalizumab)* • **Nasal Polyps (NP):** NP are painless growths inside the nose or the hollow areas inside the bones of the face, also known as sinuses. Larger growths or groups of nasal polyps can block the nose. They can lead to breathing problems, not being able to smell and infections. *78 members using Xolair (omalizumab)*		

*Costs do not reflect rebated prices or net costs. Costs based on National Average Drug Acquisition Costs (NADAC) or Wholesale Acquisition Costs (WAC) if NADAC unavailable. N/A = not available at the time of publication.
**Coverage will begin April 1,2026 when the Federal Drug Rebate Agreement becomes effective.
¥Other cheaper therapies required first: There are other treatment options available with or without a prior authorization (PA) which will be required for the member to try and fail before a PA would be issued for this new therapy.
±Not first line: The patient must have failed treatment with other therapy first per FDA.

Pharmacy Agenda Items

Recommendation 1: Vote to Prior Authorize Eliquis® Tablet for Oral Suspension and Eliquis® Sprinkle

The Drug Utilization Review Board recommends the prior authorization of Eliquis® (Apixaban) Tablet for Oral Suspension and Eliquis® Sprinkle (Apixaban) with the following criteria:

Eliquis® (Apixaban) Tablet for Oral Suspension and Eliquis® Sprinkle (Apixaban) Capsule for Oral Suspension Approval Criteria:

1. Eliquis® tablet for oral suspension and Eliquis® Sprinkle capsule for oral suspension will not require prior authorization for members 10 years of age or younger. For members 11 years of age or older, a patient-specific, clinically significant reason why the member cannot use Eliquis® tablets must be provided; and
2. Clinical exceptions for the age restriction may be considered for approval (e.g., documented dysphagia, weight-based dose cannot be achieved with the tablet formulation).

Recommendation 2: Vote to Prior Authorize Boruzu® and Lynozyfic™

The Drug Utilization Review Board recommends the prior authorization of Boruzu® (Bortezomib) and Lynozyfic™ (Linvoseltamab-gcpt) with the following criteria:

Boruzu® (Bortezomib) Approval Criteria:

1. An FDA approved diagnosis; and
2. A patient-specific, clinically significant reason the member cannot use generic Velcade® (bortezomib), which is available without a prior authorization, must be provided.

Lynozyfic™ (Linvoseltamab-gcpt) Approval Criteria [Multiple Myeloma Diagnosis]:

1. Diagnosis of relapsed or refractory multiple myeloma; and
2. Member has received at least 4 prior lines of therapy, including a proteasome inhibitor, an immunomodulatory agent, and an anti-CD38 monoclonal antibody; and
3. Member must be 18 years of age or older; and
4. Health care facilities must be trained in the management of cytokine release syndrome (CRS), neurologic toxicities, and comply with the risk evaluation and mitigation strategy (REMS) requirements.

Recommendation 3: Vote to Prior Bilprevda®, Bomyntra®, Osenvelt®

Pharmacy Agenda Items

The Drug Utilization Review Board recommends the prior authorization of Bilprevda® (Denosumab-nxxp), Bomyntra® (Denosumab-bnht), Osenvelt® (Denosumab-bmwo) with the following criteria:

Bilprevda® (Denosumab-nxxp), Bomyntra® (Denosumab-bnht), Osenvelt® (Denosumab-bmwo), Approval Criteria:

1. An FDA approved indication of 1 of the following:
    a. Prevention of skeletal-related events in members with multiple myeloma and in members with bone metastases from solid tumors; or
    b. Treatment of adults and skeletally mature adolescents with giant cell tumor of the bone (GCTB) that is unresectable or where surgical resection is likely to result in severe morbidity; and
        i. Prescriber must document that tumor is unresectable or that surgical resection is likely to result in severe morbidity; or
    c. Treatment of hypercalcemia of malignancy refractory to bisphosphonate therapy; and
        i. Member must have albumin-corrected calcium of >12.5mg/dL (3.1mmol/L) despite treatment with intravenous bisphosphonate therapy in the last 30 days prior to initiation of therapy; and
2. For Bilprevda®, Bomyntra®, and Osenvelt® ~~Wyost® (denosumab-bbdz),~~ a patient-specific, clinically significant reason why the member cannot use Wyost® or Xgeva® must be provided.
    a. Biosimilars and/or reference products are preferred based on the lowest net cost product(s) and may be moved to either preferred or non-preferred if the net cost changes in comparison to the reference product and/or other available biosimilar products.
3. These products will be covered as a medical benefit only.

Recommendation 4: Vote to Prior Authorize Forzinity™

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

Forzinity™ (Elamipretide) Approval Criteria:

1. An FDA approved diagnosis of Barth syndrome; and
    a. Diagnosis must be confirmed by genetic testing identifying a hemizygous pathogenic variant in the *TAFAZZIN* gene (results of genetic testing must be submitted); and
2. Member's current weight must be provided and must be ≥30kg; and

3. Member's current estimated glomerular filtration rate (eGFR) must be provided and:
    a. Requested dose must be appropriate for the member's eGFR, per package labeling; and
    b. Member must not be on dialysis; and
4. Must be prescribed by, or in consultation with, a specialist with expertise in the treatment of Barth syndrome (or an advanced care practitioner with a supervising physician who is a specialist with expertise in the treatment of Barth syndrome); and
5. Prescriber must confirm the member and/or caregiver will be trained on the proper administration and storage of Forzinity™ prior to starting treatment; and
6. Initial approvals will be for a duration of 6 months. After 6 months of treatment, subsequent approvals (for a duration of 1 year) may be granted if the prescriber documents the member is responding well to treatment, as indicated by an improvement in muscle strength, fatigue, or other clinical symptoms of the disease; and
7. A quantity limit of 14mL per 28 days will apply.

Recommendation 5: Vote to Prior Authorize Harliku™, Orfadin®, Nityr®, and Sephience™

The Drug Utilization Review Board recommends the prior authorization Harliku™ (Nitisinone), Orfadin® (Nitisinone), Nityr® (Nitisinone), and Sephience™ (Sepiapterin) with the following criteria:

Harliku™ (Nitisinone), Nityr® (Nitisinone), and Orfadin® (Nitisinone) Approval Criteria [Alkaptonuria (AKU) Diagnosis]:

1. An indication to reduce urine homogentisic acid (HGA) in patients with alkaptonuria (AKU); and
    1. The diagnosis of AKU must be confirmed by 1 of the following (results of the selected test must be submitted with the request):
        1. Genetic testing identifying biallelic pathogenic or likely pathogenic variants in the homogentisate 1,2-dioxygenase (HGD) gene; or
        2. Urine test for HGA showing >0.4 grams of HGA excreted in 24 hours; and
2. Nitisinone must be prescribed by, or in consultation with, a geneticist, rheumatologist, or specialist with expertise in the treatment of AKU; and
3. The prescriber must confirm the member will receive a baseline ophthalmologic examination prior to initiating nitisinone treatment; and

4. The prescriber must confirm the member has been counseled to report any unexplained ocular, neurologic, or other symptoms to their health care provider; and
5. Use of Harliku™ will require a documented failed trial of both generic nitisinone 2mg capsules and Nityr® (nitisinone) 2mg tablets and clinical justification as to why Harliku™ would be expected to confer a different response since it contains the same active ingredient (nitisinone); and
6. A quantity limit of 30 tablets for 30 days will apply; and
7. Initial approvals will be for the duration of 6 months; and
8. Subsequent approvals will be for the duration of 1 year; and
9. Reauthorization requires the following:
    1. Verification from the prescriber of continued response to therapy (i.e., decrease in urine HGA levels, improvement in joint pain, decrease in visible ochronosis).

Nityr® (Nitisinone) and Orfadin® (Nitisinone) Approval Criteria [Hereditary Tyrosinemia (HT-1) Diagnosis]:

1. An FDA approved diagnosis of HT-1; and
    a. The diagnosis of HT-1 must be confirmed by 1 of the following (results of the selected test must be submitted with the request):
        i. Genetic testing identifying biallelic pathogenic or likely pathogenic variants in the fumarylacetoacetase hydrolase (FAH) gene; or
        ii. Elevated succinylacetone concentrations in the blood or urine; and
2. Documentation of active management with a tyrosine and phenylalanine restricted diet; and
3. Nitisinone must be prescribed by, or in consultation with, a geneticist or specialist with expertise in the treatment of HT-1; and
4. The prescriber must verify the member will receive appropriate ophthalmologic examinations; and
5. The prescriber must confirm the member has been counseled to report any unexplained ocular, neurologic, or other symptoms to their health care provider; and
6. The member's recent weight must be provided on the prior authorization request in order to authorize the appropriate amount of drug required according to the package labeling; and
7. Initial approvals will be for the duration of 6 months; and
8. Subsequent approvals will be for the duration of 1 year; and
9. Reauthorization requires the following:
    a. Documentation of active management with a tyrosine and phenylalanine restricted diet; and

b. Verification from the prescriber of continued response to therapy (i.e., decrease in plasma and/or urine succinylacetone concentration).

Sephience™ (Sepiapterin) Approval Criteria:

1. An FDA approved diagnosis of phenylketonuria (PKU); and
2. Documentation of active management with a phenylalanine restricted diet; and
3. Baseline phenylalanine concentration must be documented on the prior authorization request and must be drawn within the last 30 days; and
4. Sephience must be prescribed by, or in consultation with, a geneticist, neurologist, or specialist with expertise in the treatment of PKU; and
5. Concomitant use with Palynziq® (pegvaliase-pqpz) will not be approved except to allow for temporary coverage during the titration of Palynziq®; and
6. Member must meet 1 of the following (documentation must be provided):
   a. A 3-month trial with sapropterin with inadequate response, defined as blood phenylalanine ≥360micromol/L, despite consistent use in combination with dietary phenylalanine restriction; or
   b. Member is a non-responder to sapropterin defined as ≤30% decrease in phenylalanine after 30 days of sapropterin therapy in combination with dietary phenylalanine restriction; or
   c. A diagnosis of classic PKU (blood phenylalanine ≥1,200micromol/L at diagnosis or 2 null mutations in *trans*); or
   d. A patient specific, clinically significant reason why the member cannot use generic Kuvan® (sapropterin) must be provided; and
7. Initial approvals will be for 2 weeks. After which time, the prescriber must verify that the member responded to treatment as defined by laboratory documentation of ≥30% reduction in blood phenylalanine levels from baseline; and
   a. Members younger than 2 years of age will be approved for a longer dosage titration per the package labeling up to the maximum daily dosage of 60mg/kg/day. After which time, the prescriber must verify that the member responded to treatment as defined by laboratory documentation of ≥30% reduction in blood phenylalanine levels from baseline; or
   b. If the member was initiated at 60mg/kg/day, then no additional approvals will be granted after a trial period of 2 weeks if the member did not respond to treatment as defined by laboratory documentation of ≥30% reduction in blood phenylalanine levels from baseline; and

8. Subsequent approvals will be for the duration of 1 year; and
9. Reauthorization requires the following:
    a. Documentation of active management with a phenylalanine restricted diet; and
    b. Verification from the prescriber of continued response to therapy (i.e., blood phenylalanine level, increase in dietary phenylalanine tolerance, improvement in clinical symptoms).

Recommendation 6: Vote to Prior Authorize Brinsupri™

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

Brinsupri™ (Brensocatib) Approval Criteria:

1. An FDA approved diagnosis of non-cystic fibrosis bronchiectasis (NCFB). Diagnosis must be confirmed by both of the following:
    a. Chest computed tomography (CT) scan; and
    b. Clinical history consistent with NCFB (e.g., cough, chronic sputum production, and/or recurrent respiratory infections); and
2. Member must be 12 years of age or older; and
3. Member must not have cystic fibrosis; and
4. Member must have a history of pulmonary exacerbation(s) (e.g., required treatment with antibiotics and/or required hospitalization or emergency room visit) in the last 12 months according to member's age:
    a. Members 18 years of age or older: ≥2 exacerbations; or
    b. Members 12-17 years of age: ≥1 exacerbation; and
5. Prescriber must verify that any underlying cause of NCFB is adequately treated, if applicable; and
6. Brinsupri™ must be prescribed by, or in consultation with, a pulmonary or infectious disease specialist (or an advanced care practitioner with a supervising physician who is a pulmonary or infectious disease specialist); and
7. Initial approvals will be for the duration of 6 months. For continued authorization, prescriber must verify member demonstrated a positive clinical response to Brinsupri™ as demonstrated by a decrease in NCFB symptoms and/or exacerbations. Subsequent approvals will be for 1 year.

Recommendation 7: Vote to Prior Authorize Anzupgo®

The Drug Utilization Review Board recommends the prior authorization of Anzupgo® (Delgocitinib 2% Cream) with the following criteria:

Pharmacy Agenda Items

Anzupgo® (Delgocitinib 2% Cream) Approval Criteria:

1. An FDA approved diagnosis of moderate-to-severe chronic hand eczema (CHE) meeting 1 of the following:
   a. Hand eczema has persisted for >3 months; or
   b. Hand eczema has returned twice or more within the last 12 months; and
2. Member must be 18 years of age or older; and
3. Must be prescribed by, or in consultation with, a dermatologist, allergist, or immunologist (or an advanced care practitioner with a supervising physician who is a dermatologist, allergist, or immunologist); and
4. Prescriber must attest that the member has been counseled regarding standard non-medicated skin care, including but not limited to:
   a. Frequent use of emollients/moisturizers; and
   b. Washing hands in lukewarm (not hot) water; and
   c. Avoidance of known and relevant irritants and allergens where possible; and
5. Member must have documented trials within the last 6 months for a minimum of 2 weeks that resulted in failure with all of the following therapies (or have a contraindication or documented intolerance):
   a. 1 medium potency to very-high potency Tier-1 topical corticosteroid (TCS); and
   b. 1 topical calcineurin inhibitor (TCI) [e.g., Elidel® (pimecrolimus), Protopic® (tacrolimus)]; and
6. Concurrent use with other Janus kinase (JAK) inhibitors or potent immunosuppressants will not generally be approved; and
7. Member must be counseled to apply Anzupgo® only to the hands and wrists. Anzupgo® will not be approved for application to any other area; and
8. Initial approvals will be for the duration of 1 month. Reauthorization may be granted if the prescriber documents the member is responding well to treatment; and
9. A quantity limit of 60 grams per 30 days will apply.

Recommendation 8: Vote to Prior Authorize Rhapsido®

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

Rhapsido® (Remibrutinib) Approval Criteria:

1. An FDA approved diagnosis of chronic spontaneous urticaria (CSU); and
2. Member must be 18 years of age or older; and
3. Other forms of urticaria must be ruled out; and
4. Member must have an Urticaria Activity Score (UAS) ≥16; and

5. Rhapsido® must be prescribed by a dermatologist, allergist, or immunologist or the member must have been evaluated by a dermatologist, allergist, or immunologist within the last 12 months (or an advanced care practitioner with a supervising physician who is a dermatologist, allergist, or immunologist); and
6. Member must have a documented trial of (or have a contraindication or documented intolerance to) all of the following therapies:
    a. Second-generation antihistamine dosed at 4 times the maximum FDA dose within the last 3 months for at least 4 weeks (or less if symptoms are intolerable); and
    b. Xolair® (omalizumab) for at least 12 weeks at recommended dosing; and
7. Initial approvals will be for the duration of 3 months. Reauthorization may be granted for the duration of 1 year, if the prescriber documents the member is responding well to treatment (e.g., improvement in baseline UAS score, improvement in symptoms, reduction in exacerbations). Additionally, compliance will be evaluated for continued approval.

Recommendation 9: Vote to Prior Authorize Omlyclo®

The Drug Utilization Review Board recommends the prior authorization of Omlyclo® (Omalizumab-igec) with the following criteria:

Omlyclo® (Omalizumab-igec Injection) Approval Criteria [Asthma Diagnosis]:

1. Diagnosis of severe persistent asthma [as per Global Initiative for Asthma (GINA) guidelines]; and
2. Member must be between 6 and 75 years of age; and
3. Member must have a positive skin test to at least 1 perennial aeroallergen (positive perennial aeroallergens must be listed on the prior authorization request); and
4. Member must have a pretreatment serum IgE level between 30 and 1,300 IU/mL (depending on member age); and
5. Member's weight must be between 20kg and 150kg; and
6. Member must have failed a medium-to-high-dose ICS used compliantly within the last 3-6 consecutive months (for ICS/LABA combination products, the ICS component would meet criteria at an equivalent medium-to-high dose); and
7. Prescribed dose must be an FDA approved regimen per package labeling; and

8. For authorization in a health care facility, prescriber must verify the injection will be administered in a health care setting by a health care professional prepared to manage anaphylaxis; and
9. For authorization of the prefilled autoinjector or prefilled syringe for self-administration, prescriber must verify the following:
    a. Member has no prior history of anaphylaxis; and
    b. Member must have had at least 3 doses under the guidance of a health care provider with no hypersensitivity reactions; and
    c. Member has been trained by a health care professional on subcutaneous administration, monitoring for any allergic reactions, and storage, and
10. Must be prescribed by an allergist, pulmonologist, or pulmonary specialist or the member must have been evaluated by an allergist, pulmonologist, or pulmonary specialist within the last 12 months (or an advanced care practitioner with a supervising physician who is an allergist, pulmonologist, or pulmonary specialist); and
11. Member must have been in the emergency room (ER) or hospitalized, due to an asthma exacerbation, twice in the past 12 months (date of visits must be listed on the prior authorization request), or member must have been determined to be dependent on systemic corticosteroids to prevent serious exacerbations; and
12. A patient-specific, clinically significant reason why the member cannot use Xolair® (omalizumab) must be provided. Biosimilars and/or reference products are preferred based on the lowest net cost product(s) and may be moved to either preferred or non-preferred if the net cost changes in comparison to the reference product and/or other available biosimilar products; and
13. Initial approvals will be for the duration of 6 months. Reauthorization may be granted for the duration of 1 year if the prescriber documents the member is responding well to treatment. Additionally, compliance will be evaluated for continued approval.

Omlyclo® (Omalizumab-igec Injection) Approval Criteria [Chronic Spontaneous Urticaria (CSU) Diagnosis]:

1. An FDA approved diagnosis of ~~CIU~~ CSU; and
2. Member must be 12 years of age or older; and
3. Other forms of urticaria must be ruled out; and
4. Member must have an Urticaria Activity Score (UAS) ≥16; and
5. For authorization in a health care facility, prescriber must verify the injection will be administered in a health care setting by a health care professional prepared to manage anaphylaxis; and
6. For authorization of the prefilled autoinjector or prefilled syringe for self-administration, prescriber must verify the following:
    a. Member has no prior history of anaphylaxis; and

   b. Member must have had at least 3 doses under the guidance of a health care provider with no hypersensitivity reactions; and
   c. Member has been trained by a health care professional on subcutaneous administration, monitoring for any allergic reactions, and storage, and
7. Prescriber must be an allergist, immunologist, or dermatologist (or an advanced care practitioner with a supervising physician that is an allergist, immunologist, or dermatologist); and
8. A trial of a second-generation antihistamine dosed at 4 times the maximum FDA dose within the last 3 months for at least 4 weeks (or less if symptoms are intolerable); and
9. A patient-specific, clinically significant reason why the member cannot use Xolair® (omalizumab) must be provided. Biosimilars and/or reference products are preferred based on the lowest net cost product(s) and may be moved to either preferred or non-preferred if the net cost changes in comparison to the reference product and/or other available biosimilar products; and
10. Initial dosing will only be approved for 150mg every 4 weeks. If the member has inadequate results at this dose, then the dose may be increased to 300mg every 4 weeks; and
11. Initial approvals will be for the duration of 3 months. Reauthorization may be granted for the duration of 1 year if the prescriber documents the member is responding well to treatment (e.g., improvement in baseline UAS score, improvement in symptoms, reduction in exacerbations). Additionally, compliance will be evaluated for continued approval.

Omlyclo® (Omalizumab-igec Injection) Approval Criteria [Immunoglobulin E (IgE)-Mediated Food Allergy Diagnosis]:

1. An FDA approved diagnosis of IgE-mediated food allergy for the reduction of allergic reactions; and
2. Member must be 1 year of age or older; and
3. Member must have a diagnosis of peanut, milk, egg, wheat, cashew, hazelnut, or walnut allergy confirmed by a positive skin test, positive in vitro test for food-specific IgE, or positive clinician-supervised oral food challenge; and
4. Prescriber must confirm member will use the requested product with an allergen-avoidant diet; and
5. Member must have a pretreatment serum IgE level between 30 and 1,850 IU/mL; and
6. Member's weight must be between 10kg and 150kg; and
7. Member or family member must be trained in the use of an auto-injectable epinephrine device and have such a device available for immediate use at all times; and

8. Prescribed dose must be an FDA approved regimen per package labeling; and
9. For authorization in a health care facility, prescriber must verify the injection will be administered in a health care setting by a health care professional prepared to manage anaphylaxis; and
10. For authorization of the prefilled autoinjector or prefilled syringe for self-administration, prescriber must verify the following:
    a. Member has no prior history of anaphylaxis; and
    b. Member must have had at least 3 doses ⊕ under the guidance of a health care provider with no hypersensitivity reactions; and
    c. Member has been trained by a health care professional on subcutaneous administration, monitoring for any allergic reactions, and storage of; and
11. Must be prescribed by an allergist or immunologist or the member must have been evaluated by an allergist or immunologist within the last 12 months (or an advanced care practitioner with a supervising physician who is an allergist or immunologist); and
12. A patient-specific, clinically significant reason why the member cannot use Xolair® (omalizumab) must be provided. Biosimilars and/or reference products are preferred based on the lowest net cost product(s) and may be moved to either preferred or non-preferred if the net cost changes in comparison to the reference product and/or other available biosimilar products; and
13. Approvals will be for the duration of 1 year. Reauthorization may be granted if the prescriber documents the member is responding well to therapy. Additionally, compliance will be evaluated for continued approval.

Omlyclo® (Omalizumab-igec Injection) Approval Criteria [Nasal Polyps Diagnosis]:

1. An FDA approved indication for add-on maintenance treatment of nasal polyps in adult members with inadequate response to nasal corticosteroids; and
2. Member must be 18 years of age or older; and
3. Member must have a trial of intranasal corticosteroids for at minimum the past 4 weeks; and
4. Prescriber must verify member will continue to receive intranasal corticosteroid therapy, unless contraindicated; and
5. Member has symptoms of chronic rhinosinusitis (e.g., facial pain/ pressure, reduction or loss of smell, nasal blockade/obstruction/ congestion, nasal discharge) for 12 weeks or longer despite attempts at medical management; and
6. Member has evidence of nasal polyposis by direct examination, sinus CT scan, or endoscopy; and

7. Member must have a pretreatment serum IgE level between 30 and 1,500 IU/mL; and
8. Member's weight must be between 31kg and 150kg; and
9. Prescribed dose must be an FDA approved regimen per package labeling; and
10. For authorization in a health care facility, prescriber must verify the injection will be administered in a health care setting by a health care professional prepared to manage anaphylaxis; and
11. For authorization of the prefilled autoinjector or prefilled syringe for self-administration, prescriber must verify the following:
    a. Member has no prior history of anaphylaxis; and
    b. Member must have had at least 3 doses under the guidance of a health care provider with no hypersensitivity reactions; and
    c. Member has been trained by a health care professional on subcutaneous administration, monitoring for any allergic reactions, and storage; and
12. Must be prescribed by an otolaryngologist, allergist, immunologist, or pulmonologist or the member must have been evaluated by an otolaryngologist, allergist, immunologist, or pulmonologist within the last 12 months (or an advanced care practitioner with a supervising physician who is an otolaryngologist, allergist, immunologist, or pulmonologist); and
13. A patient-specific, clinically significant reason why the member cannot use Xolair® (omalizumab) must be provided. Biosimilars and/or reference products are preferred based on the lowest net cost product(s) and may be moved to either preferred or non-preferred if the net cost changes in comparison to the reference product and/or other available biosimilar products; and
14. Initial approvals will be for the duration of 6 months. Reauthorization may be granted for the duration of 1 year if the prescriber documents the member is responding well to treatment. Additionally, compliance will be evaluated for continued approval.

OKLAHOMA
Health Care Authority

STATE PLAN AMENDMENT RATE COMMITTEE

BEHAVIORAL HEALTH TRANSPORTATION RATES

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?**
   ODMHSAS seeks to increase rates for secure behavioral health transports for members alleged to be in a behavioral health crisis, requiring transportation to a treatment facility for the purpose of examination, emergency detention, protective custody, or inpatient services.

   Based on a review of operational expenses between FY2022 and FY2025, costs related to vehicle maintenance, repairs, insurance, and workers' compensation have increased by more than 500%. While not all expenses scale directly with mileage, a significant portion of the cost burden does.

   To maintain service capacity and ensure operational sustainability, ODMHSAS worked with the transportation providers to develop a rate which the State could afford and would allow the providers to continue doing business. The rate adjustment from $2.85 to $4.80 (procedure code S0215) per mile represents a 68% increase, which reflects only a portion of the actual cost escalation. This adjustment balances fiscal responsibility with the documented increases in insurance premiums, repair costs, and vehicle replacement needs.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   Transports over 30 miles are currently reimbursed at $160.00 per encounter and $2.85 per mile.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   Transports over 30 miles will be reimbursed $160.00 per encounter and $4.80 per mile.

6. **BUDGET ESTIMATE.**
   The estimated budget impact for SFY 2026 will be an increase in the total amount of $379,372; with $127,203 in state share.

The estimated budget impact for SFY 2027 will be an increase in the total amount of $650,352; with $221,055 in state share.
ODMHSAS 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 ODMHSAS has determined that this change will have a positive impact in that the rate implementation supports the secure behavioral health transportation network.

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
ODMHSAS requests SPARC to approve the proposed rates for secure behavioral health transportation.

9. **EFFECTIVE DATE OF CHANGE.**
December 1, 2025, upon approval by CMS

January 21, 2026 Board
Proposed Rule Amendment Summaries

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

The Agency is requesting the effective date to be September 1, 2026 for all **PERMANENT** rules, contingent upon receiving legislature and gubernatorial approval.

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

APA WF #25-04A&B: Hospice for HCBS — The proposed policy revisions remove hospice services from the 1915(c) Home and Community-Based Services (HCBS) waivers, including the ADvantage and Medically Fragile waivers, as well as the Money Follows the Person demonstration. Hospice services will instead be provided under the State Plan. The revisions also update hospice certification requirements to align with federal standards, requiring statements from both the member's attending physician and the hospice provider's physician. Additional revisions clarify the length of the hospice benefit election.

Budget Impact: Budget neutral.

APA WF #25-07: Health Information Exchange (HIE) Cleanup — The proposed policy revisions align OHCA policy with current state law regarding the Health Information Exchange (HIE). The amendments clarify that participation in the HIE is voluntary, rather than mandatory. The HIE already operates under this voluntary structure, so no programmatic changes are anticipated.

Budget Impact: Budget neutral.

APA WF #25-11: Dental Policy Revisions — The proposed policy changes update dental imaging requirements to reflect the current standard of care and ensure appropriate billing for complex extractions. Current OHCA policy defines a "full mouth series" as two bitewings and panoramic images. The revision clarifies that a compensable full mouth series consists of at least 10 periapical images and at least 2 posterior bitewings, consistent with current dental practice. The changes also establish a prior authorization requirement for complex extractions (CDT codes D7210 and D7250) when more than two are performed on the same date of service by a provider other than an oral surgeon. Complex extractions performed by an oral surgeon are covered without prior authorization. There are no changes to policy or billing expectations for simple extractions (CDT code D7140).

Budget Impact: Budget neutral.

APA WF #25-10: Residential Behavioral Management Services — The proposed policy revisions, submitted on behalf of the Oklahoma Department of Human Services (OKDHS), update requirements for Qualified Residential Treatment Programs (QRTPs) under the Residential Behavioral Management Services (RBMS) policy. Revisions clarify existing QRTP nursing requirements. Additional changes will add policy language establishing expectations for weekly family therapy and timeframes for updates to the Individual Plan of Care, and implementing a Clinical Quality Review process to support consistent program oversight and service quality.

Budget Impact: Budget neutral.

APA WF #25-13: Secure Behavioral Health Transportation — The proposed rule revisions clarify eligibility and reimbursement policy for the Secure Behavioral Health Transportation program. The modifications include clearer language regarding services for which the transportation is covered, facilities to which a member may be transported, a requirement that the member meet criteria for emergency detention prior to transport, and coverage for court-ordered transportation for the purpose of evaluation and/or treatment. Modifications also include clarification that reimbursement is for loaded mileage.

Budget Impact: Budget neutral.

APA WF #25-17: Outpatient Behavioral Health Agency Services — The proposed rule revisions clarify practitioner qualifications for Onsite and Mobile Crisis Intervention Services. The revisions further define Facility Based Crisis Stabilization as a service and clarify qualifications for its practitioners. Finally, the revisions define coverage for Urgent Recovery Clinics.

Budget Impact: Budget neutral.

APA WF #25-18: Inpatient Psychiatric Accrediting Bodies — The proposed policy revisions expand recognition of facility accreditation to include all accreditation bodies approved by the Centers for Medicare & Medicaid Services (CMS). Facilities accredited by any CMS-approved organization will be eligible to contract with the Oklahoma Health Care Authority (OHCA). The revisions also include minor updates to reflect the new name of a related Behavioral Health service rule.

Budget Impact: Budget Neutral.

APA WF #25-21 Pharmacists' Policy Revisions — The proposed changes make minor administrative revisions to pharmacists' services policy. The proposed revisions remove citations of specific state law and Board of Pharmacy administrative rules. Future changes to pharmacists' scope of practice may not be reflected in the specific statute or administrative rules cited in current OHCA rules. The proposed changes will ensure that OHCA policy aligns with any statutory or regulatory changes to pharmacists' scope of practice in the future. There is no impact on current coverage of pharmacists' services.

Budget Impact: Budget Neutral.

APA WF #25-22: Elective Sterilization Clarification — The proposed policy revisions remove the requirement for a signed sterilization consent form in non-elective situations to prevent delays in medically necessary care. The requirement for a signed consent form, along with the associated 30-day waiting period, will remain in place for elective sterilization procedures. These revisions ensure timely access to urgent or emergent sterilization services while maintaining federal consent standards for elective procedures.

Budget Impact: Budget neutral.

APA WF #25-19: Medically Fragile Change of Agency — The proposed policy revisions reflect a change in operating agency for Medically Fragile Programs from OHCA to OKDHS as well as minor technical corrections to language.

Budget Impact: Budget neutral.

APA WF #25-23: Sports Physical Clarification — This policy revision seeks to add language specifying that sports physicals that occur during an Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) visit can occur but are not billable as a stand-alone service. Revisions also include clarifying language that sports physicals do not meet EPSDT screening requirements and cannot be reimbursed when performed as the only service of the day.

Budget Impact: Budget neutral.

APA WF #25-24 PACE Two-Way Agreement — The proposed policy changes establish a new contract for Programs of All-Inclusive Care for the Elderly (PACE) organizations. PACE organizations are required by federal regulation to enter into a three-way agreement with both OHCA and CMS. OHCA has limited enforcement capabilities under the three-way agreement. The proposed revisions will require PACE organizations to enter into a two-way agreement with OHCA only, in addition to the existing three-way agreement. The two-way agreement will create new guardrails around PACE and allow OHCA to better enforce federal and state regulations and contractual obligations.

Budget Impact: Budget neutral.

APA WF #25-25: Opioid Overdose Reversal Agent — The proposed revisions update coverage language to allow for new opioid overdose reversal agents as they become available on the market. Current policy specifies coverage for Naloxone by name, which was appropriate when it was the only available option. As additional opioid overdose reversal agents are now available, the revised language broadens coverage to include other clinically appropriate agents, ensuring timely access and alignment with evolving federal and clinical standards.

Budget Impact: Budget neutral.

APA WF #25-26: Lactation Consultant Revisions — The proposed policy changes amend the licensing requirements for lactation consultants. Current OHCA policy requires that lactation consultants be both an International Board Certified Lactation Consultant (IBCLC) and a registered nurse or registered dietician. The proposed revisions remove the requirement that lactation consultants be a registered nurse or registered dietician as a condition of coverage. Providers will only be required to be an IBCLC to contract with OHCA and be reimbursed for lactation consultant services. The proposed changes will also allow lactation consultant services to be provided via telehealth when appropriate. Such services will be subject to existing telehealth limitations. Lactation consultant services must be recommended by a physician or other licensed provider, such as a physician assistant, advanced practice registered nurse, certified nurse midwife, or licensed midwife. There is no change to reimbursement rates for lactation consultants.

Budget Impact: Budget neutral.

APA WF #25-27: Determination of Qualifying Categorical Relationships — The proposed rule revisions shift responsibility for determining Medicaid eligibility for TANF recipients from OKDHS to OHCA. Federal regulations no longer provide for receipt of TANF

to be an automatic eligibility trigger, instead requiring TANF recipients to have their income assessed under Modified Adjusted Gross Income (MAGI) rules. Eligibility groups for whom OKDHS determines eligibility (aged, blind, disabled, custody) are not income-based, while OHCA determines eligibility for income-based groups. Enrollment systems have already been updated in compliance with federal regulations.

Budget Impact: Budget neutral.

APA WF #25-28A&B: Developmental Disabilities Services Revisions — This policy revision seeks update Developmental Disabilities Services (DDS) policy related to skilled nursing, assistive technology, transportation, employment, and self-directed service provisions. Minor updates clarify that Oklahoma Human Services DDS registered nurses may be involved in waiver skilled nursing services. Additional revisions add a new section on assistive and enabling technology, increase annual transportation limits, and clarify service definitions and rate structures for employment and self-directed services. Overall updates improve alignment with current practice, strengthen consistency across DDS program rules, and expand flexibility for members receiving Home and Community Based Services (HCBS) waivers.

Budget Impact: Budget neutral.

Chapter 150: Employees Group Insurance Division — This rulemaking action amends rules related to the administrative operations of the Employees Group Insurance Division (EGID). House Bill 1187 of the 2025 legislative session modified the opt-out provision to remove a reference to group insurance, and these proposed rule changes remove that reference. Additional amended language clarifies audit requirements for providers to furnish requested information and documentation to EGID or its designated vendor.

Budget Impact: Budget neutral

The following **PERMANENT** rules were previously adopted by the Board under **EMERGENCY** rulemaking

APA WF #25-01: Functional Family Therapy — The Oklahoma Health Care Authority (OHCA), in collaboration with Oklahoma Juvenile Affairs (OJA) and Oklahoma Human Services (OHS), is proposing policy revisions to add coverage for Functional Family Therapy (FFT). FFT is a short-term, evidence-based therapeutic intervention designed to improve family functioning and address behavioral issues in adolescents who are at risk of or engaged in delinquent behavior, substance abuse, or other challenges. The therapy is rooted in a systemic approach, focusing on relationships within the family rather than treating the individual in isolation. The proposed policy defines eligible populations, eligible providers, referral requirements, service limitations and exclusions. Additional revisions clarify acceptable accrediting bodies for outpatient behavioral health agencies.

Budget impact: The estimated total cost SFY 2027 is $2,685,578; with $916,856 in state share. The estimated total cost for SFY 2028 is $3,222,694; with $1,100,228 in state share.

(For SFY 2027, Office of Juvenile Affairs will be responsible for 853,500 in state share and Oklahoma Human Services will be responsible for $185,577 in state share. For SFY 2028,

Office of Juvenile Affairs will be responsible for $1,024,200 in state share and Oklahoma Human Services will be responsible for $76,028 in state share)

APA WF #25-02A&B: ADvantage Waiver Revisions — The proposed revisions align the ADvantage Waiver policy with the waiver amendments approved on October 16, 2024, with a retroactive effective date of October 1, 2023. Key changes include lowering the minimum age for program eligibility from twenty-one (21) to nineteen (19) years, clarifying procedures for obtaining member or representative signatures for home-delivered meals, and removing redundant expanded criteria language now addressed under the Level of Care medical eligibility determination section. Additional revisions reformat policy for clarity, remove outdated language, improve consistency in describing ADvantage program capacity, and make adjustments to services for consistency across policy.

Budget Impact: Budget neutral

APA WF #25-03: SoonerSelect Auto-Assignment — The proposed changes clarify that members receiving only family planning services through SoonerPlan are excluded from enrollment in the SoonerSelect program. Additionally, the choice period for SoonerSelect enrollees will be changed from 60 days to 30 days. The choice period is the timeframe during which a SoonerSelect enrollee may select a plan. If a selection is not made during this timeframe, the enrollee will be automatically assigned to one of the contracted entities

Budget Impact: Budget neutral.

APA WF #25-05: Ancillary Services — The proposed policy changes revise the Nursing Facility policy to align agency rules with the Title XIX State Plan durable medical equipment (DME) reimbursement guidelines for nursing facilities, which stipulate that DME is included as part of the nursing facility rate methodology, and is not billed separately.

Budget Impact: Budget neutral

APA WF #25-06: Rapid Whole Genome Sequencing — The proposed policy changes establish coverage and reimbursement for rapid whole genome sequencing (rWGS) in accordance with House Bill 1576 (2025). Coverage applies to members under age 21 who have an unknown complex or acute illness and are receiving intensive care unit hospital services. The testing may help identify genetic changes and determine the member's condition. When medically necessary, coverage on behalf of the child will include comparator testing of one or both parents. At this time, prior authorization will be required. Rapid whole genome sequencing will be excluded from the Per Discharge Prospective Rate for hospitals and reimbursed separately under the Ambulatory Payment Classification fee schedule. Reimbursement for testing provided in an I/T/U facility will be included in the Inpatient Hospital Per Diem Rate.

Budget Impact: The estimated total cost for SFY2027 and SFY2028 is $2,600,000 with $867,880 in state share.

APA WF #25-08 Birthing Centers and Licensed Midwives — The proposed policy changes establish coverage and reimbursement methodologies for birthing centers and licensed midwives. They allow coverage of birthing center and licensed midwives' services for normal, uncomplicated, low-risk births. Birthing centers must be accredited by the Commission for the Accreditation of Birth Centers (CABC). Licensed midwives must be

Certified Midwives or Certified Professional Midwives and be licensed by the Oklahoma State Department of Health (OSDH) to provide midwifery services. Birthing centers will be reimbursed a facility charge determined by the Ambulatory Payment Classification (APC) fee schedule. Licensed midwives will be reimbursed 80% of the physician fee scheduled for services within their scope of practice as defined by state law.

Budget Impact: Budget neutral.

APA WF #25-09 RHC and FQHC Policy Revisions — The proposed policy changes revise the definition of Rural Health Center (RHC) and Federally Qualified Health Center (FQHC) core services. Marriage and Family Therapist (MFT) services and Mental Health Counselors (MHC) services will be added to the definition of RHC/FQHC core services. The following provider types meet the definition of an MHC: Licensed Professional Counselor (LPC), Licensed Behavioral Health Provider (LBHP), and providers with a Licensed Drug and Alcohol Counselor/Mental Health (LADC-MH) credential. The policy changes also include clarification that certain medical services provided by an optometrist, podiatrist, or chiropractor in an RHC or FQHC can be reimbursed the encounter rate.

Budget Impact: The estimated total cost for SFY2027 and SFY2028 is $3,222,639 with $1,080,551 in state share.

APA WF #25-12: Four Walls Clinic Services — The proposed policy revisions implement the mandatory “four walls” exception for Clinic Services when provided by Indian Health Service (IHS) clinics and Tribal clinics, as required by the 2024 Outpatient Prospective Payment System final rule. Off-site services furnished by an IHS or Tribal clinic, outside of the “four walls” of the clinic, had previously been covered under a temporary exemption to the 42 CFR 440.90 Clinic Services location requirements. The 2024 OPPS final rule codified this exemption.

Budget Impact: Budget neutral.

APA WF #25-14: Paid Family Caregiver Program — The Oklahoma Health Care Authority proposes policy revisions to implement the Paid Family Caregiver (PFC) program, as authorized by Senate Bill 56 and codified at 63 O.S. § 5013.2. This new program is intended for children approved for Private Duty Nursing (PDN) who require care beyond personal care services, but which can be safely provided by a trained family caregiver. The caregiver must meet OHCA-established criteria and be employed and trained by a PDN agency. Additional revisions clarify PDN policy, streamline the prior authorization process for both PDN and PFC services and require service documentation at treatment plan recertification.

Budget Impact: Budget neutral

APA WF #25-15: 340B Drug Discount Program — These rule revisions seek to remove certain high-cost drugs and therapies from the 340B Drug Pricing Program. The 340B program is a federal initiative that allows health care organizations to purchase certain drugs directly from pharmaceutical manufacturers at a discount. The revision creates a 340B Carve Out Drug list, consisting of cell and gene therapies, drugs currently under a value-based agreement, or Brand Preferred Drugs where the cost to the Medicaid program is $500,000 or higher, annually. Drugs on this list would be prohibited from being dispensed or administered to Oklahoma Medicaid Members if purchased at 340B prices.

Budget Impact: Budget neutral.

The following **EMERGENCY** and **PERMANENT** rules were not previously adopted and are new to the Board. The Agency is requesting emergency rules be effective upon the Governor's signature, with concurrent adoption of permanent rules.

APA WF #26-01: Removal of Physician Limit Caps — The Oklahoma Health Care Authority proposes revising policy to eliminate existing limits on physician visits for adults, allowing members to receive medically necessary services. This change is intended to improve access to primary and preventive care and ensure members can receive timely outpatient treatment. In addition, the rule includes non-substantive clean-up language.

Budget Impact: The estimated total cost for SFY 2026 is $763,761; with $170,752 in state share. The estimated total cost for SFY 2027 is $1,833,024; with $409,803 in state share.

Emergency Justification: This rule is necessary as an emergency measure to protect public health and safety.

APA WF #26-02: Telehealth Originating Site Reimbursement — The proposed revision adds a facility fee for originating sites when a member receives services via telehealth. The fee is payable to the physical site hosting the member, separate from the distant-site provider's professional claim. Eligible sites include hospitals, outpatient departments, physician and practitioner offices, RHCs, FQHCs, I/T/U clinics, and public health clinics. The fee is only allowed when the site provides staff or facility resources to support the encounter. It is not reimbursable when the member is at home or when no resources are used. Equipment and transmission costs remain non-covered.

Budget Impact: The estimated total cost for SFY 2026 is $1,390,222; with $393,940 in state share. The estimated total cost for SFY 2027 is $3,336,531; with $945,457 in state share.

Emergency Justification: This rule is necessary as an emergency measure to protect public health and safety.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPEICALTIES

PART 58. HOSPICE

317:30-5-531. Coverage

(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 members.(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~~and 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.

~~(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 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.

(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.

(4) The election of benefits stays in effect as long as the participant remains in hospice, does not revoke the election, and is not discharged from hospice for other reasons. Reasons for discharge may include: the participant is no longer considered terminally ill, the participant transfers to another hospice, the participant moves out of the hospice service area, or the participant is not receiving the required or expected care from the hospice provider.

(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 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 (180th) 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 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.

PART. 85 ADVANTAGE PROGRAM WAIVER SERVICES

317:30-5-763. Description of services

Services included in the ADvantage program are:

(1) **Case management.**

(A) Case management services, regardless of payment source, assist a member to gain access to medical, social, educational, or other services that may benefit him or her to maintain health and safety. Case managers:

(i) Initiate and oversee necessary assessments and reassessments to establish or reestablish waiver program eligibility;

(ii) Develop the member's comprehensive person-centered service plan, listing only the services necessary to prevent institutionalization of the member, as determined through the assessments;

(iii) Initiate the addition of necessary services or deletion of unnecessary services, as dictated by the member's condition and available support; and

(iv) Monitor the member's condition to ensure delivery and appropriateness of services and initiate person-centered service plan reviews. Case managers submit an individualized Services Backup Plan, on all initial service plans, annually at reassessment, and on updates as appropriate throughout the year, reflecting risk factors and measures in place to minimize risks. When a member requires hospital or nursing facility (NF) services, the case manager:

(I) Assists the member in accessing institutional care and, as appropriate, periodically monitors the member's progress during the institutional stay;

(II) Helps the member transition from institution to home by updating the person-centered service plan;

(III) Prepares services to start on the date the member is discharged from the institution; and

(IV) Must meet ADvantage program minimum requirements for qualification and training prior to providing services to ADvantage members.

(B) Providers of ADvantage services for the member or for those who have an interest in or are employed by an ADvantage provider for the member must not provide case management or develop the person-centered service plan, except when the ADvantage Administration (AA) demonstrates the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area, also provides other ADvantage services. Prior to providing services to members receiving Consumer Directed Personal Assistance Services and Supports (CD-PASS), case manager supervisors, and case managers are required to receive training and demonstrate knowledge regarding the CD-PASS service delivery model, "Independent Living Philosophy," and demonstrate competency in person-centered planning.

(C) Providers may only claim time for billable case management activities, described as:

(i) Any task or function, per Oklahoma Administrative Code (OAC) 317:30-5-763(1)(A) that only an ADvantage case manager, because of skill, training, or authority can perform on behalf of a member; and

(ii) Ancillary activities, such as clerical tasks, including, but not limited to, mailing, copying, filing, faxing, driving time, or supervisory and administrative activities are not billable case management activities. The administrative cost of these activities and other normal and customary business overhead costs are included in the reimbursement rate for billable activities.

(D) Case management services are prior authorized and billed per fifteen (15) minute unit of service using the rate associated with the location of residence of the member served.

(i) Case management services are billed using a standard rate for reimbursement for billable service activities provided to a member who resides in a county with a population density greater than twenty-five (25) persons per square mile.

(ii) Case management services are billed using a very rural/outside providers' service area rate for billable service activities provided to a member who resides in a county with a population density equal to, or less than twenty-five (25) persons per square mile. Exceptions are services to members who reside in Oklahoma Human Services (OKDHS) Community Living, Aging and Protective Services identified zip codes in Osage County adjacent to the metropolitan areas of Tulsa and Washington counties. Services to these members are prior authorized and billed using the standard rate.

(iii) The latest United States Census, Oklahoma counties population data is the source for determination of whether a member resides in a county with a population density equal to, or less than twenty-five (25) persons per square mile or resides in a county with a population density greater than twenty-five (25) persons per square mile.

(2) **Respite.**

(A) Respite services are provided to members who are unable to care for themselves. Services are provided on a short-term basis due to the primary caregiver's absence or need for relief. Payment for respite care does not include room and board costs unless more than seven (7) hours are provided in a NF. Respite care is only utilized when other sources of care and support are exhausted. Respite care is only listed on the service plan when it is necessary to prevent institutionalization of the member. Units of services are limited to the number of units approved on the service plan.

(B) In-home respite services are billed per fifteen (15) minute unit of service. Within any one (1) day period, a minimum of eight (8) units [two (2) hours] must be provided with a maximum of twenty-eight (28) units [seven (7) hours] provided. The service is provided in the member's home.

(C) Facility-based extended respite is filed for a per diem rate when provided in a NF. Extended respite must be at least eight (8) hours in duration.

(D) In-home extended respite is filed for a per diem rate. A minimum of eight (8) hours must be provided in the member's home.

(3) **Adult day health (ADH) care.**

(A) ADH is furnished on a regularly scheduled basis for one (1) or more days per week in an outpatient setting. It provides both health and social services necessary to ensure the member's optimal functioning. Most assistance with activities of daily living (ADLs), such as eating, mobility, toileting, and nail care are integral to the ADH care service and are covered by the ADH care basic reimbursement rate.

(B) ADH care is a fifteen (15) minute unit of service. No more than eight (8) hours, [thirty-two (32) units] are authorized per day. The number of units of service a member

may receive is limited to the number of units approved on the member's approved service plan.
(C) Physical, occupational, and speech therapies are only provided as an enhancement to the basic ADH care service when authorized by the service plan and are billed as a separate procedure. ADH care therapy enhancement is a maximum of one (1) session unit per day of service.
(D) Meals provided as part of this service do not constitute a full nutritional regimen. One (1) meal, that contains at least one-third (1/3) of the current daily dietary recommended intake (DRI), as established by the Food and Nutrition Board of the National Academies of Sciences, Engineering, and Medicine, is provided to those participants who are in the center for four (4) or more hours per day and does not constitute a full nutritional regimen. Member's access to food at any time must also be available in addition to the required meal and is consistent with an individual not receiving Medicaid-funded services and supports.
(E) Personal care service enhancement in ADH is assistance in bathing, hair care, or laundry service, authorized by the person-centered service plan and billed as separate procedures. This service is authorized when an ADvantage waiver member who uses ADH requires assistance with bathing, hair care, or laundry to maintain health and safety. Assistance with bathing, hair care, or laundry is not a usual and customary ADH care service. ADH personal care enhancement is a maximum of one (1) unit per day of bathing, hair care, or laundry service.
(F) OKDHS Home and Community-Based Services (HCBS) waiver settings have qualities defined in Home and Community-Based Services: Waiver Requirements, 42 Code of Federal Regulations, Section (§) 441.301 (c)(4) based on the individual's needs, defined in the member's authorized service plan.

(i) The ADH center is integrated and supports full access of ADvantage members to the greater community, including opportunities to:

(I) Seek employment and work in competitive integrated ADH Center, not a requirement for persons that are retirement age;

(II) Engage in community life;

(III) Control personal resources; and

(IV) Receive services in the community, to the same degree as individuals not receiving ADvantage Program or other Medicaid HBCS waiver services.

(ii) The ADH is selected by the member from all available service options and given the opportunity to visit and understand the options.

(iii) The ADH ensures the member's rights of privacy, dignity, respect, and freedom from coercion and restraint.

(iv) The ADH optimizes the member's initiative, autonomy, and independence in making life choices including, but not limited to:

(I) Daily activities;

(II) The physical environment; and

(III) Social interactions.

(v) The ADH facilitates the member's choice regarding services and supports including the provider.

(vi) Each member has the freedom and support to control his or her own schedules, activities, and access to food at any time.

(vii) Each member may have visitors whenever he or she chooses.

(viii) The ADH center is physically accessible to the member.

(G) ADH centers that are presumed not to be HCBS settings per 42 C.F.R. § 441.301(c)(5)(v) include, ADH centers:

(i) In a publicly- or privately-owned facility providing inpatient treatment;

(ii) On the grounds of or adjacent to a public institution; and

(iii) With the effect of isolating individuals from the broader community of individuals not receiving ADvantage program or another Medicaid HCBS;

(H) When the ADH is presumed not HCBS, according to 42 C.F.R. § 441.301(c)(5)(v), it may be subject to heightened scrutiny by AA, the Oklahoma Health Care Authority (OHCA), and the Centers for Medicare and Medicaid Services (CMS). The ADH must provide evidence that the ADH portion of the facility has clear administrative, financial, programmatic, and environmental distinctions from the institution and comply with additional monitoring by the AA.

(4) **Environmental modifications**.

(A) Environmental modifications are physical adaptations to the home, required by the member's person-centered service plan that are necessary to ensure the member's health, welfare, and safety or enable the member to function with greater independence in the home, and that without such, the member would require institutionalization. Adaptations or improvements to the home not of direct medical or remedial benefit to the waiver member are excluded.

(B) All services require prior authorization.

(5) **Specialized medical equipment and supplies.**

(A) Specialized medical equipment and supplies are devices, controls, or appliances specified in the person-centered service plan that enable members to increase their abilities to perform ADLs, or to perceive, control, or communicate with the environment in which they live. Necessary items for life support, ancillary supplies, and equipment necessary for the proper functioning of such items, and durable and non-durable medical equipment not available under the Oklahoma Medicaid State Plan are also included. This service excludes any equipment or supply items not of direct medical or remedial benefit to the waiver member and necessary to prevent institutionalization.

(B) Specialized medical equipment and supplies are billed using the appropriate HealthCare Common Procedure Code (HCPC). Reoccurring supplies shipped and delivered to the member are compensable only when the member remains eligible for waiver services, continues to reside in the home, and is not institutionalized in a hospital, skilled nursing facility, or nursing home. It is the provider's responsibility to verify the member's status prior to shipping and delivering these items. Payment for medical supplies is limited to the SoonerCare (Medicaid) rate when established, to the Medicare rate, or to actual acquisition cost, plus thirty percent (30%). All services must have prior authorization.

(6) **Advanced supportive/restorative assistance**.

(A) Advanced supportive/restorative assistance services are maintenance services used to assist a member who has a chronic, yet stable condition. These services assist with ADLs that require devices and procedures related to altered body functions. These services are for maintenance only and are not utilized as treatment services.

(B) Advanced supportive/restorative assistance service is billed per fifteen (15) minute unit of service. The number of units of service a member may receive is limited to the number of units approved on the person-centered service plan.

(7) **Nursing.**

(A) Nursing services are services listed in the person-centered service plan that are within the scope of the state's Nurse Practice Act. These services are provided by a registered nurse (RN), a licensed practical nurse (LPN), or a licensed vocational nurse (LVN) under the supervision of an RN licensed to practice and in good standing in the state in which services are provided. Nursing services may be provided on an intermittent or part-time basis or may be comprised of continuous care. The provision of the nursing service works to prevent or postpone the institutionalization of the member.

(B) Nursing services are services of a maintenance or preventative nature provided to members with stable, chronic conditions. These services are not intended to treat an acute health condition and may not include services reimbursable under either the Medicaid or Medicare home health program. This service primarily provides nurse supervision to the personal care assistant or to the advanced supportive/restorative assistance aide and assesses the member's health and prescribed medical services to ensure they meet the member's needs as specified in the person-centered service plan. A nursing assessment/evaluation, on-site visit is made to each member, with additional visits for members with advanced supportive/restorative assistance services authorized to evaluate the condition of the member and medical appropriateness of services. An assessment/evaluation report is forwarded to the ADvantage program case manager and the skilled nurse in accordance with review schedule determined between the case manager and the skilled nurse and outlined in the member's person-centered service plan, to report the member's condition or other significant information concerning each ADvantage member.

(i) The ADvantage program case manager may recommend authorization of nursing services as part of the interdisciplinary team planning for the member's person-centered service plan and/or assessment/evaluation of the:

(I) Member's general health, functional ability, and needs; and/or

(II) Adequacy of personal care and/or advanced supportive/restorative assistance services to meet the member's needs, including providing on-the-job training and competency testing for personal care or advanced supportive/restorative care aides per rules and regulations for the delegation of nursing tasks established by the Board of Nursing in the state in which services are provided.

(ii) In addition to assessment/evaluation, the ADvantage program case manager may recommend authorization of nursing services to:

(I) Prepare a one (1) week supply of insulin syringes for a person who is blind and has diabetes and can safely self-inject the medication but cannot fill his or her own syringe. This service includes monitoring the member's continued ability to self-administer the insulin;

(II) Prepare oral medications in divided daily compartments for a member who self-administers prescribed medications but needs assistance and monitoring due to a minimal level of disorientation or confusion;

(III) Monitor a member's skin condition when a member is at risk for skin

breakdown due to immobility or incontinence or the member has a chronic stage II decubitus ulcer requiring maintenance care and monitoring;

(IV) Provide nail care for a member with diabetes or who has circulatory or neurological compromise; and

(V) Provide consultation and education to the member, member's family, or other informal caregivers identified in the person-centered service plan, regarding the nature of the member's chronic condition. Skills training, including return skills demonstration to establish competency, to the member, family, or other informal caregivers as specified in the person-centered service plan for preventive and rehabilitative care procedures are also provided.

(C) Nursing service includes interdisciplinary team planning and recommendations for the member's person-centered service plan development and/or assessment/evaluation or for other services within the scope of the nurse's license, including private duty nursing. Nursing services are billed per fifteen (15) minute unit of service. A specific procedure code is used to bill for interdisciplinary team planning and recommendations for the member's person-centered service plan, but other procedure codes may be used to bill for all other authorized nursing services. A maximum of eight (8) units [two (2) hours], per day of nursing for service plan development and assessment evaluation are allowed. An agreement by a provider to perform a nurse evaluation is also an agreement to provide the Medicaid in-home care services for which the provider is certified and contracted. Reimbursement for a nurse evaluation is denied when the provider that produced the nurse evaluation fails to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted.

(8) **Skilled nursing services.**

(A) Skilled nursing services are listed in the person-centered service plan, within the state's Nurse Practice Act scope, and are ordered by a licensed physician, osteopathic physician, physician assistant, or advanced practice nurse, and are provided by a RN, LPN, or LVN under the supervision of a RN, licensed to practice and in good standing in the state where services are provided. Skilled nursing services provided in the member's home or other community setting are services requiring the specialized skills of a licensed nurse. The scope and nature of these services are intended for treatment of a disease or a medical condition and are beyond the scope of ADvantage nursing services. These intermittent nursing services are targeted toward a prescribed treatment or procedure that must be performed at a specific time or other predictable rate of occurrence. The RN contacts the member's physician to obtain necessary information or orders pertaining to the member's care. When the member has an ongoing need for service activities requiring more or less units than authorized, the RN must recommend, in writing, that the service plan be revised.

(B) Skilled nursing services are provided on an intermittent or part-time basis, and billed per fifteen (15) minute unit of service. Skilled nursing services are provided when nursing services are not available through Medicare or other sources or when SoonerCare plan nursing services limits are exhausted. Amount, frequency, and duration of services are prior-authorized in accordance with the member's person-centered service plan.

(9) **Home-delivered meals.**

(A) Home-delivered meals provide one (1) meal per day. A home-delivered meal is a meal prepared in advance and brought to the member's home. Each meal must have a

nutritional content equal to at least one-third (1/3) of the dietary reference intakes as established by the Food and Nutrition Board of the National Academies of Sciences, Engineering and Medicine. Home-delivered meals are only provided to members who are unable to prepare meals and lack an informal provider to do meal preparation.

(B) Home-delivered meals are billed per meal, with one (1) meal equaling one (1) unit of service. The limit of the number of units a member is allowed to receive is in accordance with the member's person-centered service plan. The provider must obtain a signature from the member or the member's representative at the time the meal is delivered. In the event the member is temporarily unavailable, such as at a doctor's appointment and the meal is left at the member's home, the provider must document the reason a signature was not obtained. The signature logs must be available for review.

(10) **Occupational therapy services.**

(A) Occupational therapy services are services that increase functional independence by enhancing the development of adaptive skills and performance capacities of members with physical disabilities and related psychological and cognitive impairments. Services are provided in the member's home and are intended to help the member achieve greater independence, enabling him or her to reside and participate in the community. Treatment involves the therapeutic use of self-care, work, and play activities, and may include modification of the tasks or environment to enable the member to achieve maximum independence, prevent further disability, and maintain health. Under a physician's order, a licensed occupational therapist evaluates the member's rehabilitation potential and develops an appropriate written, therapeutic regimen. The regimen utilizes paraprofessional, occupational therapy assistant services, within the limitations of his or her practice, working under the supervision of a licensed occupational therapist. The regimen includes education and training for informal caregivers to assist with or maintain services when appropriate. The occupational therapist ensures monitoring and documentation of the member's rehabilitative progress and reports to the member's case manager and physician to coordinate the necessary addition or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Occupational therapy services are billed per fifteen (15) minute unit of service. Payment is not allowed solely for written reports or record documentation.

(11) **Physical therapy services.**

(A) Physical therapy services are those services that maintain or improve physical disability through the evaluation and rehabilitation of members disabled by pain, disease, or injury. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Treatment involves the use of physical therapeutic means, such as massage, manipulation, therapeutic exercise, cold and/or heat therapy, hydrotherapy, electrical stimulation, and light therapy. Under a physician's order, a licensed physical therapist evaluates the member's rehabilitation potential and develops an appropriate, written, therapeutic regimen. Under the Oklahoma Physical Therapy Practice Act, a physical therapist may evaluate a member's rehabilitation potential and develop and implement an appropriate, written, therapeutic regimen without a referral from a licensed health care practitioner for a period not to exceed thirty (30) calendar days. Any treatment required after the thirty (30) calendar day period requires a prescription from a physician or the physician's assistant of the licensee. The regimen utilizes paraprofessional physical therapy assistant

services, within the limitations of his or her practice, working under the licensed physical therapist's supervision. The regimen includes education and training for informal caregivers to assist with and/or maintain services when appropriate. The licensed physical therapist ensures monitoring and documentation of the member's rehabilitative progress and reports to the member's case manager and physician to coordinate the necessary addition or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Physical therapy services may be authorized as ADH care therapy enhancement and are a maximum of one (1) session unit per day of service. Payment is not allowed solely for written reports or record documentation.

(12) **Speech and language therapy services.**

(A) Speech and language therapy services are those that maintain or improve speech and language communication and swallowing disorders/disability through the evaluation and rehabilitation of members disabled by pain, disease, or injury. Services are provided in an ADH service setting and are intended to help the member achieve greater independence to reside and participate in the community. Services involve the use of therapeutic means, such as evaluation, specialized treatment, or development and oversight of a therapeutic maintenance program. Under a physician's order, a licensed speech and language pathologist evaluates the member's rehabilitation potential and develops an appropriate, written, therapeutic regimen. The regimen utilizes speech language pathology assistant services within the limitations of his or her practice, working under the supervision of the licensed speech and language pathologist. The regimen includes education and training for informal caregivers to assist with and/or maintain services when appropriate. The speech and language pathologist ensures monitoring and documentation of the member's rehabilitative progress and reports to the member's case manager and physician to coordinate the necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Speech and language therapy services are authorized as ADH care-therapy enhancement and are a maximum of one (1) session unit per day of service. Payment is not allowed solely for written reports or record documentation.

~~(13) **Hospice services.**~~

~~(A) Hospice services are palliative and comfort care provided to the member and his or her family when a physician certifies the member has a terminal illness, with a life expectancy of six (6) months or less, and orders hospice care. ADvantage hospice care is authorized for a six (6) month period and requires physician certification of a terminal illness and orders of hospice care. When the member requires more than six (6) months of hospice care, a physician or nurse practitioner must have a face-to-face visit with the member thirty (30) calendar days prior to the initial hospice authorization end-date, and re-certify that the member has a terminal illness, has six (6) months or less to live, and orders additional hospice care. After the initial authorization period, additional periods of ADvantage hospice may be authorized for a maximum of sixty (60) calendar day increments with physician certification that the member has a terminal illness and six (6) months or less to live. A member's person-centered service plan that includes hospice care must comply with Waiver requirements to be within total person-centered service plan cost limits.~~

~~(B) A hospice program offers palliative and supportive care to meet the special needs~~

~~arising out of the physical, emotional, and spiritual stresses experienced during the final stages of illness, through the end of life, and bereavement. The member signs a statement choosing hospice care instead of routine medical care with the objective to treat and cure the member's illness. Once the member has elected hospice care, the hospice medical team assumes responsibility for the member's medical care for the illness in the home environment. Hospice care services include nursing care, physician services, medical equipment and supplies, drugs for symptom and pain relief, home health aide and personal care services, physical, occupational and speech therapies, medical social services, dietary counseling, and grief and bereavement counseling to the member and/or the member's family.~~

~~(C) A hospice person-centered service plan must be developed by the hospice team in conjunction with the member's ADvantage case manager before hospice services are provided. The hospice services must be related to the palliation or management of the member's terminal illness, symptom control, or to enable the member to maintain ADL and basic functional skills. A member who is eligible for Medicare hospice provided as a Medicare Part A benefit, is not eligible to receive ADvantage hospice services.~~

~~(D) Hospice services are billed per diem of service for days covered by a hospice person-centered service plan and while the hospice provider is responsible for providing hospice services as needed by the member or member's family. The maximum total annual reimbursement for a member's hospice care within a twelve (12) month period is limited to an amount equivalent to eighty-five percent (85%) of the Medicare hospice cap payment, and must be authorized on the member's person-centered service plan.~~

~~(14)~~(13) **ADvantage personal care.**

(A) ADvantage personal care is assistance to a member in carrying out ADLs, such as bathing, grooming, and toileting or in carrying out instrumental activities of daily living (IADLs), such as preparing meals and laundry service, to ensure the member's personal health and safety, or to prevent or minimize physical health regression or deterioration. Personal care services do not include service provision of a technical nature, such as tracheal suctioning, bladder catheterization, colostomy irrigation, or the operation and maintenance of equipment of a technical nature.

(B) ADvantage home care agency skilled nursing staff working in coordination with an ADvantage case manager is responsible for the development and monitoring of the member's personal care services.

(C) ADvantage personal care services are prior-authorized and billed per fifteen (15) minute unit of service, with units of service limited to the number of units on the ADvantage approved person-centered service plan.

~~(15)~~(14) **Personal emergency response system (PERS).**

(A) PERS is an electronic device that enables members at high risk of institutionalization, to secure help in an emergency. Members may also wear a portable "help" button to allow for mobility. PERS is connected to the person's phone and programmed to signal, per member preference, a friend, relative, or a response center, once the "help" button is activated. For an ADvantage member to be eligible for PERS service, the member must meet all service criteria in (i) through (vi). The member:

(i) Has a recent history of falls as a result of an existing medical condition that prevents the member from getting up unassisted from a fall;

(ii) Lives alone and without a regular caregiver, paid or unpaid, and therefore is left

alone for long periods of time;

(iii) Demonstrates the capability to comprehend the purpose of and activate the PERS;

(iv) Has a health and safety plan detailing the interventions beyond the PERS to ensure the member's health and safety in his or her home;

(v) Has a disease management plan to implement medical and health interventions that reduce the possibility of falls by managing the member's underlying medical condition causing the falls; and

(vi) Will likely avoid premature or unnecessary institutionalization as a result of PERS.

(B) PERS services are billed using the appropriate HCPC procedure code for installation, monthly service, or PERS purchase. All services are prior authorized per the ADvantage approved service plan.

~~(16)~~(15) **CD-PASS.**

(A) CD-PASS are personal services assistance (PSA) and advanced personal services assistance (APSA) that enables a member in need of assistance to reside in his or her home and community of choice, rather than in an institution; and to carry out functions of daily living, self-care, and mobility. CD-PASS services are delivered as authorized on the person-centered service plan. The member becomes the employer of record and employs the PSA and the APSA. The member is responsible, with assistance from ADvantage program administrative Financial Management Services (FMS), for ensuring the employment complies with state and federal labor law requirements. The member/employer may designate an adult family member or friend, who is not a PSA or APSA to the member, as an "authorized representative" to assist in executing the employer functions. The member/employer:

(i) Recruits, hires, and, as necessary, discharges the PSA or APSA;

(ii) Ensures the PSA or APSA has received sufficient instruction and training. If needed, the member/employer will work with the consumer-directed agent/case manager (CDA) to obtain training assistance from ADvantage skilled nurses. Prior to performing an APSA task for the first time, the APSA must demonstrate competency in the tasks in an on-the-job training session conducted by the member, and the member must document the attendant's competency in performing each task in the APSA's personnel file;

(iii) Determines where and how the PSA or APSA works, hours of work, what is to be accomplished and, within individual budget allocation limits, wages to be paid for the work;

(iv) Supervises and documents employee work time; and

(v) Provides tools and materials for work to be accomplished.

(B) The services the PSA may provide include:

(i) Assistance with mobility and transferring in and out of bed, wheelchair, or motor vehicle, or all;

(ii) Assistance with routine bodily functions, such as:

(I) Bathing and personal hygiene;

(II) Dressing and grooming; and

(III) Eating, including meal preparation and cleanup;

(iii) Assistance with home services, such as shopping, laundry, cleaning, and seasonal chores;

(iv) Companion assistance, such as letter writing, reading mail, and providing escort or transportation to participate in approved activities or events. "Approved activities or events," means community, civic participation guaranteed to all citizens including, but not limited to, exercise of religion, voting or participation in daily life activities in which exercise of choice and decision making is important to the member, and may include shopping for food, clothing, or other necessities, or for participation in other activities or events specifically approved on the person-centered service plan.

(C) An APSA provides assistance with ADLs to a member with a stable, chronic condition, when such assistance requires devices and procedures related to altered body function if such activities, in the opinion of the attending physician or licensed nurse, may be performed if the member were physically capable, and the procedure may be safely performed in the home. Services provided by the APSA are maintenance services and are never used as therapeutic treatment. Members who develop medical complications requiring skilled nursing services while receiving APSA services are referred to his or her attending physician, who may order home health services, as appropriate. APSA includes assistance with health maintenance activities that may include:

(i) Routine personal care for persons with ostomies, including tracheotomies, gastrostomies, and colostomies with well-healed stoma, external, indwelling, and suprapubic catheters that include changing bags and soap and water hygiene around the ostomy or catheter site;

(ii) Removing external catheters, inspecting skin, and reapplication of same;

(iii) Administering prescribed bowel program, including use of suppositories and sphincter stimulation, and enemas pre-packaged only without contraindicating rectal or intestinal conditions;

(iv) Applying medicated prescription lotions or ointments and dry, non-sterile dressings to unbroken skin;

(v) Using a lift for transfers;

(vi) Manually assisting with oral medications;

(vii) Providing passive range of motion (non-resistive flexion of joint) therapy, delivered in accordance with the person-centered service plan unless contraindicated by underlying joint pathology;

(viii) Applying non-sterile dressings to superficial skin breaks or abrasions; and

(ix) Using universal precautions as defined by the Centers for Disease Control and Prevention.

(D) FMS are program administrative services provided to participating CD-PASS members/employers by AA. FMS are employer-related assistance that provides Internal Revenue Service (IRS) fiscal reporting agent and other financial management tasks and functions, including, but not limited to:

(i) Processing employer payroll, after the member/employer has verified and approved the employee timesheet, at a minimum of semi-monthly, and associated withholding for taxes, or for other payroll withholdings performed on behalf of the member as employer of the PSA or APSA;

(ii) Other employer-related payment disbursements as agreed to with the member/employer and in accordance with the member/employer's individual budget

allocation;

(iii) Responsibility for obtaining criminal and abuse registry background checks on prospective hires for PSA or APSA on the member/employer's behalf;

(iv) Providing orientation and training regarding employer responsibilities, as well as employer information and management guidelines, materials, tools, and staff consultant expertise to support and assist the member to successfully perform employer-related functions; and

(v) Making Hepatitis B vaccine and vaccination series available to PSA and APSA employees in compliance with Occupational Safety and Health Administration (OSHA) standards.

(E) The PSA service is billed per fifteen (15) minute unit of service. The number of units of PSA a member may receive is limited to the number of units approved on the person-centered service plan.

(F) The APSA service is billed per fifteen (15) minute unit of service. The number of units of APSA a member may receive is limited to the number of units approved on the person-centered service plan.

~~(17)~~(16) **Institution transition services.**

(A) Institution transition services are those services necessary to enable a member to leave the institution and receive necessary support through ADvantage waiver services in his or her home and community.

(B) Transitional case management services are services per OAC 317:30-5-763(1) required by the member and included on the member's person-centered service plan that are necessary to ensure the member's health, welfare, and safety, or to enable the member to function with greater independence in the home, and without which, the member would continue to require institutionalization. ADvantage transitional case management services assist institutionalized members who are eligible to receive ADvantage services in gaining access to needed waiver and other State Plan services, as well as needed medical, social, educational, and other services to assist in the transition, regardless of the funding source for the services to which access is gained. Transitional case management services may be authorized for periodic monitoring of an ADvantage member's progress during an institutional stay and for assisting the member to transition from institution to home by updating the person-centered service plan, including necessary institution transition services to prepare services and supports to be in place or to start on the date the member is discharged from the institution. Transitional case management services may be authorized to assist individuals that have not previously received ADvantage services, but were referred by CAP to the case management provider for assistance in transitioning from the institution to the community with ADvantage services support.

(i) Institution transition case management services are prior authorized and billed per fifteen (15) minute unit of service using the appropriate HCPC procedure code and modifier associated with the location of residence of the member served, per OAC 317:30-5-763(1)(D).

(ii) A unique modifier code is used to distinguish institution transitional case management services from regular case management services.

(C) Institution transition services may be authorized and reimbursed, per the conditions in (i) through (iv).

(i) The service is necessary to enable the member to move from the institution to his or her home.

(ii) The member is eligible to receive ADvantage services outside of the institutional setting.

(iii) Institution transition services are provided to the member within one-hundred and eighty (180) calendar-days of discharge from the institution.

(iv) Services provided while the member is in the institution are claimed as delivered on the day of discharge from the institution.

(D) When the member receives institution transition services but fails to enter the waiver, any institution transition services provided are not reimbursable.

~~(18)~~(17) **Assisted living services (ALS).**

(A) ALS are personal care and supportive services furnished to waiver members who reside in a homelike, non-institutional setting that includes twenty-four (24) hour on-site response capability to meet scheduled or unpredictable member needs and to provide supervision, safety, and security. Services also include social and recreational programming and medication assistance, to the extent permitted under State law. The ALS provider is responsible for coordinating services provided by third parties to ADvantage members in the assisted living center (ALC). Nursing services are incidental rather than integral to the provision of ALS. ADvantage reimbursement for ALS includes services of personal care, housekeeping, laundry, meal preparation, periodic nursing evaluations, nursing supervision during nursing intervention, intermittent or unscheduled nursing care, medication administration, assistance with cognitive orientation, assistance with transfer and ambulation, planned programs for socialization, activities, and exercise, and for arranging or coordinating transportation to and from medical appointments. Services, except for planned programs for socialization, activities, and exercise, are to meet the member's specific needs as determined through the individualized assessment and documented on the member's person-centered service plan.

(B) The ADvantage ALS philosophy of service delivery promotes member choice, and to the greatest extent possible, member control. A member has control over his or her living space and his or her choice of personal amenities, furnishings, and activities in the residence. The ADvantage member must have the freedom to control his or her schedule and activities. The ALS provider's documented operating philosophy, including policies and procedures, must reflect and support the principles and values associated with the ADvantage assisted living philosophy and approach to service delivery emphasizing member dignity, privacy, individuality, and independence.

(C) ADvantage ALS required policies for admission and termination of services and definitions.

(i) ADvantage-certified assisted living centers (ALC) are required to accept all eligible ADvantage members who choose to receive services through the ALC, subject only to issues relating to, one (1) or more of the following:

(I) Rental unit availability;

(II) The member's compatibility with other residents;

(III) The center's ability to accommodate residents who have behavior problems, wander, or have needs that exceed the services the center provides; or

(IV) Restrictions initiated by statutory limitations.

(ii) The ALC may specify the number of units the provider is making available to

service ADvantage members. At minimum, the ALC must designate ten (10) residential units for ADvantage members. Residential units designated for ADvantage may be used for other residents at the ALC when there are no pending ADvantage members for those units. Exceptions may be requested in writing subject to the approval of AA.

(iii) Mild or moderate cognitive impairment of the applicant is not a justifiable reason to deny ALC admission. Centers are required to specify whether they are able to accommodate members who have behavior problems or wander. Denial of admission due to a determination of incompatibility must be approved by the case manager and the AA. Appropriateness of placement is not a unilateral determination by the ALC. The ADvantage case manager, the member, or member's designated representative, and the ALC in consultation determine the appropriateness of placement.

(iv) The ALC is responsible for meeting the member's needs for privacy, dignity, respect, and freedom from coercion and restraint. The ALC must optimize the member's initiative, autonomy, and independence in making life choices. The ALC must facilitate member choices regarding services and supports, and who provides them. Inability to meet those needs is not recognized as a reason for determining an ADvantage member's placement is inappropriate. The ALC agrees to provide or arrange and coordinate all services listed in the Oklahoma State Department of Health (OSDH) regulations, per OAC 310:663-3-3, except for specialized services.

(v) In addition, the ADvantage participating ALC agrees to provide or coordinate the services listed in (I) through (III).

(I) Provide an emergency call system for each participating ADvantage member.

(II) Provide up to three (3) meals per day plus snacks sufficient to meet nutritional requirements, including modified special diets, appropriate to the member's needs and choices; and provide members with twenty-four (24) hour access to food by giving members control in the selection of the foods they eat, by allowing the member to store personal food in his or her room, by allowing the member to prepare and eat food in his or her room, and allowing him or her to decide when to eat.

(III) Arrange or coordinate transportation to and from medical appointments. The ALC must assist the member with accessing transportation for integration into the community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, and control his or her personal resources and receive services in the community to the same degree of access as residents not receiving ADvantage services.

(vi) The provider may offer any specialized service or rental unit for members with Alzheimer's disease and related dementias, physical disabilities, or other special needs the facility intends to market. Heightened scrutiny, through additional monitoring of the ALC by AA, is utilized for those ALC's that also provide inpatient treatment; settings on the grounds of or adjacent to a public institution and/or other settings that tend to isolate individuals from the community. The ALC must include evidence that the ALC portion of the facility has clear administrative, financial, programmatic and environmental distinctions from the institution.

(vii) When the provider arranges and coordinates services for members, the provider is obligated to ensure the provision of those services.

(viii) Per OAC 310:663-1-2, "personal care" is defined as "assistance with meals, dressing, movement, bathing or other personal needs or maintenance, or general supervision of the physical and mental well-being of a person [Title 63 of the Oklahoma Statutes (O.S.), Section (§) 1-1902.17] and includes assistance with toileting." For ADvantage ALS, assistance with "other personal needs" in this definition includes assistance with grooming and transferring. The term "assistance" is clarified to mean hands-on help, in addition to supervision.

(ix) The specific ALS assistance provided along with amount and duration of each type of assistance is based upon the member's assessed need for service assistance and is specified in the ALC's service plan that is incorporated as supplemental detail into the ADvantage comprehensive person-centered service plan. The ADvantage case manager in cooperation with ALC professional staff, develops the person-centered service plan to meet member needs. As member needs change, the person-centered service plan is amended consistent with the assessed, documented need for change in services.

(x) Placement, or continued placement of an ADvantage member in an ALC, is inappropriate when any one (1) or more of the conditions in I through IV exist.

(I) The member's needs exceed the level of services the center provides. Documentation must support ALC efforts to provide or arrange for the required services to accommodate participant needs.

(II) The member exhibits behaviors or actions that repeatedly and substantially interfere with the rights or well-being of other residents, and the ALC documented efforts to resolve behavior problems including medical, behavioral, and increased staffing interventions. Documentation must support the ALC's attempted interventions to resolve behavior problems.

(III) The member has a complex, unstable, or unpredictable medical condition and treatment cannot be developed and implemented appropriately in the assisted living environment. Documentation must support the ALC's attempts to obtain appropriate member care.

(IV) The member fails to pay room and board charges or OKDHS determined vendor payment obligation.

(xi) Termination of residence ensues when inappropriately placed. Once a determination is made that a member is inappropriately placed, the ALC must inform the member, the member's representative, if applicable, the AA, and the member's ADvantage case manager. The ALC must develop a discharge plan in consultation with the member, the member's representative, the ADvantage case manager, and the AA. The ALC and case manager must ensure the discharge plan includes strategies for providing increased services, when appropriate, to minimize risk and meet the higher care needs of members transitioning out of the ALC, when the reason for discharge is inability to meet member needs. When voluntary termination of residency is not arranged, the ALC must provide written notice to the member and to the member's representative, with a copy to the member's ADvantage case manager and the AA. The written notice provides intent to terminate the residency agreement and move the member to an appropriate care provider. The thirty (30) calendar-day requirement must not apply when emergency termination of the residency agreement is mandated by the member's immediate health needs or when

the termination of the residency agreement is necessary for the physical safety of the member or other ALC residents. The written involuntary termination of residency notice for reasons of inappropriate placement must include:

(I) A full explanation of the reasons for the termination of residency;

(II) The notice date;

(III) The date notice was given to the member and the member's representative, the ADvantage case manager, and the AA;

(IV) The date the member must leave ALC; and

(V) Notification of appeal rights and the process for submitting appeal of termination of Medicaid ALS to OHCA.

(D) ADvantage ALS provider standards in addition to licensure standards.

(i) **Physical environment.**

(I) The ALC must provide lockable doors on the entry door of each rental unit and an attached, lockable compartment within each member unit for valuables. Members must have exclusive rights to his or her unit with lockable doors at the entrance of the individual or shared rental unit. Keys to rooms may be held by only appropriate ALC staff as designated by the member's choice. Rental units may be shared only when a request to do so is initiated by the member. Members must be given the right to choose his or her roommate.

(II) The member has a legally enforceable agreement, or lease, with the ALC. The member must have the same responsibilities and protections from eviction as all tenants under the landlord-tenant law of the state, county, city, or other designated entity.

(III) The ALC must provide each rental unit with a means for each member to control the temperature in the residential unit through the use of a damper, register, thermostat, or other reasonable means under the control of the member and that preserves privacy, independence, and safety, provided that the OSDH may approve an alternate means based on documentation that the design of the temperature control is appropriate to the special needs of each member who has an alternate temperature control.

(IV) For ALCs built prior to January 1, 2008, each ALC individual residential unit must have a minimum total living space, including closets and storage areas, of two-hundred and fifty (250) square feet; for ALCs built after December 31, 2007, each ALC individual residential unit must have a minimum total living space, including closets and storage areas, of three-hundred and sixty (360) square feet.

(V) The ALC must provide a private bathroom for each living unit that must be equipped with one (1) lavatory, one (1) toilet, and one (1) bathtub or shower stall.

(VI) The ALC must provide at a minimum; a kitchenette, defined as a space containing a refrigerator, adequate storage space for utensils, and a cooking appliance. A microwave is an acceptable cooking appliance.

(VII) The member is responsible for furnishing the rental unit. When a member is unable to supply basic furnishings defined as a bed, dresser, nightstand, chairs, table, trash can, and lamp, or if furnishings pose a health or safety risk, the member's ADvantage case manager in coordination with the ALC, must assist

the member in obtaining basic furnishings for the rental unit. The member must have the freedom to furnish and decorate the rental unit within the scope of the lease or residency agreement.

(VIII) The ALC must meet the requirements of all applicable federal and state laws and regulations including, but not limited to, state and local sanitary codes, state building and fire safety codes, and laws and regulations governing use and access by persons with disabilities.

(IX) The ALC must ensure the design of common areas accommodates the special needs of the resident population and that the rental unit accommodates the special needs of the member in compliance with the Americans with Disabilities Act accessibility guidelines per Nondiscrimination on the Basis of Disability By Public Accommodations and in in Commercial Facilities, 28 Code of Federal Regulations, Appendix A, at no additional cost to the member.

(X) The ALC must provide adequate and appropriate social and recreational space for residents and the common space must be proportionate to the number of residents and appropriate for the resident population.

(XI) The ALC must provide appropriately monitored outdoor space for resident use.

(XII) The ALC must provide the member with the right to have visitors of his or her choosing at any time. Overnight visitation is allowed as permissible by the Landlord/Tenant Agreement.

(XIII) The ALC must be physically accessible to members.

(ii) **Sanitation.**

(I) The ALC must maintain the facility, including its individual rental units in a clean, safe, and sanitary manner, ensuring that they are insect and rodent free, odorless, and in good repair at all times.

(II) The ALC must maintain buildings and grounds in a good state of repair, in a safe and sanitary condition, and in compliance with the requirements of applicable regulations, bylaws, and codes.

(III) The ALC stores clean laundry in a manner that prevents contamination and changes linens at time intervals necessary to avoid health issues.

(IV) The ALC must provide housekeeping in member rental units to maintain a safe, clean, and sanitary environment.

(V) The ALC must have policies and procedures for members' pets.

(iii) **Health and safety.**

(I) The ALC must provide building security that protects members from intruders with security measures appropriate to building design, environmental risk factors, and the resident population.

(II) The ALC must respond immediately and appropriately to missing members, accidents, medical emergencies, or deaths.

(III) The ALC must have a plan in place to prevent, contain, and report any diseases considered to be infectious or are listed as diseases that must be reported to the OSDH.

(IV) The ALC must adopt policies for the prevention of abuse, neglect, and exploitation that include screening, training, prevention, investigation, protection during investigation, and reporting.

(V) The ALC must provide services and facilities that accommodate the needs of members to safely evacuate in the event of fires or other emergencies.

(VI) The ALC must ensure staff is trained to respond appropriately to emergencies.

(VII) The ALC must ensure that fire safety requirements are met.

(VIII) The ALC must offer meals that provide balanced and adequate nutrition for members.

(IX) The ALC must adopt safe practices for meal preparation and delivery.

(X) The ALC must provide a twenty-four (24) hour response to personal emergencies appropriate to the needs of the resident population.

(XI) The ALC must provide safe transportation to and from ALC sponsored social or recreational outings.

(iv) **Staff to resident ratios.**

(I) The ALC must ensure a sufficient number of trained staff are on duty, awake, and present at all times, twenty-four (24) hours a day, and seven (7) days a week, to meet resident's needs and to carry out all processes listed in the ALC's written emergency and disaster preparedness plan for fires and other disasters.

(II) The ALC must ensure staffing is sufficient to meet ADvantage program members' needs in accordance with each member's ADvantage person-centered service plan.

(III) The ALC must have plans in place to address situations where there is a disruption to the ALC's regular work force.

(v) **Staff training and qualifications.**

(I) The ALC must ensure staff has qualifications consistent with their job responsibilities.

(II) All staff assisting in, or responsible for, food service must have attended a food service training program offered or approved by OSDH.

(III) The ALC must provide staff orientation and ongoing training to develop and maintain staff knowledge and skills. All direct care and activity staff receive at least eight (8) hours of orientation and initial training within the first month of employment and at least four (4) hours annually thereafter. Staff providing direct care on a dementia unit must receive four (4) additional hours of dementia specific training. Annual first aid and cardiopulmonary resuscitation (CPR) certification do not count toward the four (4) hours of annual training.

(vi) **Staff supervision.**

(I) The ALC must ensure delegation of tasks to non-licensed staff is consistent and in compliance with all applicable state regulations including, but not limited to, the state's Nurse Practice Act and OSDH Nurse Aide Certification rules.

(II) The ALC must ensure that, where the monitoring of food intake or therapeutic diets is provided at the prescribed services level, a registered dietitian monitors member health and nutritional status.

(vii) **Resident rights.**

(I) The ALC must provide to each member and each member's representative, at the time of admission, a copy of the resident statutory rights listed in 63 O.S. § 1-1918 amended to include additional rights and the clarification of rights as listed in the ADvantage member assurances. A copy of resident rights must be

posted in an easily accessible, conspicuous place in the facility. The facility must ensure that staff is familiar with and observes, the resident rights.

(II) The ALC must conspicuously post for display in an area accessible to residents, employees, and visitors, the ALC's complaint procedures and the name, address, and phone number of a person authorized to receive complaints. A copy of the complaint procedure must also be given to each member, the member's representative, or the legal guardian. The ALC must ensure all employees comply with the ALC's complaint procedure.

(III) The ALC must provide to each member and member's representative, at the time of admission, information about Medicaid grievance and appeal rights, including a description of the process for submitting a grievance or appeal of any decision that decreases Medicaid services to the member.

(viii) **Incident reporting.**

(I) The ALC must maintain a record of incidents that occur and report incidents to the member's ADvantage case manager and to the AA, utilizing the AA Critical Incident Reporting form. Incident reports are also made to Adult Protective Services (APS) and to the OSDH, as appropriate, per ALC licensure rules, utilizing the specific reporting forms required.

(II) Incidents requiring report by licensed ALC's are those defined by OSDH, per OAC 310:663-19-1 and listed in the Provider Question Critical Incident Category.

(III) Reports of incidents must be made to the member's ADvantage case manager and to the AA via electronic submission within one (1) business day of the reportable incident's discovery utilizing the Provider Question Critical Incident Category. When required, a follow-up report of the incident must be submitted via electronic submission to the member's ADvantage case manager and to the AA. The follow-up report must be submitted within five (5) business days of the incident. The final report must be filed with the member's ADvantage case manager and the AA when the investigation is complete, not to exceed ten (10) business days after the incident.

(IV) Each ALC having reasonable cause to believe that a member is suffering from abuse, neglect, exploitation, or misappropriation of member property must make a report to APS as soon as the person is aware of the situation per 43A O.S. § 10-104.A. Reports are also made to OSDH, as appropriate, per ALC licensure rules.

(V) The preliminary incident report must at minimum, include who, what, when, where, and the measures taken to protect the member and resident(s) during the investigation. The follow-up report must, at minimum, include preliminary information, the extent of the injury or damage, if any, and preliminary investigation findings. The final report, at minimum, includes preliminary and follow-up information, a summary of investigative actions representing a thorough investigation, investigative findings and conclusions, and corrective measures to prevent future occurrences. When it is necessary to omit items, the final report must include why such items were omitted and when they will be provided.

(ix) Provision of, or arrangement for, necessary health services. The ALC must:

(I) Arrange or coordinate transportation for members to and from medical appointments; and

(II) Provide or coordinate with the member and the member's ADvantage case manager for delivery of necessary health services. The ADvantage case manager is responsible for monitoring that all health-related services required by the member as identified through assessment and documented on the person-centered service plan, are provided in an appropriate and timely manner. The member has the freedom to choose any available provider qualified by licensure or certification to provide necessary health services in the ALC.

(E) ALCs are billed per diem of service for days covered by the ADvantage member's person-centered service plan and during which the ALS provider is responsible for providing ALS for the member. The per diem rate for ADvantage ALS for a member is one (1) of three (3) per diem rate levels based on a member's need for type of, intensity of, and frequency of service to address member ADLs, instrumental activities of daily living (IADLs), and health care needs. The rate level is based on the Uniform Comprehensive Assessment Tool (UCAT) assessment by the member's ADvantage case manager employed by a case management agency independent of the ALS provider. The determination of the appropriate per diem rate is made by the AA clinical review staff.

(F) The ALC must notify AA ninety (90) calendar days before terminating or not renewing the ALC's ADvantage contract.

(i) The ALC must give notice in writing to the member, the member's representative(s), the AA, and the member's ADvantage case manager ninety (90) calendar days before:

(I) Voluntary cessation of the ALC's ADvantage contract; or

(II) Closure of all or part of the ALC.

(ii) The notice of closure must include:

(I) The proposed ADvantage contract termination date;

(II) The termination reason;

(III) An offer to assist the member secure an alternative placement; and

(IV) Available housing alternatives.

(iii) The facility must comply with all applicable laws and regulations until the closing date, including those related to resident transfer or discharge.

(iv) Following the last move to the last ADvantage member, the ALC must provide in writing to the AA:

(I) The effective date of closure based on the discharge date of the last resident;

(II) A list of members transferred or discharged and where they relocated,; and

(III) The plan for storage of resident records per OAC 310:663-19-3(g), relating to preservation of resident records and the name, address, and phone numbers of the person responsible for the records.

~~(19)~~(18) **Remote Support (RS) services**.

(A) **Purpose and scope.** RS services are intended to promote a member's independence and self-direction. RS services are provided in the member's home to reduce reliance on in person support while ensuring the member's health and safety. RS services are included in the member's person-centered service plan and coordination of these services are made through the case manager.

(i) RS services are:

(I) Based on the member's needs as documented and supported by the member's person-centered service plan and person-centered assessments;
(II) Only authorized when submitted on the member's person-centered service plan with the consent of the member, involved household members, and guardian, as applicable;
(III) The least restrictive option and the member's preferred method to meet an assessed need; and
(IV) Provided when the member and the member's Interdisciplinary Team (IDT) agree to the provision of RS services.

(ii) RS services are not a system of surveillance or for provider convenience.

(B) **Service description**. RS services monitor a member by allowing for live, two-way communication between the member and monitoring staff using one (1) or more of the following systems:

(i) Live video feed;
(ii) Live audio feed;
(iii) Motion-sensor monitoring;
(iv) Radio frequency identification;
(v) Web-based monitoring; or
(vi) Global positioning system (GPS) monitoring devices.

(C) **General provider requirements.** RS service providers must have a valid OHCA SoonerCare (Medicaid) provider agreement to provide provider-based RS services to ADvantage HCBS waiver members and be certified by the AA. Requests for applications to provide RS services are made to AA.

(D) **Risk assessment.** Teams will complete a risk assessment to ensure remote supports can help meet the member's needs in a way that protects the right to privacy, dignity, respect, and freedom from coercion. The risk assessment is reviewed, and any issues are addressed prior to the implementation of remote supports general provider requirements.

(i) Remote support providers ensure the member's health and safety by contacting a member's informal support or activating the member's back-up plan when a health or safety issue becomes evident during monitoring.
(ii) The risk assessment and service plan require the team to develop a specific back-up plan to address health, safety and behavioral needs while remote supports are utilized so appropriate assistance can be provided. The RS back-up plan includes how assistance is provided to the member when equipment or technology fails.

(E) **RS guidelines.** Devices or monitors are placed at locations based on the member's individual needs as documented on the member's person-centered service plan and approved by the member and involved family members and guardian, as applicable.

(i) The use of camera or video equipment in the member's bedroom, bathroom, or other private area is prohibited.
(ii) When RS involves the use of audio or video equipment that permits RS staff to view activities or listen to conversations in the residence, the member who receives the service and each person who lives with the member is fully informed of what RS entails. The member's case manager documents consent in the member's person-centered service plan.

(iii) Waiver members have the ability to turn off the remote monitoring device or equipment if they choose to do so. The RS provider educates the member regarding how to turn RS devices off and on at the start of services and as desired thereafter.

(F) **Emergency response staff.**

(i) Emergency response staff are employed by a certified ADvantage Provider with a valid OHCA SoonerCare (Medicaid) contract to provide HCBS to OKDHS HCBS waiver members.

(ii) Informal emergency response persons are unpaid family members or other interested parties who agree to become, and are approved as, an emergency response person by the member and the member's IDT.

(G) **Service limitations.** RS services are limited to twenty-four (24) hours per day. RS services are not provided simultaneously with any other in-home direct care services. However, services may be provided through a combination of remote and in-home services dependent on the member's needs.

(H) **RS service discontinuation**. The member and the member's IDT determine when it is appropriate to discontinue RS services. When RS services are terminated, the RS provider coordinates service termination with the member's case manager to ensure a safe transition.

~~(20)~~(19) **Assistive Technology (AT) services.**

(A) AT services include devices, controls, and appliances, specified in the member's person-centered service plan, which enable members to increase their abilities to perform activities of daily living or to perceive, control, or communicate with the environment in which they live.

(B) Devices may include communication technology, such as smart phones and tablets, that allow members to communicate with their providers using video chat to ensure ongoing maintenance of health and welfare.

(C) Only devices that are not covered under the SoonerCare (Medicaid) or Specialized Medical Equipment services are included in this service definition.

(D) Service codes and rates vary based on the nature of the AT device;

(E) AT services may include:

(i) Assessment for the need of AT or auxiliary aids;

(ii) Training the member or provider regarding use and maintenance of equipment or auxiliary aids; and

(iii) Repair of adaptive devices; and

(iv) Equipment provided may include:

(I) Video communication technology that allows members to communicate with providers through video communication. Video communication allows providers to assess and evaluate their members' health and welfare or other needs by enabling visualization of members and their environments. Examples include smart phones, tablets, audiovisual or virtual assistant technology, or sensors; and

(II) The cost of internet services may be augmented through the Emergency Broadband Benefit which is available to waiver members.

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) for equivalent services provided for the OKDHS 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 OKDHS for the equivalent services provided for the OKDHS 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 OKDHS Aging Services (AS) during the CD-PASS service eligibility determination process. OKDHS AS 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, 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 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, 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. 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.

317:30-5-1200. Benefits for members age 65 or older with disabilities or long-term illnesses

(a) Living Choice program participants age 65 or older with disabilities or long-term illnesses may receive a range of necessary medical and home and community based services for one year after moving from an institutional setting. The one year period begins the day the member occupies a qualified residence in the community. Once this transition period is complete, the member receives services through one of the Opportunities for Living Life home and community based services waivers.

(b) Services must be billed using the appropriate HCPCS or CPT codes and must be medically necessary.

(c) All services must be necessary for the individual to live in the community, require prior authorization, and must be documented in the individual transition plan. The number of units of services the member is eligible to receive is limited to the amounts approved in the transition plan.

(d) Services that may be provided through the Living Choice program for older persons with disabilities or long-term illnesses are listed in paragraphs (1) through ~~(26)~~(25) of this subsection:

(1) case management;
(2) respite care;
(3) adult day health care;
(4) environmental modifications;
(5) specialized medical equipment and supplies;
(6) therapy services including physical, occupational, speech and respiratory;
(7) advanced supportive/restorative assistance;
(8) skilled nursing;
(9) extended duty nursing;
(10) home delivered meals;
~~(11) hospice care;~~
~~(12)~~(11) medically necessary prescription drugs;
~~(13)~~(12) personal care as described in Part 95 of this Chapter;
~~(14)~~(13) Personal Emergency Response System (PERS);
~~(15)~~(14) self-direction;
~~(16)~~(15) transition coordination;
~~(17)~~(16) community transition services as described in OAC 317:30-5-1205;
~~(18)~~(17) dental services (up to $1,000 per person annually);
~~(19)~~(18) nutrition evaluation and education services;
~~(20)~~(19) agency companion services;
~~(21)~~(20) pharmacological evaluations;
~~(22)~~(21) vision services including eye examinations and eyeglasses;
~~(23)~~(22) non-emergency transportation;
~~(24)~~(23) family training services;
~~(25)~~(24) assisted living services; and
~~(26)~~(25) SoonerCare compensable medical services.

PART 113. LIVING CHOICE PROGRAM

317:30-5-1202. Benefits for members with physical disabilities

(a) Living Choice program participants with physical disabilities may receive a range of necessary medical and home and community based services for one year after moving from the institution. The one year period begins the day the member occupies a qualified residence in the community. Once this transition period is complete, the member receives services through one of the Opportunities for Living Life home and community based services waivers.

(b) Services must be billed using the appropriate HCPCS or CPT codes and must be medically necessary.

(c) All services must be necessary for the individual to live in the community, require prior authorization, and must be documented in the individual transition plan. The number of units of services the member is eligible to receive is limited to the amounts approved in the transition plan.

(d) Services that may be provided to members with physical disabilities are listed in paragraphs (1) through ~~(32)~~(31) of this subsection:

(1) case management;
(2) personal care services as described in Part 95 of this Chapter;
(3) respite care;
(4) adult day health care with personal care and therapy enhancements;
(5) architectural modifications;
(6) specialized medical equipment and supplies;
(7) advanced supportive/restorative assistance;
(8) skilled nursing;
(9) home delivered meals;
(10) therapy services including physical, occupational, speech and respiratory;
~~(11) hospice care;~~
~~(12)~~(11) Personal Emergency Response System (PERS);
~~(13)~~(12) Self-Direction;
~~(14)~~(13) agency companion services;
~~(15)~~(14) extended duty nursing;
~~(16)~~(15) psychological services;
~~(17)~~(16) audiology treatment and evaluation;
~~(18)~~(17) non-emergency transportation;
~~(19)~~(18) assistive technology;
~~(20)~~(19) dental services (up to $1,000 per person annually);
~~(21)~~(20) vision services including eye examinations and eyeglasses;
~~(22)~~(21) pharmacotherapy management;
~~(23)~~(22) independent living skills training;
~~(24)~~(23) nutrition services;
~~(25)~~(24) family counseling;
~~(26)~~(25) family training;
~~(27)~~(26) transition coordination;
~~(28)~~(27) psychiatry services;
~~(29)~~(28) community transition services as described in OAC 317:30-5-1205;
~~(30)~~(29) pharmacological evaluations;
~~(31)~~(30) assisted living services; and

~~(32)~~(31) SoonerCare compensable medical services.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 50. HOME AND COMMUNITY-BASED WAIVER SERVICES

SUBCHAPTER 1. MEDICALLY FRAGILE WAIVER SERVICES

317:50-1-3. Medically Fragile Program overview

(a) The Medically Fragile Waiver program is a Medicaid Home and Community Based Services Waiver used to finance non-institutional long-term care services for a targeted group of physically disabled adults when there is a reasonable expectation that the person's health, due to disease process or disability, would, without appropriate services, deteriorate and require skilled nursing facility or hospital level of care to arrest the deterioration. Medically Fragile Waiver program members must be SoonerCare eligible and must not reside in an institution; room and board licensed residential care facility. The number of members who may receive Medically Fragile Waiver services is limited.

(1) To receive Medically Fragile Waiver services, individuals must meet the following criteria:

(A) be nineteen (19) years of age or older;

(B) have a chronic medical condition which results in prolonged dependency on medical care for which daily skilled intervention is necessary and is characterized by one or more of the following:

(i) a life threatening condition characterized by reasonably frequent periods of acute exacerbation which requires frequent medical supervision and/or physician consultation and which, in the absence of such supervision or consultation, would require hospitalization;

(ii) require frequent time consuming administration of specialized treatments which are medically necessary;

(iii) be dependent on medical technology such that without the technology, a reasonable level of health could not be maintained.

(2) In addition, the individual must meet the following criteria:

(A) meet service eligibility criteria [see OAC 317:50-1-3(d)]; and

(B) meet program eligibility criteria [see OAC 317:50-1-3(e)].

(b) Home and Community Based Waiver Services are outside the scope of state plan Medicaid services. The Medicaid waiver allows the Oklahoma Health Care Authority to offer certain Home and Community Based services to an annually capped number of persons who are categorically needy (refer to Department of Human Services form 08AX001E, Schedule VIII. B. 1) and without such services would be institutionalized. Services provided through the Medically Fragile Waiver are approved based on medical necessity.

(c) Services provided through the Medically Fragile Waiver are:

(1) case management;

(2) institutional transition case management;

(3) respite;

(4) environmental modifications;

(5) specialized medical equipment and supplies;

(6) physical therapy, occupational therapy, respiratory therapy, speech therapy or consultation;

(7) advanced supportive/restorative assistance;

(8) skilled nursing;
(9) home delivered meals;
~~(10) hospice care;~~
~~(11)~~(10) medically necessary prescription drugs within the limits of the waiver;
~~(12)~~(11) personal care;
~~(13)~~(12) personal emergency response system (PERS);
~~(14)~~(13) self-directed personal care, respite and advanced supportive/restorative assistance;
~~(15)~~(14) self-directed goods and services (SD-GS);
~~(16)~~(15) transitional case management; and
~~(17)~~(16) SoonerCare medical services within the scope of the state plan.

(d) A service eligibility determination is made using the following criteria:

(1) an open Medically Fragile Waiver Program waiver slot, as authorized by the waiver document approved by the Centers for Medicare and Medicaid Services (CMS), is available to assure federal participation in payment for services to the member. If it is determined that all Medically Fragile Waiver slots are filled, the member cannot be certified as eligible for Medically Fragile Waiver services and the member's name is placed on a waiting list for entry as an open slot becomes available. Medically Fragile Waiver slots and corresponding waiting lists, if necessary, are maintained.

(2) the member is in the Medically Fragile Waiver targeted service group. The target group is an individual who is age nineteen (19) or older with a physical disability and may be technology dependent.

(3) the individual does not pose a physical threat to self or others as supported by professional documentation.

(4) members of the household or persons who routinely visit the household, as supported by professional documentation, do not pose a threat of harm or injury to the individual or other household visitors.

(e) The Medically Fragile Waiver program eligibility determination is made through the service plan approval process. The following criteria are used to make the determination that an individual is not eligible:

(1) if the individual's needs as identified by Uniform Comprehensive Assessment Test assessment and other professional assessments cannot be met through Medically Fragile Waiver program services, SoonerCare state plan services and other formal or informal services. The State, as part of the waiver program approval authorization, assures CMS that each waiver member's health, safety, or welfare can be maintained in their home. If an individual's identified needs cannot be met through provision of Medically Fragile Waiver program or SoonerCare state plan services and other formal or informal services are not in place or immediately available to meet those needs, the individual's health, safety or welfare in their home cannot be assured.

(2) if the individual poses a physical threat to self or others as supported by professional documentation.

(3) if other members of the household or persons who routinely visit the household who, as supported by professional documentation, pose a threat of harm or injury to the individual or other household visitors.

(4) if the individual's needs are being met, or do not require Medically Fragile Waiver services to be met, or if the individual would not require institutionalization if needs are not met.

(5) if, after the service and care plan is developed, the risk to individual health and safety is

not acceptable to the individual, or to the interdisciplinary service plan team, or to the OHCA.
(f) Professional documentation is provided to support the recommendation for redetermination of program eligibility. The service providers continue providing services according to the service plan as provider safety permits until the member is removed from the Medically Fragile Waiver program. As a part of the procedures requesting redetermination of program eligibility, the OHCA will provide technical assistance to the provider for transitioning the member to other services.
(g) Redetermination of program eligibility can be requested for the following reasons:
(1) if the member fails to comply with the community service plan;
(2) if the member's health and safety cannot be assured;
(3) as deemed necessary by waiver review staff or the member's case manager.
(h) Individuals determined ineligible for Medically Fragile Waiver program services are notified in writing of the determination and of his or her right to appeal the decision.

317:50-1-12. Eligible providers

Medically Fragile Program service providers, must be certified by the Oklahoma Health Care Authority (OHCA) and all providers must have a current signed SoonerCare contract on file with the Medicaid Agency (Oklahoma Health Care Authority).

(1) The provider programmatic certification process verifies that the provider meets licensure, certification and training standards as specified in the Waiver document and agrees to Medically Fragile program Conditions of Participation. Providers must obtain programmatic certification to be Medically Fragile program certified.

(2) The provider financial certification process verifies that the provider uses sound business management practices and has a financially stable business.

(3) Providers may fail to gain or may lose waiver program certification due to failure to meet either programmatic or financial standards.

(4) At a minimum, provider financial certification is reevaluated annually.

(5) Providers of medical equipment and supplies environmental modifications, personal emergency response systems, ~~hospice,~~ and skilled nursing facility respite services do not have a programmatic evaluation after the initial certification.

(6) OHCA may authorize a legally responsible family member (spouse or legal guardian) of an adult member to be SoonerCare reimbursed under the 1915(c) Medically Fragile program as a service provider, if the provider meets all of the following authorization criteria and monitoring provisions:

(A) Authorization for a legally responsible family member to be the care provider for a member may occur only if the member is offered a choice of providers and documentation demonstrates that:

(i) either no other provider is available; or

(ii) available providers are unable to provide necessary care to the member; or

(iii) the needs of the member are so extensive that the spouse or legal guardian who provides the care is prohibited from working outside the home due to the member's need for care.

(B) The service must:

(i) meet the definition of a service/support as outlined in the federally approved waiver document;

(ii) be necessary to avoid institutionalization;

(iii) be a service/support that is specified in the individual service plan;

(iv) be provided by a person who meets the provider qualifications and training standards specified in the Waiver for that service;

(v) be paid at a rate that does not exceed that which would otherwise be paid to a provider of a similar service and does not exceed what is allowed by the OHCA for the payment of personal care or personal assistance services;

(vi) not be an activity that the spouse or legal guardian would ordinarily perform or is responsible to perform. If any of the following criteria are met, assistance or care provided by the spouse or guardian will be determined to exceed the extent and/or nature of the assistance they would be expected to ordinarily provide in their role as spouse or guardian:

(I) spouse or guardian has resigned from full-time/part-time employment to provide care for the member; or

(II) spouse or guardian has reduced employment from full-time to part-time to provide care for the member; or

(III) spouse or guardian has taken a leave of absence without pay to provide care for the member; or

(IV) spouse or guardian provides assistance/care for the member thirty-five (35) or more hours per week without pay and the member has remaining unmet needs because no other provider is available due to the nature of the assistance/care, special language or communication, or intermittent hours of care requirements of the member.

(C) The spouse or legal guardian who is a service provider will comply with the following:

(i) not provide more than forty (40) hours of services in a seven (7) day period;

(ii) planned work schedules must be available in advance to the member's case manager, and variations to the schedule must be noted and supplied two (2) weeks in advance to the case manager, unless change is due to an emergency;

(iii) maintain and submit time sheets and other required documentation for hours paid; and

(iv) be documented in the service plan as the member's care provider.

(D) In addition to case management, monitoring, and reporting activities required for all waiver services, the state is obligated to additional monitoring requirements when members elect to use a spouse or legal guardian as a paid service provider. The OHCA will monitor through documentation submitted by the case manager the following:

(i) at least quarterly reviews by the case manager of expenditures and the health, safety and welfare status of the individual member; and

(ii) face-to-face visits with the member by the case manager on at least a semi annual basis.

(7) The OHCA periodically performs a programmatic audit of Case Management, Home Care (providers of Skilled Nursing, State Plan Personal Care, In-Home Respite, Advanced Supportive/Restorative Assistance and Therapy Services), and Self-Directed service providers. If due to a programmatic audit, a provider plan of correction is required, the OHCA stops new case referrals to the provider until the plan of correction has been approved and implemented. Depending on the nature and severity of problems discovered during a programmatic audit, at the discretion of the OHCA, members determined to be at risk for health or safety may be transferred from a provider requiring a plan of correction to another

provider.
(8) As additional providers are certified or if a provider loses certification, the OHCA provides notice to appropriate personnel in counties affected by the certification changes.

317:50-1-14. Description of services

Services included in the Medically Fragile waiver program are as follows:

(1) **Case Management.**

(A) Case management services are services that assist a member in gaining access to medical, social, educational or other services, regardless of payment source of services, that may benefit the member in maintaining health and safety. Case managers initiate and oversee necessary assessments and reassessments to establish or reestablish waiver program eligibility. Case managers develop the member's comprehensive service plan, listing only services which are necessary to prevent institutionalization of the member, as determined through assessments. Case managers initiate the addition of necessary services or deletion of unnecessary services, as dictated by the member's condition and available support. Case managers monitor the member's condition to ensure delivery and appropriateness of services and initiate service plan reviews. If a member requires hospital or skilled nursing facility (NF) services, the case manager assists the member in accessing institutional care and, as appropriate, periodically monitors the member's progress during the institutional stay and helps the member transition from institution to home by updating the service plan and preparing services to start on the date the member is discharged from the institution. Case managers must meet Medically Fragile waiver program minimum requirements for qualification and training prior to providing services to members. Prior to providing services to members choosing to self-direct their services, case managers are required to receive training and demonstrate knowledge regarding the self-directed service delivery model.

(B) Providers may only claim time for billable case management activities described as follows:

(i) A billable case management activity is any task or function defined under Oklahoma Administrative Code (OAC) 317:50-1-15~~(1)(A)~~, that only a Medically Fragile case manager because of skill, training, or authority, can perform on behalf of a member;

(ii) Ancillary activities such as clerical tasks like mailing, copying, filing, faxing, drive time, or supervisory/administrative activities are not billable case management activities, although the administrative cost of these activities and other normal and customary business overhead costs have been included in the reimbursement rate for billable activities. Payment is not allowed for written reports or record documentation.

(C) Case management services are prior authorized and billed per fifteen (15) minute unit of service using the rate associated with the location of residence of the member served.

(i) Case Management services are billed using a standard rate for reimbursement for billable service activities provided to a member who resides in a county with population density greater than twenty-five (25) persons per square mile.

(ii) Case management services are billed using a very rural/outside providers' service rate for billable service activities provided to a member who resides in a county with population density equal to or less than twenty-five (25) persons per square mile. An

exception would be services to members that reside in OHCA-identified zip codes in Osage county adjacent to metropolitan areas of Tulsa and Washington counties. Services to these members are prior authorized and billed using the standard rate.

(iii) The latest United States Census, Oklahoma Counties population data is the source for determination of whether a member resides in a county with a population density equal to or less than twenty-five (25) persons per square mile, or resides in a county with a population density greater than twenty-five (25) persons per square mile.

(D) Case managers providing case management services to Medically Fragile waiver members must submit monthly monitoring case notes on a monthly basis to the OHCA Medically Fragile waiver staff.

(E) Providers of Home and Community-Based waiver services (HCBS) for the member, or those who have an interest in or are employed by a provider of HCBS for the member, must not provide case management or develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS.

(2) **Institutional transitional case management.**

(A) Institutional Transition case management services are required by the member's service plan, which are necessary to ensure the health, welfare, and safety of the member, or to enable the member to function with greater independence in the home, and without which, the member would continue to require institutionalization.

(B) Institutional transition case management services assist institutionalized members that are eligible to receive waiver services in gaining access to needed waiver and other state plan services, as well as needed medical, social, educational, and other services to assist the transition, regardless of the funding source for the services which access is gained.

(C) Institutional transition case management services may be authorized for periodic monitoring of a waiver member's progress during an institutional stay, and for assisting the member's transition from institution to home by updating the services plan, including preparing for necessary services and supports to be in place or to start on the date the member is discharged from the institution.

(3) **Respite.**

(A) Respite services are provided to members who are unable to care for themselves. They are provided on a short-term basis because of the absence or need for relief of the primary caregiver. Payment for respite care does not include room and board costs unless more than seven (7) hours are provided in a nursing facility (NF). Respite care will only be utilized when other sources of care and support have been exhausted. Respite care will only be listed on the service plan when it is necessary to prevent institutionalization of the member. Units of services are limited to the number of units approved on the service plan.

(B) In-home respite services are billed per fifteen (15) minute unit service. Within any one (1) day period, a minimum of eight (8) units must be provided with a maximum of twenty-eight (28) units provided. The service is provided in the member's home.

(C) Facility-based extended respite is filed for a per diem rate, if provided in a NF. Extended respite must be at least eight (8) hours in duration.

(D) In-Home Extended respite is filed for a per diem rate. A minimum of eight (8) hours must be provided in the member's home.

(4) **Environmental modifications.**

(A) Environmental modifications are physical adaptations to the home, required by the member's service plan, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home and without which, the member would require institutionalization. Adaptations or improvements to the home which are not of direct medical or remedial benefit to the waiver member are excluded.

(B) All services require prior authorization.

(C) All services shall be provided in accordance with applicable state and local building codes and conform to the Americans with Disabilities Act Accessibility Guidelines, Title 28 of the Code of Federal Regulations Part 36 Appendix A.

(D) Payment for these services is made on an individual basis following a uniform process approved by the Medicaid agency.

(5) **Medical Supplies, Equipment, and Appliances.**

(A) Medical supplies, equipment, and supplies are specified in the service plan, which enable members to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. Also included are items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment and supplies not available under the Medicaid State Plan. This service excludes any equipment and/or supply items which are not of direct medical or remedial benefit to the Waiver member. This service is necessary to prevent institutionalization.

(B) Medical supplies, equipment, and supplies are billed using the appropriate healthcare common procedure code (HCPC). Reoccurring supplies which are shipped to the member are compensable only when the member remains eligible for waiver services, continues to reside in the home and is not institutionalized in a hospital, skilled (NF) or nursing home. It is the provider's responsibility to verify the member's status prior to shipping these items. Payment for medical supplies, equipment, and supplies is limited to the Medicare rate, or the SoonerCare rate, or is determined through manual pricing. If manual pricing is used, the provider is reimbursed at the provider's documented manufacturer's suggested retail price (MSRP) minus thirty (30) percent or invoice cost plus thirty (30) percent, whichever is the lesser of the two (2). OHCA may establish a fair market price through claims review and analysis.

(6) **Advanced supportive/restorative assistance.**

(A) Advanced supportive/restorative assistance services are maintenance services to assist a member who has a chronic, yet stable, condition. These services assist with activities of daily living which require devices and procedures related to altered body functions. This service is for maintenance only and is not utilized as a treatment service.

(B) Advanced supportive/restorative assistance service is billed per fifteen (15) minute unit of service. The number of units of this service a member may receive is limited to the number of units approved on the service plan.

(7) **Nursing.**

(A) Nursing services are services listed in the service plan which are within the scope of the Oklahoma Nursing Practice Act and are provided by a registered professional nurse,

or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State. Nursing services includes skilled nursing and/or private duty nursing. Skilled nursing is provided on an intermittent or part-time basis. Private duty nursing is individual and continuous care provided to a participant at home by licensed nurses. The provision of the nursing service will work to prevent or postpone the institutionalization of the member.

(B) Nursing services are services of a maintenance or preventive nature provided to members with stable, chronic conditions. These services are not intended to treat an acute health condition and may not include services which would be reimbursable under either Medicaid or Medicare's Home Health program. This service primarily provides nurse supervision to the Personal Care Assistant or to the Advanced Supportive/Restorative Assistance Aide and assesses the member's health and prescribed medical services to ensure that they meet the member's needs as specified in the service plan. A skilled nursing assessment/evaluation on-site visit is made to each member for whom Advanced Supportive/Restorative Assistance services are authorized to evaluate the condition of the member and medical appropriateness of services. An assessment/evaluation visit report will be made to the Medically Fragile Waiver case manager in accordance with review schedule determined in consultation between the Case Manager and the Skilled Nurse, to report the member's condition or other significant information concerning each advanced supportive/restorative care member.

(i) The case manager may recommend authorization of Skilled Nursing services as part of the interdisciplinary team planning for the member's service plan and/or assessment/evaluation of:

(I) the member's general health, functional ability and needs and/or

(II) the adequacy of personal care and/or advanced supportive/restorative assistance services to meet the member's needs including providing on-the-job training and competency testing for personal care or advanced supportive/restorative care aides in accordance with rules and regulations for delegation of nursing tasks as established by the Oklahoma Board of Nursing.

(ii) In addition to assessment/evaluation, the case manager may recommend authorization of Skilled Nursing services for the following:

(I) preparing a one (1) week supply of insulin syringes for a blind diabetic, who can safely self-inject the medication but cannot fill his/her own syringe. This service would include monitoring the member's continued ability to self-administer the insulin;

(II) preparing oral medications in divided daily compartments for a member who self-administers prescribed medications but needs assistance and monitoring due to a minimal level of disorientation or confusion;

(III) monitoring a member's skin condition when a member is at risk for skin breakdown due to immobility or incontinence, or the member has a chronic stage II decubitus ulcer requiring maintenance care and monitoring;

(IV) providing nail care for the diabetic member or member with circulatory or neurological compromise;

(V) providing consultation and education to the member, member's family and/or other informal caregivers identified in the service plan, regarding the nature of the member's chronic condition. Provide skills training (including

return skills demonstration to establish competency) to the member, family and/or other informal caregivers as specified in the service plan for preventive and rehabilitative care procedures.

(C) Nursing service can be billed for service plan development and/or assessment/evaluation services or, for other services within the scope of the Oklahoma Nursing Practice Act including private duty nursing. Nursing services are billed per ~~fifteen~~fifteen (15) minute unit of service. A specific procedure code is used to bill for assessment/evaluation/service plan development skilled nursing services and other procedure codes are used to bill for all other authorized nursing services. A maximum of eight (8) units per day of skilled nursing for assessment/evaluation and/or service plan development are allowed. An agreement by a provider to perform a nurse evaluation is also an agreement, to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted. Reimbursement for a nurse evaluation is denied if the provider that produced the nurse evaluation fails to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted.

(8) **Home Delivered Meals.**

(A) Home Delivered Meals provide one (1) meal per day. A home delivered meal is a meal prepared in advance and brought to the member's home. Each meal must have a nutritional content equal to at least one third (1/3) of the recommended daily allowance as established by the Food and Nutrition Board of the National Academy of Sciences. Meals are only provided to members who are unable to prepare meals and lack an informal provider to do meal preparation.

(B) Home Delivered Meals are billed per meal, with one meal equaling one unit of service. The limit of the number of units a member is allowed to receive is limited on the member's service plan. The provider must obtain a signature from the member or the member's representative at the time the meals are delivered. In the event that the member is temporarily unavailable (i.e., doctor's appointment, etc.) and the meal is left, the provider must document the reason a signature is not obtained. The signature logs must be available for review.

(9) **Occupational Therapy services.**

(A) Occupational Therapy services are those services that increase functional independence by enhancing the development of adaptive skills and performance capacities of members with physical disabilities and related psychological and cognitive impairments. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Treatment involves the therapeutic use of self-care, work and play activities and may include modification of the tasks or environment to enable the member to achieve maximum independence, prevent further disability, and maintain health. Under a physician's order, a licensed occupational therapist evaluates the member's rehabilitation potential and develops an appropriate written therapeutic regimen. The regimen utilizes paraprofessional occupational therapy assistant services, within the limits of their practice, working under the supervision of the licensed occupational therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's

case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Occupational Therapy services are billed per fifteen (15) minute unit of service. Payment is not allowed solely for written reports or record documentation.

(10) **Physical Therapy services.**

(A) Physical Therapy services are those services that prevent physical disability through the evaluation and rehabilitation of members disabled by pain, disease or injury. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Treatment involves use of physical therapeutic means such as massage, manipulation, therapeutic exercise, cold or heat therapy, hydrotherapy, electrical stimulation and light therapy. Under a physician's order, a licensed physical therapist evaluates the member's rehabilitation potential and develops an appropriate, written therapeutic regimen. The regimen utilizes paraprofessional physical therapy assistant services, within the limits of their practice, working under the supervision of the licensed physical therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Physical Therapy services are billed per fifteen (15) minute units of service. Payment is not allowed solely for written reports or record documentation.

(11) **Speech and Language Therapy services.**

(A) Speech/Language Therapy services are those that prevent speech and language communication disability through the evaluation and rehabilitation of members disabled by pain, disease or injury. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Services involve use of therapeutic means such as evaluation, specialized treatment, and/or development and oversight of a therapeutic maintenance program. Under a physician's order, a licensed Speech/Language Pathologist evaluates the member's rehabilitation potential and develops an appropriate, written therapeutic regimen. The regimen utilizes paraprofessional therapy assistant services within the limits of their practice, working under the supervision of the licensed Speech/Language Pathologist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The Pathologist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Speech/Language Therapy services are billed per fifteen (15) minute unit of service. Payment is not allowed solely for written reports or record documentation.

(12) **Respiratory Therapy Services.**

(A) Respiratory therapy services are provided for a member who, but for the availability of in-home respiratory services, would require respiratory care as an inpatient in a hospital or nursing facility. Services are provided in the member's home under the care of a physician who is familiar with the technical and medical components of home ventilator support and the physician must determine medically that in-home respiratory care is safe

and feasible for the member. Treatment involves use of therapeutic means such as: evaluation, respiratory treatments, chest physiotherapy, and/or development and oversight of a therapeutic maintenance program. Under a physician's order, a registered respiratory therapist evaluates the member and develops an appropriate, written therapeutic regimen. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Respiratory therapy services are billed per fifteen (15) minute unit of service. Payment is not allowed solely for written reports or record documentation.

~~(13)~~ **~~Hospice Services.~~**

~~(A) 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 six (6) months or less to live and orders hospice care. Medically Fragile Waiver hospice care is authorized for a six (6) month period and requires a physician certification of a terminal illness and orders of hospice care. If the member requires more than six months of hospice care, a physician or nurse practitioner must have a face-to-face visit with the member thirty (30) days prior to the initial hospice authorization end date and re-certify that the member has a terminal illness and has six months or less to live and orders additional hospice care. After the initial authorization period, additional periods of hospice may be authorized for a maximum of sixty (60) days increments with physician certification that the member has a terminal illness and has six months or less to live. A member's service plan that includes hospice care must comply with waiver requirements to be within total service plan cost limits.~~

~~(B) A hospice program offers palliative and supportive care to meet the special needs arising out of the physical, emotional and spiritual stresses which are experienced during the final stages of illness and during dying and bereavement. The member signs a statement choosing hospice care instead of routine medical care that has the objective to treat and cure the member's illness. Once the member has elected hospice care, the hospice medical team assumes responsibility for the member's medical care for the terminal illness in the home environment. Hospice care services include nursing care, physician services, medical equipment and supplies, drugs for symptom control and pain relief, home health aide and personal care services, physical, occupational and/or speech therapy, medical social services, dietary counseling and grief and bereavement counseling to the member and/or family. A hospice plan of care must be developed by the hospice team in conjunction with the member's case manager before hospice services are provided. The hospice services must be related to the palliation or management of the member's terminal illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills. Hospice may be provided to the member in a Nursing Facility (NF) only when the member is placed in the NF for Medically Fragile Facility Based Extended Respite. Hospice provided as part of Facility Based Extended Respite may not be reimbursed for more than five days during any thirty (30) day period. A member that is eligible for Medicare Hospice provided as a Medicare Part A benefit, is not eligible to receive Medically Fragile hospice services.~~

~~(C) Hospice services are billed per diem of service for days covered by a hospice plan of~~

~~care and during which the hospice provider is responsible for providing hospice services as needed by the member or member's family.~~

~~(14)~~(13) **Personal Care.**

(A) Personal Care is assistance to a member in carrying out activities of daily living such as bathing, grooming and toileting, or in carrying out instrumental activities of daily living, such as preparing meals and doing laundry, to assure personal health and safety of the individual or to prevent or minimize physical health regression or deterioration. Personal Care services do not include service provision of a technical nature, i.e. tracheal suctioning, bladder catheterization, colostomy irrigation, and operation/maintenance of equipment of a technical nature.

(B) Medically Fragile Home Care Agency Skilled Nursing staff working in coordination with a case manager are responsible for development and monitoring of the member's Personal Care plan.

(C) Personal Care services are prior authorized and billed per fifteen (15) minute unit of service with units of service limited to the number of units on the approved service plan.

~~(15)~~(14) **Personal Emergency Response System.**

(A) Personal Emergency Response System (PERS) is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable help button to allow for mobility. The system is connected to the person's phone and programmed to signal, in accordance with member preference, a friend, a relative or a response center once a help button is activated. The response center is staffed by trained professionals. For an Medically Fragile program member to be eligible to receive PERS service, the member must meet all of the following service criteria:

(i) A recent history of falls as a result of an existing medical condition that prevents the individual from getting up from a fall unassisted;

(ii) Lives alone and has no regular caregiver, paid or unpaid, and therefore is left alone for long periods of time;

(iii) Demonstrates capability to comprehend the purpose of and activate the PERS;

(iv) Has a health and safety plan detailing the interventions beyond the PERS to assure the member's health and safety in his/her home;

(v) Has a disease management plan to implement medical and health interventions that reduce the possibility of falls by managing the member's underlying medical condition causing the falls; and,

(vi) The service avoids premature or unnecessary institutionalization of the member.

(B) PERS services are billed using the appropriate health care procedure codes for installation, monthly service or purchase of PERS. All services are prior authorized in accordance with the Medically Fragile approved service plan.

~~(16)~~(15) **Prescription drugs.** Members are eligible for a maximum of six (6) prescriptions per month with a limit of three (3) brand-name prescriptions. Seven (7) additional generic prescriptions per month are allowed if medically necessary. Medically necessary prescriptions beyond the three (3) brand-name or thirteen (13) total prescriptions will be covered with prior authorization. More information on prescription drugs is provided at OAC 317:30-5-72.

~~(17)~~(16) **Self-Direction.**

(A) Self-Direction is a method of service delivery that allows waiver members to determine supports and services they need to live successfully in a home or community

based setting. A member choosing Self-Direction is the employer of record for his/her Personal Care and Advanced Supportive/Restorative Care service providers and must have an approved service plan prior to initiation of any Self-Directed activities.

(B) The OHCA uses the following criteria to determine a member's eligibility to participate in the Self-Directed option:

(i) Have an existing need for Self-Directed services to prevent institutionalization;

(ii) Member's health and safety with Self-Directed services can reasonably be assured based on a review of service history records and a review of member capacity and readiness to assume employer responsibilities under Self-Direction with any one of the following findings as basis to deny a request for Self-Direction due to inability to assure member health and safety;

(I) The member does not have the ability to make decisions about his/her care or service planning and the member's authorized representative is not willing to assume Self-Directed services responsibilities; or

(II) The member is not willing to assume responsibility, or to enlist an authorized representative to assume responsibility, in one (1) or more areas of Self-Direction such as in service planning, or in assuming the role of employer of the Personal Care Assistant (PCA) or Advanced Supportive/Restorative (ASR) service provider, or in monitoring and managing health or in preparation for emergency backup; or

(III) The member has a recent history of self-neglect or self-abuse as evidenced by Adult Protective Services intervention within the past twelve (12) months and does not have an authorized representative with capacity to assist with Self-Direction responsibilities.

(C) The member voluntarily makes an informed choice to Self-Direct services. As part of the informed choice, decision making process for Self-Direction, the OHCA staff or the case manager provides consultation and assistance as the member completes a self-assessment of preparedness to assume the role of employer for their PCA. The orientation and enrollment process will provide the member with a basic understanding of what will be expected of them under Self-Direction, the supports available to assist them to successfully perform employer responsibilities and an overview of the potential risks involved.

(D) The OHCA uses the following criteria to determine that based upon documentation, a person is no longer able to participate in the Self-Directed services option:

(i) The member does not have the ability to make decisions about his/her care or service planning and the member's authorized representative is not willing to assume Self-Direction responsibilities; or

(ii) The member is not willing to assume responsibility, or to enlist an authorized representative to assume responsibility, in one or more areas of Self-Direction such as in service planning, or in assuming the role of employer of the PCA or ASR service providers, or in monitoring and managing health or in preparation for emergency backup; or

(iii) The member has a recent history of self-neglect or self-abuse as evidenced by Adult Protective Services intervention and does not have an "authorized representative" with capacity to assist with Self-Direction responsibilities; or

(iv) The member abuses or exploits their employee; or

(v) The member falsifies time-sheets or other work records; or

(vi) The member, even with case manager and financial management services assistance, is unable to operate successfully within their Individual Budget Allocation (IBA); or

(vii) Inferior quality of services provided by member/employer's employee, or the inability of the member/employer's employee to provide the number of service units the member requires, jeopardizes the member's health and/or safety.

(E) The member may designate a family member or friend as an "authorized representative" to assist in the service planning process and in executing member employer responsibilities. If the member chooses to designate an "authorized representative", the designation and agreement identifying the "willing adult" to assume this role and responsibility is documented with dated signatures of the member, the designee and the member's case manager or the OHCA staff.

(i) A person having guardianship or legal power of attorney or other court sanctioned authorization to make decisions on behalf of the member has legal standing to be the member's designated "authorized representative".

(ii) An individual hired to provide Personal Services Assistance to a member may not be designated the "authorized representative" for the member.

(F) Self-Directed Services are delivered as authorized on the service plan and are limited to Personal Care, Respite and Advanced Supportive/Restorative Care. The member employs the respite or PCA and/or the ASR provider and is responsible, with assistance from the Administrative Financial Management Services (FMS), for ensuring that the employment complies with state and federal labor law requirements. The member:

(i) Recruits, hires and, as necessary, discharges the PCA and ASR;

(ii) Provides instruction and training to the PCA or ASR on tasks to be done and works with the case manager to obtain skilled nursing services assistance with training when necessary. Prior to performing an ASR provider task for the first time, the ASR must demonstrate competency in the tasks in an on-the-job training session conducted by the member and the member must document the attendant's competency in performing each task in the ASR provider personnel file;

(iii) Determines where and how the PCA or ASR works, hours of work, what is to be accomplished and, within IBA limits, wages to be paid for the work;

(iv) Supervises and documents employee work time; and

(v) Provides tools and materials for work to be accomplished.

(G) FMS are program administrative services provided to participating Self-Directed Service employer/members by agencies contracted with the OHCA. FMS are employer related assistance that provides Internal Revenue Service (IRS) fiscal reporting agent and other financial management tasks and functions including, but not limited to:

(i) Employer payroll, at a minimum of semi monthly, and associated withholding for taxes, or for other payroll withholdings performed on behalf of the member as employer of the PCA or ASR provider;

(ii) Other employer related payment disbursements as agreed to with the member and in accordance with the member's IBA;

(iii) Responsibility for obtaining criminal and abuse registry background checks, on behalf of the member, on prospective hires for PCA or ASR provider;

(iv) Providing to the member, as needed, assistance with employer related cognitive

tasks, decision-making and specialized skills that may include assistance with IBA planning and support for making decisions including training and providing reference material and consultation regarding employee management tasks such as recruiting, hiring, training and supervising the member's respite or PCA or ASR provider; and

(H) The service of respite or PCA is billed per fifteen (15) minute unit of service. The number of units of PCA a member may receive is limited to the number of units approved on the Service Plan.

(I) ASR services are billed per fifteen (15) minute unit of service. The number of units of ASR a member may receive is limited to the number of units approved on the Service Plan.

(J) Self-Directed Services rates are determined using the IBA expenditure accounts determination process for each member. The IBA expenditure accounts determination process includes consideration and decisions about the following:

(i) The IBA expenditure accounts determination constrains total SoonerCare reimbursement for Self-Directed services to be less than expenditures for equivalent services using agency providers.

(ii) The PCA and ASR service unit rates are calculated by the ~~OHCA~~OKDHS during the Self-Directed service eligibility determination process. The allocation of portions of the PCA and/or ASR rate to cover salary, mandatory taxes, and optional benefits (including worker's compensation insurance, if available) is determined individually for each member using the Self-Directed services IBA expenditure accounts determination process.

(iii) The IBA Expenditure Accounts Determination process defines the level of program financial resources required to meet the member's need for Self-Directed services. If the member's need for services changes due to a change in health/disability status and/or a change in the level of support available from other sources, the case manager, based upon an updated assessment, amends the service plan to increase Self-Directed service units appropriate to meet additional member need. The OHCA, upon favorable review, authorizes the amended plan and updates the member's IBA. Service amendments based on changes in member need for services do not change an existing PCA or ASR rate. The member, with assistance from the FMS, reviews and revises the IBA expenditure accounts calculation annually or more often to the extent appropriate and necessary.

~~(18)~~(17) **Self-Directed Goods and Services (SD-GS).**

(A) Self-Directed Goods and Services (SD-GS) are incidental, non-routine goods and services that promote the member's self-care, daily living, adaptive functioning, general household activity, meal preparation and leisure skills needed to reside successfully in the community and do not duplicate other services authorized in the member's service plan.

(B) These goods and services are purchased from the self-directed budget. All goods and services must be approved by the Medically Fragile wavier staff. Documentation must be available upon request.

~~(19)~~(18) **Transitional case management.**

(A) Transitional case management are one-time billable expenses for members who transition from within the community to the Medically Fragile waiver.

(B) Transitional case management must be reasonable and necessary as determined through the transition plan development process and must be clearly identified in the plan.
(C) Transitional case management assist members that are eligible to receive waiver services in gaining access to needed waiver and other state plan services, as well as needed medical, social, educational, and other services to assist the transition, regardless of the funding source for the services which access is gained.
(D) Transitional case management may be authorized for assisting the member transition to the Medically Fragile Waiver by updating the service plan, including preparing for necessary services and supports to be in place or to start on the date the member is effective with the waiver.

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-35. Oklahoma Statewide Health Information Exchange

(a) **Authority.** This rule is promulgated under the authority granted in Title 63 of the Oklahoma Statutes Section 1-133 (63 O.S. § 1-133). This Section is intended to be read in conjunction with applicable Oklahoma statutes and federal law.

(b) **Applicability and purpose.**

(1) **Applicability.** This section shall apply to and govern the establishment and operation of the statewide health information exchange (HIE)

(2) **Purpose.** The Office of the State Coordinator for HIE is the office within the Oklahoma Health Care Authority (OHCA) that holds the power and duty to oversee the state-designated entity (SDE) for HIE.

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

(1) **"Health care provider"** means any public or private organization, corporation, authority, partnership, sole proprietorship, association, agency, network, joint venture, or other entity that is established and licensed, certified, or otherwise authorized by the laws of this state to administer health care in the ordinary course of business or practice of a profession and/or employs licensed health care workers in the State of Oklahoma. Health care provider includes but is not limited to facilities such as: ambulatory surgery centers, clinics, home care agencies, hospices, hospitals, intermediate care facilities, laboratories, long-term care agencies, medical centers, mental health and substance use disorder treatment centers, nursing homes, PACE centers, pharmacies, physicians' offices, psychiatric hospitals, public health clinics, and rehabilitation centers.

(2) **"Health Information Exchange (HIE)"** means the electronic movement of health-related information among organizations according to nationally recognized standards for purposes including, but not limited to payment, treatment, and administration.

(3) **"Health information exchange organization"** means an entity whose primary business activity is health information exchange and which is governed by its stakeholders.

(4) **"OKSHINE"** means the Oklahoma Statewide Health Information Network and Exchange, a collective effort of the Office of the State Coordinator and SDE in support of statewide health information exchange.

(5) **"Report data to"** means that health care providers shall establish a direct, secure connection to the state designated entity for HIE and submit data according to the United States Core Date for Interoperability (USCDI) standard. The form and format are further defined in the specifications on the OKSHINE website. Providers shall transmit data types they collect within their Electronic Health Record, with the exception of any data that: 1) the provider determines to be sensitive patient information that is to be suppressed from transmission to the SDE; 2) is subject to a patients' request for exclusion, consistent with a

provider-implemented policy; or 3) such transmission would violate state or federal law or regulation.

(6) **"State designated entity (SDE)"** means the health information exchange organization designated by the State of Oklahoma. The name and contact information for the state designated entity for HIE is found on the OKSHINE website.

(7) **"Utilize"** means to actively use the HIE services to securely access records during and/or in support of patient treatment or health care operations.

(d) **~~Required~~HIE participation.**

(1) All health care providers as defined above and who are licensed by and located in the state of Oklahoma and are not otherwise exempted, ~~shall~~may submit an application to report data to and utilize the SDE. Providers may register for an exemption from required participation as specified in paragraph (f) of this Section.

(2) Paragraph (d) of this Section shall not apply to:

(A) A health care provider that does not currently own or subscribe to an electronic health records technology system or service.

(B) Health care providers classified as substance abuse treatment facilities covered by 42 Code of Federal Regulations (CFR) Part 2.

(3) Patient-specific protected health information requiring patient consent prior to disclosure, shall only be disclosed in compliance with relevant state or federal privacy laws, rules, regulations, or policies including, but not limited to, the Health Insurance Portability and Accountability Act of 1996, and any laws that require patient consent prior to sharing health information.

~~(4) The state acknowledges that establishing the connection to the HIE can take substantial time to complete. A health care provider will be considered to have met the requirement to report data to the SDE as long as the provider is actively engaged with the HIE in the onboarding process of connecting to the HIE, and as reported by the SDE.~~

(4)~~(5)~~ In order to ~~meet the requirement to~~ utilize the SDE, each health care provider shall secure access to HIE services by the following:

(A) Completing and maintaining an active participation agreement with the SDE for HIE;

(B) Executing annually an order form electing at a minimum the set of core services relevant to the provider practice or organization; and

(C) Maintaining good standing as a participating organization in the SDE for HIE by remaining compliant with the terms and conditions, network policies and procedures, and paying all fees associated with the services elected on the order form.

(e) **Fees.**

(1) **Subscription fees.** Health care providers ~~as defined in this section are required to subscribe and~~which do participate in the HIE will be responsible to pay a subscription fee directly to the SDE on a monthly or annual basis. Subscription fees are determined based on the organization type and size. Subscription fee schedule is established by the SDE based on network operating costs as approved by the SDE board and can be obtained upon request to the SDE. The Office of the State Coordinator for HIE shall receive notice from the SDE of the established subscription fee schedule or changes to the fee schedule no later than ninety (90) days prior to the effective date.

(2) **Connection fees.** Health care providers ~~as defined in this section are required~~which do

participate in the HIE will need to connect their electronic health record to the SDE to securely report data to the HIE. This is a variable one-time fee paid to the SDE. The Office of the State Coordinator for HIE shall receive notice of connection fees established by the SDE no later than thirty (30) days of being established.

~~(3) **Grant funds.** Health care providers may apply for a grant to cover connection fees subject to the availability of funds. Grant fees for connection will be paid directly to the SDE on behalf of the provider. Information on grant eligibility can be found on OKSHINE website.~~

(f) **Exemptions.**

(1) Any health care provider as defined in paragraph (c) of this section may register an exemption from reporting data to the SDE and/or utilizing the HIE on the OKSHINE website by registering an exemption with the Office of the State Coordinator for HIE.

(2) All providers that register an exemption shall be granted such exemption and shall not be subject to pay subscription fees and/or connection fees.

(3) The exemption will automatically renew annually unless the provider withdraws their exemption and elects to participate.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 79. DENTISTS

317:30-5-696. Coverage by category

Payment is made for dental services as set forth in this Section.

(1) **Adults.** The OHCA Dental Program provides basic medically necessary treatment. The services listed below are compensable for members twenty-one (21) years of age and over without prior authorization.

(A) **Comprehensive oral evaluation.** The comprehensive oral evaluation may be performed when a member has not been seen by the same dentist for more than thirty-six (36) months. The comprehensive oral evaluation must precede any images, and chart documentation must include image interpretations, six-point periodontal charting, and both medical and dental health history of the member. The comprehensive treatment plan should be the final result of this procedure.

(B) **Periodic oral evaluation.** This procedure may be provided for a member once every six (6) months. An examination must precede any images, and chart documentation must include image interpretations, and both medical and dental health history of member. The comprehensive treatment plan should be the final result of this procedure.

(C) **Limited oral evaluation.** This procedure is only compensable to the same dentist or practice for two (2) visits prior to a comprehensive or periodic evaluation examination being completed.

(D) **Images.** To be SoonerCare compensable, images must be of diagnostic quality and medically necessary. A clinical examination must precede any images. Documentation must indicate medical necessity and diagnostic findings. Images must be properly labeled with date and member name. Periapical images must include at least three (3) millimeters beyond the apex of the tooth being imaged. Full mouth images are allowable once in a three (3) year period and must be of diagnostic quality. A series of at least ten (10) periapical films and at least two (2) posterior bitewings is considered a compensable full mouth series. Individually listed intraoral images by the same dentist/dental office are considered a complete series if the number of individual images equals or exceeds the traditional number for a complete series. Panoramic films are only compensable when chart documentation clearly indicates reasons for the exposure based on clinical findings. This type of panoramic film exposure is not to ~~rule out or~~ evaluate caries. Prior authorization and a narrative detailing medical/dental necessity are required for additional panoramic films taken within three (3) years of the original set.

(E) **Dental prophylaxis.** Dental prophylaxis is provided once every six (6) months along with topical application of fluoride.

(F) **Periodontal Maintenance.** This procedure is provided once every six (6) months for members who have a history of periodontitis and are no longer eligible for oral prophylaxis.

(G) **Smoking and tobacco use cessation counseling.** Smoking and tobacco use cessation counseling is covered per Oklahoma Administrative Code (OAC) 317:30-5-2 (DD) (i) through (iv).

(H) ~~**Medically necessary extractions**~~**Extractions.** ~~Medically necessary extractions, as defined in OAC 317:30-5-695.~~ Tooth extraction must have medical need documented. Medical necessity criteria for extraction is described in OAC 317:30-5-695.

(i) **Simple**. Simple extractions are those that do not require sectioning of tooth or cutting of bone. Simple extractions are covered without prior authorization.

(ii) **Complex**. Complex extractions are those that require sectioning of tooth, cutting of bone, or flap reflection. Complex extractions of two (2) or fewer teeth performed on the same date of service by a qualified provider other than an oral surgeon are covered without prior authorization. Complex extractions performed by an oral surgeon are covered without prior authorization.

(I) **Medical and surgical services.** Medical and surgical services performed by a dentist or physician to the extent such services may be performed under State law when those services would be covered if performed by a physician.

(J) **Additional services.** Additional covered services, which require a prior authorization, are outlined in OAC 317:30-5-698.

(2) **Children.** The OHCA Dental Program for children provides medically necessary treatment. For services rendered to a minor, the minor's parent or legal guardian must provide a signed, written consent prior to the service being rendered, unless there is an explicit state or federal exception to this requirement. The services listed below are compensable for members under twenty-one (21) years of age without prior authorization. All other dental services must be prior authorized. Anesthesia services are covered for children in the same manner as adults per OAC 317:30-5-696.1. All providers performing preventive services must be available to perform needed restorative services for those members receiving any evaluation and preventive services.

(A) **Comprehensive oral evaluation.** A comprehensive oral evaluation may be performed when a member has not been seen by the same dentist for more than thirty-six (36) months. The comprehensive oral evaluation must precede any images, and chart documentation must include image interpretations, caries risk assessment, six-point periodontal charting, and both medical and dental health history of member. The comprehensive treatment plan should be the final result of this procedure.

(B) **Periodic oral evaluation.** This procedure may be provided for a member once every six (6) months. An examination must precede any images, and chart documentation must include image interpretations, and both medical and dental health history of member. The comprehensive treatment plan should be the final result of this procedure.

(C) **Limited oral evaluation.** This procedure is only compensable to the same dentist or practice for two (2) visits prior to a comprehensive or periodic evaluation examination being completed.

(D) **Images.** To be SoonerCare compensable, images must be of diagnostic quality and medically necessary. A clinical examination must precede any images, and chart documentation must indicate medical necessity and diagnostic findings. Images must be properly labeled with date and member name. Periapical images must include at least

three (3) millimeters beyond the apex of the tooth being imaged. Full mouth images are allowable once in a three (3) year period and must be of diagnostic quality. A series of at least ten (10) periapical films and at least two (2) posterior bitewings are considered a full mouth series.~~Panoramic films and two (2) bitewings are considered full mouth images. Full mouth series is made up of 2-4 bitewings and full mouth periapical images once every 3 years images as noted above or traditional [minimum of twelve (12) periapical films and two (2) posterior bitewings] are allowable once in a three (3) year period and must be of diagnostic quality.~~ Individually listed intraoral images by the same dentist/dental office are considered a complete series if the number of individual images equals or exceeds the traditional number for a complete series. Panoramic films are only compensable when chart documentation clearly indicates reasons for the exposure based on clinical findings. This type of exposure is not to ~~rule out or~~ evaluate caries. Prior authorization and a detailed medical/dental need narrative are required for additional panoramic films taken within three (3) years of the original set.

(E) **Dental sealants.** Tooth numbers 2, 3, 14, 15, 18, 19, 30 and 31 must be caries free on the interproximal and occlusal surfaces to be eligible for this service. This service is available through eighteen (18) years of age and is compensable once every thirty-six (36) months if medical necessity is documented.

(F) **Interim caries arresting medicament application.** This service is available for primary and permanent teeth once every six (6) months for two (2) occurrences per tooth in a lifetime. The following criteria must be met for reimbursement:

(i) A member is documented to be unable to receive restorative services in the typical office environment within a reasonable amount of time;

(ii) A tooth that has been treated should not have any non-carious structure removed;

(iii) A tooth that has been treated should not receive any other definitive restorative care for three (3) months following an application;

(iv) Reimbursement for extraction of a tooth that has been treated will not be allowed for three (3) months following an application; and

(v) The specific teeth treated and number and location of lesions must be documented.

(G) **Dental prophylaxis.** This procedure is provided once every six (6) months along with topical application of fluoride.

(H) **Periodontal Maintenance.** This procedure is provided once every six (6) months for members who have a history of periodontitis and are no longer eligible for oral prophylaxis.

(I) **Stainless steel crowns for primary teeth.** The use of any stainless steel crowns is allowed as follows:

(i) Stainless steel crowns are allowed if:

(I) The child is five (5) years of age or under;

(II) Seventy percent (70%) or more of the root structure remains; or

(III) The procedure is provided more than twelve (12) months prior to normal exfoliation.

(ii) Stainless steel crowns are treatment of choice for:

(I) Primary teeth treated with pulpal therapy, if the above conditions exist;

(II) Primary teeth where three (3) surfaces of extensive decay exist; or

(III) Primary teeth where cuspal occlusion is lost due to decay or accident.

(iii) Preoperative periapical images and/or written documentation explaining the extent of decay must be available for review, if requested.

(iv) Placement of a stainless steel crown is allowed once for a minimum period of twenty-four (24) months. No other restoration on that tooth is compensable during that period of time. A stainless steel crown is not a temporizing treatment to be used while a permanent crown is being fabricated.

(J) **Stainless steel crowns for permanent teeth**. The use of any stainless steel crowns is allowed as follows:

(i) Stainless steel crowns are the treatment of choice for:

(I) Posterior permanent teeth that have completed endodontic therapy if three (3) or more surfaces of tooth is destroyed;

(II) Posterior permanent teeth that have three (3) or more surfaces of extensive decay; or

(III) Where cuspal occlusion is lost due to decay prior to age sixteen (16) years.

(ii) Preoperative periapical images and/or written documentation explaining the extent of decay must be available for review, if requested.

(iii) Placement of a stainless steel crown excludes placement of any other type of crown for a period of twenty-four (24) months. No other restoration on that tooth is compensable during that period of time.

(K) **Pulpotomies and pulpectomies.**

(i) Therapeutic pulpotomies and pulpal debridement are allowable once per lifetime. Pre-and post-operative periapical images must be available for review, if requested. Therapeutic pulpotomies and pulpal debridement is available for the following:

(I) Primary molars having at least seventy percent (70%) or more of their root structure remaining or more than twelve (12) months prior to normal exfoliation;

(II) Tooth numbers O and P before age five (5) years;

(III) Tooth numbers E and F before six (6) years;

(IV) Tooth numbers N and Q before five (5) years;

(V) Tooth numbers D and G before five (5) years.

(ii) Therapeutic pulpotomies and pulpal debridement are allowed for primary teeth if exfoliation of the teeth is not expected to occur for at least one (1) year or if seventy percent (70%) or more of root structure is remaining.

(L) **Space maintainers.** Certain limitations apply with regard to this procedure. Providers are responsible for recementation of any maintainer placed by them for six (6) months post insertion.

(i) **Band and loop type space maintenance.** This procedure must be provided in accordance with the following guidelines:

(I) This procedure is compensable for all primary molars where permanent successor is missing or where succedaneous tooth is more than five (5) millimeters below the crest of the alveolar ridge.

(II) First primary molars are not allowed space maintenance if the second primary and first permanent molars are present and in cuspal interlocking occlusion regardless of the presence or absence of normal relationship.

(III) If there are missing posterior teeth bilaterally in the same arch, under the above guidelines, bilateral space maintainer is the treatment of choice.

(IV) The teeth numbers shown on the claim must be those of the missing teeth.

(V) Post-operative bitewing images must be available for review.

(VI) Bilateral band and loop space maintainer is allowed if member does not have eruption of the four (4) mandibular anterior teeth in position or if sedation case that presents limitations to fabricate other space maintenance appliances.

(ii) **Lingual arch bar.** Payment is made for the services provided in accordance with the following:

(I) Lingual arch bar is used when permanent incisors are erupted and the second primary molar (K or T) is missing in the same arch.

(II) The requirements are the same as for band and loop space maintainer.

(III) Pre and post-operative images must be available.

(M) **Analgesia.** Analgesia services are reimbursable in accordance with the following:

(i) **Inhalation of nitrous oxide.** Use of nitrous oxide is compensable for four (4) occurrences per year and is not separately reimbursable, if provided on the same date as IV sedation, non-intravenous conscious sedation, or general anesthesia. The medical need for this service must be documented in the member's record.

(ii) **Non-intravenous conscious sedation.** Non-intravenous conscious sedation is not separately reimbursable, if provided on the same date as analgesia, anxiolysis, inhalation of nitrous oxide, IV sedation, or general anesthesia. Non-intravenous conscious sedation is reimbursable when determined to be medically necessary for documented handicapped members, uncontrollable members or justifiable medical or dental conditions. The report must detail the member's condition. No services are reimbursable when provided primarily for the convenience of the member and/or the dentist, it must be medically necessary.

(N) **Pulp caps.** Indirect and direct pulp cap must be ADA accepted calcium hydroxide or mineral trioxide aggregate (MTA) materials, not a cavity liner or chemical used for dentinal hypersensitivity. Indirect and direct pulp cap codes require specific narrative support addressing materials used, intent and reasons for use. Application of chemicals used for dentinal hypersensitivity is not allowed as indirect pulp cap. Utilization of these codes is verified by post payment review.

(O) **Protective restorations.** This restoration includes removal of decay, if present, and is reimbursable for the same tooth on the same date of service with a direct or indirect pulp cap, if needed. Permanent restoration of the tooth is allowed after sixty (60) days unless the tooth becomes symptomatic and requires pain relieving treatment.

(P) **Smoking and tobacco use cessation counseling.** Smoking and tobacco use cessation counseling is covered per OAC 317:30-5-2 (DD) (i) through (iv).

(Q) **Extractions.** Tooth extraction must have medical need documented. Medical necessity criteria for extraction is described in OAC 317:30-5-695.

(i) **Simple**. Simple extractions are those that do not require sectioning of tooth or

cutting of bone. Simple extractions are covered without prior authorization.

(ii) **Complex**. Complex extractions are those that require sectioning of tooth, cutting of bone, or flap reflection. Complex extractions of two (2) or fewer teeth performed on the same date of service by a qualified provider other than an oral surgeon are covered without prior authorization. Complex extractions performed by an oral surgeon are covered without prior authorization.

~~(Q)~~(R) **Additional services.** Additional covered services, which require a prior authorization, are outlined in OAC 317:30-5-698.

(3) **1915(c) home and community-based services (HCBS) waivers.** Dental services are defined in each waiver and must be prior authorized.

317:30-5-698. Services requiring prior authorization

(a) **Prior authorizations.** Providers must have prior authorization for certain specified services before delivery of that service, unless the service is provided on an emergency basis [See Oklahoma Administrative Code (OAC) 317:30-5-695(d)(2)]. Requests for dental services requiring prior authorization must be accompanied by sufficient documentation.

(b) **Requests for prior authorization.** Requests for prior authorization, and any related documents, must be submitted electronically through the OHCA secure provider portal. Prior authorized services must be billed exactly as they appear on the prior authorization. Payment is not made for any services provided prior to receiving authorization except for the relief of pain.

(c) **Prosthodontic services.** Prosthodontic services provided to members who have become ineligible mid-treatment are covered if the member was eligible for SoonerCare on the date the final impressions were made.

(d) **Adults.** Listed below are examples of services requiring prior authorization for members twenty-one (21) years of age and over/older. Minimum required records to be submitted with each request are right and left mounted bitewings and periapical films or images of tooth/teeth involved or the edentulous areas if not visible in the bitewings. Images must be of diagnostic quality. Images must be identified by the tooth number and include date of exposure, member name, member ID, provider name, and provider ID. If diagnostic quality radiographs are not possible, detailed narrative and other images identifying the dentition affected by the treatment plan must be submitted. All images, regardless of the media, must be submitted together with a completed and signed comprehensive treatment plan that details all needed treatment at the time of examination, with the prior authorization requesting all needed treatment. The images, digital media, and photographs must be of sufficient type and quality to clearly demonstrate for the reviewer, the pathology which is the basis for the authorization request. Documentation of a periodontal evaluation with six (6) point measurements for teeth to remain must be included with requests.

(1) **Removable prosthetics.**

(A) This includes full and partial dentures.

(i) One (1) per every five (5) years is available for adults under twenty-five (25) years of age.

(ii) One (1) per every seven (7) years is available for adults twenty-five (25) years of age and over.

(iii) Provider is responsible for any needed follow up for a period of two (2) years post insertion.

(B) Partial dentures are allowed for replacement of missing anterior permanent teeth or two (2) or more missing posterior teeth in the same arch. Provider must indicate which teeth will be replaced.

(2) **Periodontal scaling and root planing.** Procedure involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. This procedure requires that each tooth involved have three (3) or more of the six-point measurements (probing pocket depths) equivalent to four (4) millimeters or greater, and image supported alveolar bone loss. Image supported subgingival calculus, and bleeding on probing, must be demonstrated on multiple teeth for consideration of scaling and root planing. A minimum of two (2) teeth per quadrant must be involved, with the appropriate CDT code usage for fewer than four (4) teeth per quadrant. This procedure is not allowed in conjunction with any other periodontal surgery. Four quadrants of scaling and root planing will not be approved in conjunction with recent oral prophylaxis.

(3) **Scaling in the presence of generalized moderate or severe gingival inflammation.** Procedure is designed for removal of plaque, calculus and stain from supra- and sub-gingival tooth surfaces when there is generalized moderate or severe gingival inflammation as indicated by generalized suprabony pockets and bleeding on probing, in the absence of periodontitis (alveolar bone loss). Generalized supra- and sub-gingival calculus, and moderate to severe inflammation must be demonstrated, with probing pocket depths of five (5) mm or greater. This procedure is intended for scaling of the entire mouth in lieu of oral prophylaxis, and is only performed after a comprehensive evaluation has been completed.

(4) **Complex extractions**. Complex extractions are those that require sectioning of tooth, cutting of bone, or flap reflection. Complex extractions of more than two (2) teeth performed on the same date of service by a qualified provider other than an oral surgeon require prior authorization. Medical necessity criteria for extractions is described in OAC 317:30-5-695.

(e) **Children.** Listed below are examples of services requiring prior authorization for members under twenty-one (21) years of age. Minimum required records to be submitted with each request are right and left mounted bitewings and periapical films or images of tooth/teeth involved or the edentulous areas if not visible in the bitewings. Images must be of diagnostic quality. Images must be identified by the tooth number and include date of exposure, member name, member ID, provider name, and provider ID. If diagnostic quality radiographs are not possible, detailed narrative and other images identifying the dentition affected by the treatment plan must be submitted. All images, regardless of the media, must be submitted together with a completed and signed comprehensive treatment plan that details all needed treatment at the time of examination, and a completed prior authorization requesting all needed treatments. The images, digital media, and photographs must be of sufficient quality to clearly demonstrate for the reviewer, the pathology which is the basis for the authorization request.

(1) **Endodontics.** Root canal therapy is not considered an emergency procedure unless due to trauma to an anterior tooth. The provider must document the member's improved oral hygiene and flossing ability and submit it with the prior authorization request to be considered when requesting endodontic therapy for multiple teeth. Pulpal debridement may be performed for the relief of pain while waiting for the decision from the Oklahoma Health Care Authority (OHCA) on request for endodontics.

(A) Payment is made for services provided in accordance with the following guidelines:

(i) Permanent teeth only;
(ii) Only ADA accepted materials are acceptable under the OHCA policy;
(iii) Pre and post-operative periapical images must be available for review;
(iv) Providers are responsible for any follow-up treatment required by a failed endodontically treated tooth within twenty-four (24) months post completion;
(v) A tooth will not be approved if it appears there is not adequate natural tooth structure remaining to establish good tooth/restorative margins or if crown to root ratio is poor. Approval of second molars is contingent upon proof of medical necessity; and
(vi) An endodontic procedure may not be approved if the tooth requires a post and core to retain a crown due to lack of tooth structure.

(B) Endodontics will not be considered if:
(i) An opposing tooth has super erupted;
(ii) The tooth impinges upon space of adjacent tooth space by one third or greater;
(iii) Fully restored tooth will not be in functional occlusion with opposing tooth;
(iv) Opposing second molars are involved unless prior authorized;
(v) The member has multiple teeth failing due to previous inadequate root canal therapy or follow-up.

(C) All rampant, active caries must be removed prior to requesting endodontics.

(D) Endodontically treated teeth must be restored to limited occlusal function and all contours must be replaced. Core build-up code is only available for use if other restorative codes are not sufficient. These teeth will not be approved for a crown if it appears the apex is not adequately sealed.

(2) **Crowns for permanent teeth.** Crowns are compensable for restoration of natural teeth for members who are sixteen (16) through twenty (20) years of age. Certain criteria and limitations apply.

(A) The following conditions must exist for approval of this procedure:
(i) All rampant, active caries must be removed prior to requesting any type of crown;
(ii) The tooth must be decayed to such an extent to prevent proper cuspal or incisal function;
(iii) The clinical crown is fractured or destroyed by one-half or more; and
(iv) Endodontically treated teeth must have three (3) or more surfaces restored or lost due to carious activity to be considered for a crown.

(B) The conditions listed above in (A)(i) through (iv) must be clearly visible on the submitted images when a request is made for any type of crown.

(C) Routine build-up(s) for authorized crowns are included in the fee for the crown.

(D) A crown will not be approved if adequate tooth structure does not remain to establish cleanable margins, there is invasion of the biologic width, poor crown to root ratio, or the tooth appears to retain insufficient amounts of natural tooth structure. Cast dowel cores are not allowed for molar or pre-molar teeth.

(E) Preformed post(s) and core build-up(s) are not routinely provided with crowns for endodontically treated teeth.

(F) Chart documentation must include the OHCA caries risk assessment form demonstrating member is at a low to moderate risk and be submitted with the prior

authorization request for crowns for permanent teeth.

(G) Provider is responsible for replacement or repair of all crowns if failure is caused by poor laboratory processes or procedure by provider for forty-eight (48) months post insertion.

(3) **Partial dentures.**

(A) This appliance is the treatment of choice for replacement of missing anterior permanent teeth or two (2) or more missing posterior teeth in the same arch for members sixteen (16) years of age and older.

(B) Interim partial dentures are available for children five (5) years of age and older.

(C) Provider must indicate which teeth will be replaced.

(D) Members must have improved oral hygiene documented for at least twelve (12) months in the provider's records and submitted with prior authorization request to be considered.

(E) Provider is responsible for any needed follow up for a period of two (2) years post insertion.

(F) This appliance includes all necessary clasps and rests.

(4) **Occlusal guard.** Narrative of medical necessity must be sent with prior authorization.

(5) **Fixed cast non-precious metal or porcelain/metal bridges.** Only members seventeen (17) through twenty (20) years of age will be considered for this treatment. Destruction of healthy teeth to replace a single missing tooth is not considered medically necessary. Members must have excellent oral hygiene documented for at least eighteen (18) months in the requesting provider's records and submitted with prior authorization request to be considered. Provider is responsible for any needed follow up until member loses eligibility.

(6) **Periodontal scaling and root planing.** Procedure involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. This procedure requires that each tooth involved have three (3) or more of the six-point measurements (probing pocket depths) equivalent to four (4) millimeters or greater, and image supported alveolar bone loss. Image supported subgingival calculus, and bleeding on probing, must be demonstrated on multiple teeth for consideration of scaling and root planing. A minimum of two (2) teeth per quadrant must be involved, with the appropriate CDT code usage for fewer than four (4) teeth per quadrant. This procedure is not allowed in conjunction with any other periodontal surgery. Four quadrants of scaling and root planing will not be approved in conjunction with recent oral prophylaxis.

(7) **Scaling in the presence of generalized moderate or severe gingival inflammation.** Procedure is designed for removal of plaque, calculus and stain from supra- and sub-gingival tooth surfaces when there is generalized moderate or severe gingival inflammation as indicated by generalized suprabony pockets and bleeding on probing, in the absence of periodontitis (alveolar bone loss). Generalized supra- and sub-gingival calculus, and moderate to severe inflammation must be demonstrated, with probing pocket depths of five (5) mm or greater. This procedure is intended for scaling of the entire mouth in lieu of oral prophylaxis, and is only performed after a comprehensive evaluation has been completed.

(8) **Complex extractions**. Complex extractions are those that require sectioning of tooth, cutting of bone, or flap reflection. Complex extractions of more than two (2) teeth performed

on the same date of service by a qualified provider other than an oral surgeon require prior authorization. Medical necessity criteria for extractions is described in OAC 317:30-5-695.

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SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 105. RESIDENTIAL BEHAVIORAL MANAGEMENT SERVICES IN GROUP SETTINGS

317:30-5-1043. Coverage by category

(a) **Adults.** Residential Behavioral Management Services (RBMS) in group settings are not covered for adults.

(b) **Children.** RBMS in group settings are covered for children as set forth in this subsection.

(1) **Description**. RBMS are provided by Organized Health Care Delivery Systems (OHCDS) for children in the care and custody of the State who have special psychological, behavioral, emotional and social needs that require more intensive care than can be provided in a family or foster home setting. The behavior management services are provided in the least restrictive environment and within a therapeutic milieu. The group setting is restorative in nature, allowing children with emotional and psychological problems to develop the necessary control to function in a less restrictive setting. RBMS are reimbursed in accordance with established rate methodology as described in the Oklahoma Medicaid State Plan. It is expected that RBMS in group settings are an all-inclusive array of treatment services provided in one (1) day. In the case of a child who needs additional specialized services, under the Rehabilitation Option or by a psychologist, prior authorization by the OHCA or designated agent is required. Only specialized rehabilitation or psychological treatment services to address unique, unusual or severe symptoms or disorders will be authorized. If additional services are approved, the OHCDS collaborates with the provider of such services as directed by the OHCA or its agent. Any additional specialized behavioral health services provided to children in state custody are funded in the normal manner. The OHCDS must provide concurrent documentation that these services are not duplicative. The OHCDS determines the need for RBMS.

(2) **Medical necessity criteria.** The following medical necessity criteria must be met for RBMS.

(A) Any Diagnostic and Statistical Manual of Mental Disorders (DSM) primary diagnosis, with the exception of V codes, with a detailed description of the symptoms supporting the diagnosis. A detailed description of the child's emotional, behavioral and psychological condition must be on file.

(B) The child is medically stable and not actively suicidal or homicidal and not in need of substance abuse detoxification services.

(C) It has been determined by the OHCDS that the current disabling symptoms could not have been or have not been manageable in a less intensive treatment program.

(D) Documentation that the child's presenting emotional and/or behavioral problems prevent the child from living in a traditional family home. The child requires the availability of twenty-four (24) hour crisis response/behavior management and intensive clinical interventions from professional staff.

(E) The agency which has permanent or temporary custody of the child agrees to active participation in the child's treatment needs and planning.

(F) All of the medical necessity criteria must also be met for continued stay in residential group settings.

(3) **Treatment components.**

(A) **Individual plan of care development.** A comprehensive individualized plan of care for each resident shall be formulated by the provider agency staff within ~~thirty (30)~~ten (10) days of admission, for intensive treatment services (ITS) level within seventy-two (72) hours, with documented input from the agency which has permanent or temporary custody of the child and when possible, the parent. This plan must be revised and updated at least every ~~three (3) months~~thirty (30) days for children under thirteen (13) years of age and every sixty (60) days for youth age thirteen (13) and older, and every seven (7) days for ITS, with documented involvement of the agency which has permanent or temporary custody of the child. Documented involvement can be written approval of the individual plan of care by the agency which has permanent or temporary custody of the child and indicated by the signature of the agency case worker or liaison on the individual plan of care. It is acceptable in circumstances where it is necessary to fax a service plan to someone for review and then have him/her fax back his/her signature; however, the provider obtains the original signature for the clinical file within thirty (30) days. No stamped or Xeroxed signatures are allowed. An individual plan of care is considered inherent in the provision of therapy and is not covered as a separate item of behavior management services. The individual plan of care is individualized taking into account the child's age, history, diagnosis, functional levels, and culture. It includes appropriate goals and time limited and measurable objectives. Each member's individual plan of care must also address the provider agency's plans with regard to the provision of services in each of the following areas:

(i) Group therapy;
(ii) Individual therapy;
(iii) Family therapy;
(iv) Alcohol and other drug counseling;
(v) Basic living skills redevelopment;
(vi) Social skills redevelopment;
(vii) Behavior redirection; and
(viii) The provider agency's plan to access appropriate educational placement services. (Any educational costs are excluded from calculation of the daily rate for behavior management services.)

(B) **Individual therapy.** The provider agency must provide individual therapy on a weekly basis with a minimum of one (1) or more sessions totaling one (1) hour or more of treatment per week to children and youth receiving RBMS in group homes. Individual therapy must be age appropriate and the techniques and modalities employed relevant to the goals and objectives of the individual's plan of care. Individual counseling is a face-to-face, one-to-one service, and must be provided in a confidential setting.

(C) **Group therapy.** The provider agency must provide group therapy to children and youth receiving RBMS. Group therapy must be a face-to-face interaction, age appropriate and the techniques and modalities employed relevant to the goals and objectives of the individual's plan of care. The minimum expected occurrence would be one (1) hour per week in group homes. Group size should not exceed six (6) members and group therapy

sessions must be provided in a confidential setting. Thirty (30) minutes of individual therapy may be substituted for one (1) hour of group therapy.

(D) **Family therapy.** The provider agency must provide family therapy on a weekly basis with a minimum of one (1) or more sessions totaling one (1) hour or more of treatment per week to children and youth receiving RBMS in group homes. Family therapy is a face-to-face interaction between the therapist/counselor and family, to facilitate emotional, psychological or behavioral changes and promote successful communication and understanding. ~~The provider agency must provide family therapy as indicated by the resident's individual plan of care.~~ The agency must work with the caretaker to whom the resident will be discharged, as identified by the OHCDS custody worker such as a family member or adult community connection. If no family member or connection is identified, an OHCDS custody worker must participate unless granted an exception by the OHCDS. The agency must seek to support and enhance the child's relationships with family members (nuclear and appropriate extended), if the custody plan for the child indicates family reunification. The RBMS provider must also seek to involve the child's parents in treatment team meetings, plans and decisions and to keep them informed of the child's progress in the program. Any service provided to the family must have the child as the focus.

(E) **Alcohol and other drug abuse treatment education, prevention, therapy.** The provider agency must provide alcohol and other drug abuse treatment for residents who have emotional or behavioral problems related to substance abuse/chemical dependency, to begin, maintain and enhance recovery from alcoholism, problem drinking, drug abuse, drug dependency addiction or nicotine use and addiction. This service is considered ancillary to any other formal treatment program in which the child participates for treatment and rehabilitation. For residents who have no identifiable alcohol or other drug use, abuse, or dependency, age appropriate education and prevention activities are appropriate. These may include self-esteem enhancement, violence alternatives, communication skills or other skill development curriculums.

(F) **Basic living skills redevelopment.** The provider agency must provide goal-directed activities designed for each resident to restore, retain, and improve those basic skills necessary to independently function in a family or community. Basic living skills redevelopment is age appropriate and relevant to the goals and objectives of the individual plan of care. This may include, but is not limited to food planning and preparation, maintenance of personal hygiene and living environment, household management, personal and household shopping, community awareness and familiarization with community resources, mobility skills, job application and retention skills.

(G) **Social skills redevelopment.** The provider agency must provide goal-directed activities designed for each resident to restore, retain and improve the self-help, communication, socialization, and adaptive skills necessary to reside successfully in home and community based settings. These are age appropriate, culturally sensitive and relevant to the goals of the individual plan of care. For ITS level of care, the minimum skill redevelopment per day is three (3) hours. Any combination of basic living skills and social skills redevelopment that is appropriate to the need and developmental abilities of the child is acceptable.

(H) **Behavior redirection.** The provider agency must be able to provide behavior

redirection management by agency staff as needed twenty-four (24) hours a day, seven (7) days per week. The agency must ensure staff availability to respond in a crisis to stabilize residents' behavior and prevent placement disruption. In addition, ITS group homes will be required to provide crisis stabilization interaction and treatment for new residents twenty-four (24) hours a day, seven (7) days a week.

(4) **Providers.** For eligible RBMS agencies to bill the OHCA for services provided by their staff for behavior management therapies (individual, group, family) as of July 1, 2007, providers must have the following qualifications:

(A) Be licensed in the state in which the services are delivered as a licensed psychologist, social worker (clinical specialty only), professional counselor, marriage and family therapist, or behavioral practitioner, alcohol and drug counselor or under Board approved supervision to be licensed in one (1) of the above stated areas; or

(B) Be licensed as an advanced practice registered nurse (APRN) certified in a psychiatric mental health specialty, and licensed as a registered nurse (RN) with a current certification of recognition from the Board of Nursing in the state in which services are provided; and

(C) Demonstrate a general professional or educational background in the following areas:

(i) Case management, assessment and treatment planning;

(ii) Treatment of victims of physical, emotional, and sexual abuse;

(iii) Treatment of children with attachment disorders;

(iv) Treatment of children with hyperactivity or attention deficit disorders;

(v) Treatment methodologies for emotionally disturbed children and youth;

(vi) Normal childhood development and the effect of abuse and/or neglect on childhood development;

(vii) Treatment of children and families with substance abuse and chemical dependency disorders;

(viii) Anger management; and

(ix) Crisis intervention.

(D) Staff providing basic living skills redevelopment, social skills redevelopment, and alcohol and other substance abuse treatment, must meet one (1) of the following areas:

(i) Bachelor's or master's degree in a behavioral health related field including but not limited to, psychology, sociology, criminal justice, school guidance and counseling, social work, occupational therapy, family studies, alcohol and drug; or

(ii) Currently licensed and in good standing as an RN in the state in which services are provided; or

(iii) Certification as an alcohol and drug counselor to provide substance abuse rehabilitative treatment to those with alcohol and/or other drug dependencies or addictions as a primary or secondary DSM diagnosis; or

(iv) Current certification as a behavioral health case manager from the Oklahoma Department of Mental Health and Substance Abuse (ODMHSAS) and meets OHCA requirements to perform case management services, as described in Oklahoma Administrative Code (OAC) 317:30-5-240 through 317:30-5-249.

(E) Staff providing behavior redirection services must have current certification and required updates in nationally recognized behavior management techniques, such as Controlling Aggressive Patient Environment (CAPE) or MANDT. Additionally, staff

providing these services must receive initial and ongoing training in at least one (1) of the following areas:

(i) Trauma-informed methodology;

(ii) Anger management;

(iii) Crisis intervention;

(iv) Normal child and adolescent development and the effect of abuse;

(v) Neglect and/or violence on such development;

(vi) Grief and loss issues for children in out of home placement;

(vii) Interventions with victims of physical, emotional and sexual abuse;

(viii) Care and treatment of children with attachment disorders;

(ix) Care and treatment of children with hyperactive, or attention deficit, or conduct disorders;

(x) Care and treatment of children, youth and families with substance abuse and chemical dependency disorders;

(xi) Passive physical restraint procedures; or

(xii) Procedures for working with delinquents or the Inpatient Mental Health and Substance Abuse Treatment of Minors Act.

(F) In addition, behavior management staff must have access to consultation with an appropriately licensed mental health professional.

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SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 34. SECURE BEHAVIORAL HEALTH TRANSPORTATION

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 purposes delineated in OAC 317:30-5-348(a), including ~~for the following~~:

(1) Transportation to ~~a facility~~hospitals and other appropriate behavioral health facilities ~~arranged by individuals~~ authorized by ODMHSAS~~, including but not limited to, hospitals and other mental health facilities~~;

(2) Facility-to-facility transports~~; and~~, provided that the member has been assessed as meeting criteria for emergency detention prior to transport; and

~~(3) Transport of a member seeking voluntary admission to a facility.~~

(3) Court-ordered transport for the purpose of evaluation and/or treatment.

(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.

317:30-5-351. 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 for loaded mileage per the methodology described in the Oklahoma Medicaid State Plan.

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PART 21. OUTPATIENT BEHAVIORAL HEALTH AGENCY 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~~substance use disorder 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) **Qualified practitioners**. Services must be provided by an LBHP or licensure candidate. Additional qualified team members who are behavioral health professionals/paraprofessionals may assist with LBHP or licensure candidate direction and supervision.

~~(2)~~(3) **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.

~~(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.~~ for the resolution of crisis situations within a crisis unit where the individual is admitted for treatment. Services include triage, evaluation, detoxification, and crisis stabilization.

(1) **Qualified practitioners.** FBCS services are provided under the supervision of a physician aided by ~~a~~ licensed ~~nurse~~nurses, and also include LBHPs, ~~and~~ licensure candidates, and other support staff for the provision of group and individual treatments. A physician must be available twenty-four (24) hours a day, seven (7) days per week, either on-site or on-call. ~~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. 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. 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.~~

(c) **Urgent Recovery Clinic (URC).** Urgent Recovery Clinic services are non-hospital emergency services provided in a clinic setting for mental health and substance use crisis response. Services include triage crisis response, crisis intervention, assessment, intervention plan development, and referral, when necessary, to a higher level of care and/or other treatment services. Services are aimed at the assessment and immediate stabilization of acute symptoms of mental illness, substance use disorder, and emotional distress.

(1) Qualified practitioners. A minimum of one (1) Licensed Practical Nurse or Registered Nurse shall be available, either in-person or via telehealth, at the URC twenty-four (24) hours a day, seven (7) days per week. Licensed behavioral health professionals and other support staff shall be adequate in number to provide care needed by consumers twenty-four (24) hours a day, seven (7) days per week. The URC shall provide or otherwise ensure the capacity for a practitioner with prescriptive authority and adequate staff with the authority to administer medications at all times for consumers in need of emergency medication services.

(2) Limitations. The unit of service is per event. 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. Providers of this service must meet the requirements delineated in the OAC 450:23.

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

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PART 6. INPATIENT PSYCHIATRIC AND SUBSTANCE USE DISORDER SERVICES

317:30-5-95.40. Other required standards

The provider is required to maintain all programs and services according to applicable C.F.R. requirements, the Joint Commission (TJC) and American Osteopathic Association (AOA) standards for behavioral health care, Oklahoma State Department of Health's (OSDH) hospital standards for psychiatric care, and Oklahoma Department of Human Services (OKDHS) licensing standards for residential treatment facilities. PRTFs may substitute accreditation by the Commission on Accreditation of Rehabilitation Facilities (CARF) or any other accreditation provider approved by the Center for Medicare and Medicaid Services (CMS)~~accreditation~~ in lieu of TJC or AOA accreditation. In addition to federal requirements, out-of-state inpatient psychiatric facilities must adhere to OAC 317:30-5-95 and 317:30-5-95.24.

317:30-5-95.44. Residential substance use disorder (SUD) - Eligible providers and requirements

(a) Eligible providers shall:

(1) Have and maintain current certification from the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) as a residential level of care provider of SUD treatment services, unless exempt from state jurisdiction or an exempted entity as defined in Section 3-415 of Title 43A of the Oklahoma Statutes;

(2) Have a contract with the OHCA;

(3) Have a Certificate of Need, if required by ODMHSAS in accordance with OAC 450:18-17-2 or OAC 450:24-27-2.

(4) Have a current accreditation status appropriate to provide residential behavioral health services from:

(A) The Joint Commission; or

(B) The Commission on Accreditation of Rehabilitative Facilities (CARF); or

(C) The Council on Accreditation (COA)~~.~~; or

(D) any other accreditation provider approved by the Center for Medicare and Medicaid Services (CMS).

(b) Providers certified by ODMHSAS as a residential level of care provider of SUD treatment services prior to October 1, 2020 shall have until January 1, 2022 to obtain accreditation as required in (4) above.

(c) Residential treatment facilities providing SUD treatment services to individuals under the age of eighteen (18) must have a residential child care facility license from the Oklahoma Department of Human Services (DHS). Residential treatment facilities providing child care services must have a child care center license from DHS.

317:30-5-95.52. Documentation of records for adults receiving Residential Substance Use Disorder services

(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.

(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 115. PHARMACISTS

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 Oklahoma State Board of Pharmacy 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.

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SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 1. PHYSICIANS

317:30-5-18. ~~Elective sterilizations~~Sterilizations

(a) Elective Sterilizations

~~(a)~~(1) Payment is made to hospitals for elective sterilizations performed ~~in~~on behalf of eligible individuals if all of the following circumstances are met:

~~(1)~~(A) The patient must be at least 21 years of age at the time the consent form is signed,

~~(2)~~(B) The patient must be mentally competent,

~~(3)~~(C) A properly completed Federally mandated consent for sterilization form is attached to the claim, and

~~(4)~~(D) The form is signed by the patient at least 30 days, but not more than 180 days prior to the surgery.

~~(b)~~(2) When a sterilization procedure is performed in conjunction with a C-section, it is considered multiple surgery and a consent form for the sterilization is required.

~~(c)~~(3) Reversal of sterilization procedures for the purposes of conception are not covered. Reversal of sterilization procedures may be covered when medically necessary and substantiating documentation is attached to the claim.

(b) Non-elective sterilizations

(1) Surgical procedures performed for medically necessary reasons other than elective sterilization, but which result in sterilization do not require the OHCA sterilization consent form and accompanying 30-day minimum wait period when one of the following circumstances are met:

(A) A properly completed acknowledgement is attached to the claim form. The acknowledgment must clearly state that the patient or their representative was informed, orally, and in writing prior to the surgery that they would be rendered permanently incapable of reproduction.

(B) The surgeon must certify in writing that the patient was sterile prior to the surgery. The reason for sterility, i.e. chemotherapy, radiation, etc. must be given.

(C) The surgeon must certify that the surgery was performed in an emergency, life endangering situation. The life endangering circumstances must be given.

(2) The acknowledgement for surgical procedures performed for medically necessary reasons other than elective sterilization may be signed by the patient and dated after the surgery as long as the acknowledgment meets all other requirements including being advised orally and in writing that they would be rendered sterile as a result of the surgery.

PART 3. HOSPITALS

317:30-5-51. ~~Elective sterilizations~~Sterilizations

(a) Elective Sterilizations

~~(a)~~(1) Payment is made to hospitals for elective sterilizations performed ~~in~~on behalf of eligible individuals if all of the following circumstances are met:

~~(1)~~(A) The patient must be at least 21 years of age at the time the consent form is signed,

~~(2)~~(B) The patient must be mentally competent,

~~(3)~~(C) A properly completed Federally mandated consent for sterilization form is attached to the claim, and

~~(4)~~(D) The form is signed by the patient at least 30 days, but not more than 180 days prior to the surgery.

~~(b)~~(2) When a sterilization procedure is performed in conjunction with a C-section, it is considered multiple surgery and a consent form for the sterilization is required.

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(1) Surgical procedures performed for medically necessary reasons other than elective sterilization, but which result in sterilization do not require the OHCA sterilization consent form and accompanying 30-day minimum wait period when one of the following circumstances are met:

(A) A properly completed acknowledgement is attached to the claim form. The acknowledgment must clearly state that the patient or their representative was informed, orally, and in writing prior to the surgery that they would be rendered permanently incapable of reproduction.

(B) The surgeon must certify in writing that the patient was sterile prior to the surgery. The reason for sterility, i.e. chemotherapy, radiation, etc. must be given.

(C) The surgeon must certify that the surgery was performed in an emergency, life endangering situation. The life endangering circumstances must be given.

(2) The acknowledgement for surgical procedures performed for medically necessary reasons other than elective sterilization may be signed by the patient and dated after the surgery as long as the acknowledgment meets all other requirements including being advised orally and in writing that they would be rendered sterile as a result of the surgery.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 50. HOME AND COMMUNITY-BASED WAIVER SERVICES

SUBCHAPTER 1. MEDICALLY FRAGILE WAIVER SERVICES

317:50-1-1. Purpose

The Medically Fragile Waiver Program is a Medicaid Home and Community Based Services (HCBS) Waiver used to finance non-institutional long-term care services through Oklahoma's SoonerCare program for medically fragile individuals. To receive Medically Fragile Program services, individuals must be at least 19 years of age, be SoonerCare eligible, and meet the ~~OHCA~~Oklahoma Human Services (OKDHS) skilled nursing facility (SNF) or hospital level of care (LOC) criteria. Eligibility does not guarantee placement in the program as Waiver membership is limited.

317:50-1-2. Definitions

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

"ADL" means the activities of daily living. Activities of daily living are activities that reflect the member's ability to perform self-care tasks essential for sustaining health and safety such as:

(A) bathing,
(B) eating,
(C) dressing,
(D) grooming,
(E) transferring (includes getting in and out of a tub, bed to chair, etc.),
(F) mobility,
(G) toileting, and
(H) bowel/bladder control.

"Cognitive Impairment" means that the person, as determined by the clinical judgment of the Long Term Care Nurse or the information obtained in the Uniform Comprehensive Assessment Test Tool (UCAT) assessment does not have the capability to think, reason, remember or learn required task for self-care, communicating needs, directing care givers and/or using appropriate judgment for maintenance of their own health or safety. The clinical judgment of cognitive impairment is based on mental status questionnaire performance in combination with a more general evaluation of cognitive function from interaction with the person during the UCAT assessment.

"Developmental Disability" means a severe, chronic disability of an individual that:

(A) is attributable to a mental or physical impairment or combination of mental and physical impairments;
(B) is manifested before the individual attains age 22;
(C) is likely to continue indefinitely;
(D) results in substantial functional limitations in three or more of the following areas of major life activity:
(i) self-care;
(ii) receptive and expressive language;
(iii) learning;
(iv) mobility;

(v) self-direction;
(vi) capacity for independent living; and
(vii) economic self-sufficiency; and

(E) reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services, supports, or other assistance that is of lifelong or extended duration and is individually planned and coordinated.

"IADL" means the instrumental activities of daily living.

"Instrumental activities of daily living" means those activities that reflect the member's ability to perform household chores and tasks within the community essential for sustaining health and safety such as:

(A) shopping,
(B) cooking,
(C) cleaning,
(D) managing money,
(E) using a telephone,
(F) doing laundry,
(G) taking medication, and
(H) accessing transportation.

"Intellectual Disability" means that the person has, as determined by a Preadmission Screening Resident Review level II evaluation, substantial limitations in functional ability due to significantly sub-average intellectual functioning related to an event occurring before the age of eighteen (18).

"Level of Care Services" To be eligible for level of care services, meeting the minimum Uniform Comprehensive Assessment ~~Test~~Tool criteria established for skilled nursing facility or hospital level of care demonstrates the individual must:

(A) require a treatment plan involving the planning and administration of services that require the skills of licensed or otherwise certified technical or professional personnel, and are provided directly or under the supervision of such personnel;

(B) have a physical impairment or combination of physical, mental and/or functional impairments;

(C) require professional nursing supervision (medication, hygiene and/or dietary assistance);

(D) lack the ability to adequately and appropriately care for self or communicate needs to others;

(E) require medical care and treatment in order to minimize physical health regression or deterioration;

(F) require care that is not available through family and friends, Medicare, Veterans Administration, or other federal entitlement program with the exception of Indian Health Services; and

(G) require care that cannot be met through Medicaid state plan Services, including Personal Care, if financially eligible.

"MSQ" means the mental status questionnaire.

"Progressive degenerative disease process that responds to treatment" means a process such as, but not limited to, Multiple Sclerosis (MS), Parkinson's Disease, Human Immunodeficiency Virus (HIV), or Acquired Immunodeficiency Syndrome (AIDS), that, untreated, systematically impairs normal body function which leads to acute illness and/or

disability but that reacts positively to a medically prescribed treatment intervention (usually medication) which arrests or significantly delays the destructive action of the process.

317:50-1-3. Medically Fragile Program overview

(a) The Medically Fragile Waiver program is a Medicaid Home and Community Based Services Waiver used to finance non-institutional long-term care services for a targeted group of physically disabled adults when there is a reasonable expectation that the person's health, due to disease process or disability, would, without appropriate services, deteriorate and require skilled nursing facility or hospital level of care to arrest the deterioration. Medically Fragile Waiver program members must be SoonerCare eligible and must not reside in an institution; room and board licensed residential care facility. The number of members who may receive Medically Fragile Waiver services is limited.

(1) To receive Medically Fragile Waiver services, individuals must meet the following criteria:

(A) be nineteen (19) years of age or older;

(B) have a chronic medical condition which results in prolonged dependency on medical care for which daily skilled intervention is necessary and is characterized by one or more of the following:

(i) a life threatening condition characterized by reasonably frequent periods of acute exacerbation which requires frequent medical supervision and/or physician consultation and which, in the absence of such supervision or consultation, would require hospitalization;

(ii) require frequent time consuming administration of specialized treatments which are medically necessary;

(iii) be dependent on medical technology such that without the technology, a reasonable level of health could not be maintained.

(2) In addition, the individual must meet the following criteria:

(A) meet service eligibility criteria [see OAC 317:50-1-3(d)]; and

(B) meet program eligibility criteria [see OAC 317:50-1-3(e)].

(b) Home and Community Based Waiver Services are outside the scope of state plan Medicaid services. The Medicaid waiver allows the Oklahoma Health Care Authority to offer certain Home and Community Based services to an annually capped number of persons who are categorically needy (refer to Department of Human Services form 08AX001E, Schedule VIII. B. 1) and without such services would be institutionalized. Services provided through the Medically Fragile Waiver are approved based on medical necessity.

(c) Services provided through the Medically Fragile Waiver are:

(1) case management;

(2) institutional transition case management;

(3) respite;

(4) environmental modifications;

(5) specialized medical equipment and supplies;

(6) physical therapy, occupational therapy, respiratory therapy, speech therapy or consultation;

(7) advanced supportive/restorative assistance;

(8) skilled nursing;

(9) home delivered meals;

(10) hospice care;

(11) medically necessary prescription drugs within the limits of the waiver;

(12) personal care;

(13) personal emergency response system (PERS);
(14) self-directed personal care, respite and advanced supportive/restorative assistance;
(15) self-directed goods and services (SD-GS);
(16) transitional case management; and
(17) SoonerCare medical services within the scope of the state plan.

(d) A service eligibility determination is made using the following criteria:

(1) an open Medically Fragile Waiver Program waiver slot, as authorized by the waiver document approved by the Centers for Medicare and Medicaid Services (CMS), is available to assure federal participation in payment for services to the member. If it is determined that all Medically Fragile Waiver slots are filled, the member cannot be certified as eligible for Medically Fragile Waiver services and the member's name is placed on a waiting list for entry as an open slot becomes available. Medically Fragile Waiver slots and corresponding waiting lists, if necessary, are maintained.

(2) the member is in the Medically Fragile Waiver targeted service group. The target group is an individual who is age nineteen (19) or older with a physical disability and may be technology dependent.

(3) the individual does not pose a physical threat to self or others as supported by professional documentation.

(4) members of the household or persons who routinely visit the household, as supported by professional documentation, do not pose a threat of harm or injury to the individual or other household visitors.

(e) The Medically Fragile Waiver program eligibility determination is made through the service plan approval process. The following criteria are used to make the determination that an individual is not eligible:

(1) if the individual's needs as identified by Uniform Comprehensive Assessment Test assessment and other professional assessments cannot be met through Medically Fragile Waiver program services, SoonerCare state plan services and other formal or informal services. The State, as part of the waiver program approval authorization, assures CMS that each waiver member's health, safety, or welfare can be maintained in their home. If an individual's identified needs cannot be met through provision of Medically Fragile Waiver program or SoonerCare state plan services and other formal or informal services are not in place or immediately available to meet those needs, the individual's health, safety or welfare in their home cannot be assured.

(2) if the individual poses a physical threat to self or others as supported by professional documentation.

(3) if other members of the household or persons who routinely visit the household who, as supported by professional documentation, pose a threat of harm or injury to the individual or other household visitors.

(4) if the individual's needs are being met, or do not require Medically Fragile Waiver services to be met, or if the individual would not require institutionalization if needs are not met.

(5) if, after the service and care plan is developed, the risk to individual health and safety is not acceptable to the individual, or to the interdisciplinary service plan team, or to the ~~OHCA~~OKDHS.

(f) Professional documentation is provided to support the recommendation for redetermination of program eligibility. The service providers continue providing services according to the service plan as provider safety permits until the member is removed from the Medically Fragile Waiver

program. As a part of the procedures requesting redetermination of program eligibility, the ~~OHCA~~OKDHS will provide technical assistance to the provider for transitioning the member to other services.

(g) Redetermination of program eligibility can be requested for the following reasons:

(1) if the member fails to comply with the community service plan;

(2) if the member's health and safety cannot be assured;

(3) as deemed necessary by waiver review staff or the member's case manager.

(h) Individuals determined ineligible for Medically Fragile Waiver program services are notified in writing of the determination and of his or her right to appeal the decision.

317:50-1-4. Application for Medically Fragile Waiver services

(a) The application process is initiated by the receipt of a UCAT, Part I or by receipt of the initial waiver referral form. A written financial application is not required for an individual who is a SoonerCare member at the time of application. A financial application for Medically Fragile Waiver services consists of the Medical Assistance Application form. The form is signed by the applicant, parent, spouse, guardian or someone else acting on the applicant's behalf.

(1) All conditions of financial eligibility must be verified and documented in the case record. When current information is already available that establishes financial 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) An individual residing in a NF or requesting waiver services, or the individual's community spouse may request an assessment of resources available to each spouse by using DHS form 08MA011E, Assessment of Assets, when SoonerCare application is not being made. The individual and/or spouse must provide documentation of resources. The 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 SoonerCare long-term care eligibility is made.

(3) When SoonerCare application is being made, an assessment of resources must be completed if it was not completed when the individual entered the NF or began receiving waiver services. For applicants of the Medically Fragile waiver, those resources owned by the couple the month the application was made determines the spousal share of resources. If the individual applies for SoonerCare at the time of entry into the Medically Fragile Waiver, Form 08MA011E is not appropriate. However, the spousal share must be determined using the resource information provided on the SoonerCare application form and computed using DHS form 08MA12E, Title XIX Worksheet.

(b) **Date of application**. The date of application is the date the signed application is received or the date when the request for SoonerCare is made orally and the financial application form is signed later. The date of the oral request is noted above the date the form is signed.

(c) **Medically Fragile Waiver waiting list procedures.** Medically Fragile Waiver Program capacity is the number of members that may be enrolled in the Program without exceeding, on an annualized basis, the maximum number authorized by the waiver to be served in the waiver year. If available waiver capacity has been realized, requests for services are not processed as applications, but placed on a waiting list. As available capacity permits, the ~~OHCA~~OKDHS selects in chronological order (first on, first off) requests for services from the waiting list to forward for

application processing. When waiver capacity exceeds the number on the waiting list and after all persons on the waiting list have been processed, waiting list procedures are suspended.

317:50-1-5. Medically Fragile Waiver program medical eligibility determination

A medical eligibility determination is made for Medically Fragile Waiver program services based on the Uniform Comprehensive Assessment Tool (UCAT) assessment, professional judgment and the determination that the member has unmet care needs that require Medically Fragile Waiver Program, skilled nursing facility (SNF) or hospital services to assure member health and safety. Medically Fragile Waiver services are initiated to support the informal care that is being provided in the member's home, or, that based on the UCAT, can be expected to be provided in the member's home upon discharge of the member from a SNF or hospital. These services are not intended to take the place of regular care provided by family members and/or by significant others. When there is an informal (not paid) system of care available in the home, Medically Fragile Waiver service provision will supplement the system within the limitations of Medically Fragile Waiver program policy.

(1) Categorical relationship must be established for determination of eligibility for Medically Fragile Waiver services. If categorical relationship to disability has not already been established, the Level of Care Evaluation Unit (LOCEU) will render a decision on categorical relationship to the disabled using the same definition used by Social Security Administration. A follow-up is required with the Social Security Administration to be sure their disability decision agrees with the decision of LOCEU.

(2) Community agencies complete the UCAT, Part I and forward the form to the ~~Oklahoma Health Care Authority~~OKDHS. If the UCAT, Part I indicates that the applicant does not qualify for SoonerCare long-term care services, the applicant is referred to appropriate community resources.

(3) The member and family are informed of agencies certified to deliver Medically Fragile Waiver case management and in-home care services in the local area to obtain the member's primary and secondary informed choices.

(A) If the member and/or family declines to make a provider choice, that decision is documented on the member choice form.

(B) A rotating system is used to select an agency for the member from a list of all local certified case management and in-home care agencies.

(4) The names of the chosen agencies and the agreement (by dated signature) of the member to receive services provided by the agencies are documented.

(5) If the needs of the member require an immediate interdisciplinary team (IDT) meeting with home health agency nurse participation to develop a care plan and service plan, the need is documented.

(6) If, based upon the information obtained during the assessment, the nurse determines that the member's health and safety may be at risk, Department of Human Services Adult Protective Services (APS) staff are notified immediately and the referral is documented on the UCAT.

(7) Within ten (10) working days of receipt of a complete UCAT, medical eligibility is determined using level of care criteria and service eligibility criteria.

(8) Once eligibility has been established, notification is given to the member and the case management provider so that care plan and service plan development may begin. The

member's case management provider is notified of the member's name, address and case number.

(9) If the member has a current certification and requests a change to Medically Fragile Waiver services, a new UCAT is required. The UCAT is updated when a member requests a change from Medically Fragile Waiver services to Personal Care services. If a member is receiving Medically Fragile Waiver services and requests to go to a nursing facility, a new medical level of care decision is not needed.

(10) When a UCAT assessment has been completed more than sixty (60) days prior to submission for determination of a medical decision, the UCAT must be updated to reflect changes in the medical condition; if submitted after ninety (90) days, a new assessment is required.

317:50-1-6. Determining financial eligibility for the Medically Fragile Waiver program

Financial eligibility for Medically Fragile Waiver services is determined using the rules on income and resources according to the category to which the individual is related. Only individuals who are categorically related to Aged Blind and Disabled (ABD) may be served through the Medically Fragile Waiver. Income, resources and expenses are evaluated on a monthly basis for all individuals requesting payment for the Medically Fragile Waiver Program. In determining income and resources for the individual categorically related to ABD, the family includes the individual and spouse, if any. However, consideration is not given to the income and resources of a spouse included in a Temporary Assistance for Needy Families case. If an individual and spouse cease to live together for reasons other than institutionalization, income and resources are considered available to each other through the month in which they are separated. Mutual consideration ceases with the month after the month in which the separation occurs. Any amounts which are actually contributed to the spouse after the mutual consideration has ended are considered. Financial eligibility for individuals in Medically Fragile Waiver program services is as follows:

(1) **Individual without a spouse**. For an individual without a spouse, the following rules are used to determine financial eligibility.

(A) **Income eligibility**. To determine the income of the individual, the rules in (i) through (iii) of this subparagraph apply.

(i) If payment of income is made to the individual and another person(s), the income is considered in proportion to the individual's interest.

(ii) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.

(iii) After determination of income, the gross income of the individual cannot exceed the categorically needy standard in DHS form 08AX001E, Schedule VIII. B. 1., to be eligible for Medically Fragile Waiver services. If the individual's gross income exceeds that standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [OAC 317:35-5-41.6(6)(B)].

(B) **Resource eligibility**. In order for an individual without a spouse to be eligible for Medically Fragile Waiver services, his/her countable resources cannot exceed the maximum resource standard for an individual listed in ~~DHS~~OKDHS form 08AX001E, Schedule VIII. D.

(C) **Equity in capital resources**. If the equity in the individual's capital resources is in excess of the maximum resource standards, certification is delayed up to thirty (30) days providing plans are made for the applicant to utilize the excess resource. Certification is

made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources cannot reasonably be expected to come within standards in one month, the application is denied.

(2) **Individual with a spouse who receives Home and Community-Based Services (HCBS), or is institutionalized in a Nursing Facility (NF) or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), or is sixty-five (65) or over and in a mental health hospital.** For an individual with a spouse who receives HCBS, or is institutionalized in a NF or ICF/IID, or is sixty-five (65) or over and in a mental health hospital, resources are determined for each individual as the amount owned by each individual plus one-half of the jointly owned resources of the couple. Once this separation of assets is made, a resource of either spouse is not considered available to the other during the receipt of HCBS program services.

(A) **Income eligibility.** Income is determined separately for an individual and his/her spouse if the spouse is in a HCBS program, or is institutionalized in a NF or ICF/IID, or is sixty-five (65) or older and in a mental health hospital. The income of either spouse is not considered as available to the other during the receipt of Medically Fragile Waiver services. The rules in (i) - (v) of this subparagraph apply in this situation:

(i) If payment of income is made solely to one or the other, the income is considered available only to that individual.

(ii) If payment of income is made to both, one-half is considered for each individual.

(iii) If payment of income is made to either one or both and another person(s), the income is considered in proportion to either spouse's interest (if payment is to that spouse) or one-half of the joint interest if no interest is specified.

(iv) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.

(v) After determination of income, the gross income of the individual cannot exceed the categorically needy standard in ~~DHS~~OKDHS form 08AX001E, Schedule VIII. B. 1., to be eligible for Medically Fragile Waiver services. If the individual's gross income exceeds this standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust OAC 317:35-5-41.6(6)(B)].

(B) **Resource eligibility.** In order for an individual with a spouse who receives HCBS, or is institutionalized in a NF or ICF/IID or is sixty-five (65) or older and in a mental health hospital to be eligible for the Medically Fragile Waiver services, his/her countable resources cannot exceed the maximum resource standard for an individual listed in ~~DHS~~OKDHS form 08AX001E, Schedule VIII. D.

(C) **Equity in capital resources.** If the equity in the individual's capital resources is in excess of the maximum resource standards, certification is delayed up to thirty (30) days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources cannot reasonably be expected to come within standards in one month, the application is denied.

(3) **Individual with a spouse in the home who is not in a Home and Community Based Services program**. When only one individual of a couple in their own home is in a HCBS Program, income and resources are determined separately. However, the income and

resources of the individual who is not in the HCBS program (community spouse) must be included on the application form. At redetermination of eligibility, the community spouse's income must be included in the review process. During any month that the individual is receiving Medically Fragile Waiver program services, the income of the community spouse is not considered available to that individual. The following rules are used to determine the income and resources of each:

(A) **Income eligibility**. To determine the income of both spouses, the rules in (i) - (v) of this subparagraph apply.

(i) If payment of income is made solely to one or the other, the income is considered available only to that individual.

(ii) If payment of income is made to both, one-half is considered for each individual.

(iii) If payment of income is made to either one or both and another person(s), the income is considered in proportion to either spouse's interest (if payment is to that spouse) or one-half of the joint interest if no interest is specified.

(iv) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.

(v) After determination of income, the gross income of the individual in the Medically Fragile Waiver program cannot exceed the categorically needy standard in ~~DHS~~OKDHS form 08AX001E, Schedule VIII. B. 1., to be eligible for care. If the individual's gross income exceeds this standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [OAC 317:35-5-41.6(6)(B)].

(B) **Resource eligibility**. To determine resource eligibility, it is necessary to determine the amount of resources for both spouses for the month of the individual's application for the Medically Fragile Waiver program. Of the resources available to the couple (both individual and joint ownership) an amount will be protected for the community spouse which will not be considered available to the spouse receiving Medically Fragile Waiver program services. The amount determined as the spousal share is used for all subsequent applications for SoonerCare, regardless of changes in the couple's resources. The protected spousal share cannot be changed for any reason. When application for SoonerCare is made at the same time the individual begins receiving Medically Fragile program services, ~~DHS~~OKDHS Form 08MA012E, Title XIX Worksheet, is used.

(i) The first step in the assessment process is to establish the total amount of resources for the couple during the month of application of the spouse into the Medically Fragile Waiver program (regardless of payment source).

(ii) The community spouse's share is equal to one-half of the total resources of the couple not to exceed the maximum amount of resource value that can be protected for the community spouse, as shown on ~~DHS~~OKDHS form 08AX001E, Schedule XI.

(iii) The minimum resource standard for the community spouse, as established by the ~~OHCA~~OKDHS, is found on ~~DHS~~OKDHS form 08AX001E, Schedule XI. When the community spouse's share is less than the minimum standard, an amount may be deemed from the other spouse's share to ensure the minimum resource standard for the community spouse. If the community spouse's share equals or exceeds the minimum resource standard, deeming cannot be done.

(iv) If deeming is necessary to meet the minimum resource standard for the community spouse, the amount that is deemed must be legally transferred to the

community spouse within one year of the effective date of certification for SoonerCare. At the first redetermination of eligibility, the worker must document that the resources have been transferred. After the first year of SoonerCare eligibility, resources of the community spouse will not be available to the other spouse and resources cannot be deemed to the community spouse.

(v) After the month in which the institutionalized spouse and community spouse have met the resource standard and the institutionalized spouse is determined eligible for benefits, no resources of the community spouse, regardless of value, will be considered available to the institutionalized spouse. If the resources of the community spouse grow to exceed the original deemed amount, the State cannot require the community spouse to apply any of these excess resources toward the cost of the care of the institutionalized spouse.

(vi) When determining eligibility for SoonerCare, the community spouse's share of resources is protected and the remainder considered available to the spouse receiving Medically Fragile Waiver program services.

(vii) The resources determined in (i) - (vi) of this subparagraph for the individual receiving Medically Fragile Waiver program services cannot exceed the maximum resource standard for an individual as shown in ~~DHS~~OKDHS form 08AX001E, Schedule VIII. D.

(viii) Once the dollar value of the community spouse's share of resources is established for the month of the other spouse's entry into the Medically Fragile Waiver program, that amount is used when determining resource eligibility for a subsequent SoonerCare application for long-term care for either spouse.

(ix) Once a determination of eligibility for SoonerCare is made, either spouse is entitled to a fair hearing. A fair hearing regarding the determination of the community spouse's resource allowance is held within thirty (30) days of the date of the request for the hearing. Either spouse is entitled to a fair hearing if dissatisfied with a determination of:

(I) the community spouse's monthly income allowance;

(II) the amount of monthly income otherwise available to the community spouse;

(III) determination of the spousal share of resource;

(IV) the attribution of resources (amount deemed); or

(V) the determination of the community spouse's resource allowance.

(x) The rules on determination of income and resources are applicable only when an individual receiving Medically Fragile Waiver program services is likely to remain under care for thirty (30) consecutive days. The thirty (30) day requirement is considered to have been met even if a hospital stay interrupts it or the individual is deceased before the thirty (30) day period ends.

(C) **Excess resources**. If the equity in the individual's capital resources is in excess of the maximum resource standards, certification is delayed up to thirty (30) days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources cannot reasonably be expected to come within standards in one month, the application is denied.

(4) **Transfer of assets on or after August 11, 1993 but before February 8, 2006.** An institutionalized individual, an institutionalized individual's spouse, the guardian or legal representative of the individual or individual's spouse who disposes of assets on or after August 11, 1993 but before February 8, 2006 for less than fair market value on or after the look-back date specified in (A) of this paragraph subjects the individual to a penalty period for the disposal of such assets.

(A) For an institutionalized individual, the look-back date is thirty-six (36) months before the first day the individual is both institutionalized and has applied for SoonerCare. However, in the case of payments from a trust or portions of a trust that are treated as transfers of assets, the look back date is sixty (60) months.

(B) For purposes of this paragraph, an institutionalized individual is one who is receiving HCBS program services.

(C) The penalty period begins the first day of the first month during which assets have been transferred and which does not occur in any other period of ineligibility due to an asset transfer. When there have been multiple transfers, all transferred assets are added together to determine the penalty.

(D) The penalty period consists of a period of ineligibility (whole number of months) determined by dividing the total uncompensated value of the asset by the average monthly cost ($2,000) to a private patient in an skilled nursing facility or hospital level of care in Oklahoma. In this calculation, any partial month is dropped. There is no limit to the length of the penalty period for these transfers. Uncompensated value is defined as the difference between the fair market value at the time of transfer less encumbrances and the amount received for the resource.

(E) Assets are defined as all income and resources of the individual and the individual's spouse, including any income or resources which the individual or such individual's spouse is entitled to but does not receive because of action:

(i) by the individual or such individual's spouse;

(ii) by a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or such individual's spouse; or

(iii) by any person, including any court or administrative body acting at the direction or upon the request of the individual or such individual's spouse.

(F) A penalty would not apply if:

(i) the title to the individual's home was transferred to:

(I) the spouse;

(II) the individual's child who is under age twenty-one (21) or is blind or totally disabled as determined by the Social Security Administration;

(III) a sibling who has equity interest in the home and resided in the home for at least one (1) year immediately prior to the institutionalization of the individual; or

(IV) the individual's son or daughter who resided in the home and provided care for at least two (2) years immediately prior to the individual's institutionalization.

(ii) the individual can show satisfactorily that the intent was to dispose of assets at fair market value or that the transfer was exclusively for a purpose other than eligibility. It is presumed that any transfer of assets made for less than fair market value was made in order to qualify the individual for SoonerCare. In order to rebut

this presumption, the individual must present compelling evidence that a transfer was made for reasons other than to qualify for SoonerCare. It is not sufficient for an individual to claim that assets were transferred solely for the purposes of allowing another to have them with ostensibly no thought of SoonerCare if the individual qualifies for SoonerCare as a result of the transfer.

(iii) the transfer was to the community spouse or to another person for the sole benefit of the community spouse in an amount equal to the community spouse's asset allowance.

(iv) the asset was transferred to the individual's child who is blind or totally disabled as determined by the Social Security Administration. The transfer may be to a trust established for the benefit of the individual's child.

(v) the asset was transferred to or from the spouse (either community or institutionalized) or to another person for the sole benefit of the spouse if the assets are not subsequently transferred to still another person for less than fair market value.

(vi) the asset is transferred to a trust established solely for the benefit of a disabled individual under the age of sixty-five (65).

(vii) the denial would result in undue hardship. Such determination should be referred to ~~DHS~~OKDHS for a decision.

(G) The individual is advised by a written notice of a period of ineligibility due to transfer of assets. The notice explains the period of ineligibility for payment of Medically Fragile Waiver program services and the continuance of eligibility for other SoonerCare services.

(H) The penalty period can be ended by either all assets being restored or commensurate return being made to the individual.

(I) Once the restoration or commensurate return is made, eligibility is re-determined considering the value of the restored asset or the amount of commensurate return.

(J) The restoration or commensurate return will not entitle the member to benefits for the period of time that the asset remained transferred. An applicant cannot be certified for Medically Fragile Waiver program services for a period of asset ineligibility.

(K) When assets are held by an individual with another person or persons, whether held in joint tenancy or tenancy in common or similar arrangement, and the individual's ownership or control of the asset is reduced or eliminated is considered a transfer.

(L) When a transfer of assets by the spouse of an individual results in a period of ineligibility and the spouse who made such transfer subsequently becomes institutionalized, the period of ineligibility will be apportioned between the two institutionalized spouses.

(5) **Transfer of assets on or after February 8, 2006.** An institutionalized individual, an institutionalized individual's spouse, the guardian or legal representative of the individual or individual's spouse who disposes of assets on or after February 8, 2006 for less than fair market value on or after the look-back date specified in (A) of this paragraph subjects the individual to a penalty period for the disposal of such assets.

(A) For an institutionalized individual, the look-back date is sixty (60) months before the first day the individual is both institutionalized and has applied for SoonerCare. However, individuals that have purchased an Oklahoma Long-Term Care Partnership program approved policy may be completely or partially exempted from this Section depending on the monetary extent of the insurance benefits paid.

(B) For purposes of this paragraph, an institutionalized individual is one who is receiving Medically Fragile program services.
(C) The penalty period will begin with the later of:
(i) the first day of a month during which assets have been transferred for less than fair market value; or
(ii) the date on which the individual is:
(I) eligible for medical assistance; and
(II) receiving institutional level of care services that, were it not for the imposition of the penalty period, would be covered by SoonerCare.
(D) The penalty period:
(i) cannot begin until the expiration of any existing period of ineligibility;
(ii) will not be interrupted or temporarily suspended once it is imposed;
(iii) when there have been multiple transfers, all transferred assets are added together to determine the penalty.
(E) The penalty period consists of a period of ineligibility determined by dividing the total uncompensated value of the asset by the average monthly cost to a private patient in a nursing facility in Oklahoma shown on ~~DHS~~OKDHS form 08AX001E. In this calculation, the penalty must include a partial month disqualification based upon the relationship between that fractional amount and the average monthly cost to a private patient in a nursing facility in Oklahoma. There is no limit to the length of the penalty period for these transfers. Uncompensated value is defined as the difference between the fair market value at the time of transfer less encumbrances and the amount received for the resource.
(F) Assets are defined as all income and resources of the individual and the individual's spouse, including any income or resources which the individual or such individual's spouse is entitled to but does not receive because of action:
(i) by the individual or such individual's spouse;
(ii) by a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or such individual's spouse; or
(iii) by any person, including any court or administrative body acting at the direction or upon the request of the individual or such individual's spouse.
(G) Special situations that would apply:
(i) **Separate Maintenance or Divorce.**
(I) There shall be presumed to be a transfer of assets if an applicant or member receives less than half of the couple's resources pursuant to a Decree of Separate Maintenance or a Decree of Divorce.
(II) There shall be presumed to be a transfer of assets if the income is reduced to an amount lower than the individual's own income plus half of the joint income. The transfer penalty shall be calculated monthly.
(III) Assets which were exempt lose the exempt character when not retained by the applicant or member in the divorce or separate maintenance. These assets, if received by the other spouse, are counted when determining the penalty.
(IV) The applicant or member may rebut the presumption of transfer by showing compelling evidence that the uneven division of income or resources was the result of factors unrelated to SoonerCare eligibility.
(ii) **Inheritance from a spouse.**

(I) Oklahoma law provides that a surviving spouse is entitled to a minimum portion of a deceased spouse's probate estate. The amount depends on several factors.

(II) It is considered a transfer if the deceased spouse's will places all, or some, of the statutory share the applicant or member is entitled to receive in a trust which the applicant or member does not have unfettered access to or leaves less than the statutory amount to the applicant or member, who does not then elect to receive the statutory share in probate proceedings.

(H) A penalty would not apply if:

(i) the title to the individual's home was transferred to:

(I) the spouse; or

(II) the individual's child who is under age twenty-one (21) or is blind or totally disabled as determined by the Social Security Administration; or

(III) a sibling who has equity interest in the home and resided in the home for at least one (1) year immediately prior to the institutionalization of the individual; or

(IV) the individual's son or daughter who resided in the home and provided care for at least two (2) years immediately prior to the individual's institutionalization.

(ii) the individual can show satisfactorily that the intent was to dispose of assets at fair market value or that the transfer was exclusively for a purpose other than eligibility. It is presumed that any transfer of assets made for less than fair market value was made in order to qualify the individual for SoonerCare. In order to rebut this presumption, the individual must present compelling evidence that a transfer was made for reasons other than to qualify for SoonerCare. It is not sufficient for an individual to claim that assets were transferred solely for the purposes of allowing another to have them with ostensibly no thought of SoonerCare if the individual qualifies for SoonerCare as a result of the transfer.

(iii) the transfer was to the community spouse or to another person for the sole benefit of the community spouse in an amount equal to the community spouse's asset allowance. Sole benefit means that the amount transferred will be used for the benefit of the community spouse during his or her expected life.

(iv) the asset was transferred to the individual's child who is blind or totally disabled as determined by Social Security. The transfer may be to a trust established for the benefit of the individual's child.

(v) the asset was transferred to or from the spouse (either community or institutionalized) or to another person for the sole benefit of the spouse if the assets are not subsequently transferred to still another person for less than fair market value. Sole benefit means that the amount transferred will be used for the benefit of the spouse (either community or institutionalized) during his or her expected life.

(vi) the asset is transferred to a trust established solely for the benefit of a disabled individual under the age of sixty-five (65).

(vii) the denial would result in undue hardship. Undue hardship exists when application of a transfer of assets penalty would deprive the individual of medical care such that the individual's health or life would be endangered; or of food, clothing, shelter, or other necessities of life.

(I) An undue hardship does not exist if the individual willingly transferred assets for the purpose of qualifying for SoonerCare services through the use of the undue hardship exemption.
(II) Such determination should be referred to DHS State Office for a decision.
(III) If the undue hardship exists because the applicant was exploited, legal action must be pursued to return the transferred assets to the applicant before a hardship waiver will be granted. Pursuing legal action means an Adult Protective Services referral has been made to the district attorney's office or a lawsuit has been filed and is being pursued against the perpetrator.

(I) The individual is advised by a written notice of a period of ineligibility due to transfer of assets, a timely process for determining whether an undue hardship waiver will be granted and a process for an adverse determination appeal. The notice explains the period of ineligibility for payment of Medically Fragile Waiver program services and the continuance of eligibility for other SoonerCare services.
(J) The penalty period can be ended by either all assets being restored or commensurate return being made to the individual.
(K) Once the restoration or commensurate return is made, eligibility is re-determined considering the value of the restored asset or the amount of commensurate return.
(L) The restoration or commensurate return will not entitle the member to benefits for the period of time that the asset remained transferred. An applicant cannot be certified for Medically Fragile Waiver program services for a period of asset ineligibility.
(M) Assets which are held by an individual with another person or persons, whether held in joint tenancy or tenancy in common or similar arrangement, and the individual's ownership or control of the asset is reduced or eliminated is considered a transfer. The exception to this rule is if ownership of a joint account is divided according to the amount contributed by each owner.

(i) Documentation must be provided to show each co-owner's contribution;
(ii) The funds contributed by the applicant or SoonerCare member end up in an account owned solely by the applicant or member.

(N) When a transfer of assets by the spouse of an individual results in a period of ineligibility and the spouse who made such transfer subsequently becomes institutionalized, the period of ineligibility will be apportioned between the two (2) institutionalized spouses.

(6) **Commensurate return.** Commensurate return for purposes of this Section is defined as actual money payment or documentation of money spent on the member's behalf; i.e., property taxes, medical debts, nursing care expenses, etc., corresponding to the market value of the transferred property. The definition does not include personal services, labor or provision of rent-free shelter. It also does not include a monetary value assigned and projected for future payment either by cash or provision of services. Any transfer of property within the five (5) years prior to application or during receipt of assistance must be analyzed in regard to commensurate return as well as determination of intent.

317:50-1-12. Eligible providers

Medically Fragile Program service providers, must be certified by the Oklahoma Health Care Authority (~~OHCA~~OHCA) and all providers must have a current signed SoonerCare contract on file with the Medicaid Agency (Oklahoma Health Care Authority).

(1) The provider programmatic certification process verifies that the provider meets licensure, certification and training standards as specified in the Waiver document and agrees to Medically Fragile program Conditions of Participation. Providers must obtain programmatic certification to be Medically Fragile program certified.
(2) The provider financial certification process verifies that the provider uses sound business management practices and has a financially stable business.
(3) Providers may fail to gain or may lose waiver program certification due to failure to meet either programmatic or financial standards.
(4) At a minimum, provider financial certification is reevaluated annually.
(5) Providers of medical equipment and supplies environmental modifications, personal emergency response systems, hospice, and skilled nursing facility respite services do not have a programmatic evaluation after the initial certification.
(6) ~~OHCA~~OKDHS may authorize a legally responsible family member (spouse or legal guardian) of an adult member to be SoonerCare reimbursed under the 1915(c) Medically Fragile program as a service provider, if the provider meets all of the following authorization criteria and monitoring provisions:

(A) Authorization for a legally responsible family member to be the care provider for a member may occur only if the member is offered a choice of providers and documentation demonstrates that:

(i) either no other provider is available; or
(ii) available providers are unable to provide necessary care to the member; or
(iii) the needs of the member are so extensive that the spouse or legal guardian who provides the care is prohibited from working outside the home due to the member's need for care.

(B) The service must:

(i) meet the definition of a service/support as outlined in the federally approved waiver document;
(ii) be necessary to avoid institutionalization;
(iii) be a service/support that is specified in the individual service plan;
(iv) be provided by a person who meets the provider qualifications and training standards specified in the Waiver for that service;
(v) be paid at a rate that does not exceed that which would otherwise be paid to a provider of a similar service and does not exceed what is allowed by the ~~OHCA~~OHCA for the payment of personal care or personal assistance services;
(vi) not be an activity that the spouse or legal guardian would ordinarily perform or is responsible to perform. If any of the following criteria are met, assistance or care provided by the spouse or guardian will be determined to exceed the extent and/or nature of the assistance they would be expected to ordinarily provide in their role as spouse or guardian:

(I) spouse or guardian has resigned from full-time/part-time employment to provide care for the member; or
(II) spouse or guardian has reduced employment from full-time to part-time to provide care for the member; or
(III) spouse or guardian has taken a leave of absence without pay to provide care for the member; or

(IV) spouse or guardian provides assistance/care for the member thirty-five (35) or more hours per week without pay and the member has remaining unmet needs because no other provider is available due to the nature of the assistance/care, special language or communication, or intermittent hours of care requirements of the member.

(C) The spouse or legal guardian who is a service provider will comply with the following:

(i) not provide more than forty (40) hours of services in a seven (7) day period;

(ii) planned work schedules must be available in advance to the member's case manager, and variations to the schedule must be noted and supplied two (2) weeks in advance to the case manager, unless change is due to an emergency;

(iii) maintain and submit time sheets and other required documentation for hours paid; and

(iv) be documented in the service plan as the member's care provider.

(D) In addition to case management, monitoring, and reporting activities required for all waiver services, the state is obligated to additional monitoring requirements when members elect to use a spouse or legal guardian as a paid service provider. The ~~OHCA~~OKDHS will monitor through documentation submitted by the case manager the following:

(i) at least quarterly reviews by the case manager of expenditures and the health, safety and welfare status of the individual member; and

(ii) face-to-face visits with the member by the case manager on at least a semi annual basis.

(7) The ~~OHCA~~OKDHS periodically performs a programmatic audit of Case Management, Home Care (providers of Skilled Nursing, State Plan Personal Care, In-Home Respite, Advanced Supportive/Restorative Assistance and Therapy Services), and Self-Directed service providers. If due to a programmatic audit, a provider plan of correction is required, the ~~OHCA~~OKDHS stops new case referrals to the provider until the plan of correction has been approved and implemented. Depending on the nature and severity of problems discovered during a programmatic audit, at the discretion of the ~~OHCA~~OKDHS, members determined to be at risk for health or safety may be transferred from a provider requiring a plan of correction to another provider.

(8) As additional providers are certified or if a provider loses certification, the ~~OHCA~~OKDHS provides notice to appropriate personnel in counties affected by the certification changes.

317:50-1-13. Coverage

Individuals receiving Waiver services must have been determined to be eligible for the program and must have an approved service plan. Any Medically Fragile Program service provided must be listed on the approved service plan and must be necessary to prevent institutionalization of the member. Waiver services which are expansions of Oklahoma Medicaid State Plan services may only be provided after the member has exhausted these services available under the State Plan.

(1) Case Managers within the Self-Directed Services approved area will provide information and materials that explain the service option to the members. The ~~OHCA~~OKDHS provides information and material on Self-Direction to Case Managers for distribution to members.

(2) The member may request to Self-Direct their services from their Case Manager or call the Medically Fragile Program toll-free number to request the Self-Directed Services option.

317:50-1-14. Description of services

Services included in the Medically Fragile waiver program are as follows:

(1) **Case Management.**

(A) Case management services are services that assist a member in gaining access to medical, social, educational or other services, regardless of payment source of services, that may benefit the member in maintaining health and safety. Case managers initiate and oversee necessary assessments and reassessments to establish or reestablish waiver program eligibility. Case managers develop the member's comprehensive service plan, listing only services which are necessary to prevent institutionalization of the member, as determined through assessments. Case managers initiate the addition of necessary services or deletion of unnecessary services, as dictated by the member's condition and available support. Case managers monitor the member's condition to ensure delivery and appropriateness of services and initiate service plan reviews. If a member requires hospital or skilled nursing facility (NF) services, the case manager assists the member in accessing institutional care and, as appropriate, periodically monitors the member's progress during the institutional stay and helps the member transition from institution to home by updating the service plan and preparing services to start on the date the member is discharged from the institution. Case managers must meet Medically Fragile waiver program minimum requirements for qualification and training prior to providing services to members. Prior to providing services to members choosing to self-direct their services, case managers are required to receive training and demonstrate knowledge regarding the self-directed service delivery model.

(B) Providers may only claim time for billable case management activities described as follows:

(i) A billable case management activity is any task or function defined under Oklahoma Administrative Code (OAC) 317:50-1-15(1)(A), that only a Medically Fragile case manager because of skill, training, or authority, can perform on behalf of a member;

(ii) Ancillary activities such as clerical tasks like mailing, copying, filing, faxing, drive time, or supervisory/administrative activities are not billable case management activities, although the administrative cost of these activities and other normal and customary business overhead costs have been included in the reimbursement rate for billable activities. Payment is not allowed for written reports or record documentation.

(C) Case management services are prior authorized and billed per fifteen (15) minute unit of service using the rate associated with the location of residence of the member served.

(i) Case Management services are billed using a standard rate for reimbursement for billable service activities provided to a member who resides in a county with population density greater than twenty-five (25) persons per square mile.

(ii) Case management services are billed using a very rural/outside providers' service rate for billable service activities provided to a member who resides in a county with population density equal to or less than twenty-five (25) persons per square mile. An exception would be services to members that reside in ~~OHCA~~OKDHS-identified zip

codes in Osage county adjacent to metropolitan areas of Tulsa and Washington counties. Services to these members are prior authorized and billed using the standard rate.

(iii) The latest United States Census, Oklahoma Counties population data is the source for determination of whether a member resides in a county with a population density equal to or less than twenty-five (25) persons per square mile, or resides in a county with a population density greater than twenty-five (25) persons per square mile.

(D) Case managers providing case management services to Medically Fragile waiver members must submit monthly monitoring case notes on a monthly basis to the ~~OHCA~~OKDHS Medically Fragile waiver staff.

(E) Providers of Home and Community-Based waiver services (HCBS) for the member, or those who have an interest in or are employed by a provider of HCBS for the member, must not provide case management or develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS.

(2) **Institutional transitional case management.**

(A) Institutional Transition case management services are required by the member's service plan, which are necessary to ensure the health, welfare, and safety of the member, or to enable the member to function with greater independence in the home, and without which, the member would continue to require institutionalization.

(B) Institutional transition case management services assist institutionalized members that are eligible to receive waiver services in gaining access to needed waiver and other state plan services, as well as needed medical, social, educational, and other services to assist the transition, regardless of the funding source for the services which access is gained.

(C) Institutional transition case management services may be authorized for periodic monitoring of a waiver member's progress during an institutional stay, and for assisting the member's transition from institution to home by updating the services plan, including preparing for necessary services and supports to be in place or to start on the date the member is discharged from the institution.

(3) **Respite.**

(A) Respite services are provided to members who are unable to care for themselves. They are provided on a short-term basis because of the absence or need for relief of the primary caregiver. Payment for respite care does not include room and board costs unless more than seven (7) hours are provided in a nursing facility (NF). Respite care will only be utilized when other sources of care and support have been exhausted. Respite care will only be listed on the service plan when it is necessary to prevent institutionalization of the member. Units of services are limited to the number of units approved on the service plan.

(B) In-home respite services are billed per fifteen (15) minute unit service. Within any one (1) day period, a minimum of eight (8) units must be provided with a maximum of twenty-eight (28) units provided. The service is provided in the member's home.

(C) Facility-based extended respite is filed for a per diem rate, if provided in a NF. Extended respite must be at least eight (8) hours in duration.

(D) In-Home Extended respite is filed for a per diem rate. A minimum of eight (8) hours must be provided in the member's home.

(4) **Environmental modifications.**

(A) Environmental modifications are physical adaptations to the home, required by the member's service plan, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home and without which, the member would require institutionalization. Adaptations or improvements to the home which are not of direct medical or remedial benefit to the waiver member are excluded.

(B) All services require prior authorization.

(C) All services shall be provided in accordance with applicable state and local building codes and conform to the Americans with Disabilities Act Accessibility Guidelines, Title 28 of the Code of Federal Regulations Part 36 Appendix A.

(D) Payment for these services is made on an individual basis following a uniform process approved by the Medicaid agency.

(5) **Medical Supplies, Equipment, and Appliances.**

(A) Medical supplies, equipment, and supplies are specified in the service plan, which enable members to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. Also included are items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment and supplies not available under the Medicaid State Plan. This service excludes any equipment and/or supply items which are not of direct medical or remedial benefit to the Waiver member. This service is necessary to prevent institutionalization.

(B) Medical supplies, equipment, and supplies are billed using the appropriate healthcare common procedure code (HCPC). Reoccurring supplies which are shipped to the member are compensable only when the member remains eligible for waiver services, continues to reside in the home and is not institutionalized in a hospital, skilled (NF) or nursing home. It is the provider's responsibility to verify the member's status prior to shipping these items. Payment for medical supplies, equipment, and supplies is limited to the Medicare rate, or the SoonerCare rate, or is determined through manual pricing. If manual pricing is used, the provider is reimbursed at the provider's documented manufacturer's suggested retail price (MSRP) minus thirty (30) percent or invoice cost plus thirty (30) percent, whichever is the lesser of the two (2). OHCA may establish a fair market price through claims review and analysis.

(6) **Advanced supportive/restorative assistance.**

(A) Advanced supportive/restorative assistance services are maintenance services to assist a member who has a chronic, yet stable, condition. These services assist with activities of daily living which require devices and procedures related to altered body functions. This service is for maintenance only and is not utilized as a treatment service.

(B) Advanced supportive/restorative assistance service is billed per fifteen (15) minute unit of service. The number of units of this service a member may receive is limited to the number of units approved on the service plan.

(7) **Nursing.**

(A) Nursing services are services listed in the service plan which are within the scope of the Oklahoma Nursing Practice Act and are provided by a registered professional nurse,

or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State. Nursing services includes skilled nursing and/or private duty nursing. Skilled nursing is provided on an intermittent or part-time basis. Private duty nursing is individual and continuous care provided to a participant at home by licensed nurses. The provision of the nursing service will work to prevent or postpone the institutionalization of the member.

(B) Nursing services are services of a maintenance or preventive nature provided to members with stable, chronic conditions. These services are not intended to treat an acute health condition and may not include services which would be reimbursable under either Medicaid or Medicare's Home Health program. This service primarily provides nurse supervision to the Personal Care Assistant or to the Advanced Supportive/Restorative Assistance Aide and assesses the member's health and prescribed medical services to ensure that they meet the member's needs as specified in the service plan. A skilled nursing assessment/evaluation on-site visit is made to each member for whom Advanced Supportive/Restorative Assistance services are authorized to evaluate the condition of the member and medical appropriateness of services. An assessment/evaluation visit report will be made to the Medically Fragile Waiver case manager in accordance with review schedule determined in consultation between the Case Manager and the Skilled Nurse, to report the member's condition or other significant information concerning each advanced supportive/restorative care member.

(i) The case manager may recommend authorization of Skilled Nursing services as part of the interdisciplinary team planning for the member's service plan and/or assessment/evaluation of:

(I) the member's general health, functional ability and needs and/or

(II) the adequacy of personal care and/or advanced supportive/restorative assistance services to meet the member's needs including providing on-the-job training and competency testing for personal care or advanced supportive/restorative care aides in accordance with rules and regulations for delegation of nursing tasks as established by the Oklahoma Board of Nursing.

(ii) In addition to assessment/evaluation, the case manager may recommend authorization of Skilled Nursing services for the following:

(I) preparing a one (1) week supply of insulin syringes for a blind diabetic, who can safely self-inject the medication but cannot fill his/her own syringe. This service would include monitoring the member's continued ability to self-administer the insulin;

(II) preparing oral medications in divided daily compartments for a member who self-administers prescribed medications but needs assistance and monitoring due to a minimal level of disorientation or confusion;

(III) monitoring a member's skin condition when a member is at risk for skin breakdown due to immobility or incontinence, or the member has a chronic stage II decubitus ulcer requiring maintenance care and monitoring;

(IV) providing nail care for the diabetic member or member with circulatory or neurological compromise;

(V) providing consultation and education to the member, member's family and/or other informal caregivers identified in the service plan, regarding the nature of the member's chronic condition. Provide skills training (including

return skills demonstration to establish competency) to the member, family and/or other informal caregivers as specified in the service plan for preventive and rehabilitative care procedures.

(C) Nursing service can be billed for service plan development and/or assessment/evaluation services or, for other services within the scope of the Oklahoma Nursing Practice Act including private duty nursing. Nursing services are billed per fifteeen (15) minute unit of service. A specific procedure code is used to bill for assessment/evaluation/service plan development skilled nursing services and other procedure codes are used to bill for all other authorized nursing services. A maximum of eight (8) units per day of skilled nursing for assessment/evaluation and/or service plan development are allowed. An agreement by a provider to perform a nurse evaluation is also an agreement, to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted. Reimbursement for a nurse evaluation is denied if the provider that produced the nurse evaluation fails to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted.

(8) **Home Delivered Meals.**

(A) Home Delivered Meals provide one (1) meal per day. A home delivered meal is a meal prepared in advance and brought to the member's home. Each meal must have a nutritional content equal to at least one third (1/3) of the recommended daily allowance as established by the Food and Nutrition Board of the National Academy of Sciences. Meals are only provided to members who are unable to prepare meals and lack an informal provider to do meal preparation.

(B) Home Delivered Meals are billed per meal, with one meal equaling one unit of service. The limit of the number of units a member is allowed to receive is limited on the member's service plan. The provider must obtain a signature from the member or the member's representative at the time the meals are delivered. In the event that the member is temporarily unavailable (i.e., doctor's appointment, etc.) and the meal is left, the provider must document the reason a signature is not obtained. The signature logs must be available for review.

(9) **Occupational Therapy services.**

(A) Occupational Therapy services are those services that increase functional independence by enhancing the development of adaptive skills and performance capacities of members with physical disabilities and related psychological and cognitive impairments. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Treatment involves the therapeutic use of self-care, work and play activities and may include modification of the tasks or environment to enable the member to achieve maximum independence, prevent further disability, and maintain health. Under a physician's order, a licensed occupational therapist evaluates the member's rehabilitation potential and develops an appropriate written therapeutic regimen. The regimen utilizes paraprofessional occupational therapy assistant services, within the limits of their practice, working under the supervision of the licensed occupational therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's

case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Occupational Therapy services are billed per fifteen (15) minute unit of service. Payment is not allowed solely for written reports or record documentation.

(10) **Physical Therapy services.**

(A) Physical Therapy services are those services that prevent physical disability through the evaluation and rehabilitation of members disabled by pain, disease or injury. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Treatment involves use of physical therapeutic means such as massage, manipulation, therapeutic exercise, cold or heat therapy, hydrotherapy, electrical stimulation and light therapy. Under a physician's order, a licensed physical therapist evaluates the member's rehabilitation potential and develops an appropriate, written therapeutic regimen. The regimen utilizes paraprofessional physical therapy assistant services, within the limits of their practice, working under the supervision of the licensed physical therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Physical Therapy services are billed per fifteen (15) minute units of service. Payment is not allowed solely for written reports or record documentation.

(11) **Speech and Language Therapy services.**

(A) Speech/Language Therapy services are those that prevent speech and language communication disability through the evaluation and rehabilitation of members disabled by pain, disease or injury. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Services involve use of therapeutic means such as evaluation, specialized treatment, and/or development and oversight of a therapeutic maintenance program. Under a physician's order, a licensed Speech/Language Pathologist evaluates the member's rehabilitation potential and develops an appropriate, written therapeutic regimen. The regimen utilizes paraprofessional therapy assistant services within the limits of their practice, working under the supervision of the licensed Speech/Language Pathologist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The Pathologist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Speech/Language Therapy services are billed per fifteen (15) minute unit of service. Payment is not allowed solely for written reports or record documentation.

(12) **Respiratory Therapy Services.**

(A) Respiratory therapy services are provided for a member who, but for the availability of in-home respiratory services, would require respiratory care as an inpatient in a hospital or nursing facility. Services are provided in the member's home under the care of a physician who is familiar with the technical and medical components of home ventilator support and the physician must determine medically that in-home respiratory care is safe

and feasible for the member. Treatment involves use of therapeutic means such as: evaluation, respiratory treatments, chest physiotherapy, and/or development and oversight of a therapeutic maintenance program. Under a physician's order, a registered respiratory therapist evaluates the member and develops an appropriate, written therapeutic regimen. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Respiratory therapy services are billed per fifteen (15) minute unit of service. Payment is not allowed solely for written reports or record documentation.

(13) **Hospice Services**.

(A) 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 six (6) months or less to live and orders hospice care. Medically Fragile Waiver hospice care is authorized for a six (6) month period and requires a physician certification of a terminal illness and orders of hospice care. If the member requires more than six months of hospice care, a physician or nurse practitioner must have a face-to-face visit with the member thirty (30) days prior to the initial hospice authorization end date and re-certify that the member has a terminal illness and has six months or less to live and orders additional hospice care. After the initial authorization period, additional periods of hospice may be authorized for a maximum of sixty (60) days increments with physician certification that the member has a terminal illness and has six months or less to live. A member's service plan that includes hospice care must comply with waiver requirements to be within total service plan cost limits.

(B) A hospice program offers palliative and supportive care to meet the special needs arising out of the physical, emotional and spiritual stresses which are experienced during the final stages of illness and during dying and bereavement. The member signs a statement choosing hospice care instead of routine medical care that has the objective to treat and cure the member's illness. Once the member has elected hospice care, the hospice medical team assumes responsibility for the member's medical care for the terminal illness in the home environment. Hospice care services include nursing care, physician services, medical equipment and supplies, drugs for symptom control and pain relief, home health aide and personal care services, physical, occupational and/or speech therapy, medical social services, dietary counseling and grief and bereavement counseling to the member and/or family. A hospice plan of care must be developed by the hospice team in conjunction with the member's case manager before hospice services are provided. The hospice services must be related to the palliation or management of the member's terminal illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills. Hospice may be provided to the member in a Nursing Facility (NF) only when the member is placed in the NF for Medically Fragile Facility Based Extended Respite. Hospice provided as part of Facility Based Extended Respite may not be reimbursed for more than five days during any thirty (30) day period. A member that is eligible for Medicare Hospice provided as a Medicare Part A benefit, is not eligible to receive Medically Fragile hospice services.

(C) Hospice services are billed per diem of service for days covered by a hospice plan of care and during which the hospice provider is responsible for providing hospice services as needed by the member or member's family.

(14) **Personal Care.**

(A) Personal Care is assistance to a member in carrying out activities of daily living such as bathing, grooming and toileting, or in carrying out instrumental activities of daily living, such as preparing meals and doing laundry, to assure personal health and safety of the individual or to prevent or minimize physical health regression or deterioration. Personal Care services do not include service provision of a technical nature, i.e. tracheal suctioning, bladder catheterization, colostomy irrigation, and operation/maintenance of equipment of a technical nature.

(B) Medically Fragile Home Care Agency Skilled Nursing staff working in coordination with a case manager are responsible for development and monitoring of the member's Personal Care plan.

(C) Personal Care services are prior authorized and billed per fifteen (15) minute unit of service with units of service limited to the number of units on the approved service plan.

(15) **Personal Emergency Response System.**

(A) Personal Emergency Response System (PERS) is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable help button to allow for mobility. The system is connected to the person's phone and programmed to signal, in accordance with member preference, a friend, a relative or a response center once a help button is activated. The response center is staffed by trained professionals. For an Medically Fragile program member to be eligible to receive PERS service, the member must meet all of the following service criteria:

(i) A recent history of falls as a result of an existing medical condition that prevents the individual from getting up from a fall unassisted;

(ii) Lives alone and has no regular caregiver, paid or unpaid, and therefore is left alone for long periods of time;

(iii) Demonstrates capability to comprehend the purpose of and activate the PERS;

(iv) Has a health and safety plan detailing the interventions beyond the PERS to assure the member's health and safety in his/her home;

(v) Has a disease management plan to implement medical and health interventions that reduce the possibility of falls by managing the member's underlying medical condition causing the falls; and,

(vi) The service avoids premature or unnecessary institutionalization of the member.

(B) PERS services are billed using the appropriate health care procedure codes for installation, monthly service or purchase of PERS. All services are prior authorized in accordance with the Medically Fragile approved service plan.

(16) **Prescription drugs.** Members are eligible for a maximum of six (6) prescriptions per month with a limit of three (3) brand-name prescriptions. Seven (7) additional generic prescriptions per month are allowed if medically necessary. Medically necessary prescriptions beyond the three (3) brand-name or thirteen (13) total prescriptions will be covered with prior authorization. More information on prescription drugs is provided at OAC 317:30-5-72.

(17) **Self-Direction**.

(A) Self-Direction is a method of service delivery that allows waiver members to determine supports and services they need to live successfully in a home or community based setting. A member choosing Self-Direction is the employer of record for his/her Personal Care and Advanced Supportive/Restorative Care service providers and must have an approved service plan prior to initiation of any Self-Directed activities.
(B) The ~~OHCA~~OKDHS uses the following criteria to determine a member's eligibility to participate in the Self-Directed option:

(i) Have an existing need for Self-Directed services to prevent institutionalization;
(ii) Member's health and safety with Self-Directed services can reasonably be assured based on a review of service history records and a review of member capacity and readiness to assume employer responsibilities under Self-Direction with any one of the following findings as basis to deny a request for Self-Direction due to inability to assure member health and safety;

(I) The member does not have the ability to make decisions about his/her care or service planning and the member's authorized representative is not willing to assume Self-Directed services responsibilities; or
(II) The member is not willing to assume responsibility, or to enlist an authorized representative to assume responsibility, in one (1) or more areas of Self-Direction such as in service planning, or in assuming the role of employer of the Personal Care Assistant (PCA) or Advanced Supportive/Restorative (ASR) service provider, or in monitoring and managing health or in preparation for emergency backup; or
(III) The member has a recent history of self-neglect or self-abuse as evidenced by Adult Protective Services intervention within the past twelve (12) months and does not have an authorized representative with capacity to assist with Self-Direction responsibilities.

(C) The member voluntarily makes an informed choice to Self-Direct services. As part of the informed choice, decision making process for Self-Direction, the ~~OHCA~~OKDHS staff or the case manager provides consultation and assistance as the member completes a self-assessment of preparedness to assume the role of employer for their PCA. The orientation and enrollment process will provide the member with a basic understanding of what will be expected of them under Self-Direction, the supports available to assist them to successfully perform employer responsibilities and an overview of the potential risks involved.
(D) The ~~OHCA~~OKDHS uses the following criteria to determine that based upon documentation, a person is no longer able to participate in the Self-Directed services option:

(i) The member does not have the ability to make decisions about his/her care or service planning and the member's authorized representative is not willing to assume Self-Direction responsibilities; or
(ii) The member is not willing to assume responsibility, or to enlist an authorized representative to assume responsibility, in one or more areas of Self-Direction such as in service planning, or in assuming the role of employer of the PCA or ASR service providers, or in monitoring and managing health or in preparation for emergency backup; or

(iii) The member has a recent history of self-neglect or self-abuse as evidenced by Adult Protective Services intervention and does not have an "authorized representative" with capacity to assist with Self-Direction responsibilities; or

(iv) The member abuses or exploits their employee; or

(v) The member falsifies time-sheets or other work records; or

(vi) The member, even with case manager and financial management services assistance, is unable to operate successfully within their Individual Budget Allocation (IBA); or

(vii) Inferior quality of services provided by member/employer's employee, or the inability of the member/employer's employee to provide the number of service units the member requires, jeopardizes the member's health and/or safety.

(E) The member may designate a family member or friend as an "authorized representative" to assist in the service planning process and in executing member employer responsibilities. If the member chooses to designate an "authorized representative", the designation and agreement identifying the "willing adult" to assume this role and responsibility is documented with dated signatures of the member, the designee and the member's case manager or the ~~OHCA~~OKDHS staff.

(i) A person having guardianship or legal power of attorney or other court sanctioned authorization to make decisions on behalf of the member has legal standing to be the member's designated "authorized representative".

(ii) An individual hired to provide Personal Services Assistance to a member may not be designated the "authorized representative" for the member.

(F) Self-Directed Services are delivered as authorized on the service plan and are limited to Personal Care, Respite and Advanced Supportive/Restorative Care. The member employs the respite or PCA and/or the ASR provider and is responsible, with assistance from the Administrative Financial Management Services (FMS), for ensuring that the employment complies with state and federal labor law requirements. The member:

(i) Recruits, hires and, as necessary, discharges the PCA and ASR;

(ii) Provides instruction and training to the PCA or ASR on tasks to be done and works with the case manager to obtain skilled nursing services assistance with training when necessary. Prior to performing an ASR provider task for the first time, the ASR must demonstrate competency in the tasks in an on-the-job training session conducted by the member and the member must document the attendant's competency in performing each task in the ASR provider personnel file;

(iii) Determines where and how the PCA or ASR works, hours of work, what is to be accomplished and, within IBA limits, wages to be paid for the work;

(iv) Supervises and documents employee work time; and

(v) Provides tools and materials for work to be accomplished.

(G) FMS are program administrative services provided to participating Self-Directed Service employer/members by agencies contracted with the OHCA. FMS are employer related assistance that provides Internal Revenue Service (IRS) fiscal reporting agent and other financial management tasks and functions including, but not limited to:

(i) Employer payroll, at a minimum of semi monthly, and associated withholding for taxes, or for other payroll withholdings performed on behalf of the member as employer of the PCA or ASR provider;

(ii) Other employer related payment disbursements as agreed to with the member and in accordance with the member's IBA;

(iii) Responsibility for obtaining criminal and abuse registry background checks, on behalf of the member, on prospective hires for PCA or ASR provider;

(iv) Providing to the member, as needed, assistance with employer related cognitive tasks, decision-making and specialized skills that may include assistance with IBA planning and support for making decisions including training and providing reference material and consultation regarding employee management tasks such as recruiting, hiring, training and supervising the member's respite or PCA or ASR provider; and

(H) The service of respite or PCA is billed per fifteen (15) minute unit of service. The number of units of PCA a member may receive is limited to the number of units approved on the Service Plan.

(I) ASR services are billed per fifteen (15) minute unit of service. The number of units of ASR a member may receive is limited to the number of units approved on the Service Plan.

(J) Self-Directed Services rates are determined using the IBA expenditure accounts determination process for each member. The IBA expenditure accounts determination process includes consideration and decisions about the following:

(i) The IBA expenditure accounts determination constrains total SoonerCare reimbursement for Self-Directed services to be less than expenditures for equivalent services using agency providers.

(ii) The PCA and ASR service unit rates are calculated by the ~~OHCA~~OKDHS during the Self-Directed service eligibility determination process. The allocation of portions of the PCA and/or ASR rate to cover salary, mandatory taxes, and optional benefits (including worker's compensation insurance, if available) is determined individually for each member using the Self-Directed services IBA expenditure accounts determination process.

(iii) The IBA Expenditure Accounts Determination process defines the level of program financial resources required to meet the member's need for Self-Directed services. If the member's need for services changes due to a change in health/disability status and/or a change in the level of support available from other sources, the case manager, based upon an updated assessment, amends the service plan to increase Self-Directed service units appropriate to meet additional member need. The ~~OHCA~~OKDHS, upon favorable review, authorizes the amended plan and updates the member's IBA. Service amendments based on changes in member need for services do not change an existing PCA or ASR rate. The member, with assistance from the FMS, reviews and revises the IBA expenditure accounts calculation annually or more often to the extent appropriate and necessary.

(18) **Self-Directed Goods and Services (SD-GS)**.

(A) Self-Directed Goods and Services (SD-GS) are incidental, non-routine goods and services that promote the member's self-care, daily living, adaptive functioning, general household activity, meal preparation and leisure skills needed to reside successfully in the community and do not duplicate other services authorized in the member's service plan.

(B) These goods and services are purchased from the self-directed budget. All goods and services must be approved by the Medically Fragile wavier staff. Documentation must be available upon request.

(19) **Transitional case management.**

(A) Transitional case management are one-time billable expenses for members who transition from within the community to the Medically Fragile waiver.

(B) Transitional case management must be reasonable and necessary as determined through the transition plan development process and must be clearly identified in the plan.

(C) Transitional case management assist members that are eligible to receive waiver services in gaining access to needed waiver and other state plan services, as well as needed medical, social, educational, and other services to assist the transition, regardless of the funding source for the services which access is gained.

(D) Transitional case management may be authorized for assisting the member transition to the Medically Fragile Waiver by updating the service plan, including preparing for necessary services and supports to be in place or to start on the date the member is effective with the waiver.

317:50-1-16. Billing procedures for Medically Fragile Waiver services

(a) Billing procedures for long-term care medical services are contained in the OKMMIS Billing and Procedure Manual. Questions regarding billing procedures which cannot be resolved through a study of the manual should be referred to the ~~OHCA~~OKDHS.

(b) The approved Medically Fragile Waiver service plan is the basis for the MMIS service prior authorization, specifying:

(1) service;

(2) service provider;

(3) units authorized; and

(4) begin and end dates of service authorization.

(c) As part of Medically Fragile Waiver quality assurance, provider audits are used to evaluate whether paid claims are consistent with service plan authorizations and documentation of service provision. Evidence of paid claims that are not supported by service plan authorization and/or documentation of service provision will be turned over to the OHCA ~~ProviderAudit~~Program Integrity Unit for follow-up investigation.

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 4. EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) PROGRAM/CHILD-HEALTH SERVICES

317:30-3-65. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program/Child-health Services

Payment is made to eligible providers for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services on behalf of eligible individuals under the age of twenty-one (21).

(1) The EPSDT program is a comprehensive child-health program, designed to ensure the availability of, and access to, required health care resources and help parents and guardians of Medicaid-eligible children and adolescents use these resources. An effective EPSDT program assures that health problems are diagnosed and treated early before they become more complex and their treatment more costly. The physician plays a significant role in educating parents and guardians about all services available through the EPSDT program. The receipt of an identified EPSDT screening makes the member eligible for all necessary follow-up care that is within the scope of the SoonerCare program. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) covers services, supplies, or equipment that are determined to be medically necessary for a child or adolescent, and which are included within the categories of mandatory and optional services in Section 1905(a) of Title XIX, regardless of whether such services, supplies, or equipment are listed as covered in Oklahoma's Medicaid State Plan.

(2) Federal regulations also require that the State set standards and protocols for each component of EPSDT services. The standards must provide for services at intervals which meet reasonable standards of medical and dental practice. The standards must also provide for EPSDT services at other intervals as medically necessary to determine the existence of certain physical or behavioral health illnesses or conditions.

(3) SoonerCare providers who perform EPSDT screenings must assure that the screenings they provide meet the minimum standards established by the Oklahoma Health Care Authority in order to be reimbursed at the level established for EPSDT services.

(4) An EPSDT screening is considered a comprehensive examination.

(A) If a member is receiving an EPSDT screening and an additional focused complaint arises that requires evaluation and management to address the complaint, the provider may deliver all medically necessary care and submit a claim for both the EPSDT screening and the appropriate level of focused service if the following requirements are met:

(i) The medical issue is significant enough to require additional work to address the issue;

(ii) The visit is documented on a separate note;

(iii) Appropriate documentation that clearly lists the condition being managed at the time of the encounter and supports the billing of both services; and

(iv) Modifier 25 is added to the appropriate code that indicates that a separate evaluation and management service was provided by the same physician on the same day as the EPSDT screening. All claims submitted with Modifier 25 will be reviewed prior to payment, per Oklahoma Administrative Code (OAC) 317:30-3-33. The following items will be reviewed prior to any payment:

(I) Medical necessity;

(II) Appropriate utilization of Modifier 25; and

(III) All documentation to support both the EPSDT screening and the additional evaluation and management for a focused complaint must be submitted for review.

(v) All claims are subject to a post payment review by the OHCA's Program Integrity Unit.

(B) When providing evaluation and management of a focused complaint, during an EPSDT screening, the provider may claim only the additional time that is required above and beyond the completion of the EPSDT screening.

(C) An insignificant or trivial problem that is encountered in the process of performing the preventive evaluation and management service and does not require additional work is included in the EPSDT visit and should not be billed/reported.

(5) There may be other additional diagnostic procedures or treatments not normally considered part of a comprehensive examination, including diagnostic tests and administration of immunizations, required at the time of screening. Additional diagnostic procedures or treatments may be billed independently from the screening. Some services as set out in this section may require prior authorization.

(6) For an EPSDT screening to be considered a completed reimbursable service, providers must perform, and document, all required components of the screening examination. Documentation of screening services performed must be retained for future review.

(A) Sports physicals do not meet EPSDT screening requirements and cannot be reimbursed when performed as the only service of the day.

(B) Sports physicals that occur during an EPSDT visit are permissible but are not billable as a stand-alone service.

(7) All comprehensive screenings provided to individuals under age twenty-one (21) must be filed on HCFA-1500 using the appropriate preventive medicine procedure code or an appropriate Evaluation and Management code from the Current Procedural Terminology Manual (CPT) accompanied by the appropriate well-child exam diagnosis code.

(8) For EPSDT services in a school-based setting that are provided pursuant to an IEP, please refer to Part 103, Qualified Schools As Providers Of Health-Related Services, in OAC 317:30-5-1020 through 317:30-5-1028.

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, 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 must enter into a two-way PACE agreement with OHCA for the operation of a PACE program, in addition to the three-way PACE agreement required by 42 CFR 460.30.

~~(b)~~(c) 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)~~(d) 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)~~(e) 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)~~(f) PACE programs are license-exempt only when they provide services exclusively to PACE participants.

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TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 5. PHARMACIES

317:30-5-72. Categories of service eligibility

(a) **Coverage for adults.** Prescription drugs for categorically needy adults are covered as set forth in this subsection.

(1) With the exception of (2) and (3) of this subsection, categorically needy adults are eligible for a maximum of six (6) covered prescriptions per month with a limit of two (2) brand name prescriptions. A prior authorization may be granted for a third brand name if determined to be medically necessary by OHCA and if the member has not already utilized their six (6) covered prescriptions for the month.

(2) Subject to the limitations set forth in Oklahoma Administrative Code (OAC) 317:30-5-72.1, 317:30-5-77.2, and 317:30-5-77.3, exceptions to the six (6) medically necessary prescriptions per month limit are:

(A) Unlimited monthly medically necessary prescriptions for categorically related individuals who are residents of nursing facilities (NF) or intermediate care facilities for individuals with an intellectual disability (ICF/IID); and

(B) Seven (7) additional medically necessary prescriptions which are generic products per month to the six (6) covered under the State Plan [including three (3) brand name prescriptions] are allowed for adults receiving services under the 1915(c) Home and Community-Based Services (HCBS) waivers. Medically necessary prescriptions beyond the three (3) brand name or thirteen (13) total prescriptions will be covered with prior authorization.

(3) For purposes of this Section, "exempt from the prescription limit" means claims filed for any of these prescriptions will not count toward the prescriptions allowed per month. Drugs exempt from the prescription limit include:

(A) Antineoplastics;

(B) Anti-retroviral agents for persons diagnosed with Acquired Immune Deficiency Syndrome (AIDS) or who have tested positive for the Human Immunodeficiency Virus (HIV);

(C) Frequently monitored prescription drugs. A complete list of the selected drugs considered as frequently monitored can be viewed on the agency's website at www.okhca.org.

(D) Medication-assisted treatment (MAT) drugs for opioid use disorder;

(E) Contraceptives;

(F) Hemophilia drugs;

(G) Compensable smoking and tobacco cessation products;

(H) ~~Naloxone for use in opioid overdose~~Opioid overdose reversal agents;

(I) Certain carrier or diluent solutions used in compounds (i.e., sodium chloride, sterile water, etc.);

(J) Drugs used for the treatment of tuberculosis; and

(K) Prenatal vitamins.

(4) When a brand drug is preferred over its generic equivalent due to lower net cost, that drug

shall not count toward the brand limit; however, it will count toward the monthly prescription limit.

(b) **Coverage for children**. Prescription drugs for SoonerCare eligible individuals under twenty-one (21) years of age are not limited in number per month, but may be subject to prior authorization, quantity limits or other restrictions.

(c) **Individuals eligible for Part B of Medicare.** Individuals eligible for Part B of Medicare are also eligible for the Medicare Part D prescription drug benefit. Coordination of benefits between Medicare Part B and Medicare Part D is the responsibility of the pharmacy provider. The SoonerCare pharmacy benefit does not include any products which are available through either Part B or Part D of Medicare.

(d) **Individuals eligible for a prescription drug benefit through a Prescription Drug Plan (PDP) or Medicare Advantage - Prescription Drug (MA-PD) plan as described in the Medicare Modernization Act (MMA) of 2003.** Individuals who qualify for enrollment in a PDP or MA-PD are specifically excluded from coverage under the SoonerCare pharmacy benefit. This exclusion applies to these individuals in any situation which results in a loss of Federal Financial Participation for the SoonerCare program. This exclusion shall not apply to items covered at OAC 317:30-5-72.1(2) unless those items are required to be covered by the prescription drug provider in the MMA or subsequent federal action.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 20. LACTATION CONSULTANTS

317:30-5-231. Eligible providers

Eligible providers must be ~~licensed by the state as a nurse or dietician and be a~~n International Board Certified Lactation Consultant (IBCLC)~~Consultants (IBCLCs)~~. Providers must have a current contract on file with the Oklahoma Health Care Authority.

317:30-5-232. Coverage

Lactation Consultant services within the scope of practice of IBCLC certification are covered for pregnant women and women up to twelve (12) months postpartum. SoonerCare members ~~may self-refer or~~must be referred by ~~any~~a physician or other licensed provider. Reasons for lactation services include but are not limited to the following:

(1) Prenatal education/training for first-time mothers;

(2) Women who have not previously breastfed, have a history of breastfeeding difficulty, have identified risk factors for breastfeeding difficulty or lactation insufficiency (e.g., history of breast surgery, infertility, hormonal imbalance, diabetes, obesity);

(3) Women expecting an infant with risk factors for ineffective breastfeeding (e.g., preterm, multiples, congenital birth defects);

(4) Latch-on difficulties;

(5) Low milk supply;

(6) Breastfeeding a premature baby (thirty-six (36) weeks or less gestation);

(7) Breastfeeding multiples; and

(8) A baby with special needs (e.g., Down Syndrome, cleft lip/or palate).

317:30-5-233. Limitations

(a) Services billed by a contracted IBCLC are only covered when performed in the IBCLC's office setting, patient's home, or other confidential outpatient setting (including telehealth). Payment for inpatient services provided by a Lactation Consultant is included in the hospital's per diem rate.

(b) No separate reimbursement will be made to a facility.

(c) Services are not to duplicate any basic breastfeeding education/training a member may have received through another program such as WIC or the Children's First Program and services must be problem focused.

(d) Services provided by a contracted IBCLC must be provided face-to-face and in an individual setting.

(e) Reimbursement is limited to not more than 6 sessions per pregnancy and must be objectively documented as medically necessary.

317:30-5-234. Reimbursement

(a) Covered services are reimbursed according to the methodology described in the Oklahoma

Medicaid State Plan.
(b) IBCLCs who are employed by or remunerated by another provider may not bill the SoonerCare program directly for services if that billing would result in duplicate payment for the same service.

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

SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME

317:35-5-2. Categorically related programs

(a) In order to be eligible for SoonerCare, an individual must first meet the description of a member eligibility group.

(1) For individuals related to the aged, blind, or disabled groups, categorical relationship is established using the same definitions of age, disability, and blindness as used by the Social Security Administration (SSA) in determining eligibility for Supplemental Security Income (SSI) or SSA benefits.

(2) If the individual is a SSA/SSI recipient in current payment status (including presumptive eligibility), ~~a Temporary Assistance for Needy Families (TANF) recipient,~~ an adoption assistance or kinship guardianship assistance recipient, or is under age nineteen (19), categorical relationship is automatically established.

(3) For individuals related to expansion adults the categorical relationship is established and defined by 42 Code of Federal Regulations (C.F.R.) § 435.119.

(4) Categorical relationship to the pregnancy group is established when the determination is made by medical evidence that the individual is or has been pregnant. Verification of pregnancy is only required if the individual's declaration that she is pregnant is not reasonably compatible with other information available to the agency. Pregnancy-related services include all medical services provided within the scope of the program during the prenatal, delivery and postpartum periods for women in this pregnancy group; see Subchapter 22 of this Chapter for services for unborn children covered under Title XXI.

(5) For an individual age nineteen (19) or over to be related to the parent and caretaker relative group, the individual must have a minor dependent child.

(6) For an individual to be related to the former foster care children group, the individual must have been receiving Medicaid benefits as a foster care child in Oklahoma or another state when he/she attained the age of eighteen (18), or aged out of foster care, until he/she reaches the age of twenty-six (26). If the individual aged out of foster care in a state other than Oklahoma, the date of ageing out had to occur on January 1, 2023, or later, and the individual must now be residing in Oklahoma. There is no income or resource test for the former foster care children group.

(7) Categorical relationship to refugee services is established in accordance with OAC 317:35-5-25.

(8) Categorical relationship for the Breast and Cervical Cancer (BCC) treatment program is established in accordance with Subchapter 21 of this Chapter.

(9) Categorical relationship for the SoonerPlan family planning program is established in accordance with OAC 317:35-5-8.

(10) Categorical relationship for pregnancy related benefits covered under Title XXI is established in accordance with Subchapter 22 of the Chapter. Benefits for pregnancies covered under Title XXI medical services are provided within the scope of the program during

the prenatal, delivery and postpartum care when included in the global delivery payment.

(b) To be eligible for SoonerCare benefits, an individual must be related to one (1) of the following eligibility groups and as defined above in this Section:

(1) Aged;
(2) Disabled;
(3) Blind;
(4) Pregnancy;
(5) Children, including newborns deemed eligible;
(6) Parents and caretaker relatives;
(7) Refugee;
(8) BCC treatment program;
(9) SoonerPlan family planning program;
(10) Benefits for pregnancies covered under Title XXI;
(11)Former foster care children; or
(12) Expansion adults.

(c) The Authority may provide SoonerCare to reasonable categories of individuals under age twenty-one (21).

(1) Individuals eligible for SoonerCare benefits include individuals between the ages of nineteen (19) and twenty-one (21):

(A) For whom a public agency is assuming full or partial financial responsibility who are in custody as reported by Oklahoma Human Services (OKDHS) and in foster homes, private institutions or public facilities; or

(B) In adoptions subsidized in full or in part by a public agency; or

(C) Individuals under age twenty-one (21) receiving active treatment as inpatients in public psychiatric facilities or programs if inpatient psychiatric services for individuals under age twenty-one (21) are provided under the State Plan and the individuals are supported in full or in part by a public agency; or

(2) Individuals eligible for SoonerCare benefits include individuals between the ages of eighteen (18) and twenty-one (21) if they are in custody as reported by OKDHS on their eighteenth (18^{th}) birthday and living in an out-of-home placement.

317:35-5-63. Agency responsible for determination of eligibility

(a) **Determination of eligibility by Oklahoma Health Care Authority (OHCA).** OHCA is responsible for determining eligibility for the following eligibility groups:

(1) Children;
(2) Newborns deemed eligible;
(3) Pregnant women;
(4) Pregnancy-related services under Title XXI;
(5) Parents and caretaker relatives;
(6) Former foster care children;
(7) Breast and Cervical Cancer (BCC) treatment program;
(8) SoonerPlan family planning program;
(9) Programs of All-Inclusive Care for the Elderly (PACE); ~~and~~
(10) Expansion adults~~.~~; and

(11) TANF recipients.

(b) **Determination of eligibility by OKDHS.** OKDHS is responsible for determining eligibility for the following eligibility groups:

~~(1) TANF recipients;~~

(1)~~(2)~~ Recipients of adoption assistance or kinship guardianship assistance;

(2)~~(3)~~ State custody;

(3)~~(4)~~ Refugee medical assistance;

(4)~~(5)~~ Aged;

(5)~~(6)~~ Blind;

(6)~~(7)~~ Disabled;

(7)~~(8)~~ Tuberculosis;

(8)~~(9)~~ Qualified Medicare Beneficiary Plus (QMBP);

(9)~~(10)~~ Qualified Disabled Working Individual (QDWI);

(10)~~(11)~~ Specified Low-Income Medicare Beneficiary (SLMB);

(11)~~(12)~~ Qualifying Individual (QI-1);

(12)~~(13)~~ Long-term care services; and

(13)~~(14)~~ Alien emergency services.

(c) **Determination of eligibility for programs offered through the Health Insurance Exchange.** OHCA assesses applicants who are found to be ineligible for SoonerCare for potential eligibility for affordable insurance programs offered through the Health Insurance Exchange. OHCA does not determine eligibility or ineligibility for those programs. OHCA facilitates the determination for those affordable insurance programs by forwarding applicants' electronic applications to the Health Insurance Exchange.

SUBCHAPTER 6. SOONERCARE FOR PREGNANT WOMEN AND FAMILIES WITH CHILDREN

PART 5. DETERMINATION OF ELIGIBILITY FOR SOONERCARE HEALTH BENEFITS FOR PREGNANT WOMEN AND FAMILIES WITH CHILDREN

317:35-6-37. Financial eligibility of categorically needy individuals related to aid to families with dependent children (AFDC), pregnancy-related services, parent/caretaker relatives, families with children, and expansion adults

Individuals whose income is less than the SoonerCare income guidelines for the applicable eligibility group are financially eligible for SoonerCare.

(1) **Categorically related to pregnancy-related services.** For an individual related to pregnancy-related services to be financially eligible, the countable income must be less than the appropriate standard according to the family size on the SoonerCare income guidelines. In determining the household size, the pregnant woman and her unborn child(ren) are included.

(2) **Categorically related to the children and parent/caretaker relative groups.**

(A) **Parent/caretaker relative group.** For the individual in the parent/caretaker relative group to be considered categorically needy, the SoonerCare income guidelines must be used.

(i) Individuals age nineteen (19) years or older, other than pregnant women, are determined categorically needy if countable income is equal to or less than the categorically needy standard, according to the family size.

(ii) All individuals under nineteen (19) years of age are determined categorically needy if countable income is equal to or less than the categorically needy standard, according to the size of the family.

(B) **Families with children.** Individuals in the children or parent/caretaker relative groups are eligible if they meet applicable MAGI-based income standards and all other Medicaid eligibility requirements.~~Individuals who meet financial eligibility criteria for the children and parent/caretaker relative groups are:~~

~~(i) All persons included in an active TANF case.~~

~~(ii) Individuals related to the children or parent/caretaker relative groups whose countable income is within the current appropriate income standard, but who do not receive TANF assistance.~~

~~(iii) All persons in a TANF case in work supplementation status who meet TANF eligibility conditions other than earned income.~~

~~(iv) Those individuals who continue to be eligible for Medicaid in a TANF case after they become ineligible for a TANF payment. These individuals will continue to be considered categorically needy if the TANF case was closed due to child or spousal support, the loss or reduction of earned income exemption by any member of the assistance unit, or the new or increased earnings of the parent/caretaker relative.~~

(3) **Expansion adults.** Individuals who meet financial eligibility criteria for expansion adults are established and defined by 42 C.F.R. §' 435.119 and by the Oklahoma Medicaid State Plan.

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 Temporary Assistance for Needy Families (TANF) is certified effective the first day of the month of TANF eligibility.~~

(b)~~(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.~~

(c)~~(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.

(d)~~(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.

SUBCHAPTER 7. MEDICAL SERVICES

PART 7. CERTIFICATION, REDETERMINATION AND NOTIFICATION

317:35-7-61. Redetermination of eligibility for persons receiving ABD ~~or TANF~~

A periodic redetermination of eligibility for Medical Services is required every twelve months on all categorically needy cases which also receive a money payment, QMBP, SLMB, QI-1, QDWI, or TEFRA.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 39. SKILLED NURSING SERVICES

317:30-5-391. Coverage for skilled nursing services

(a) All skilled nursing services must be ordered and prescribed by a physician, supported by a nursing plan of care, included in the individual plan as described in Oklahoma Administrative Code (OAC) 340:100-5-53 and reflected in the plan of care approved in accordance with OAC 340:100-3-33 and 340:100-3-33.1. For purposes of this Section, a physician is defined as all licensed medical and osteopathic physicians, physician assistants (PAs) and advanced practice registered nurses (APRNs) in accordance with the rules and regulations covering the OHCA's medical care program. Arrangements for waiver skilled nursing services are made through the personal support team with the specific involvement of the assigned Oklahoma ~~Department of~~ Human Services (OKDHS) Developmental Disabilities Services ~~Division (DDSD)~~ registered nurse (RN). ~~The DDSD RN develops a nursing service support plan subject to review and authorization by the DDSD state nursing director or designee.~~

(b) Skilled nursing services are rendered in such a manner as to provide the service recipient as much autonomy as possible.

(1) Skilled nursing services must be flexible and responsive to changes in the service recipient's needs.

(2) Providers are expected to participate in annual personal support team meetings and other team meetings as required.

(3) Appropriate supervision of skilled nursing services including services provided by licensed practical nurses (LPNs) is provided pursuant to State law and regulatory board requirements.

(4) Individual service providers must be RNs or LPNs currently licensed and in good standing in the state in which services are provided.

CHAPTER 40. DEVELOPMENTAL DISABILITIES

SUBCHAPTER 5. MEMBER SERVICES

PART 9. SERVICE PROVISIONS

317:40-5-100. Assistive technology (AT) devices and services

(a) **Applicability.** This Section applies to AT services and devices authorized by Oklahoma Human Services (OKDHS) Developmental Disabilities Services (DDS) through Home and Community-Based Services (HCBS) Waivers.

(b) **General information.**

(1) AT devices include the purchase, rental, customization, maintenance, and repair of devices, controls, and appliances. AT devices include:

(A) ~~Visual alarms~~Talking computerized devices;

(B) ~~Telecommunication devices~~Devices for the protection of health and safety of members who are blind, visually impaired, deaf or hard of hearing;
~~(C) Telephone amplifying devices;~~
~~(D) Devices for the protection of health and safety of members who are deaf or hard of hearing;~~
~~(E) Tape recorders;~~
~~(F) Talking calculators;~~
~~(G) Specialized lamps;~~
~~(H) Magnifiers;~~
~~(I) Braille writers;~~
~~(J) Braille paper;~~
~~(K) Talking computerized devices;~~
~~(L) Devices for the protection of health and safety of members who are blind or visually impaired;~~
~~(M) Augmentative and alternative communication devices including language board and electronic communication devices;~~
~~(N) Competence-based cause and effect systems, such as switches;~~
~~(O)~~(C) Mobility and positioning devices including:
(i) Wheelchairs;
(ii) ~~Travel chairs~~Wedges;
(iii) ~~Walkers~~Bed rail padding;
(iv) ~~Positioning systems~~Specialized car seats;
(v) ~~Ramps~~Adapted strollers;
(vi) ~~Seating systems~~Specialized beds;
(vii) ~~Standers~~Lifts; and
(viii) ~~Lifts;~~Therapeutic indoor swings.
~~(ix) Bathing equipment;~~
~~(x) Specialized beds;~~
~~(xi) Specialized chairs; and~~
(P) Orthotic and prosthetic devices, including:
(i) Braces;
(ii) Precribed modified shoes;
(iii) Splints; and
(iv) Hearing aids.
(Q) Environmental controls or devices;
(R) Items necessary for life support, and devices necessary for the proper functioning of such items, including durable and non-durable medical equipment not available through SoonerCare (Medicaid);
(S) Enabling technology (ET) devices to protect the member's health and safety or support increased independence in the home, employment site or community can include, but are not limited to:
(i) ~~Motion sensors~~Sensors for:
(I) Motion detection;
(II) Beds or chairs
(III) Doors and windows; or
(IV) Pressure detection in mats on floors.

(ii) Smoke and carbon monoxide alarms;
(iii) ~~Bed or chair sensors~~Cameras located outside the home or only in common areas inside the home;
~~(iv) Door and window sensors;~~
~~(v) Pressure sensors in mats on the floor;~~
~~(vi)~~(iv) Stove guards or oven shut off systems;
~~(vii)~~(v) Live web-based remote supports;
~~(viii) Cameras;~~
~~(ix) Medication~~(vi) Automated medication dispenser systems per OAC 340:100-5-32;
~~(x)~~(vii) Software to operate accessories included for environmental control;
~~(xi)~~(viii) Software applications;
~~(xii)~~(ix) Personal Emergency Response Systems (PERS) or ~~mobile~~Mobile PERS;
~~(xiii)~~(x) Emergency Response Systems;
~~(xiv)~~(xi) Global positioning system monitoring devices;
~~(xv)~~(xii) Radio frequency identification;
~~(xvi)~~(xiii) Computers, smart watches and tablets; and
~~(xvii)~~(xiv) Any other device approved by the DDS director or designee;

~~(T) Eye glasses lenses, frames or visual aids.~~

(2) AT services include:
(A) Sign language interpreter services for members who are deaf;
(B) Reader services;
(C) Auxiliary aids;
(D) Training the member and provider in the use and maintenance of equipment and auxiliary aids;
(E) Repair of AT devices;
(F) Evaluation of the member's AT needs; and
~~(G) Eye examinations.~~

(3) AT devices and services must be included in the member's Individual Plan (Plan), prescribed by a ~~physician, or appropriate medical professional~~licensed health care provider with ~~a~~an active SoonerCare (Medicaid) contract, and arrangements for this HCBS service must be made through the member's case manager.
(4) AT devices are provided by vendors with a durable medical equipment or other appropriate contract with the Oklahoma Health Care Authority (OHCA).
(5) AT devices and services are authorized per requirements of the Oklahoma Central Purchasing Act, other applicable statutory provisions, Oklahoma Administrative Code (OAC) 580:15 and OKDHS-approved purchasing procedures.
(6) AT services are provided by an appropriate professional services or ET provider with a current HCBS contract with OHCA and current, unrestricted licensure and certification with their professional board, when applicable.
(7) AT devices or services may be authorized when the device or service:
(A) Has no utility apart from the needs of the person receiving services;
(B) Is not otherwise available through SoonerCare (Medicaid), Medicare or private insurances, ~~an~~any AT retrieval program, the Oklahoma Rehabilitation Services, or any other third party or known community resource;
(C) Has no less expensive equivalent that meets the member's needs;

(D) Is not solely for family or staff convenience or preference;
(E) Is based on the assessment and Personal Support Team (Team) consideration of the member's unique needs;
(F) Is of direct medical or remedial benefit to the member or will enhance the independence of the member;
(G) Enables the member to maintain, increase, or improve functional capabilities;
(H) Is supported by objective documentation included in a professional or ET assessment with a thorough justification, including drawings, diagrams, or pictures, when necessary, except as specified, per OAC 317:40-5-100;
(I) Is within the scope of AT, per OAC 317:40-5-100;
(J) Is the most appropriate and cost effective bid, when applicable; or
(K) Exceeds a cost of seventy-five dollars ($75) AT devices or services with a cost of seventy-five dollars ($75) or less, are not authorized through DDS HCBS Waivers~~.~~; or
(L) Is denied through a Third Party Liability entity.

(8) The homeowner must sign a written agreement for any AT equipment that attaches to the home or property.

(c) **Assessments.** Recommendations for ~~enabling technology~~ET devices are completed by ~~the DDS programs manager for remote supports or their designee~~an HCBS ET contracted provider. Assessments for AT devices or services are performed by a licensed, professional service provider and reviewed by other providers whose services may be affected by the device selected. A licensed, professional service provider must:

(1) Determine if the member's identified outcome can be accomplished through the creative use of other resources, such as:
(A) Household items or toys;
(B) Equipment loan programs;
(C) Low-technology devices or other less intrusive options; or
(D) A similar, more cost-effective device; and

(2) Recommend the most appropriate AT based on the member's:
(A) Present and future needs, especially for members with degenerative conditions;
(B) History of use of similar AT, and his or her current ability to use the device; and
(C) Outcomes; and

(3) Complete an assessment, including a decision making review and device trial that provides supporting documentation for purchase, rental, customization, or fabrication of an AT device. Supporting documentation must include:
(A) A device review;
(B) Availability of the device rental with discussion of advantages and disadvantages;
(C) How frequently and in what situations the device is used in daily activities and routines;
(D) How the member and caregiver(s) are trained to safely use the AT device; and
(E) The features and specifications of the device necessary for the member, including rationale for why other alternatives are not available to meet the member's needs; and

(4) Upon DDS staff's request, provide a current, unedited video or photographs of the member using the device, including recorded trial time frames.

(d) **Repairs and ~~placement~~replacement part authorization.** AT device repairs or parts replacements, do not require a professional assessment or recommendation if the DDS waiver

purchased the item. DDS resource development staff ~~with AT experience~~ may authorize repairs and replacement of parts for previously recommended AT.

(e) **AT device retrieval.** When a member no longer needs an AT device, OKDHS DDS staff may retrieve the device or assist with procurement for other waiver recipients with similar critical health and safety needs.

(f) **Team decision-making process.** The member's Team reviews the licensed professional's or ET assessment and decision-making review. The Team ensures the recommended AT:

(1) Is needed by the member to achieve a specific, identified functional outcome.

(A) A functional outcome, in this Section, means the activity is meaningful to the member, occurs on a frequent basis, and would require assistance from others, if the member could not perform the activity independently, such as self-care, assistance with eating, or transfers.

(B) Functional outcomes must be reasonable and necessary given a member's age, diagnosis, and abilities; and

(2) Allows the member receiving services to:

(A) Improve or maintain critical health and safety needs;

(B) Participate in community life;

(C) Express choices; or

(D) Participate in vocational training or employment; and

(3) Is used frequently or in a variety of situations;

(4) Is easily fit into the member's lifestyle and work place;

(5) Is specific to the member's unique needs; and

(6) Is not authorized solely for family or staff convenience.

(g) **Requirements and standards for AT devices and service providers.**

(1) Providers guarantee devices, work, and materials for one (1) calendar year, and supply necessary follow-up evaluation to ensure optimum usability.

(2) Providers ensure a licensed occupational therapist, physical therapist, speech therapist, or rehabilitation engineer evaluates the need for AT, and individually customizes AT devices to the member's needs.

(h) **Services not covered through AT devices and services.** AT devices and services do not include:

(1) Trampolines;

(2) exercise equipment;

~~(2)~~(3) Hot tubs;

(4) Swimming pools, including lifts and accessories;

~~(3)~~(5) Bean bag chairs;

(6) Special needs chairs including, but not limited to, feeder and all positioning chairs;

~~(4)~~(7) Recliners with lift capabilities;

~~(5)~~(8) Computers~~, except as adapted for individual needs~~ used as a primary means of oral communication~~, and approved, per OAC 317:40-5-100~~;

~~(6)~~(9) Massage, therapy, bedside, and changing tables;

~~(7)~~(10) Educational and learning games and toys; ~~or~~

~~(8)~~(11) Generators~~.~~;

(12) Humidifiers;

(13) Air purifiers;

(14) Heating and air conditioning components;

(15) Porch swings, swing sets, outdoor playground equipment;
(16) Bicycles, tricycles, bicycle trailer, and all terrain equipment; or
(17) Duplicate services or hypotheitical situations such as secondary or back up devices.

(i) **AT approval or denial.** DDS approval~~, conditional approval for pre-determined trial use, or denial of the purchase, rental, or lease or purchase~~ of the AT is determined~~,~~ per OAC 317:40-5-100.

(1) The DDS case manager ~~sends~~submits the AT request to~~ designated DDS AT-experienced~~ resource development unit (RDU) staff for procurement. The request must include:

(A) The licensed professional's assessment ~~and decision making review~~or a recommendation signed by a SoonerCare contracted health care provider when the request is for enabling technology;

~~(B) A copy of the Plan of Care;~~

~~(C)~~(B) Documentation of the current Team consensus, including all consideration of pertinent issues, per OAC 317:40-5-100; and

~~(D)~~(C) All additional documentation to support the AT device or service need.

(2) The designated ~~AT-experienced resource development~~RDU staff approves or denies procurement of the AT ~~request when the device costs less than $5000.~~

~~(3) The State Office programs manager for AT approves or denies the AT request when the device has a cost of $5000 or more. When authorization of an AT device of $5000 or more is requested:~~. The RDU staff issues a letter of authorization, a written denial, or a request for additional information within five (5) business days of receipt of all required AT documentation.

~~(A) The AT-experienced resource development staff:~~

~~(i) Solicits three (3) AT bids; and~~

~~(ii) Submits the AT request, bids, and other relevant information identified in (1) of this subsection to the State Office DDS AT programs manager or designee within five (5) business days of receipt of the required bids; and~~

~~(B) The State Office DDS AT programs manager or designee issues a letter of authorization, a written denial, or a request for additional information within five (5) business days of receipt of all required AT documentation.~~

(4) Authorization for purchase or a written denial is provided within ten (10) business days of receipt of a complete request.

(A) If the AT is approved, a letter of authorization is issued.

(B) If additional documentation is required by the ~~AT-experienced resource development~~RDU staff, to authorize the recommended AT, the request packet is returned to the case manager for completion.

(C) When necessary, the case manager contacts the licensed professional or ET provider to request the additional documentation.

(j) **Vehicle approval adaptations.** Vehicle adaptations are assessed and approved, per OAC 317:40-5-100. In addition, the requirements in (1) through ~~(3)~~(5) of this subsection must be met.

(1) The vehicle must be owned or in the process of being purchased by the member receiving services or his or her family ~~in order~~ to be adapted.

(2) The AT request must include a ~~certified mechanic's~~ statement from a certified mechanic who owns or is employed by a business registered and in good standing with the Oklahoma Secretary of State that the vehicle and adaptations are mechanically sound.

(3) Vehicle adaptations are limited to ~~one vehicle~~$50,000.00 in a ten (10) year period per member. Authorization ~~for more than one vehicle adaptation~~to exceed $50,000.00 in a ten (10) year period must be approved by the DDS director or designee.

(4) Once approved, the family must add the modifications performed by the DDS waiver to their insurance for coverage in case of an accident.

~~(k) **Eye glasses and eye exams.** Routine eye examination or the purchase of corrective lenses for members twenty-one (21) years of age and older, not covered by SoonerCare (Medicaid), may be authorized for the purpose of prescribing glasses or visual aids, determination of refractive state, treatment of refractive errors, or purchase of lenses, frames, or visual aids. Payment can be made to a licensed optometrist who has a current contract on file with OHCA for services within the scope of Optometric practice as defined by the appropriate State law; provided, however, that services performed by out-of-state providers are only compensable to the extent that they are covered services.~~

~~(l)~~(k) **AT denial.** Procedures for denial of an AT device or service are described in (1) through (3) of this subsection.

(1) The ~~person~~RDU staff denying the AT request completes and provides ~~a written denial~~ OKDHS Form 06MP004E, DDS-4 Notice of Action to the case manager citing the reason for denial, per OAC 317:40-5-100.

(2) The case manager sends ~~OKDHS Form~~the completed form, 06MP004E~~, Notice of Action,~~ to the member and his or her family or guardian.

(3) AT service denials may be appealed through the OKDHS hearing process, per OAC 340:2-5.

~~(m)~~(l) **AT device returns.** When, during a trial use period or rental of a device, the therapist or Team including the licensed professional who recommended the AT and, when available, determines the device is not appropriate, the licensed professional sends a brief report describing the change of device recommendation to the DDS case manager. The DDS case manager forwards the report to the designated resource development staff, who arranges for the equipment return to the vendor or manufacturer.

~~(n)~~(m) **AT device rental.** AT devices are rented when the licensed professional or AT-experienced resource development staff determines rental of the device is more cost effective than purchasing the device or the licensed professional recommends a trial period to determine if the device meets the member's needs.

(1) The rental period begins on the date the manufacturer or vendor delivers the equipment to the member, unless otherwise stated in advance by the manufacturer or vendor.

(2) AT-experienced resource development staff monitor use of equipment during the rental agreement for:

(A) Rental time frame cost effectiveness;

(B) Renewal conditions; and

(C) The Team's, including the licensed professional's re-evaluation of the member's need for the device, per OAC 317:40-5-100.

(3) Rental costs are applied toward the purchase price of the device when the option is available from the manufacturer or vendor.

(4) When a device is rented for a trial-use period, the Team including the licensed professional, decides within ninety (90) calendar days whether the device:

(A) Meets the member's needs; and

(B) Needs to be purchased or returned.

~~(o)~~(n) **AT committee.** The AT committee reviews equipment requests when deemed necessary by the OKDHS DDS State Office AT programs manager.

(1) The AT committee is comprised of:

~~(A) DDS professional staff members of the appropriate therapy;~~

~~(B)~~(A) DDS State Office AT programs manager;

~~(C)~~(B) The DDS ~~area~~regional field administrator or designee; and

~~(D)~~(C) An AT expert, not employed by OKDHS.

(2) The AT committee performs a ~~paper~~ review, providing technical guidance, oversight, and consultation.

(3) The AT committee may endorse or recommend denial of a device or service, based on criteria provided in this Section. Any endorsement or denial includes a written rationale for the decision and, when necessary, an alternative solution, directed to the case manager within twenty (20) business days of the receipt of the request. Requests reviewed by the AT committee result in suspension of time frames specified, per OAC 317:40-5-100.

317:40-5-103. Transportation

(a) **Applicability.** The rules in this Section apply to transportation services provided through Oklahoma Human Services, Developmental Disabilities Services (DDS); Home and Community-Based Services (HCBS) Waivers.

(b) **General Information.** Transportation services include adapted, non-adapted, and public transportation.

(1) Transportation services are provided to promote inclusion in the community, access to programs and services, and participation in activities to enhance community living skills. Members are encouraged to utilize natural supports or community agencies that can provide transportation without charge before accessing transportation services.

(2) Services include, but are not limited to, transportation to and from medical appointments, work or employment services, recreational activities, and other community activities within the number of miles authorized in the Plan of Care (POC).

(A) Adapted or non-adapted transportation may be provided for each eligible person.

(B) Public transportation may be provided up to a maximum of ~~$15,000~~$25,000 per POC year. The DDS director or designee may approve requests for public transportation services totaling more than ~~$$15,000~~$25,000 per year when public transportation promotes the member's independence, is the most cost-effective option or only service option available for necessary transportation. For the purposes of this Section, public transportation is defined as:

(i) Services, such as an ambulance when medically necessary, a bus, or a taxi; or

(ii) A transportation program operated by the member's employment services or day services provider.

(3) Transportation services must be included in the member's Individual Plan (Plan) and arrangements for this service must be made through the member's case manager.

(4) Authorization of Transportation Services is based on:

(A) Personal Support Team (Team) consideration, per Oklahoma Administrative Code (OAC) 340:100-5-52, of the unique needs of the person and the most cost effective type of transportation services that meets the member's need, per (d) of this Section; and

(B) The scope of transportation services as explained in this Section.

(c) **Standards for transportation providers.** All drivers employed by contracted transportation providers must have a valid and current Oklahoma driver license, and the vehicle(s) must meet applicable local and state requirements for vehicle licensure, inspection, insurance, and capacity.

(1) The provider must ensure that any vehicle used to transport members:

(A) Meets the member's needs;

(B) Is maintained in a safe condition;

(C) Has a current vehicle tag; and

(D) Is operated per local, state, and federal law, regulation, and ordinance.

(2) The provider maintains at least $100,000.00 liability ~~insurance in an amount sufficient~~ to pay for injuries or loss to persons or property occasioned by negligence or malfeasance by the agency, its agents, or employees.

(3) The provider ensures all members wear safety belts during transport.

(4) Regular vehicle maintenance and repairs are the responsibility of the transportation provider. Providers of adapted transportation services are also responsible for maintenance and repairs of modifications made to vehicles. Providers of non-adapted transportation with a vehicle modification funded through HCBS assistive technology services may have repairs authorized per OAC 317:40-5-100.

(5) Providers must maintain documentation, fully disclosing the extent of services furnished that specifies the:

(A) Service date;

(B) Location and odometer mileage reading at the starting point and destination; or trip mileage calculation from global positioning system software;

(C) Name of the member transported; and

(D) Purpose of the trip.

(6) A family member, including a family member living in the same household of an adult member may establish a contract to provide transportation services to:

(A) Work or employment services;

(B) Medical appointments; and

(C) Other activities identified in the Plan as necessary to meet the needs of the member, per OAC 340:100-3-33.1.

(7) Individual transportation providers must provide verification of vehicle licensure, insurance and capacity to the DDS area office before a contract may be established and updated verification of each upon expiration. Failure to provide updated verification of a current and valid Oklahoma driver license or vehicle licensure may result in cancellation of the contract.

(d) **Services not covered.** Services that cannot be claimed as transportation services include:

(1) Services not approved by the Team;

(2) Services not authorized by the POC;

(3) Trips that have no specified purpose or destination;

(4) Trips for family, provider, or staff convenience;

(5) Transportation provided by the member;

(6) Transportation provided by the member's spouse;

(7) Transportation provided by the biological, step or adoptive parents of the member or legal guardian, when the member is a minor;

(8) Trips when the member is not in the vehicle;

(9) Transportation claimed for more than one (1) member per vehicle at the same time or for the same miles, except public transportation;
(10) Transportation outside Oklahoma unless:
(A) The transportation is provided to access the nearest available medical or therapeutic service; or
(B) Advance written approval is given by the DDS area manager or designee;
(11) Services that are mandated to be provided by the public schools pursuant to the Individuals with Disabilities Education Act;
(12) Transportation that occurs during the performance of the member's paid employment, even when the employer is a contract provider; or
(13) Transportation when a closer appropriate location was not selected.

(e) **Assessment and Team process.** At least annually, the Team addresses the member's transportation needs. The Team determines the most appropriate means of transportation based on the:
(1) Present needs of the member. When addressing the possible need for adapted transportation, the Team only considers the member's needs. The needs of other individuals living in the same household are considered separately;
(2) Member's ability to access public transportation services; and
(3) Availability of other transportation resources including natural supports, and community agencies.

(f) **Adapted transportation.** Adapted transportation may be transportation provided in modified vehicles with wheelchair or stretcher-safe travel systems or lifts that meet the member's medical needs that cannot be met with the use of a standard passenger vehicle, including a van when the modification to the vehicle was not funded through HCBS assistive technology service and is owned or leased by the DDS HCBS provider agency, family of an adult member, agency companion provider or specialized foster care provider.
(1) Adapted transportation is not authorized when a provider agency leases an adapted vehicle from a member or a member's family.
(2) Exceptions to receive adapted transportation services for modified vehicles other than those with wheelchair or stretcher safe travel systems and lifts may be authorized by the DDS programs manager for transportation services when documentation supports the need, and there is evidence the modification costs exceeded $10,000. All other applicable requirements of OAC 317:40-5-103 must be met.
(3) Adapted transportation services do not include vehicles with modifications including, but not limited to:
(A) Restraint systems;
(B) Plexi-glass windows;
(C) Barriers between the driver and the passengers;
(D) Turney seats; and
(E) Seat belt extenders.
(4) The Team determines if the member needs adapted transportation according to:
(A) The member's need for physical support when sitting;
(B) The member's need for physical assistance during transfers from one surface to another;
(C) The portability of the member's wheelchair;
(D) Associated health problems the member may have; and

(E) Less costly alternatives to meet the need.

(5) The transportation provider and the equipment vendor ensure that the Americans with Disabilities Act requirements are met.

(6) The transportation provider ensures all staff assisting with transportation is trained according to the requirements specified by the Team and the equipment manufacturer.

(g) **Authorization of transportation services.** The limitations in this subsection include the total of all transportation units on the POC, not only the units authorized for the identified residential setting.

(1) Up to 12,000 units of transportation services may be authorized in a member's POC per OAC 340:100-3-33 and OAC 340:100-3-33.1.

(2) When there is a combination of non-adapted transportation and public transportation on a POC, the total cost for transportation cannot exceed the cost for non-adapted transportation services at the current non-adapted transportation reimbursement rate multiplied by 12,000 miles for the POC year.

(3) The DDS area manager or designee may approve:

(A) Up to 14,400 miles per POC year for people who have extensive needs for transportation services; and

(B) A combination of non-adapted transportation and public transportation when the total cost for transportation does not exceed the cost for non-adapted transportation services at the current, non-adapted transportation reimbursement rate multiplied by 14,400 miles for the POC year.

(4) The DDS division director or designee may approve:

(A) Transportation services in excess of 14,400 miles per POC year in extenuating situations when person-centered planning identified specific needs that require additional transportation for a limited period; or

(B) Any combination of public transportation services with adapted or non-adapted transportation when the total cost for transportation exceeds the cost for non-adapted transportation services at the current, non-adapted transportation reimbursement rate multiplied by 14,400 miles for the POC year; or

(C) Public transportation services in excess of $25,000, when it promotes the member's independence, is the most cost effective or only service option available for necessary transportation.

SUBCHAPTER 7. EMPLOYMENT SERVICES THROUGH HOME AND COMMUNITY-BASED SERVICES WAIVER

317:40-7-2. Definitions

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

"Commensurate wage" means wages paid to a worker with a disability based on the worker's productivity in proportion to the wages and productivity of workers without a disability performing essentially the same work in the same geographic area. Commensurate wages must be based on the prevailing wage paid to experienced workers without disabilities doing the same job.

"Competitive integrated employment" means work in the competitive labor market performed on a full-time or part-time basis in integrated community settings. The individual is

compensated at or above minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Competitive employment is an individual placement.

~~**"Employment assessment"**~~**"Assessment"** means the evaluation that identifies the unique preferences, strengths, and needs of members in relation to work. The assessment determines work skills and work behaviors, is supplemented by personal interviews and behavioral observations, and incorporates information that addresses the member's desired medical, physical, psychological, social, cultural, and educational outcomes, as well as present and future employment options. The assessment is updated annually or more frequently as needed, and includes support needs, environmental preferences, and possible accommodations.

"Enhanced rate" means a differential rate established to provide an incentive to provider agencies to provide community employment services to members with significant needs.

"Group placement" means either two (2) to three (3) workers with disabilities making minimum wage or four (4) to five (5) workers with disabilities who may earn less than minimum wage situated close together, who are provided continuous, long-term training and support in an integrated job site. Members may be employed by the company or by the provider agency. The terms "work crew" and "enclave" also describe a group placement.

"Individual placement in community-based services" means the member is provided supports that enable him or her to participate in approved community-based activities per Oklahoma Administrative Code 317:40-7-5, individually and not as part of a group placement.

"Individual placement in job coaching services" means one member receiving job coaching services, who:

(A) Works in an integrated job setting;

(B) Receives minimum wage or more;

(C) Does not receive services from a job coach who is simultaneously responsible for continuous job coaching for a group;

(D) Is employed by a community employer or the provider agency; and

(E) Has a job description that is specific to his or her work.

"Integrated employment site" means an activity or job that provides regular interaction with people without disabilities, excluding service providers, to the same extent that a worker without disabilities in a comparable position interacts with others.

"Job coach" means an individual who holds a DDS-approved training job coach certification and provides ongoing support services to eligible persons in supported employment placements. Services directly support the member's work activity including marketing and job development, job and work site assessment, training and worker assessment, job matching procedures, development of co-worker natural and paid supports, and teaching job skills.

"Job development" means the process of consulting with employers in a comprehensive professional manner for the purpose of identifying job opportunities. It also includes developing resumes, making job applications, interviewing, and job networking.

"Job discovery" means the process of determining a member's job strengths, weaknesses, likes and dislikes through completion of skills assessments, informal interviews, career exploration, job shadowing and job trials.

"Job sampling" means a paid situational assessment whereby a member performs a job at a prospective employer's integrated job site in order to determine the member's interests and abilities. Situational assessments adhere to the Department of Labor (DOL) regulations regarding

wages. The Personal Support Team determines the appropriate type and number of situational assessments for each member.

"On-site supports" means a situation in which the job coach is physically at the job site providing job training to a member.

"Self-Employment" or "Employment Based at Home" means the member works for themselves or a non-DDS provider agency in their own home with supports provided through job coaching services. The hourly rate is determined by dividing number of hours worked per calendar week by total dollar amount of sales of product or service during the same calendar week. An Employment Service Justification form that includes a business proposal for self-employment must be submitted to the DDS vocational program manager for approval. Members must:

(A) have a designated space to work;
(B) complete job tasks a non-disabled person performs;
(C) provide a marketable product or service; and
(D) perform at least 80% of their job in their home and 20% in community. An exception to this requirement may be approved by the DDS director or designee.

~~**"Situational assessment"** means a comprehensive community-based evaluation of the member's functioning in relation to the supported job including the job site, community through which the member must travel to and from the job, and those at the job site, such as the job coach, co-workers, and supervisors.~~

~~**"Sub-contract with industry"** means the provider agency enters into a sub-contract with an industry or business to pay industry employees to provide supports to members. When the industry agrees, the provider agency may contract directly with an industry employee(s) to provide the services. The state continues to pay the provider agency and the agency provides all pertinent information required for persons served by the agency. The Team determines what, if any, training is required for the employees of the industry providing services.~~

"Supported employment" means competitive work in an integrated work setting with ongoing support services for members for whom competitive employment has not traditionally occurred or was interrupted or intermittent as a result of the member's disabilities.

"Unpaid training" means unpaid experience in integrated employment sites per Sections 785.27 through 785.32 of Title 29 of the Code of Federal Regulations (29 C.F.R. §§ 785.27 through 785.32). Members do a variety of tasks that do not equal the full job description of a regular worker.

"Volunteer job" means an unpaid activity in which a member freely participates.

317:40-7-5. Community-based services

Community-based services are provided in sites and at times typically used by others in the community and promote independence, community inclusion, and the creation of natural supports. Community-based services must reflect the member's choice and values in typical age and cultural situations.

(1) Approved community-based services are individualized work-related supports targeting inclusion into integrated experiences and are pre-planned, pre-identified places, documented activities supported by a schedule relating to the member's identified employment outcomes. Approved community-based services activities include:

(A) active participation in formalized volunteer activities;
(B) active participation in paid or unpaid work experience sites in community settings;

(C) training through generic entities such as trade schools, technology centers, community colleges, on-line training identified by team, or other community groups. The provider is paid for the time when direct supports are necessary and provided;
(D) stamina-enhancing programs in integrated settings;
(E) transportation to and from employment or community-based activities;
(F) meals and breaks during the member's employment activities that occur in the community at a location used for the same purpose, with others without disabilities;
(G) job tours or job shadowing scheduled with and provided by a community-business entity;
(H) using Workforce OK services; and
(I) attending job fairs.

(2) Any other work-related, community-based activities must be approved through the exception process, per Oklahoma Administrative Code (OAC) 317:40-7-21.

(3) Community-based services continue when the member goes to a center-based facility for support, such as repositioning or personal care, ~~as long as~~when the member returns immediately to a planned community-based activity. The amount of time for the repositioning and personal care are based upon a Team-approved health care positioning plan.

(4) Community-based services are available for individual and group placements.

(A) Individual placement means the member is provided supports that enable him or her to participate in individual community-based activities described in this Section and not as part of a group placement.

(B) Group placement means two-to-five members are provided supports that enable participation in the approved community-based activities described in this Section.

317:40-7-8. Employment training specialist services

Employment training specialist (ETS) services include ~~evaluation,~~ training, job development, job discovery, and supportive assistance that allow the member to obtain and engage in remunerative employment. ETS services are:

(1) available only when not otherwise funded through another state or federal entity;
~~(1)~~(2) provided by a certified job coach;
~~(2)~~(3) not available when subcontracting;
(4) not claimed during the same period of time another type of service is provided;
~~(3)~~(5) used to help a member with a new job in a generic employment setting.

(A) ETS services are:

(i) not available if the member held the same job for the same employer in the past;
(ii) available when the member requires 100% on-site intervention for up to the number of hours the member works per week for six weeks per Plan of Care year; and
~~(iii) used in training members employed in individual placements on new jobs when the:~~

~~(I) member receives at least minimum wage; and~~
~~(II) employer is not the employment services provider.~~

~~(B) If the member does not use all of the training units on the first job placement in the Plan of Care year, the balance of training units may be used on a subsequent job placement with the current provider, or with a new provider;~~

~~(4) used in assessment and outcome development for members residing in the community who are new to the provider agency, when determined necessary by the Personal Support Team (Team). The provider:~~

~~(A) may claim a documented maximum of 20 hours per member for initial assessment. The projected units for the assessment and outcome development must:~~

~~(i) be approved in advance by the Team; and~~

~~(ii) relate to the member's desired outcomes; and~~

~~(B) cannot claim the same period of time for more than one type of service;~~

~~(5)~~(6) used ~~in~~for Team meetings~~,~~ when the case manager ~~has requested~~requests participation of ~~direct service~~ employment staff in accordance with OAC 340:100-5-52, up to 20 hours per Plan of Care year;

(7) used for job discovery per OAC 317:40-7-2 when a member is new to vocational services, or the member wishes to obtain a new job. The member must be part of the conversation 100% of the time.

(A) Up to fifteen (15) hours may be authorized for assessment per plan of care (POC) year and may be reauthorized after two years if the member wishes to change jobs.

(B) The member's team and the DDS director or designee must approve services beyond the initial authorization.

~~(6)~~(8) used ~~in~~for job development ~~for a member on an individual job site upon the member's completion of three consecutive months on the job~~per OAC 317:40-7-2.

(A) ~~Up to 40 hours may be used during a Plan of Care year after documentation of job development activities is submitted to the case manager.~~Vocational providers:

(i) must submit to the case manager a quarterly review of progress for job development per OAC 340:100-5-52. The member must be part of the job development at least 50% of the time; and

(ii) may claim a documented maximum of twenty five (25) hours per member for job development per POC year if obtaining a new job or changing jobs.

(B) The job must:

(i) be approved by the member's team and related to the member’s desired outcomes or assessment findings.

~~(i)~~(ii) pay at least minimum wage;

~~(ii)~~(iii) employ each member at least 15 hours per week; and

~~(iii)~~(iv) be provided by an employer who is not the member's contract provider;

~~(7)~~(9) used ~~in~~for development of a Plan for Achieving Self-Support (PASS) up to 40 hours per Plan of Care year after documentation of PASS development, if not developed by a Community Work Incentives Coordinator or the Department of Rehabilitation Services, and implementation of an approved PASS after documentation has been submitted to the case manager;

~~(8)~~(10) used ~~in~~for development of an Impairment Related Work Expense (IRWE) up to 20 hours per Plan of Care year after documentation of IRWE development, if not developed by a Community Work Incentives Coordinator or Oklahoma Department of Rehabilitation, and implementation of an approved IRWE after documentation is submitted to the case manager; ~~and~~

~~(9)~~(11) used ~~in~~for interviewing for ~~a~~an ETS eligible job ~~that is eligible for ETS services.~~; and

~~(10)~~(12) ~~If~~are authorized when the member needs job coach services after expiration of Stabilization Services~~, Employment Training Specialist Services may be authorized~~ for the hours necessary to provide direct support to the member or consultation to the employer as described in outcomes and methods in the Individual Plan. The plan should include the process for fading as the member's independence ~~increases and progress documented on OKDHS form 06WP066E~~.

317:40-7-12. Enhanced rates

An enhanced rate is available for both community-based group services andgroup job-coaching services when necessary to meet a member's intensive personal needs in the employment setting(s). The need for the enhanced rate is identified through the Personal Support Team process and is supported by documentation in the Individual Plan (Plan) with consideration of risk assessment per Oklahoma Administrative Code (OAC) 340:100-5-56 and assessment of medical, nutritional, mobility needs, and the:

(1) Team assessment of the member's needs per OAC 340:100-5-51, OAC 340:100-5-56, OAC 340:100-5-57, and OAC 340:100-5-26;

(2) member must:

(A) have a protective intervention protocol (PIP) that:

(i) contains a restrictive or intrusive procedure per OAC 340:100-1-2 implemented in the employment setting; and

(ii) is approved by the State Behavior Review Committee (SHRBRC) per OAC 340:100-3-14 or by the Developmental Disabilities Services (DDS) staff per OAC 340:100-5-57;

(B) have procedures included in the Plan that address dangerous behavior that places the member or others at risk of serious physical harm but are neither restrictive or intrusive procedures per OAC 340:100-1-2. The Team submits documentation of this risk and the procedures to the positive support field specialist to ensure positive approaches are being used to manage dangerous behavior;

(C) have a visual or hearing impairment that requires assistance for mobility or safety;

(D) have nutritional needs requiring tube feeding or other dependency for food intake that must occur in the employment setting;

(E) have mobility needs, such that he or she requires two or more people for lifts, transfers, and personal care. Use of a mechanical lift or other assistive technology is evaluated for the current employment program and determined not feasible by the DDS division director or designee; or

(F) reside in alternative group home per OAC 317:40-5-152; and

(3) enhanced rate can be claimed only when the person providing services fulfills all applicable training criteria specified in OAC 340:100-3-38. There are no exceptions for the enhanced rate other than as allowed in this Section.

317:40-7-15. Service requirements for employment services through Home and Community-Based Services (HCBS) Waivers

(a) The Oklahoma Human Services (OKDHS) Developmental Disabilities Services (DDS) case manager, the member, the member's family or, when applicable, the member's legal guardian, and the member's provider develop a preliminary plan of services including the:

(1) Site and amount of the services offered;

(2) Types of services to be delivered; and
(3) Expected outcomes.

(b) To promote community integration and inclusion, employment services are delivered in non-residential sites.

(1) Employment services through HCBS waivers cannot be reimbursed when those services occur in the residence or property of the member or provider-paid staff, including garages and sheds, whether or not the garage or shed is attached to the home.

(2) No exceptions to Oklahoma Administrative Code (OAC) 317:40-7-15(b) are authorized except when a home-based business is established and supported through Oklahoma Rehabilitation Services (DRS). Once DRS stabilization services end, DDS stabilization services are then utilized.

(c) The service provider is required to notify the DDS case manager in writing ~~when the member~~:

(1) ~~Is placed in a new job~~Prior to when the member is placed in a new job, unless in an emergency, or when new goals and outcomes are needed;

(2) ~~Loses~~When the member loses his or her job. A personal support team (Team) meeting must be held when the member loses the job;

(3) ~~Experiences~~When the member experiences significant changes in the community-based or employment schedule; or

(4) ~~Is~~When the member is involved in critical and non-critical incidents per OAC 340:100-3-34.

(d) The provider submits a DHS Provider Progress Report, per OAC 340:100-5-52, for each member receiving services.

(e) The cost of a member's employment services, excluding transportation and state-funded services cannot exceed limits set forth in OKDHS Appendix D-26, Developmental Disabilities Services Rates Schedule, per Plan of Care (POC) year.

(f) Each member receiving HCBS is supported in opportunities to seek employment and work in competitive integrated settings. When the member is not employed in a competitive integrated job, the Team identifies pathways to include outcomes, action steps, or both, to create opportunities that move the member toward competitive integrated employment.

(g) Each member receiving residential supports, per OAC 340:100-5-22.1, or group-home services is employed for thirty (30) hours per week or receives a minimum of thirty (30) hours of employment services each week, excluding transportation to and from his or her residence.

(1) Thirty (30) hours of employment service each week may be a combination of community-based services, center-based services, employment training specialist (ETS) intensive training services, stabilization services, or job coaching services. Center-based services cannot exceed fifteen (15) hours per week for members receiving services through the Homeward Bound Waiver.

(2) When the member does not participate in thirty (30) hours per week of employment services, the Team:

(A) Documents the pathways with outcomes and/or action steps ~~to create a pathway~~ that moves toward employment activities;

(B) Describes a plan to provide a meaningful day including opportunities for integrated experiences in the community; or

(C) Increases the member's employment activities to thirty (30) hours per week.

(h) ~~Adult members~~Members receiving In-Home Supports waiver services who are at least sixteen (16) years old can access ~~individual placement in~~ job coaching, stabilization, and employment training specialist services not to exceed limits specified in OKDHS Appendix D-26, per POC year.

317:40-7-18. Contracts with industry

~~(a)~~ The Oklahoma ~~Department of~~ Human Services (OKDHS) Developmental Disabilities Services ~~Division (DDSD)~~(DDS) may contract with an industry to provide job coaching services through a Natural Supports Initiative. The employer:

(1) designates an existing employee to serve as job coach.

(A) The job coach completes ~~training as approved by the DDSD director of Human Resource Development~~per Oklahoma Administrative Code 340:100-3-38.2.

(B) Training and support are available for members on the job; and

(2) is reimbursed at the individual placement in job coaching rate based on the hours the member works for the first six months.

(A) After the first six months of employment, the employer is reimbursed at the stabilization rate based on the hours the member works.

(B) Stabilization services may be provided for up to one year per job.

~~(b) An employment provider may subcontract with an industry to provide job coaching services to members who are eligible.~~

~~(1) The subcontract with an industry must be reviewed and accepted by the Personal Support Team and member or legal guardian prior to the execution of the subcontract.~~

~~(2) Approval by OKDHS:~~

~~(A) of any subcontract does not relieve the primary employment provider of any responsibility for performance per OAC 317:40-7; and~~

~~(B) to subcontract with an industry is given only when it is determined the member's needs can best be met by additional natural supports provided by industry employees.~~

317:40-7-22. Value-Based Payments (VBP)

(a) **Purpose.** Oklahoma Human Services (OKDHS) Developmental Disabilities Services (DDS) provides incentive payments to support a member as he or she moves toward competitive integrated employment. VBPs are intended to further opportunities for Oklahomans with disabilities to live independently and work in competitive integrated employment. VBPs are included in the member's Individual Plan (Plan) and arrangements for this service are made through the DDS case manager. VBPs support members ~~eighteen (18)~~sixteen (16) years of age and older who receive employment services through the:

(1) In-Home Supports Waiver;

(2) Homeward Bound Waiver; or

(3) Community Waiver.

(b) **Payment criteria.** VBPs support a member as he or she progresses towards competitive employment per the OKDHS Appendix D-26, Developmental Disabilities Services Rates Schedule. VBPs are paid:

(1) After a member is employed for fifteen (15) business days;

(2) When the member is employed a minimum of fifteen (15) hours weekly; and

(3) In accordance with the limits set forth in OKDHS Appendix D-26, Developmental Disabilities Services Rates Schedule.

SUBCHAPTER 9. SELF-DIRECTED SERVICES

317:40-9-1. Self-directed services (SDS)

(a) **Applicability.** This Section applies to SDS provided through Home and Community-Based Services (HCBS) Waivers operated by the Oklahoma Human Services (OKDHS) Developmental Disabilities Services (DDS).

(b) **Member option.** Traditional service delivery methods are available for eligible members who do not elect to self-direct services. Members may also choose to self-direct part or all of their services as permitted within this section.

(c) **General information.** SDS are an option for members receiving HCBS through the In-Home Supports Waiver (IHSW) for Adults, ~~In-Home Supports Waiver~~IHSW for Children, and the Community Waiver when the member lives in a non-residential setting. SDS provides members the opportunity to exercise choice and control in identifying, accessing, and managing specific Waiver services and supports in accordance with his or her needs and personal preferences. SDS are Waiver services OKDHS DDS specifies may be directed by the member or representative using employer and budget authority.

(1) SDS may be directed by:

(A) An adult member, when the member has the ability to self-direct;

(B) A member's legal representative including a parent, spouse or legal guardian; or

(C) A non-legal representative who the member or legal representative freely chooses.

(2) The person directing services:

(A) Is eighteen (18) years of age or older;

(B) Complies with DDS and Oklahoma Health Care Authority (OHCA) rules and regulations;

(C) Completes required DDS training for self-direction;

(D) Signs an agreement with DDS;

(E) Is a member or legal representative approved to act in a representative capacity;

(F) Demonstrates knowledge and understanding of the member's needs and preferences; ~~and~~

(G) Does not serve as the Self-Directed (SD) habilitation training specialist (HTS) for the member when he or she is directing the member's services.

(H) Must reside within sixty-miles of the Oklahoma state border when they reside in another state. Exceptions to this rule must be approved by the DDS Director or designee;

(I) Participates in the Individual Planning process; and

(J) Submits quarterly progress reports to the Case Manager according to OAC 340:100-5-52.

(d) **The SDS program includes:**

(1) The SDS budget. ~~A Plan of Care (POC) is developed to meet the member's needs without SDS consideration. The member~~Members who receive services through the IHSW may elect to self-direct part or the entire amount ~~identified~~allowed for ~~traditional HTS services. This amount is under the member's control and discretion in accordance with this policy and the approved POC, and is the allocated amount that may be used to develop the SDS budget. The SDS budget details the specific spending plan.~~the IHSW. Members who receive services

through the community waiver may not exceed limits for SD-HTS services as described in OAC 340:100-5-35.

(A) The SDS budget is developed annually at the time of the annual plan and updated. Individuals who participate in the budget development include, the member, case manager, parent, legal guardian, and others the member invites to participate.

(B) Payment may only be authorized for goods and services (GS) not covered by SoonerCare, or other generic funding sources, and must meet service necessity criteria, per ~~Oklahoma Administrative Code (OAC)~~OAC 340:100-3-33.1.

(C) The member's SDS budget includes the actual cost of administrative activities including fees for financial management services (FMS) subagent~~, background checks~~, workers' compensation insurance, and the amount identified for SD-HTS, SD Job Coaching, SD-community based services, and Self-directed goods and services (SD-GS). The SDS budget may also include fees for background checks and CPR/First Aid training for SD-HTS, SD-Job Coach and prevocational staff providing SD-community-based vocational services.

~~(D) The SDS budget is added to the POC to replace any portion of traditional HTS services to be self-directed.~~

~~(E)~~(D) The member's employment services costs, excluding transportation services, cannot exceed limits set forth in OKDHS Appendix D-26, Developmental Disabilities Services Rates Schedule, per POC year.

(2) The SD-HTS supports the member's self-care and the daily living and leisure skills needed to reside successfully in the community. Services are provided in community-based settings in a manner that contributes to the member's independence, self-sufficiency, community inclusion, and well-being. SD-HTS services must be included in the approved SDS budget. Payment is not made for routine care and supervision that is typically provided by a family member or the member's spouse. SD-HTS services are provided only during periods when staff is engaged in purposeful activity that directly or indirectly benefits the member. ~~SD-HTS services are limited to a daily average of no more than nine (9) hours per day, per OAC 340:100-5-35.~~ At no time are SD-HTS services authorized for periods when staff is allowed to sleep. Legally responsible ~~persons~~individuals may ~~not provide services~~serve as a paid SD-HTS, per OAC 340:100-3-33.2. ~~Other family members providing services must be employed by provider agencies per OAC 340:100-3-33.2. For the purpose of this rule, family members include parents, siblings, step-parents, step siblings, and anyone living in the same home as the member.~~ Payment does not include room and board, maintenance, or upkeep or improvements to the member's or family's residence. An SD-HTS:

(A) Is eighteen (18) years of age and older;

(B) Passes a background check, per OAC 340:100-3-39;

(C) Demonstrates competency to perform required tasks;

(D) Completes required training, per OAC 340:100-3-38 et seq.;

(E) Signs an agreement with DDS and the member;

(F) Is physically able and mentally alert to carry out the job's duties;

(G) Does not work as an SD-HTS more than forty (40) hours in any week;

(H) Does not implement prohibited procedures, per OAC 340:100-5-58;

(I) Provides services to only one (1) member at any given time. This does not preclude providing services in a group setting where services are shared among group members; and

(J) Does not perform any job duties associated with other employment, including on-call duties, at the same time they are providing SD-HTS services.

(3) SD-Job Coaching (SD-JC) services per OAC 317:40-7-7:

(A) ~~Are pre-planned, documented activities related to the member's identified employment outcomes. This includes training at the work site and support by job coach staff who have completed DDS sanctioned training per OAC 340:100-3-38.2~~SD-JC services are only available for individual placements;

(B) ~~Promote the member's capacity to secure and maintain integrated employment at the member's chosen job, provided the job pays at or more than minimum wage, or the member is working to achieve minimum wage'~~An SD-Job Coach signs an agreement with DDS and the member; and

(C) ~~Provide active participation in paid work. Efforts are made in cooperation with employers, and an active relationship with the business is maintained, to adapt normal work environments to fit the member's needs~~The SD-JC must complete training per 340:100-3-38.2.

~~(D) Are available for individual placements. Individual placement is one member receiving job coaching services who:~~

~~(i) Works in an integrated job setting;~~

~~(ii) Is paid at or more than minimum wage;~~

~~(iii) Does not receive services from a job coach who is simultaneously responsible for continuous job coaching for a group;~~

~~(iv) Is employed by a community employer; and~~

~~(v) Has a job description that is specific to the member's work; and~~

~~(E) Is authorized when on-site supports by a certified job coach are provided more than twenty (20 percent of the member's compensable work time. Job coaching services rate continues until a member reaches twenty (20) percent or less job coach intervention for four (4) consecutive weeks, at which time stabilization services begin.~~

~~(F) Are based on the amount of time the member is compensated by the employer, except per OAC 317:40-7-11;~~

~~(G) For members in individual placements, the Personal Support Team (Team):~~

~~(i) Evaluates the job coaching services need at least annually; and~~

~~(ii) Documents a plan for fading job coaching services as the member's independence increases.~~

~~(H) In order to participate in individual placement, the individual is found ineligible for services funded through the Department of Rehabilitation Services or have a closed case; and~~

~~(I) An SD-Job Coach:~~

~~(i) Is eighteen (18) years of age;~~

~~(ii) Passes a background check per OAC 340:100-3-39;~~

~~(iii) Demonstrates competency to perform required tasks;~~

~~(iv) Completes required training per OAC 340:100-3-38 et seq.;~~

~~(v) Signs an agreement with DDS and the member;~~

~~(vi) Is physically able and mentally alert to carry out job duties;~~

~~(vii) Does not work more than forty (40) hours in any week as an SD-Job Coach or SD-HTS;~~
~~(viii) Does not implement restrictive or intrusive procedures per OAC 340:100-5-57;~~
~~(ix) Provides services to only one member at any given time; and~~
~~(x) Does not perform any job duties associated with other employment including on-call duties at the same time he or she is providing SD-Job Coaching services; and~~

(4) SD-Community Based (SD-CB) Services per OAC 317:40-7-5.

(A) SD-CB services are only available for individual placements.

(B) Prevocational staff who provide SD-CB signs an agreement with DDS and the member

(C) Prevocational staff who provide SD-CB services must complete training per 340:100-3-38.2.

(5) SD-Transportation per OAC 317:40-5-103.

~~(4)~~(6) SD-GS are incidental, non-routine, and promote the member's self-care, daily living, adaptive functioning, general household activities, meal preparation, and leisure skills needed to reside successfully in the community. SD-GS do not duplicate other services authorized in the member's POC. These SD-GS must be included in the Individual Plan (Plan) and approved SDS budget. SD-GS must meet the requirements listed in (A) through (F) of this paragraph.

(A) The item or service is justified by a recommendation from a licensed ~~professional's recommendation.~~professional that:

(i) Is updated annually;

(ii) Is dated;

(iii) Includes a recommendation for all goods and services requested; and

(iv) Identifies how all goods and services requested will directly benefit the individual.

(B) The item or service is not prohibited by federal or state statutes and regulations.

(C) The item or service meets one (1) or more of the criteria listed in (i) through (iii) of this subparagraph. The item or service:

(i) Increases the member's functioning related to the disability;

(ii) Increases the member's safety in the home environment; or

(iii) Decreases dependence on other SoonerCare funded services.

(D) SD-GS may include, but are not limited to:

(i) Fitness items that can be purchased at retail stores when accessing a gym in the community is not an option;

(ii) Short duration camps lasting fourteen (14) consecutive calendar days or less;

(iii) ~~A food catcher~~Adaptive bikes;

(iv) A specialized swing set for outdoors;

(v) ~~Toothettes or an electric toothbrush~~Sensory toys;

~~(vi) A seat lift;~~

~~(vii)~~(vi) Weight loss programs ~~or gym memberships~~ when:

(I) There is an identified weight loss or increased physical activityneed;

(II) Justified by outcomes related to weight loss, increased physical activity or stamina; and

(III) In subsequent POC year requests, documentation is provided that supports the member's progress toward weight loss, increased physical activity, or stamina; ~~or~~

~~(viii)~~(vii) Swimming lessons~~.~~;

(viii) Recreational classes such as equine therapy (horseback riding), music lessons, dance lessons, cheer classes, karate lessons, etc.;

(ix) Uniform, costume, recital fees required for authorized recreational classes or lessons;

(x) Enrollment fees or equipment costs for authorized gyms, recreational classes or lessons;

(xi) Adult Activity Centers for members 18 years of age and over; and

(xii) Gym memberships.

(E) SD-GS is not used for:

(i) Medical services co-payments;

(ii) Over-the-counter medications;

(iii) Items or treatments not approved by the Food and Drug Administration;

(iv) Homeopathic services;

(v) Services available through any other funding source, such as SoonerCare, Medicare, private insurance, the public school system, rehabilitation services, or natural supports;

(vi) Room and board including deposits, rent, and mortgage payments;

(vii) Personal items and services not directly related to the member's disability;

(viii) Vacation expenses;

(ix) Insurance;

(x) Vehicle maintenance or other transportation related expense;

(xi) Costs related to internet access;

(xii) Clothing;

(xiii) Tickets and related costs to attend recreational events;

(xiv) Services, goods, or supports ~~provided to the member or~~ benefiting persons other than the member;

(xv) Experimental goods or services;

(xvi) Personal trainers;

(xvii) Spa treatments or massage therapy; ~~or~~

(xviii) Goods or services with costs that significantly exceed community norms for the same or similar goods or services.

(xix) Any service available through a traditional DDS waiver, whether or not the service is included in the waiver in which the member is enrolled;

(xx) Daycare or after school care services for minor children;

(xxi) Educational programs and materials for members eligible for Individuals with Disabilities Education Act; or

(xxii) Medications.

(F) SD-GS are reviewed and approved by the DDS director or designee.

(e) **Member Responsibilities.** When the member chooses the SDS option, the member or member's representative who is the employer of record (EOR) and:

(1) ~~Within forty-five (45) calendar days of enrolling in SDS training, the member or member's representatives completes~~Completes the DDS-sanctioned self-direction training

course before enrolling in SDS. ~~Exceptions to this timeframe may be approved by the DDS director or his/her designee. The training is completed prior to implementing SD.~~ The training covers:

(A) Staff recruitment;
(B) Hiring of staff as an employer of record;
(C) Staff orientation and instruction;
(D) Staff supervision including scheduling and service provisions;
(E) Staff evaluation;
(F) Staff discharge;
(G) SD philosophy
(H) OHCA SD policy;
(I) Individual budgeting;
(J) SD support plan development;
(K) Cultural diversity; and
(L) Rights, risks, and responsibilities, and

(2) Signs ~~an~~the SDS agreement ~~with DDS~~form;
(3) Agrees to utilize the FMS subagent services;
(4) Agrees to pay administrative costs for background checks, FMS subagent fees, and workers' compensation insurance from his or her SDS budget;
(5) Complies with federal and state employment laws and ensures no employee works more than forty (40) hours per week in an SD-HTS capacity;
(6) Ensures that each employee is qualified to provide the services for which he or she is employed to do and that all billed services are actually provided;
(7) Ensures that each employee complies with all DDS training requirements per OAC 340:100-3-38 et seq.;
(8) Recruits, hires, supervises, and discharges all employees providing SDS, when necessary;
(9) Verifies employee qualifications;
(10) Obtains background screenings on all employees providing SD-HTS services per OAC 340:100-3-39;
(11) Sends progress reports per OAC 340:100-5-52.
(12) Participates in the Plan and SDS budget process;
(13) Notifies the DDS case manager of any emergencies or changes in circumstances that may require modification of the type or amount of services provided for in the member's Plan or SDS budget;
(14) Waits for budget modification approval before implementing changes;
(15) Complies with DDS and OHCA administrative rules;
(16) Cooperates with DDS monitoring requirements per OAC 340:100-3-27;
(17) Cooperates with FMS subagent requirements to ensure accurate records and prompt payroll processing including:

(A) Reviewing and signing employee time cards;
(B) Verifying the accuracy of hours worked; and
(C) Ensuring the appropriate fund expenditures; and

(18) Completes all required documents within established timeframes, including submission of incident reports per OAC 340:100-3-34;
(19) Pays for services incurred in excess of the budget amount;

(20) Pays for services not identified and approved in the member's SDS budget. The EOR is responsible for any costs resulting when a vendor payment request is not submitted within five (5) months after the service is rendered;
(21) Pays for services provided by an unqualified provider or an unauthorized vendor;
(22) Determines staff duties and qualifications and specifies service delivery practices consistent with SD-HTS Waiver service specifications;
(23) Orients and instructs staff in duties;
(24) Evaluates staff performance;
(25) Identifies and trains back-up staff, when required;
(26) Determines amount paid for services within plan limits;
(27) Schedules staff and the services provisions;
(28) Ensures SD-HTS do not implement prohibited procedures per OAC 340:100-5-58; and
(29) Signs an agreement with the SD-HTS.

(f) **FMS.** The FMS subagent is an entity that DDS designates as an agent to act on a member's behalf who has employer and budget authority.The FMS subagent's purpose is to manage payroll tasks for the member's employee(s) and SD-GS payments as authorized in the member's plan. FMS subagent duties include, but are not limited to:
(1) Compliance with all DDS and OHCA administrative rules and contract requirements;
(2) Compliance with DDS or OHCA random and targeted audits;
(3) Tracking individual expenditures and monitoring SDS budgets;
(4) Processing the member's employee payroll, withholding, filing and paying of applicable federal, state, and local employment-related taxes and insurance;
(5) Employee time sheets collection and processing and making payment to member's employees;
(6) SD-GS invoice collection and processing as authorized in the member's SDS budget;
(7) Providing each member with information that assists with the SDS budget management;
(8) Providing reports members and member representatives, as well as providing monthly reports to DDS and to OHCA upon request;
(9) Providing DDS and OHCA authorities access to individual member's accounts through a web-based program;
(10) Assisting members in verifying employee citizenship status;
(11) Maintaining separate accounts for each member's SDS budget;
(12) Tracking and reporting member funds, balances, and disbursements;
(13) Receiving and disbursing funds for SDS payment per OHCA agreement; and
(14) Executing and maintaining a contractual agreement between DDS and the SD-HTS (employee).

(g) **DDS case management responsibilities in support of SDS.**
(1) The DDS case manager develops the member's plan per OAC 340:100-5-50 through 340:100-5-58.
(2) The DDS case manager meets with the member or, when applicable, the member's representativeor legal guardian to discuss the Waiver service delivery options in (A) and (B) of this paragraph:
(A) Traditional Waiver services; and
(B) SDS including information regarding scope of choices, options, rights, risks, and responsibilities associated with SDS.
(3) When the member chooses SDS, the DDS case manager:

(A) Discusses the available amount in the budget with the member or the member's representative;
(B) Assists the member or representative in developing and modifying the SDS budget;
(C) Submits request for SD-GS to the DDS director or designee for review and approval;
(D) Assists the member or representative developing or revising an emergency back-up plan;
(E) Monitors plan implementation per OAC 340:100-3-27;
(F) Ensures0 services are initiated within required time frames;
(G) Conducts ongoing monitoring of plan implementation and of the member's health and welfare; and
(H) Ensures the SD-HTS does not implement prohibited procedures, per OAC 340:100-5-58. If the Team determines restrictive or intrusive procedures are necessary to address behavioral challenges, requirements must be met, per OAC 340:100-5-57.

(h) **Government fiscal/employer agent model.** DDS serves as the Organized Health Care Delivery System (OHCDS) and FMS provider in a Centers for Medicare and Medicaid Services approved government fiscal/employer agent model. DDS has an interagency agreement with OHCA.

(i) **Voluntary termination of self-directed services.** Members may discontinue SDS without disruption at any time, provided traditional Waiver services are in place. Members or representatives may not choose the SDS option again until the next annual planning meeting, with services resuming no earlier than the beginning of the next POC. A member desiring to file a complaint must follow procedures per OAC 340:2-5-61.

(j) **SDS involuntary termination.**

(1) Members may be involuntarily terminated from SDS and offered traditional Waiver services when the DDS director or designee has determined that any of the criteria in (A) through (F) of this paragraph exist:
(A) Immediate health and safety risks associated with self-direction, such as, imminent risk of death or irreversible or serious bodily injury related to Waiver services;
(B) Intentional misuse of funds following notification, assistance and support from DDS;
(C) Failure to follow and implement policies of self-direction after receiving DDS technical assistance and guidance;
(D) Suspected fraud or abuse of funds;
(E) A member no longer receives a minimum of one (1) SDS Waiver service per month and DDS is unable to monitor the member; or
(F) Reliable information shows the employer of record or SD-HTS engaged in illegal activity.

(2) When action is taken to involuntarily terminate the member from SDS, the case manager assists the member in assessing needed and appropriate services through the traditional Waiver services option.The case manager ensures that no lapse in necessary services occurs for which the member is eligible.

(3) The Fair Hearing process, per OAC 340:100-3-13 applies.

(k) **Reporting requirements.** While operating as an OHCDS, DDS provides OHCA reports detailing provider activity in the format and at times OHCA requires.

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

SUBCHAPTER 3. ADMINISTRATION OF PLANS

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.

SUBCHAPTER 5. COVERAGE AND LIMITATIONS

PART 3. HEALTHCHOICE PLANS

317:150-5-17. Program integrity

EGID may have a Program Integrity Initiative. The purpose of EGID's Program Integrity Initiative is to identify, recover, and prevent inappropriate provider billings and payments through provider audits. ~~The p~~Providers shall furnish any and all claims information and medical documentation, upon request and at no cost, to EGID or its designated vendor. 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.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 21. OUTPATIENT BEHAVIORAL HEALTH SERVICES

317:30-5-240.2. Provider participation standards

(a) **Accreditation and certification status.** Any agency may participate as an Outpatient Behavioral Health (OPBH) provider if the agency is qualified to render a covered service and meets the OHCA requirements for provider participation.

(1) Private, Community-based Organizations must be accredited as a provider of outpatient behavioral health services from one of the accrediting bodies listed in (c)(1) below and be an incorporated organization governed by a board of directors or be certified by the certifying agency in accordance with 43A O.S. §§ 3-317, 3-323A, 3-306.1, or 3-415;

(2) State-operated programs under the direction of ODMHSAS must be accredited by one of the accrediting bodies or be certified by the certifying agency in accordance with 43A O.S. §§ 3-317, 3-323A, 3-306.1 or 3-415;

(3) Freestanding Psychiatric Hospitals must be licensed and certified by the State Survey Agency as meeting Medicare psychiatric hospital standards and JCAHO accreditation;

(4) General Medical Surgical Hospitals must be appropriately licensed and certified by the State Survey Agency as meeting Medicare standards, including a JCAHO or AOA accreditation;

(5) Federally Qualified Health Centers/Community Health Centers facilities that qualify under OAC 317:30-5-660;

(6) Indian Health Services/Tribal Clinics/Urban Tribal Clinics facilities that qualify under federal regulation;

(7) Rural Health Clinics facilities that qualify under OAC 317:30-5-355;

(8) Public Health Clinics and County Health Departments;

(9) Public School Systems.

(b) **Certifications.** In addition to the accreditation in paragraph (a) above or ODMHSAS certification in accordance with 43A O.S. §§ 3-317, 3-323A, 3-306.1 or 3-415, provider specific credentials are required for the following:

(1) Substance Abuse agencies (OAC 450:18-1-1);

(2) Evidence Based Best Practices but not limited to:

(A) Assertive Community Treatment (OAC 450:55-1-1);

(B) Multi-Systemic Therapy (Office of Juvenile Affairs);

(C) Function Family Therapy; and

~~(C)~~(D) Peer Support/Community Recovery Support;

(3) Systems of Care (OAC 340:75-16-46);

(4) Mobile and Facility-based Crisis Intervention (OAC 450:23-1-1);

(5) Case Management (OAC 450:50-1-1);

(6) RBMS in group homes (OAC 377:10-7) or therapeutic foster care settings (OAC 340:75-8-4);

(7) Day Treatment - CARF, JCAHO, ACHC or COA for Day Treatment Services; and

(8) Partial Hospitalization/Intensive Outpatient CARF, JCAHO, ACHC or COA for Partial Hospitalization services.

(c) **Provider enrollment and contracting.**

(1) Organizations who have accreditation from JCAHO, CARF, COA, ACHC ~~or,~~ AOA or any other accreditation provider approved by the Center for Medicare and Medicaid Services (CMS) or ODMHSAS certification in accordance with 43A O.S. §§ 3-317, 3-323A, 3-306.1 or 3-415 will supply the documentation from the accrediting body or certifying agency, along with other information as required for contracting purposes to the OHCA. The contract must include copies of all required state licenses, accreditation and certifications.

(2) If the contract is approved, a separate provider identification number for each outpatient behavioral health service site will be assigned. Each site operated by an outpatient behavioral health facility must have a separate provider contract and site-specific accreditation and/or certification as applicable. A site is defined as an office, clinic, or other business setting where outpatient behavioral health services are routinely performed. When services are rendered at the member's residence, a school, or when provided occasionally at an appropriate community based setting, a site is determined according to where the professional staff perform administrative duties and where the member's chart and other records are kept. Failure to obtain and utilize site specific provider numbers will result in disallowance of services.

(3) All behavioral health providers are required to have an individual contract with OHCA in order to receive SoonerCare reimbursement. This requirement includes outpatient behavioral health agencies and all individual rendering providers who work within an agency setting. Individual contracting rendering provider qualification requirements are set forth in OAC 317:30-3-2 and 317:30-5-240.3.

(d) **Standards and criteria.** Eligible organizations must meet each of the following:

(1) Have a well-developed plan for rehabilitation services designed to meet the recovery needs of the individuals served.

(2) Have a multi-disciplinary, professional team. This team must include all of the following:

(A) One of the LBHPs;

(B) A Certified Behavioral Health Case Manager II (CM II) or CADC, if individual or group rehabilitative services for behavioral health disorders are provided, and the designated LBHP(s) or licensure candidate(s) on the team will not be providing rehabilitative services;

(C) An AODTP, if treatment of substance use disorders is provided;

(D) A registered nurse, advanced practice nurse, or physician assistant, with a current license to practice in the state in which the services are delivered if Medication Training and Support Service is provided;

(E) The member for whom the services will be provided, and parent/guardian for those under eighteen (18) years of age.

(F) A member treatment advocate if desired and signed off on by the member.

(3) Demonstrate the ability to provide each of the following outpatient behavioral health treatment services as described in OAC 317:30-5-241 et seq., as applicable to their program. Providers must provide proper referral and linkage to providers of needed services if their agency does not have appropriate services.

(A) Assessments and Service Plans;

(B) Psychotherapies;

(C) Behavioral Health Rehabilitation services;

(D) Crisis Intervention services;
(E) Support Services; and
(F) Day Treatment/Intensive Outpatient.

(4) Be available twenty-four (24) hours a day, seven (7) days a week, for Crisis Intervention services.

(5) Provide or have a plan for referral to physician and other behavioral health services necessary for the treatment of the behavioral disorders of the population served.

(6) Comply with all applicable federal and state regulations.

(7) Have appropriate written policy and procedures regarding confidentiality and protection of information and records, member grievances, member rights and responsibilities, and admission and discharge criteria, which shall be posted publicly and conspicuously.

(8) Demonstrate the ability to keep appropriate records and documentation of services performed.

(9) Maintain and furnish, upon request, a current report of fire and safety inspections of facilities clear of any deficiencies.

(10) Maintain and furnish, upon request, all required staff credentials including certified transcripts documenting required degrees.

317:30-5-240.3. Staff credentials

(a) **Licensed behavioral health professional (LBHPs).** LBHPs are defined as any of the following practitioners:

(1) An allopathic or osteopathic physician with a current license and board certification in psychiatry or board eligible in the state in which services are provided, or a current resident in psychiatry practicing as described in OAC 317:30-5-2.

(2) A practitioner with a current license to practice in the state in which services are provided, within one (1) of the areas of practice listed in (A) through (F). The exemptions from licensure under 59 O.S. ' 1353(4) and (5), 59 O.S. ' 1903(C) and (D), 59 O.S. ' 1925.3(B) and (C), and 59 O.S. ' 1932(C) and (D) do not apply to outpatient behavioral health services.

(A) Psychology;
(B) Social work (clinical specialty only);
(C) Professional counselor;
(D) Marriage and family therapist;
(E) Behavioral practitioner; or
(F) Alcohol and drug counselor.

(3) An advanced practice registered nurse (APRN) certified in a psychiatric mental health specialty, and licensed as a registered nurse (RN) with a current certification of recognition from the board of nursing in the state in which services are provided.

(4) A physician assistant who is licensed and in good standing in the state in which services are provided and has received specific training for and is experienced in performing mental health therapeutic, diagnostic, or counseling functions.

(b) **Licensure candidates.** Licensure candidates are practitioners actively and regularly receiving board-approved supervision, and extended supervision by a fully licensed clinician if board's supervision requirement is met but the individual is not yet licensed, to become licensed by one (1) of the areas of practice listed in (2)(A) through (F) above. The supervising LBHP responsible for the member's care must:

(1) Staff the member's case with the candidate;

(2) Be personally available, or ensure the availability of an LBHP to the licensure candidate for consultation while they are providing services;
(3) Agree with the current plan for the member;
(4) Confirm that the service provided by the candidate was appropriate; and
(5) The member's medical record must show that the requirements for reimbursement were met and the LBHP responsible for the member's care has reviewed, countersigned, and dated the service plan and any updates thereto so that it is documented that the licensed professional is responsible for the member's care.

(c) **Certified alcohol and drug counselors (CADCs).** CADCs are defined as having a current certification as a CADC in the state in which services are provided.

(d) **Multi systemic therapy (MST) provider**. Master's level therapist who works on a team established by the Oklahoma Juvenile Affairs Office (OJA) which may include bachelor's level staff.

(e) **Functional family therapy (FFT) provider**. Providers must be part of an active FFT team.

(1) **FFT Team.** An active FFT team must be trained and certified and receive ongoing consultation and monitoring by FFT, LLC. and shall meet the following requirements:

(A) be employed by a certified behavioral health agency; and
(B) be comprised of three (3) to eight (8) full time practitioners with up to one (1) of those practitioners acting in the role of a functional family supervisor. In the event an established team falls below the minimum of three (3) members, the provider agency must actively recruit and train a replacement practitioner to restore the team to compliance.

(2) **Functional Family Practitioner** A practitioner must have a master's degree in psychology, social work, counseling or closely related field. In some cases, upon consultation with FFT LLC, bachelor's level practitioners may be acceptable. An FFT practitioner must:

(A) be certified to provide FFT services through FFT LLC, while adhering to ongoing training, reporting and consultation requirements for direct service of the functional family therapy model implementation; and
(B) maintain a caseload minimum of ten (10) active cases for a full-time FFT practitioner and a minimum of five (5) active cases for a part time FFT practitioner.

(3) **Functional Family Supervisor.** A supervisor must have at minimum, a master's degree in the fields noted above.

(i) An FFT supervisor must have completed all required FFT, LLC. trainings, and the FFT externship; and
(ii) maintain a caseload minimum of five (5) active cases.

~~(e)~~(f) **Peer recovery support specialist (PRSS)/Family peer recovery support specialist (F-PRSS).** The PRSS and F-PRSS must be certified by ODMHSAS pursuant to requirements found in OAC 450:53.

~~(f)~~(g) **Qualified behavioral health aide (QBHA)**. QBHAs must:

(1) Possess current certification as a Behavioral Health Case Manager I;
(2) Have successfully completed the specialized training and education curriculum provided by the ODMHSAS;
(3) Be supervised by a bachelor's level individual with a minimum of two (2) years case management or care coordination experience;
(4) Have service plans be overseen and approved by an LBHP or licensure candidate; and

(5) Function under the general direction of an LBHP, or licensure candidate and/or systems of care team, with an LBHP or licensure candidate available at all times to provide back up, support, and/or consultation.

~~(g)~~(h) **Behavioral health case manager.** For behavioral health case management services to be compensable by SoonerCare, the provider performing the services must be an LBHP, licensure candidate, CADC or have and maintain a current certification as a Behavioral Health Case Manager II (CM II) or Behavioral Health Case Manager I (CM I) from ODMHSAS in accordance with requirements found in OAC 450:50

(1) A Wraparound Facilitator Case Manager must be an LBHP, licensure candidate or CADC that meets the qualifications for CM II and has the following:

(A) Successful completion of the ODMHSAS training for wraparound facilitation within six (6) months of employment; and

(B) Participate in ongoing coaching provided by ODMHSAS and employing agency;

(C) Successfully complete wraparound credentialing process within nine (9) months of beginning process; and

(D) Direct supervision or immediate access and a minimum of one (1) hour weekly clinical consultation with a qualified mental health professional, as required by ODMHSAS.

(2) An Intensive Case Manager must be an LBHP, licensure candidate, or CADC that meets the provider qualifications of a CM II and has the following:

(A) A minimum of two (2) years behavioral health case management experience; and

(B) Crisis diversion experience.

317:30-5-241.8. ~~Multi-systemic therapy (MST)~~Targeted Therapies for Juveniles

(a) Multi-systemic therapy (MST). MST intensive outpatient program services are limited to children within an Office of Juvenile Affairs (OJA) MST treatment program which provides an intensive, family and community-based treatment targeting specific BH disorders in children with SED who exhibit chronic, aggressive, antisocial, and/or substance abusing behaviors, and are at risk for out of home placement. Caseloads are kept low due to the intensity of the services provided.

(1) **Qualified professionals**. All MST services are provided by LBHPs or licensure candidates. Licensure candidate signatures must be co-signed by a fully-licensed LBHP in good standing. Additional team support services may be provided by a behavioral health case manager II (CM II) and/or peer recovery support specialist (PRSS) per OAC 317:30-5-240.3.

(2) **Documentation requirements.** Providers must comply with documentation requirements in OAC 317:30-5-248.

(3) **Limitations**. Services are subject to the following:

(A) Partial billing is not allowed. When only one (1) service is provided in a day, providers should not bill for services performed for less than eight (8) minutes.

(B) MST cannot be billed in conjunction with the following:

(i) Children's psychosocial rehabilitation;

(ii) Partial hospitalization/intensive outpatient treatment;

(iii) Targeted case management;

(iv) Individual, family, and group therapy;

(v) Mobile crisis intervention;

(vi) Peer-to-peer services.

(C) Duration of MST services is between three (3) to six (6) months. Weekly interventions may range from three (3) to twenty (20) hours per week. Weekly hours may be lessened as case nears closure.

(4) **Reimbursement.** MST services are reimbursed pursuant to the methodology described in the Oklahoma Medicaid State Plan.

(b) Functional Family Therapy (FFT). Functional Family Therapy is defined as:

(1) **Evidence-based intervention.** FFT is an intensive, short-term, therapeutic model for that offers in-person, face-to-face services in the home to dysfunctional youth experiencing behavioral or emotional problems and their entire family. Referrals for FFT shall be made by the Oklahoma Office of Juvenile Affairs (OJA) or Oklahoma Human Services (OHS). Each referral shall be reviewed and approved by a licensed professional employed by the referring agency prior to the initiation of services. FFT services are provided through a team approach working collaboratively together using the FFT services as defined by FFT LLC.

(2) **Populations.** Target populations are at-risk preadolescents and youth with serious behavioral problems, including but not limited to conduct disorder, violent acting-out, substance use and other identified problematic behaviors. While FFT targets youth eleven (11) to eighteen (18) year-olds, siblings in the home also benefit from FFT services. FFT services are not available for institutionalized individuals.

(3) **Qualified professionals**. All Functional Family Therapy services must be performed or supervised by a fully Licensed Behavioral Health Practitioner (LBHP) or licensure candidate as determined by one of Oklahoma's licensing boards. Licensure candidate signatures must be co-signed by a fully licensed LBHP practitioner in good standing and must meet the FFT provider requirements per OAC 317:30-5-240.3.

(4) **Documentation requirements.** Providers must comply with documentation requirements in OAC 317:30-5-248.

(5) **Coverage and Limitations**. Services are subject to the following:

(A) Intervention ranges from, on average, twelve (12) to sixteen (16) one-hour sessions. Prior authorization is required when services exceed fifteen (15) hours The duration of FFT is typically three (3) to five (5) months. Weekly interventions may range from one (1) to three (3) hours per week per family.

(B) FFT Services are not Medicaid compensable when:

(i) The target child is unavailable at the time of service; or

(ii) The target child is residing in an institution.

(C) FFT cannot be billed in conjunction with the following:

(i) Family Therapy; or

(ii) Acute, Acute II/PRTF, and Residential SUD.

(6) **Reimbursement.** FFT services are 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 85. ADVANTAGE PROGRAM WAIVER SERVICES

317:30-5-760. ADvantage program

The ADvantage ~~Program~~program is a Medicaid Home and Community Based Services (HCBS) ~~Waiver~~waiver used to finance noninstitutional long-term care services through Oklahoma's Medicaid program for ~~elderly and disabled individuals.~~the elderly, sixty-five (65) years of age and older; and a targeted group of adults with physical disabilities, nineteen (19) to sixty-four (64) years of age who do not have an intellectual disability or a cognitive impairment related to a developmental disability per Oklahoma Administrative Code (OAC) 317:35-9. To receive ADvantage Program services, individuals must ~~meet the nursing facility (NF) level of care (LOC) criteria, be age 65 years or older, or age 21 or older if physically disabled and not developmentally disabled, or if developmentally disabled and between the ages of 21 and 65, not have an intellectual disability or a cognitive impairment related to the developmental disability. ADvantage Program members must~~be Medicaid eligible and meet eligibility requirements per OAC 317:35-17. The number of ~~members of~~individuals who may receive ADvantage services is limited.

317:30-5-763. Description of services

Services included in the ADvantage program are:

(1) **Case management.**

(A) Case management services, regardless of payment source, assist a member to gain access to medical, social, educational, or other services that may benefit him or her to maintain health and safety. Case managers:

(i) Initiate and oversee necessary assessments and reassessments to establish or reestablish waiver program eligibility;

(ii) Develop the member's comprehensive person-centered service plan, listing only the services necessary to prevent institutionalization of the member, as determined through the assessments;

(iii) Initiate the addition of necessary services or deletion of unnecessary services, as dictated by the member's condition and available support; and

(iv) Monitor the member's condition to ensure delivery and appropriateness of services and initiate person-centered service plan reviews. Case managers submit an individualized Services Backup Plan, on all initial service plans, annually at reassessment, and on updates as appropriate throughout the year, reflecting risk factors and measures in place to minimize risks. When a member requires hospital or nursing facility (NF) services, the case manager:

(I) Assists the member in accessing institutional care and, as appropriate, periodically monitors the member's progress during the institutional stay;

(II) Helps the member transition from institution to home by updating the person-centered service plan;

(III) Prepares services to start on the date the member is discharged from the

institution; and

(IV) Must meet ADvantage program minimum requirements for qualification and training prior to providing services to ADvantage members.

(B) Providers of ADvantage services for the member or for those who have an interest in or are employed by an ADvantage provider for the member must not provide case management or develop the person-centered service plan, except when the ADvantage Administration (AA) demonstrates the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area, also provides other ADvantage services. Prior to providing services to members receiving Consumer Directed Personal Assistance Services and Supports ~~(CD-PASS)~~(CDPASS), case manager supervisors, and case managers are required to receive training and demonstrate knowledge regarding the ~~CD-PASS~~CDPASS service delivery model, "Independent Living Philosophy," and demonstrate competency in person-centered planning.

(C) Providers may only claim time for billable case management activities, described as:

(i) Any task or function, per Oklahoma Administrative Code (OAC) 317:30-5-763(1)(A) that only an ADvantage case manager, because of skill, training, or authority can perform on behalf of a member; and

(ii) Ancillary activities, such as clerical tasks, including, but not limited to, mailing, copying, filing, faxing, driving time, or supervisory and administrative activities are not billable case management activities. The administrative cost of these activities and other normal and customary business overhead costs are included in the reimbursement rate for billable activities.

(D) Case management services are prior authorized and billed per fifteen (15) minute unit of service using the rate associated with the location of residence of the member served.

(i) Case management services are billed using a standard rate for reimbursement for billable service activities provided to a member who resides in a county with a population density greater than twenty-five (25) persons per square mile.

(ii) Case management services are billed using a very rural/outside providers' service area rate for billable service activities provided to a member who resides in a county with a population density equal to, or less than twenty-five (25) persons per square mile. Exceptions are services to members who reside in Oklahoma Human Services (OKDHS) Community Living, Aging and Protective Services identified zip codes in Osage County adjacent to the metropolitan areas of Tulsa and Washington counties. Services to these members are prior authorized and billed using the standard rate.

(iii) The latest United States Census, Oklahoma counties population data is the source for determination of whether a member resides in a county with a population density equal to, or less than twenty-five (25) persons per square mile or resides in a county with a population density greater than twenty-five (25) persons per square mile.

(2) **Respite.**

(A) Respite services are provided to members who are unable to care for themselves. Services are provided on a short-term basis due to the primary caregiver's absence or need for relief. Payment for respite care does not include room and board costs unless more than seven (7) hours are provided in a NF. Respite care is only utilized when other sources of care and support are exhausted. Respite care is only listed on the service plan when it

is necessary to prevent institutionalization of the member. Units of services are limited to the number of units approved on the service plan.

(B) In-home respite services are billed per fifteen (15) minute unit of service. Within any one (1) day period, a minimum of eight (8) units [two (2) hours] must be provided with a maximum of twenty-eight (28) units [seven (7) hours] provided. The service is provided in the member's home.

(C) Facility-based extended respite is filed for a per diem rate when provided in a NF. Extended respite must be at least eight (8) hours in duration.

(D) In-home extended respite is filed for a per diem rate. A minimum of eight (8) hours must be provided in the member's home.

(3) **Adult day health (ADH) care.**

(A) ADH is furnished on a regularly scheduled basis for one (1) or more days per week in an outpatient setting. It provides both health and social services necessary to ensure the member's optimal functioning. Most assistance with activities of daily living (ADLs), such as eating, mobility, toileting, and nail care are integral to the ADH care service and are covered by the ADH care basic reimbursement rate.

(B) ADH care is a fifteen (15) minute unit of service. No more than eight (8) hours, [thirty-two (32) units] are authorized per day. The number of units of service a member may receive is limited to the number of units approved on the member's approved service plan.

(C) Physical, occupational, and speech therapies are only provided as an enhancement to the basic ADH care service when authorized by the service plan and are billed as a separate procedure. ADH care therapy enhancement is a maximum of one (1) session unit per day of service.

(D) Meals provided as part of this service do not constitute a full nutritional regimen. One (1) meal, that contains at least one-third (1/3) of the current daily dietary recommended intake (DRI), as established by the Food and Nutrition Board of the National Academies of Sciences, Engineering, and Medicine, is provided to those participants who are in the center for four (4) or more hours per day and does not constitute a full nutritional regimen. Member's access to food at any time must also be available in addition to the required meal and is consistent with an individual not receiving Medicaid-funded services and supports.

(E) Personal care service enhancement in ADH is assistance in bathing, hair care, or laundry service, authorized by the person-centered service plan and billed as separate procedures. This service is authorized when an ADvantage waiver member who uses ADH requires assistance with bathing, hair care, or laundry to maintain health and safety. Assistance with bathing, hair care, or laundry is not a usual and customary ADH care service. ADH personal care enhancement is a maximum of one (1) unit per day of bathing, hair care, or laundry service.

(F) OKDHS Home and Community-Based Services (HCBS) waiver settings have qualities defined in Home and Community-Based Services: Waiver Requirements, 42 Code of Federal Regulations, Section (§) 441.301 (c)(4) based on the individual's needs, defined in the member's authorized service plan.

(i) The ADH center is integrated and supports full access of ADvantage members to the greater community, including opportunities to:

(I) Seek employment and work in competitive integrated ADH Center, not a requirement for persons that are retirement age;
(II) Engage in community life;
(III) Control personal resources; and
(IV) Receive services in the community, to the same degree as individuals not receiving ADvantage Program or other Medicaid HBCS waiver services.

(ii) The ADH is selected by the member from all available service options and given the opportunity to visit and understand the options.

(iii) The ADH ensures the member's rights of privacy, dignity, respect, and freedom from coercion and restraint.

(iv) The ADH optimizes the member's initiative, autonomy, and independence in making life choices including, but not limited to:
(I) Daily activities;
(II) The physical environment; and
(III) Social interactions.

(v) The ADH facilitates the member's choice regarding services and supports including the provider.

(vi) Each member has the freedom and support to control his or her own schedules, activities, and access to food at any time.

(vii) Each member may have visitors whenever he or she chooses.

(viii) The ADH center is physically accessible to the member.

(G) ADH centers that are presumed not to be HCBS settings per 42 C.F.R. § 441.301(c)(5)(v) include, ADH centers:
(i) In a publicly- or privately-owned facility providing inpatient treatment;
(ii) On the grounds of or adjacent to a public institution; and
(iii) With the effect of isolating individuals from the broader community of individuals not receiving ADvantage program or another Medicaid HCBS;

(H) When the ADH is presumed not HCBS, according to 42 C.F.R. § 441.301(c)(5)(v), it may be subject to heightened scrutiny by AA, the Oklahoma Health Care Authority (OHCA), and the Centers for Medicare and Medicaid Services (CMS). The ADH must provide evidence that the ADH portion of the facility has clear administrative, financial, programmatic, and environmental distinctions from the institution and comply with additional monitoring by the AA.

(4) **Environmental modifications**.

(A) Environmental modifications are physical adaptations to the home, required by the member's person-centered service plan that are necessary to ensure the member's health, welfare, and safety or enable the member to function with greater independence in the home, and that without such, the member would require institutionalization. Adaptations or improvements to the home not of direct medical or remedial benefit to the waiver member are excluded.

(B) All services require prior authorization.

(5) **Specialized medical equipment and supplies.**

(A) Specialized medical equipment and supplies are devices, controls, or appliances specified in the person-centered service plan that enable members to increase their abilities to perform ADLs, or to perceive, control, or communicate with the environment in which they live. Necessary items for life support, ancillary supplies, and equipment

necessary for the proper functioning of such items, and durable and non-durable medical equipment not available under the Oklahoma Medicaid State Plan are also included. This service excludes any equipment or supply items not of direct medical or remedial benefit to the waiver member and necessary to prevent institutionalization.

(B) Specialized medical equipment and supplies are billed using the appropriate HealthCare Common Procedure Code (HCPC). Reoccurring supplies shipped and delivered to the member are compensable only when the member remains eligible for waiver services, continues to reside in the home, and is not institutionalized in a hospital, skilled nursing facility, or nursing home. It is the provider's responsibility to verify the member's status prior to shipping and delivering these items. Payment for medical supplies is limited to the SoonerCare (Medicaid) rate when established, to the Medicare rate, or to actual acquisition cost, plus thirty percent (30%). All services must have prior authorization.

(6) **Advanced supportive/restorative assistance**.

(A) Advanced supportive/restorative assistance services are maintenance services used to assist a member who has a chronic, yet stable condition. These services assist with ADLs that require devices and procedures related to altered body functions. These services are for maintenance only and are not utilized as treatment services.

(B) Advanced supportive/restorative assistance service is billed per fifteen (15) minute unit of service. The number of units of service a member may receive is limited to the number of units approved on the person-centered service plan.

(7) **Nursing.**

(A) Nursing services are services listed in the person-centered service plan that are within the scope of the state's Nurse Practice Act. These services are provided by a registered nurse (RN), a licensed practical nurse (LPN), or a licensed vocational nurse (LVN) under the supervision of an RN licensed to practice and in good standing in the state in which services are provided. Nursing services may be provided on an intermittent or part-time basis or may be comprised of continuous care. The provision of the nursing service works to prevent or postpone the institutionalization of the member.

(B) Nursing services are services of a maintenance or preventative nature provided to members with stable, chronic conditions. These services are not intended to treat an acute health condition and may not include services reimbursable under either the Medicaid or Medicare home health program. This service primarily provides nurse supervision to the personal care assistant or to the advanced supportive/restorative assistance aide and assesses the member's health and prescribed medical services to ensure they meet the member's needs as specified in the person-centered service plan. A nursing assessment/evaluation, on-site visit is made to each member, with additional visits for members with advanced supportive/restorative assistance services authorized to evaluate the condition of the member and medical appropriateness of services. An assessment/evaluation report is forwarded to the ADvantage program case manager and the skilled nurse in accordance with review schedule determined between the case manager and the skilled nurse and outlined in the member's person-centered service plan, to report the member's condition or other significant information concerning each ADvantage member.

(i) The ADvantage program case manager may recommend authorization of nursing services as part of the interdisciplinary team planning for the member's person-centered service plan and/or assessment/evaluation of the:

(I) Member's general health, functional ability, and needs; and/or

(II) Adequacy of personal care and/or advanced supportive/restorative assistance services to meet the member's needs, including providing on-the-job training and competency testing for personal care or advanced supportive/restorative care aides per rules and regulations for the delegation of nursing tasks established by the Board of Nursing in the state in which services are provided.

(ii) In addition to assessment/evaluation, the ADvantage program case manager may recommend authorization of nursing services to:

(I) Prepare a one (1) week supply of insulin syringes for a person who is blind and has diabetes and can safely self-inject the medication but cannot fill his or her own syringe. This service includes monitoring the member's continued ability to self-administer the insulin;

(II) Prepare oral medications in divided daily compartments for a member who self-administers prescribed medications but needs assistance and monitoring due to a minimal level of disorientation or confusion;

(III) Monitor a member's skin condition when a member is at risk for skin breakdown due to immobility or incontinence or the member has a chronic stage II decubitus ulcer requiring maintenance care and monitoring;

(IV) Provide nail care for a member with diabetes or who has circulatory or neurological compromise; and

(V) Provide consultation and education to the member, member's family, or other informal caregivers identified in the person-centered service plan, regarding the nature of the member's chronic condition. Skills training, including return skills demonstration to establish competency, to the member, family, or other informal caregivers as specified in the person-centered service plan for preventive and rehabilitative care procedures are also provided.

(C) Nursing service includes interdisciplinary team planning and recommendations for the member's person-centered service plan development and/or assessment/evaluation or for other services within the scope of the nurse's license, including private duty nursing. Nursing services are billed per fifteen (15) minute unit of service. A specific procedure code is used to bill for interdisciplinary team planning and recommendations for the member's person-centered service plan, but other procedure codes may be used to bill for all other authorized nursing services. A maximum of eight (8) units [two (2) hours], per day of nursing for service plan development and assessment evaluation are allowed. An agreement by a provider to perform a nurse evaluation is also an agreement to provide the Medicaid in-home care services for which the provider is certified and contracted. Reimbursement for a nurse evaluation is denied when the provider that produced the nurse evaluation fails to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted.

(8) **Skilled nursing services.**

(A) Skilled nursing services are listed in the person-centered service plan, within the state's Nurse Practice Act scope, and are ordered by a licensed physician, osteopathic

physician, physician assistant, or advanced practice nurse, and are provided by a RN, LPN, or LVN under the supervision of a RN, licensed to practice and in good standing in the state where services are provided. Skilled nursing services provided in the member's home or other community setting are services requiring the specialized skills of a licensed nurse. The scope and nature of these services are intended for treatment of a disease or a medical condition and are beyond the scope of ADvantage nursing services. These intermittent nursing services are targeted toward a prescribed treatment or procedure that must be performed at a specific time or other predictable rate of occurrence. The RN contacts the member's physician to obtain necessary information or orders pertaining to the member's care. When the member has an ongoing need for service activities requiring more or less units than authorized, the RN must recommend, in writing, that the service plan be revised.

(B) Skilled nursing services are provided on an intermittent or part-time basis, and billed per fifteen (15) minute unit of service. Skilled nursing services are provided when nursing services are not available through Medicare or other sources or when SoonerCare plan nursing services limits are exhausted. Amount, frequency, and duration of services are prior-authorized in accordance with the member's person-centered service plan.

(9) **Home-delivered meals.**

(A) Home-delivered meals provide ~~one (1) meal~~up to two (2) meals per day. A home-delivered meal is a meal prepared in advance and brought to the member's home. Each meal must have a nutritional content equal to at least one-third (1/3) of the dietary reference intakes as established by the Food and Nutrition Board of the National Academies of Sciences, Engineering and Medicine. Home-delivered meals are only provided to members who are unable to prepare meals and lack an informal provider to do meal preparation.

(B) Home-delivered meals are billed per meal, with one (1) meal equaling one (1) unit of service. The limit of the number of units a member is allowed to receive is in accordance with the member's person-centered service plan. ~~The provider must obtain a signature from the member or the member's representative at the time the meal is delivered. In the event the member is temporarily unavailable, such as at a doctor's appointment and the meal is left at the member's home, the provider must document the reason a signature was not obtained. The signature logs must be available for review.~~ Providers will redeliver missing meals as reported by the member unless the provider has a reliable mechanism for showing meals were delivered including, but not limited to, a signature of the member or the member's representative; a delivery driver's attestation that delivery occurred; a tracking statement of a common carrier, or delivery invoice of a common carrier. Signatures are not required to verify delivery. Electronic systems for verifying delivery are permitted.

(10) **Occupational therapy services.**

(A) Occupational therapy services are services that increase functional independence by enhancing the development of adaptive skills and performance capacities of members with physical disabilities and related psychological and cognitive impairments. Services are provided in the member's home and are intended to help the member achieve greater independence, enabling him or her to reside and participate in the community. Treatment involves the therapeutic use of self-care, work, and play activities, and may include modification of the tasks or environment to enable the member to achieve maximum

independence, prevent further disability, and maintain health. Under a physician's order, a licensed occupational therapist evaluates the member's rehabilitation potential and develops an appropriate written, therapeutic regimen. The regimen utilizes paraprofessional, occupational therapy assistant services, within the limitations of his or her practice, working under the supervision of a licensed occupational therapist. The regimen includes education and training for informal caregivers to assist with or maintain services when appropriate. The occupational therapist ensures monitoring and documentation of the member's rehabilitative progress and reports to the member's case manager and physician to coordinate the necessary addition or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Occupational therapy services are billed per fifteen (15) minute unit of service. Payment is not allowed solely for written reports or record documentation.

(11) **Physical therapy services.**

(A) Physical therapy services are those services that maintain or improve physical disability through the evaluation and rehabilitation of members disabled by pain, disease, or injury. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Treatment involves the use of physical therapeutic means, such as massage, manipulation, therapeutic exercise, cold and/or heat therapy, hydrotherapy, electrical stimulation, and light therapy. Under a physician's order, a licensed physical therapist evaluates the member's rehabilitation potential and develops an appropriate, written, therapeutic regimen. Under the Oklahoma Physical Therapy Practice Act, a physical therapist may evaluate a member's rehabilitation potential and develop and implement an appropriate, written, therapeutic regimen without a referral from a licensed health care practitioner for a period not to exceed thirty (30) calendar days. Any treatment required after the thirty (30) calendar day period requires a prescription from a physician or the physician's assistant of the licensee. The regimen utilizes paraprofessional physical therapy assistant services, within the limitations of his or her practice, working under the licensed physical therapist’s supervision. The regimen includes education and training for informal caregivers to assist with and/or maintain services when appropriate. The licensed physical therapist ensures monitoring and documentation of the member's rehabilitative progress and reports to the member's case manager and physician to coordinate the necessary addition or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Physical therapy services may be authorized as ADH care therapy enhancement and are a maximum of one (1) session unit per day of service. Payment is not allowed solely for written reports or record documentation.

(12) **Speech and language therapy services.**

(A) Speech and language therapy services are those that maintain or improve speech and language communication and swallowing disorders/disability through the evaluation and rehabilitation of members disabled by pain, disease, or injury. Services are provided in an ADH service setting and are intended to help the member achieve greater independence to reside and participate in the community. Services involve the use of therapeutic means, such as evaluation, specialized treatment, or development and oversight of a therapeutic maintenance program. Under a physician's order, a licensed speech and language pathologist evaluates the member's rehabilitation potential and

develops an appropriate, written, therapeutic regimen. The regimen utilizes speech language pathology assistant services within the limitations of his or her practice, working under the supervision of the licensed speech and language pathologist. The regimen includes education and training for informal caregivers to assist with and/or maintain services when appropriate. The speech and language pathologist ensures monitoring and documentation of the member's rehabilitative progress and reports to the member's case manager and physician to coordinate the necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Speech and language therapy services are authorized as ADH care-therapy enhancement and are a maximum of one (1) session unit per day of service. Payment is not allowed solely for written reports or record documentation.

(13) **Hospice services.**

(A) Hospice services are palliative and comfort care provided to the member and his or her family when a physician certifies the member has a terminal illness, with a life expectancy of six (6) months or less, and orders hospice care. ADvantage hospice care is authorized for a six (6) month period and requires physician certification of a terminal illness and orders of hospice care. When the member requires more than six (6) months of hospice care, a physician or nurse practitioner must have a face-to-face visit with the member thirty (30) calendar days prior to the initial hospice authorization end-date, and re-certify that the member has a terminal illness, has six (6) months or less to live, and orders additional hospice care. After the initial authorization period, additional periods of ADvantage hospice may be authorized for a maximum of sixty (60) calendar day increments with physician certification that the member has a terminal illness and six (6) months or less to live. A member's person-centered service plan that includes hospice care must comply with Waiver requirements to be within total person-centered service plan cost limits.

(B) A hospice program offers palliative and supportive care to meet the special needs arising out of the physical, emotional, and spiritual stresses experienced during the final stages of illness, through the end of life, and bereavement. The member signs a statement choosing hospice care instead of routine medical care with the objective to treat and cure the member's illness. Once the member has elected hospice care, the hospice medical team assumes responsibility for the member's medical care for the illness in the home environment. Hospice care services include nursing care, physician services, medical equipment and supplies, drugs for symptom and pain relief, home health aide and personal care services, physical, occupational and speech therapies, medical social services, dietary counseling, and grief and bereavement counseling to the member and/or the member's family.

(C) A hospice person-centered service plan must be developed by the hospice team in conjunction with the member's ADvantage case manager before hospice services are provided. The hospice services must be related to the palliation or management of the member's terminal illness, symptom control, or to enable the member to maintain ADL and basic functional skills. A member who is eligible for Medicare hospice provided as a Medicare Part A benefit, is not eligible to receive ADvantage hospice services.

(D) Hospice services are billed per diem of service for days covered by a hospice person-centered service plan and while the hospice provider is responsible for providing hospice services as needed by the member or member's family. The maximum total annual

reimbursement for a member's hospice care within a twelve (12) month period is limited to an amount equivalent to eighty-five percent (85%) of the Medicare hospice cap payment, and must be authorized on the member's person-centered service plan.

(14) **ADvantage personal care.**

(A) ADvantage personal care is assistance to a member in carrying out ADLs, such as bathing, grooming, and toileting or in carrying out instrumental activities of daily living (IADLs), such as preparing meals and laundry service, to ensure the member's personal health and safety, or to prevent or minimize physical health regression or deterioration. Personal care services do not include service provision of a technical nature, such as tracheal suctioning, bladder catheterization, colostomy irrigation, or the operation and maintenance of equipment of a technical nature.

(B) ADvantage home care agency skilled nursing staff working in coordination with an ADvantage case manager is responsible for the development and monitoring of the member's personal care services.

(C) ADvantage personal care services are prior-authorized and billed per fifteen (15) minute unit of service, with units of service limited to the number of units on the ADvantage approved person-centered service plan.

(15) **Personal emergency response system (PERS).**

(A) PERS is an electronic device that enables members at high risk of institutionalization, to secure help in an emergency. Members may also wear a portable "help" button to allow for mobility. PERS is connected to the person's phone and programmed to signal, per member preference, a friend, relative, or a response center, once the "help" button is activated. For an ADvantage member to be eligible for PERS service, the member must meet all service criteria in (i) through (vi). The member:

(i) Has a recent history of falls as a result of an existing medical condition that prevents the member from getting up unassisted from a fall;

(ii) Lives alone and without a regular caregiver, paid or unpaid, and therefore is left alone for long periods of time;

(iii) Demonstrates the capability to comprehend the purpose of and activate the PERS;

(iv) Has a health and safety plan detailing the interventions beyond the PERS to ensure the member's health and safety in his or her home;

(v) Has a disease management plan to implement medical and health interventions that reduce the possibility of falls by managing the member's underlying medical condition causing the falls; and

(vi) Will likely avoid premature or unnecessary institutionalization as a result of PERS.

(B) PERS services are billed using the appropriate HCPC procedure code for installation, monthly service, or PERS purchase. All services are prior authorized per the ADvantage approved service plan.

(16) ~~**CD-PASS.**~~**CDPASS.**

(A) ~~CD-PASS~~CDPASS are personal services assistance (PSA) and advanced personal services assistance (APSA) that enables a member in need of assistance to reside in his or her home and community of choice, rather than in an institution; and to carry out functions of daily living, self-care, and mobility. ~~CD-PASS~~CDPASS services are delivered as authorized on the person-centered service plan. The member becomes the

employer of record and employs the PSA and the APSA. The member is responsible, with assistance from ADvantage program administrative Financial Management Services (FMS), for ensuring the employment complies with state and federal labor law requirements. The member/employer may designate an adult family member or friend, who is not a PSA or APSA to the member, as an "authorized representative" to assist in executing the employer functions. The member/employer:

(i) Recruits, hires, and, as necessary, discharges the PSA or APSA;

(ii) Ensures the PSA or APSA has received sufficient instruction and training. If needed, the member/employer will work with the consumer-directed agent/case manager (CDA) to obtain training assistance from ADvantage skilled nurses. Prior to performing an APSA task for the first time, the APSA must demonstrate competency in the tasks in an on-the-job training session conducted by the member, and the member must document the attendant's competency in performing each task in the APSA's personnel file;

(iii) Determines where and how the PSA or APSA works, hours of work, what is to be accomplished and, within individual budget allocation limits, wages to be paid for the work;

(iv) Supervises and documents employee work time; and

(v) Provides tools and materials for work to be accomplished.

(B) The services the PSA may provide include:

(i) Assistance with mobility and transferring in and out of bed, wheelchair, or motor vehicle, or all;

(ii) Assistance with routine bodily functions, such as:

(I) Bathing and personal hygiene;

(II) Dressing and grooming; and

(III) Eating, including meal preparation and cleanup;

(iii) Assistance with home services, such as shopping, laundry, cleaning, and seasonal chores;

(iv) Companion assistance, such as letter writing, reading mail, and providing escort or transportation to participate in approved activities or events. "Approved activities or events," means community, civic participation guaranteed to all citizens including, but not limited to, exercise of religion, voting or participation in daily life activities in which exercise of choice and decision making is important to the member, and may include shopping for food, clothing, or other necessities, or for participation in other activities or events specifically approved on the person-centered service plan.

(C) An APSA ~~provides assistance with ADLs to~~assists a member with a stable, chronic condition with ADLs, when such assistance requires devices and procedures related to altered body function if such activities, in the opinion of the attending physician or licensed nurse, may be performed if the member were physically capable, and the procedure may be safely performed in the home. Services provided by the APSA are maintenance services and are never used as therapeutic treatment. Members who develop medical complications requiring skilled nursing services while receiving APSA services are referred to his or her attending physician, who may order home health services, as appropriate. APSA includes assistance with health maintenance activities that may include:

(i) Routine personal care for persons with ostomies, including tracheotomies, gastrostomies, and colostomies with well-healed stoma, external, indwelling, and suprapubic catheters that include changing bags and soap and water hygiene around the ostomy or catheter site;

(ii) Removing external catheters, inspecting skin, and reapplication of same;

(iii) Administering prescribed bowel program, including use of suppositories and sphincter stimulation, and enemas pre-packaged only without contraindicating rectal or intestinal conditions;

(iv) Applying medicated prescription lotions or ointments and dry, non-sterile dressings to unbroken skin;

(v) Using a lift for transfers;

(vi) Manually assisting with oral medications;

(vii) Providing passive range of motion (non-resistive flexion of joint) therapy, delivered in accordance with the person-centered service plan unless contraindicated by underlying joint pathology;

(viii) Applying non-sterile dressings to superficial skin breaks or abrasions; and

(ix) Using universal precautions as defined by the Centers for Disease Control and Prevention.

(D) FMS are program administrative services provided to participating ~~CD-PASS~~CDPASS members/employers by AA. FMS are employer-related assistance that provides Internal Revenue Service (IRS) fiscal reporting agent and other financial management tasks and functions, including, but not limited to:

(i) Processing employer payroll, after the member/employer has verified and approved the employee timesheet, at a minimum of semi-monthly, and associated withholding for taxes, or for other payroll withholdings performed on behalf of the member as employer of the PSA or APSA;

(ii) Other employer-related payment disbursements as agreed to with the member/employer and in accordance with the member/employer's individual budget allocation;

(iii) Responsibility for obtaining criminal and abuse registry background checks on prospective hires for PSA or APSA on the member/employer's behalf;

(iv) Providing orientation and training regarding employer responsibilities, as well as employer information and management guidelines, materials, tools, and staff consultant expertise to support and assist the member to successfully perform employer-related functions; and

(v) Making Hepatitis B vaccine and vaccination series available to PSA and APSA employees in compliance with Occupational Safety and Health Administration (OSHA) standards.

(E) The PSA service is billed per fifteen (15) minute unit of service. The number of units of PSA a member may receive is limited to the number of units approved on the person-centered service plan.

(F) The APSA service is billed per fifteen (15) minute unit of service. The number of units of APSA a member may receive is limited to the number of units approved on the person-centered service plan.

(17) **Institution transition services.**

(A) Institution transition services are those services necessary to enable a member to leave the institution and receive necessary support through ADvantage waiver services in his or her home and community.

(B) Transitional case management services are services per OAC 317:30-5-763(1) required by the member and included on the member's person-centered service plan that are necessary to ensure the member's health, welfare, and safety, or to enable the member to function with greater independence in the home, and without which, the member would continue to require institutionalization. ADvantage transitional case management services assist institutionalized members who are eligible to receive ADvantage services in gaining access to needed waiver and other State Plan services, as well as needed medical, social, educational, and other services to assist in the transition, regardless of the funding source for the services to which access is gained. Transitional case management services may be authorized for periodic monitoring of an ADvantage member's progress during an institutional stay and for assisting the member to transition from institution to home by updating the person-centered service plan, including necessary institution transition services to prepare services and supports to be in place or to start on the date the member is discharged from the institution. Transitional case management services may be authorized to assist individuals that have not previously received ADvantage services, but were referred by CAP to the case management provider for assistance in transitioning from the institution to the community with ADvantage services support.

(i) Institution transition case management services are prior authorized and billed per fifteen (15) minute unit of service using the appropriate HCPC procedure code and modifier associated with the location of residence of the member served, per OAC 317:30-5-763(1)(D).

(ii) A unique modifier code is used to distinguish institution transitional case management services from regular case management services.

(C) Institution transition services may be authorized and reimbursed, per the conditions in (i) through (iv).

(i) The service is necessary to enable the member to move from the institution to his or her home.

(ii) The member is eligible to receive ADvantage services outside of the institutional setting.

(iii) Institution transition services are provided to the member within one-hundred and eighty (180) calendar-days of discharge from the institution.

(iv) Services provided while the member is in the institution are claimed as delivered on the day of discharge from the institution.

(D) When the member receives institution transition services but fails to enter the waiver, any institution transition services provided are not reimbursable.

(18) **Assisted living services (ALS).**

(A) ALS are personal care and supportive services furnished to waiver members who reside in a homelike, non-institutional setting that includes twenty-four (24) hour on-site response capability to meet scheduled or unpredictable member needs and to provide supervision, safety, and security. Services also include social and recreational programming and medication assistance, to the extent permitted under State law. The ALS provider is responsible for coordinating services provided by third parties to ADvantage members in the assisted living center (ALC). Nursing services are incidental

rather than integral to the provision of ALS. ADvantage reimbursement for ALS includes services of personal care, housekeeping, laundry, meal preparation, periodic nursing evaluations, nursing supervision during nursing intervention, intermittent or unscheduled nursing care, medication administration, assistance with cognitive orientation, assistance with transfer and ambulation, planned programs for socialization, activities, and exercise, and for arranging or coordinating transportation to and from medical appointments. Services, except for planned programs for socialization, activities, and exercise, are to meet the member's specific needs as determined through the individualized assessment and documented on the member's person-centered service plan.

(B) The ADvantage ALS philosophy of service delivery promotes member choice, and to the greatest extent possible, member control. A member has control over his or her living space and his or her choice of personal amenities, furnishings, and activities in the residence. The ADvantage member must have the freedom to control his or her schedule and activities. The ALS provider's documented operating philosophy, including policies and procedures, must reflect and support the principles and values associated with the ADvantage assisted living philosophy and approach to service delivery emphasizing member dignity, privacy, individuality, and independence.

(C) ADvantage ALS required policies for admission and termination of services and definitions.

(i) ADvantage-certified assisted living centers (ALC) are required to accept all eligible ADvantage members who choose to receive services through the ALC, subject only to issues relating to, one (1) or more of the following:

(I) Rental unit availability;

(II) The member's compatibility with other residents;

(III) The center's ability to accommodate residents who have behavior problems, wander, or have needs that exceed the services the center provides; or

(IV) Restrictions initiated by statutory limitations.

(ii) The ALC may specify the number of units the provider is making available to service ADvantage members. At minimum, the ALC must designate ten (10) residential units for ADvantage members. Residential units designated for ADvantage may be used for other residents at the ALC when there are no pending ADvantage members for those units. Exceptions may be requested in writing subject to the approval of AA.

(iii) Mild or moderate cognitive impairment of the applicant is not a justifiable reason to deny ALC admission. Centers are required to specify whether they are able to accommodate members who have behavior problems or wander. Denial of admission due to a determination of incompatibility must be approved by the case manager and the AA. Appropriateness of placement is not a unilateral determination by the ALC. The ADvantage case manager, the member, or member's designated representative, and the ALC in consultation determine the appropriateness of placement.

(iv) The ALC is responsible for meeting the member's needs for privacy, dignity, respect, and freedom from coercion and restraint. The ALC must optimize the member's initiative, autonomy, and independence in making life choices. The ALC must facilitate member choices regarding services and supports, and who provides them. Inability to meet those needs is not recognized as a reason for determining an ADvantage member's placement is inappropriate. The ALC agrees to provide or

arrange and coordinate all services listed in the Oklahoma State Department of Health (OSDH) regulations, per OAC 310:663-3-3, except for specialized services.
(v) In addition, the ADvantage participating ALC agrees to provide or coordinate the services listed in (I) through (III).

(I) Provide an emergency call system for each participating ADvantage member.

(II) Provide up to three (3) meals per day plus snacks sufficient to meet nutritional requirements, including modified special diets, appropriate to the member's needs and choices; and provide members with twenty-four (24) hour access to food by giving members control in the selection of the foods they eat, by allowing the member to store personal food in his or her room, by allowing the member to prepare and eat food in his or her room, and allowing him or her to decide when to eat.

(III) Arrange or coordinate transportation to and from medical appointments. The ALC must assist the member with accessing transportation for integration into the community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, and control his or her personal resources and receive services in the community to the same degree of access as residents not receiving ADvantage services.

(vi) The provider may offer any specialized service or rental unit for members with Alzheimer's disease and related dementias, physical disabilities, or other special needs the facility intends to market. Heightened scrutiny, through additional monitoring of the ALC by AA, is utilized for those ALC's that also provide inpatient treatment; settings on the grounds of or adjacent to a public institution and/or other settings that tend to isolate individuals from the community. The ALC must include evidence that the ALC portion of the facility has clear administrative, financial, programmatic and environmental distinctions from the institution.
(vii) When the provider arranges and coordinates services for members, the provider is obligated to ensure the provision of those services.
(viii) Per OAC 310:663-1-2, "personal care" is defined as "assistance with meals, dressing, movement, bathing or other personal needs or maintenance, or general supervision of the physical and mental well-being of a person [Title 63 of the Oklahoma Statutes (O.S.), Section (§) 1-1902.17] and includes assistance with toileting." For ADvantage ALS, assistance with "other personal needs" in this definition includes assistance with grooming and transferring. The term "assistance" is clarified to mean hands-on help, in addition to supervision.
(ix) The specific ALS assistance provided along with amount and duration of each type of assistance is based upon the member's assessed need for service assistance and is specified in the ALC's service plan that is incorporated as supplemental detail into the ADvantage comprehensive person-centered service plan. The ADvantage case manager in cooperation with ALC professional staff, develops the person-centered service plan to meet member needs. As member needs change, the person-centered service plan is amended consistent with the assessed, documented need for change in services.
(x) Placement, or continued placement of an ADvantage member in an ALC, is inappropriate when any one (1) or more of the conditions in I through IV exist.

(I) The member's needs exceed the level of services the center provides.

Documentation must support ALC efforts to provide or arrange for the required services to accommodate participant needs.

(II) The member exhibits behaviors or actions that repeatedly and substantially interfere with the rights or well-being of other residents, and the ALC documented efforts to resolve behavior problems including medical, behavioral, and increased staffing interventions. Documentation must support the ALC's attempted interventions to resolve behavior problems.

(III) The member has a complex, unstable, or unpredictable medical condition and treatment cannot be developed and implemented appropriately in the assisted living environment. Documentation must support the ALC's attempts to obtain appropriate member care.

(IV) The member fails to pay room and board charges or OKDHS determined vendor payment obligation.

(xi) Termination of residence ensues when inappropriately placed. Once a determination is made that a member is inappropriately placed, the ALC must inform the member, the member's representative, if applicable, the AA, and the member's ADvantage case manager. The ALC must develop a discharge plan in consultation with the member, the member's representative, the ADvantage case manager, and the AA. The ALC and case manager must ensure the discharge plan includes strategies for providing increased services, when appropriate, to minimize risk and meet the higher care needs of members transitioning out of the ALC, when the reason for discharge is inability to meet member needs. When voluntary termination of residency is not arranged, the ALC must provide written notice to the member and to the member's representative, with a copy to the member's ADvantage case manager and the AA. The written notice provides intent to terminate the residency agreement and move the member to an appropriate care provider. The thirty (30) calendar-day requirement must not apply when emergency termination of the residency agreement is mandated by the member's immediate health needs or when the termination of the residency agreement is necessary for the physical safety of the member or other ALC residents. The written involuntary termination of residency notice for reasons of inappropriate placement must include:

(I) A full explanation of the reasons for the termination of residency;

(II) The notice date;

(III) The date notice was given to the member and the member's representative, the ADvantage case manager, and the AA;

(IV) The date the member must leave ALC; and

(V) Notification of appeal rights and the process for submitting appeal of termination of Medicaid ALS to OHCA.

(D) ADvantage ALS provider standards in addition to licensure standards.

(i) **Physical environment.**

(I) The ALC must provide lockable doors on the entry door of each rental unit and an attached, lockable compartment within each member unit for valuables. Members must have exclusive rights to his or her unit with lockable doors at the entrance of the individual or shared rental unit. Keys to rooms may be held by only appropriate ALC staff as designated by the member's choice. Rental units

may be shared only when a request to do so is initiated by the member. Members must be given the right to choose his or her roommate.
(II) The member has a legally enforceable agreement, or lease, with the ALC. The member must have the same responsibilities and protections from eviction as all tenants under the landlord-tenant law of the state, county, city, or other designated entity.
(III) The ALC must provide each rental unit with a means for each member to control the temperature in the residential unit through the use of a damper, register, thermostat, or other reasonable means under the control of the member and that preserves privacy, independence, and safety, provided that the OSDH may approve an alternate means based on documentation that the design of the temperature control is appropriate to the special needs of each member who has an alternate temperature control.
(IV) For ALCs built prior to January 1, 2008, each ALC individual residential unit must have a minimum total living space, including closets and storage areas, of two-hundred and fifty (250) square feet; for ALCs built after December 31, 2007, each ALC individual residential unit must have a minimum total living space, including closets and storage areas, of three-hundred and sixty (360) square feet.
(V) The ALC must provide a private bathroom for each living unit that must be equipped with one (1) lavatory, one (1) toilet, and one (1) bathtub or shower stall.
(VI) The ALC must provide at a minimum; a kitchenette, defined as a space containing a refrigerator, adequate storage space for utensils, and a cooking appliance. A microwave is an acceptable cooking appliance.
(VII) The member is responsible for furnishing the rental unit. When a member is unable to supply basic furnishings defined as a bed, dresser, nightstand, chairs, table, trash can, and lamp, or if furnishings pose a health or safety risk, the member's ADvantage case manager in coordination with the ALC, must assist the member in obtaining basic furnishings for the rental unit. The member must have the freedom to furnish and decorate the rental unit within the scope of the lease or residency agreement.
(VIII) The ALC must meet the requirements of all applicable federal and state laws and regulations including, but not limited to, state and local sanitary codes, state building and fire safety codes, and laws and regulations governing use and access by persons with disabilities.
(IX) The ALC must ensure the design of common areas accommodates the special needs of the resident population and that the rental unit accommodates the special needs of the member in compliance with the Americans with Disabilities Act accessibility guidelines per Nondiscrimination on the Basis of Disability By Public Accommodations and in in Commercial Facilities, 28 Code of Federal Regulations, Appendix A, at no additional cost to the member.
(X) The ALC must provide adequate and appropriate social and recreational space for residents and the common space must be proportionate to the number of residents and appropriate for the resident population.
(XI) The ALC must provide appropriately monitored outdoor space for resident

use.

(XII) The ALC must provide the member with the right to have visitors of his or her choosing at any time. Overnight visitation is allowed as permissible by the Landlord/Tenant Agreement.

(XIII) The ALC must be physically accessible to members.

(ii) **Sanitation.**

(I) The ALC must maintain the facility, including its individual rental units in a clean, safe, and sanitary manner, ensuring that they are insect and rodent free, odorless, and in good repair at all times.

(II) The ALC must maintain buildings and grounds in a good state of repair, in a safe and sanitary condition, and in compliance with the requirements of applicable regulations, bylaws, and codes.

(III) The ALC stores clean laundry in a manner that prevents contamination and changes linens at time intervals necessary to avoid health issues.

(IV) The ALC must provide housekeeping in member rental units to maintain a safe, clean, and sanitary environment.

(V) The ALC must have policies and procedures for members' pets.

(iii) **Health and safety.**

(I) The ALC must provide building security that protects members from intruders with security measures appropriate to building design, environmental risk factors, and the resident population.

(II) The ALC must respond immediately and appropriately to missing members, accidents, medical emergencies, or deaths.

(III) The ALC must have a plan in place to prevent, contain, and report any diseases considered to be infectious or are listed as diseases that must be reported to the OSDH.

(IV) The ALC must adopt policies for the prevention of abuse, neglect, and exploitation that include screening, training, prevention, investigation, protection during investigation, and reporting.

(V) The ALC must provide services and facilities that accommodate the needs of members to safely evacuate in the event of fires or other emergencies.

(VI) The ALC must ensure staff is trained to respond appropriately to emergencies.

(VII) The ALC must ensure that fire safety requirements are met.

(VIII) The ALC must offer meals that provide balanced and adequate nutrition for members.

(IX) The ALC must adopt safe practices for meal preparation and delivery.

(X) The ALC must provide a twenty-four (24) hour response to personal emergencies appropriate to the needs of the resident population.

(XI) The ALC must provide safe transportation to and from ALC sponsored social or recreational outings.

(iv) **Staff to resident ratios.**

(I) The ALC must ensure a sufficient number of trained staff are on duty, awake, and present at all times, twenty-four (24) hours a day, and seven (7) days a week, to meet resident's needs and to carry out all processes listed in the ALC's written emergency and disaster preparedness plan for fires and other disasters.

(II) The ALC must ensure staffing is sufficient to meet ADvantage program members' needs in accordance with each member's ADvantage person-centered service plan.

(III) The ALC must have plans in place to address situations where there is a disruption to the ALC's regular work force.

(v) **Staff training and qualifications.**

(I) The ALC must ensure staff has qualifications consistent with their job responsibilities.

(II) All staff assisting in, or responsible for, food service must have attended a food service training program offered or approved by OSDH.

(III) The ALC must provide staff orientation and ongoing training to develop and maintain staff knowledge and skills. All direct care and activity staff receive at least eight (8) hours of orientation and initial training within the first month of employment and at least four (4) hours annually thereafter. Staff providing direct care on a dementia unit must receive four (4) additional hours of dementia specific training. Annual first aid and cardiopulmonary resuscitation (CPR) certification do not count toward the four (4) hours of annual training.

(vi) **Staff supervision.**

(I) The ALC must ensure delegation of tasks to non-licensed staff is consistent and in compliance with all applicable state regulations including, but not limited to, the state's Nurse Practice Act and OSDH Nurse Aide Certification rules.

(II) The ALC must ensure that, where the monitoring of food intake or therapeutic diets is provided at the prescribed services level, a registered dietitian monitors member health and nutritional status.

(vii) **Resident rights.**

(I) The ALC must provide to each member and each member's representative, at the time of admission, a copy of the resident statutory rights listed in 63 O.S. § 1-1918 amended to include additional rights and the clarification of rights as listed in the ADvantage member assurances. A copy of resident rights must be posted in an easily accessible, conspicuous place in the facility. The facility must ensure that staff is familiar with and observes, the resident rights.

(II) The ALC must conspicuously post for display in an area accessible to residents, employees, and visitors, the ALC's complaint procedures and the name, address, and phone number of a person authorized to receive complaints. A copy of the complaint procedure must also be given to each member, the member's representative, or the legal guardian. The ALC must ensure all employees comply with the ALC's complaint procedure.

(III) The ALC must provide to each member and member's representative, at the time of admission, information about Medicaid grievance and appeal rights, including a description of the process for submitting a grievance or appeal of any decision that decreases Medicaid services to the member.

(viii) **Incident reporting.**

(I) The ALC must maintain a record of incidents that occur and report incidents to the member's ADvantage case manager and to the AA, utilizing the AA Critical Incident Reporting form. Incident reports are also made to Adult

Protective Services (APS) and to the OSDH, as appropriate, per ALC licensure rules, utilizing the specific reporting forms required.

(II) Incidents requiring report by licensed ALC's are those defined by OSDH, per OAC 310:663-19-1 and listed in the Provider Question Critical Incident Category.

(III) Reports of incidents must be made to the member's ADvantage case manager and to the AA via electronic submission within one (1) business day of the reportable incident's discovery utilizing the Provider Question Critical Incident Category. When required, a follow-up report of the incident must be submitted via electronic submission to the member's ADvantage case manager and to the AA. The follow-up report must be submitted within five (5) business days of the incident. The final report must be filed with the member's ADvantage case manager and the AA when the investigation is complete, not to exceed ten (10) business days after the incident.

(IV) Each ALC having reasonable cause to believe that a member is suffering from abuse, neglect, exploitation, or misappropriation of member property must make a report to APS as soon as the person is aware of the situation per 43A O.S. § 10-104.A. Reports are also made to OSDH, as appropriate, per ALC licensure rules.

(V) The preliminary incident report must at minimum, include who, what, when, where, and the measures taken to protect the member and resident(s) during the investigation. The follow-up report must, at minimum, include preliminary information, the extent of the injury or damage, if any, and preliminary investigation findings. The final report, at minimum, includes preliminary and follow-up information, a summary of investigative actions representing a thorough investigation, investigative findings and conclusions, and corrective measures to prevent future occurrences. When it is necessary to omit items, the final report must include why such items were omitted and when they will be provided.

(ix) Provision of, or arrangement for, necessary health services. The ALC must:

(I) Arrange or coordinate transportation for members to and from medical appointments; and

(II) Provide or coordinate with the member and the member's ADvantage case manager for delivery of necessary health services. The ADvantage case manager is responsible for monitoring that all health-related services required by the member as identified through assessment and documented on the person-centered service plan, are provided in an appropriate and timely manner. The member has the freedom to choose any available provider qualified by licensure or certification to provide necessary health services in the ALC.

(E) ALCs are billed per diem of service for days covered by the ADvantage member's person-centered service plan and during which the ALS provider is responsible for providing ALS for the member. The per diem rate for ADvantage ALS for a member is one (1) of three (3) per diem rate levels based on a member's need for type of, intensity of, and frequency of service to address member ADLs, instrumental activities of daily living (IADLs), and health care needs. The rate level is based on the Uniform Comprehensive Assessment Tool (UCAT) assessment by the member's ADvantage case

manager employed by a case management agency independent of the ALS provider. The determination of the appropriate per diem rate is made by the AA clinical review staff.

(F) The ALC must notify AA ninety (90) calendar days before terminating or not renewing the ALC's ADvantage contract.

(i) The ALC must give notice in writing to the member, the member's representative(s), the AA, and the member's ADvantage case manager ninety (90) calendar days before:

(I) Voluntary cessation of the ALC's ADvantage contract; or

(II) Closure of all or part of the ALC.

(ii) The notice of closure must include:

(I) The proposed ADvantage contract termination date;

(II) The termination reason;

(III) An offer to assist the member secure an alternative placement; and

(IV) Available housing alternatives.

(iii) The facility must comply with all applicable laws and regulations until the closing date, including those related to resident transfer or discharge.

(iv) Following the last move to the last ADvantage member, the ALC must provide in writing to the AA:

(I) The effective date of closure based on the discharge date of the last resident;

(II) A list of members transferred or discharged and where they relocated,; and

(III) The plan for storage of resident records per OAC 310:663-19-3(g), relating to preservation of resident records and the name, address, and phone numbers of the person responsible for the records.

(19) **Remote Support (RS) services**.

(A) **Purpose and scope.** RS services are intended to promote a member's independence and self-direction. RS services are provided in the member's home to reduce reliance on in person support while ensuring the member's health and safety. RS services are included in the member's person-centered service plan and coordination of these services are made through the case manager.

(i) RS services are:

(I) Based on the member's needs as documented and supported by the member's person-centered service plan and person-centered assessments;

(II) Only authorized when submitted on the member's person-centered service plan with the consent of the member, involved household members, and guardian, as applicable;

(III) The least restrictive option and the member's preferred method to meet an assessed need; and

(IV) Provided when the member and the member's Interdisciplinary Team (IDT) agree to the provision of RS services.

(ii) RS services are not a system of surveillance or for provider convenience.

(B) **Service description**. RS services monitor a member by allowing for live, two-way communication between the member and monitoring staff using one (1) or more of the following systems:

(i) Live video feed;

(ii) Live audio feed;

(iii) Motion-sensor monitoring;

(iv) Radio frequency identification;
(v) Web-based monitoring; or
(vi) Global positioning system (GPS) monitoring devices.

(C) **General provider requirements.** RS service providers must have a valid OHCA SoonerCare (Medicaid) provider agreement to provide provider-based RS services to ADvantage HCBS waiver members and be certified by the AA. Requests for applications to provide RS services are made to AA.

(D) **Risk assessment.** Teams will complete a risk assessment to ensure remote supports can help meet the member's needs in a way that protects the right to privacy, dignity, respect, and freedom from coercion. The risk assessment is reviewed, and any issues are addressed prior to the implementation of remote supports general provider requirements.

(i) Remote support providers ensure the member's health and safety by contacting a member's informal support or activating the member's back-up plan when a health or safety issue becomes evident during monitoring.

(ii) The risk assessment and service plan require the team to develop a specific back-up plan to address health, safety and behavioral needs while remote supports are utilized so appropriate assistance can be provided. The RS back-up plan includes how assistance is provided to the member when equipment or technology fails.

(E) **RS guidelines.** Devices or monitors are placed at locations based on the member's individual needs as documented on the member's person-centered service plan and approved by the member and involved family members and guardian, as applicable.

(i) The use of camera or video equipment in the member's bedroom, bathroom, or other private area is prohibited.

(ii) When RS involves the use of audio or video equipment that permits RS staff to view activities or listen to conversations in the residence, the member who receives the service and each person who lives with the member is fully informed of what RS entails. The member's case manager documents consent in the member's person-centered service plan.

(iii) Waiver members have the ability to turn off the remote monitoring device or equipment if they choose to do so. The RS provider educates the member regarding how to turn RS devices off and on at the start of services and as desired thereafter.

(F) **Emergency response staff.**

(i) Emergency response staff are employed by a certified ADvantage Provider with a valid OHCA SoonerCare (Medicaid) contract to provide HCBS to OKDHS HCBS waiver members.

(ii) Informal emergency response persons are unpaid family members or other interested parties who agree to become, and are approved as, an emergency response person by the member and the member's IDT.

(G) **Service limitations.** RS services are limited to twenty-four (24) hours per day. RS services are not provided simultaneously with any other in-home direct care services. However, services may be provided through a combination of remote and in-home services dependent on the member's needs.

(H) **RS service discontinuation**. The member and the member's IDT determine when it is appropriate to discontinue RS services. When RS services are terminated,

the RS provider coordinates service termination with the member's case manager to ensure a safe transition.

(20) **Assistive Technology (AT) services.**

(A) AT services include devices, controls, and appliances, specified in the member's person-centered service plan, which enable members to increase their abilities to perform activities of daily living or to perceive, control, or communicate with the environment in which they live.

(B) Devices may include communication technology, such as smart phones and tablets, that allow members to communicate with their providers using video chat to ensure ongoing maintenance of health and welfare.

(C) Only devices that are not covered under the SoonerCare (Medicaid) or Specialized Medical Equipment services are included in this service definition.

(D) Service codes and rates vary based on the nature of the AT device;

(E) AT services may include:

(i) Assessment for the need of AT or auxiliary aids;

(ii) Training the member or provider regarding use and maintenance of equipment or auxiliary aids; and

(iii) Repair of adaptive devices; and

(iv) Equipment provided may include:

(I) Video communication technology that allows members to communicate with providers through video communication. Video communication allows providers to assess and evaluate their members' health and welfare or other needs by enabling visualization of members and their environments. Examples include smart phones, tablets, audiovisual or virtual assistant technology, or sensors; and

(II) The cost of internet services may be augmented through the Emergency Broadband Benefit which is available to waiver members.

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

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 Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (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 (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.~~Long-term medical care for the categorically needy includes:

(1) Care in a nursing facility, per Oklahoma Administrative Code (OAC) 317:35-19;

(2) Public and private intermediate care facility for individuals with intellectual disabilities, per OAC 317:35-9;

(3) Persons age sixty-five (65) years or older in mental health hospitals, per OAC 317:35-9;

(4) Home and Community Based Waiver Services for the Intellectually Disabled, per OAC 317:35-9;

(5) Home and Community Based Waiver Services for the ADvantage program, per OAC 317:35-17; and

(6) State Plan Personal Care provides services, per OAC 317:35-15.

(b) Any time an individual is certified as eligible for ~~Medicaid coverage of~~ long-term care SoonerCare coverage, the individual is also eligible for other ~~Medicaid~~ SoonerCare 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~~ is made to see if eligibility conditions as a ~~Qualified Medicare Beneficiary (QMB)~~QMB or ~~Specified Low-Income Medicare Beneficiary (SLMB)~~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)~~(c) **~~Medicaid recovery.~~** The State of Oklahoma operates a Medicaid ~~Recovery~~ program to recover cost 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.~~

SUBCHAPTER 17. ADVANTAGE WAIVER SERVICES

317:35-17-3. ADvantage program services

(a) The ADvantage program is a Medicaid Home and Community-Based waiver used to finance non-institutional, long-term care services for the elderly and a targeted group of physically disabled adults when there is a reasonable expectation that within a thirty (30) calendar day period, the person's health, due to disease process or disability, would without appropriate services, deteriorate and require long-term care (LTC) facility care to arrest the deterioration. Individuals may not be enrolled in ADvantage for the sole purpose of enabling them to obtain Medicaid eligibility. Eligibility for ADvantage program services is contingent on an individual requiring one (1) or more of the services offered in the waiver, at least monthly, to avoid institutionalization.

(b) The number of individuals who may receive ADvantage services is limited.

(1) To receive ADvantage program services, individuals must meet one of the categories in (A) through ~~(D)~~(C) of this paragraph. He or she must:

(A) Be sixty-five (65) years of age or older; or

(B) Be nineteen (19) to sixty-four (64) years of age with a physical disability; or

(C) Be nineteen (19) to sixty-four (64) years of age with a developmental disability, provided he or she does not have ~~a~~an intellectual disability or cognitive impairment ~~(intellectual disability); or~~related to the developmental disability.

~~(D) Be nineteen (19) to sixty-four (64) years of age with a clinically documented, progressive, degenerative disease process that responds to treatment and previously required hospital or LTC facility level of care services to maintain the treatment regimen to prevent health deterioration.~~

(2) In addition, the individual must meet criteria in (A) through (C) of this paragraph. He or she must:

(A) Require long-term care facility level of care, per Oklahoma Administrative Code (OAC) 317:35-17-2;

(B) Meet service eligibility criteria, per OAC 317:35-17-3(f); and

(C) Meet program eligibility criteria, per OAC 317:35-17-3(g).

(c) ADvantage members are eligible for limited types of living arrangements. The specific living arrangements are set forth in (1) through (5) of this subsection.

(1) ADvantage program members are not eligible to receive services while residing in an unlicensed institutional living arrangement, such as a room and board home or facility; an institutional setting including, but not limited to, licensed facilities, such as a hospital, a LTC facility, licensed residential care facility, or licensed assisted living facility, unless the facility is an ADvantage assisted living center.

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

(3) ADvantage program members may receive services in a shelter or similar temporary-housing arrangement that may or may not meet the definition of home or apartment in emergency situations, for a period not to exceed sixty (60) calendar days during which location and transition to permanent housing is sought.

(4) For ADvantage members who are full-time students, a dormitory room qualifies as an allowable living arrangement in which to receive ADvantage services while the member is a student.

(5) Members may receive ADvantage respite services in an LTC facility for a continuous period not to exceed thirty (30) calendar days.

(d) Home and Community-Based waiver services are outside of the scope of Medicaid State Plan services. The Medicaid waiver allows the Oklahoma Health Care Authority to offer certain Home and Community-Based services to an annually capped number of persons, who are categorically needy, per Oklahoma Human Services (OKDHS) Appendix C-1, Schedule VIII. B. 1., and without such services would be institutionalized. The estimated cost of providing an individual's care outside of the LTC facility cannot exceed the annual cost of caring for that individual in a LTC facility. When determining the ADvantage service plan cost cap for an individual, the comparable Medicaid cost to serve that individual in a LTC facility is estimated.

(e) Services provided through the ADvantage waiver are:

(1) Case management;

(2) Respite;

(3) Adult day health care;

(4) Environmental modifications;

(5) Specialized medical equipment and supplies;

(6) Physical, occupational, or speech therapy or consultation;

(7) Advanced supportive and/or restorative assistance;

(8) Nursing;

(9) Skilled nursing;

(10) Home-delivered meals;

~~(11) Hospice care;~~

~~(12)~~(11) Medically necessary prescription drugs, within the limits of the ADvantage waiver;

~~(13)~~(12) Personal care, State Plan, or ADvantage personal care;

~~(14)~~(13) A Personal Emergency Response System (PERS);

~~(15)~~(14) Consumer Directed Personal Assistance Services and Supports ~~(CD-PASS)~~(CDPASS);

~~(16)~~(15) Institution Transition Services (Transitional Case Management);

~~(17)~~(16) Assisted living;

~~(18)~~(17) Remote Supports;

~~(19)~~(18) Assistive technology; and

~~(20)~~(19) SoonerCare medical services for individuals, ~~twenty-one (21)~~nineteen (19) years of age and over, within the State Plan scope.

(f) The OKDHS area nurse or nurse designee determines service eligibility prior to evaluating the Uniform Comprehensive Assessment Tool (UCAT) assessment for long-term care facility level of care. The criteria in (1) through (5) of this subsection are used to make the service eligibility determination, which includes:

(1) An open ADvantage program waiver slot, as authorized by the Centers for Medicare and Medicaid Services (CMS), is available to ensure federal participation in payment for services

to the individual. When Oklahoma Human Services Community Living, Aging and Protective Services (CAP) determines all slots are filled, the individual cannot be certified as eligible for ADvantage services, and his or her name is placed on a waiting list for entry when an open slot becomes available.

(2) The ADvantage waiver-targeted service groups are individuals, who:

(A) Are frail and sixty-five (65) years of age and older; or

(B) Are nineteen(19) to sixty-four (64) years of age and physically disabled; or

(C) When developmentally disabled and nineteen (19) to sixty-four (64) years of age ~~and~~ do not have an intellectual disability or cognitive impairment related to the developmental disability~~; or~~.

~~(D) Are nineteen (19) to sixty-four (64) years of age and not physically disabled but have a clinically documented, progressive, degenerative disease process that responds to treatment and previously required hospital or long-term care facility level of care services to maintain the treatment regimen to prevent health deterioration. The individual must meet criteria, per OAC 317:35-17-3(b)(2)(A) through (C).~~

(3) An individual is ineligible when posing a physical threat to self or others, as supported by professional documentation.

(4) An individual is ineligible when members of the household or persons who routinely visit the household pose a threat of harm or injury to the individual or other household visitors, as supported by professional documentation.

(5) An individual is ineligible when his or her living environment poses a physical threat to self or others, as supported by professional documentation where applicable, and measures to correct hazardous conditions or assist the individual to move are unsuccessful or not feasible.

(g) The State, as part of the ADvantage waiver program approval process, ensures CMS that each member's health, safety, or welfare can be maintained in his or her home. When a member's identified needs cannot be met through provision of the ADvantage program or Medicaid State Plan services and other formal or informal services are not in place or immediately available to meet those needs, the individual's health, safety, or welfare in his or her home cannot be ensured. The ADvantage Administration (AA) determines ADvantage program eligibility through the service plan approval process. An individual is deemed ineligible for the ADvantage program based on criteria (1) through (8) of this subsection.

(1) The individual's needs, as identified by the UCAT and other professional assessments, cannot be met through ADvantage program services, Medicaid State Plan services, or other formal or informal services.

(2) One (1) or more members of the individual's household pose a physical threat to themselves, or others as supported by professional documentation.

(3) The individual or other household members use threatening, intimidating, degrading, or use sexually inappropriate language or innuendo or behavior towards service providers, in the home or through other contact or communications, and significant efforts were attempted to correct such behavior, as supported by professional documentation or other credible documentation.

(4) The individual, or the individual's authorized agent, is uncooperative or refuses to participate in service development or service delivery and these actions result in unacceptable increases of risk to the individual's health, safety, or welfare in his or her home, as determined by the individual, the interdisciplinary team, or the AA.

(5) The individual's living environment poses a physical threat to self or others, as supported

by professional documentation, and measures to correct hazardous conditions or assist the person to move are unsuccessful or are not feasible.

(6) The individual provides false or materially inaccurate information necessary to determine program eligibility or withholds information necessary to determine program eligibility.

(7) The individual does not require at least one ADvantage service monthly.

(8) The individual, his or her family member(s), associate(s), or any other person(s) or circumstances as relates to care and coordination in the living environment produces evidence of illegal drug activity or substances used illegally as intoxicants. This includes:

(A) The use, possession, or distribution of illegal drugs;

(B) The abusive use of other drugs, such as medication prescribed by a doctor;

(C) The use of substances, such as inhalants including, but not limited to:

(i) Typewriter correction fluid;

(ii) Air conditioning coolant;

(iii) Gasoline;

(iv) Propane;

(v) Felt-tip markers;

(vi) Spray paint;

(vii) Air freshener;

(viii) Butane;

(ix) Cooking spray;

(x) Paint; and

(xi) Glue;

(D) The observed intoxication, consumption, or sensory indicators, such as smell of the use of any drug or intoxicant by the individual, family members, associates, or any other person(s) present at the time care is provided may be construed as evidence indicative of illegal drug activity or intoxication. This includes drug use or intoxicated activity that is menacing to the member or staff providing services;

(E) The observance of drug paraphernalia or any instrument used in the manufacturing, production, distribution, sale, or consumption of drugs or substances including, but not limited to:

(i) Smoking pipes used to consume substances other than tobacco;

(ii) Roach clips containing marijuana cigarettes;

(iii) Needles and other implements used for injecting drugs into the body;

(iv) Plastic bags or other containers used to package drugs;

(v) Miniature spoons used to prepare drugs; or

(vi) Kits used in the production of synthetic controlled substances including descriptive materials that accompany the item, describing or depicting its use.

(F) Instructions, verbal or written, concerning the item or device including, but not limited to, the manner in which the object is labeled and displayed for sale;

(G) The typical use of such items in the community; or

(H) Testimony of an expert witness regarding use of the item.

(h) The case manager provides the AA with professional documentation or other credible documentation to support the recommendation for redetermination of program eligibility. The service providers continue providing services according to the person-centered service plan as provider safety permits until the individual is removed from the ADvantage program. As a part of the procedures requesting redetermination of program eligibility, CAP provides technical

assistance to the provider for transitioning the individual to other services.
(i) Individuals determined ineligible for ADvantage program services are notified in writing by CAP of the determination and of their right to appeal the decision.

317:35-17-4. Application for ADvantage services

(a) **Application procedures for ADvantage services**. If waiver slots are available, the application process initiates when an online application is completed for ADvantage services. A written financial application is not required for an individual who has an active Medicaid case. A financial application for ADvantage services consists of the Medical Assistance Application form. The form is signed by the applicant, parent, spouse, guardian, or someone else acting on the applicant's behalf.

(1) All conditions of financial eligibility must be verified and documented in the case record. When current information already available in the local office establishes financial 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) When Medicaid application is being made, an assessment of resources must be completed. For applicants of the ADvantage waiver, those resources owned by the couple the month the application was made determines the spousal share of resources.

(3) When an application is received from an individual residing in a nursing facility, the applicant is referred to the ~~Oklahoma Health Care Authority (OHCA)~~ Living Choice program ~~as the appropriate entity~~ to assist individuals from nursing facility care.

(A) If ~~OHCA~~ Living Choice determines the applicant is ineligible for services due to the inability to assure health and welfare in a community setting, the individual is also ineligible for ADvantage waiver services.

(B) If ~~OHCA~~ Living Choice determines the applicant does not meet Living Choice eligibility criteria for reasons unrelated to health and welfare, the individual is eligible for the ADvantage waiver if medically and financially approved.

(b) **Date of application**.

(1) The date of application is:

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

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

(C) the date when the request for Medicaid is made orally and the financial application form is signed later. The date of the oral request is entered in "red" above the date the form is signed.

(2) An exception is when OKDHS has contracts with certain providers to take applications and obtain documentation. After the documentation is obtained, the contracted provider forwards the application and documentation to the OKDHS county office of the applicant's county of residence for Medicaid eligibility determination. The application date is the date the applicant signed the application form for the provider.

(c) **ADvantage ~~waiting list procedures~~capacity.** ADvantage Program "available capacity" is the number of members that may be enrolled in the Program without exceeding, on an annualized

basis, the maximum number authorized by the waiver to be served in the waiver year. ~~Upon notification from the AA that 90% of the available capacity has been exceeded, OKDHS Community Living, Aging and Protective Services notifies OKDHS county offices and contract agencies approved to complete the UCAT that, until further notice, requests for ADvantage services are not to be processed as applications but referred to AA to be placed on a waiting list of requests for ADvantage services. As available capacity permits, but remaining in compliance with waiver limits of maximum capacity, and until an increase in ADvantage available capacity occurs, the AA selects in chronological order (first on, first off) requests for ADvantage from the waiting list to forward to the appropriate OKDHS county office for processing the application. When the waiver capacity exceeds the number on the waiting list and after all persons on the waiting list have been processed, waiting list procedures are suspended.~~ Waitlist procedures are implemented when the maximum number authorized by the waiver to be served in the waiver year is met.

317:35-17-14. Case management services

(a) Case management services involve ongoing assessment, service planning and implementation, service monitoring and evaluation, member advocacy, and discharge planning.

(1) Within one-business (1-business) day of receipt of an ADvantage referral from the ADvantage Administration (AA), the case processor assigns a case manager to the member. The case manager makes a home visit to review the ADvantage program, including its purpose, philosophy, and the roles and responsibilities of the member, service provider, case manager, and Oklahoma Human Services (OKDHS). The case manager will review and, when needed, update the Uniform Comprehensive Assessment Tool (UCAT) and discuss service needs and ADvantage service providers. The case manager notifies the member's primary physician, identified in the UCAT, in writing that the member was determined eligible to receive ADvantage services. The notification is a preprint form that contains the member's signed permission to release this health information and requests physician's office verification of primary and secondary diagnoses and diagnoses code obtained from the UCAT.

(2) Within 10 business days of the receipt of an ADvantage referral, the case manager completes and submits a person-centered service plan for the member, signed by the member and the case manager, to the case manager supervisor for approval and submission to the AA. The case manager completes and submits the annual reassessment person-centered service plan documents at least thirty (30) days before, but no sooner than ~~sixty~~ninety calendar days ~~(60-calendar)~~(90-calendar) days before the existing service plan end-date. The case manager submits revisions for denied services to be resubmitted for approval within seven-business (7-business) days to the AA. Within ten-business (10-business) days of notification of service conditions for short-term authorizations from the AA, the case manager submits the correction. Within seven-business (7-business) days of assessed need, the case manager completes and submits a service plan change to the AA to amend current services. The person-centered service plan is based on the member's service needs identified by the UCAT, and includes only those services required to sustain or promote the health and safety of the member. The case manager uses an interdisciplinary team (IDT) planning approach for person-centered service plan development. IDT meetings are held in the member's home and include, at minimum, the member and member's legal representative if applicable, case manager, and homecare Registered Nurse.

(3) The case manager identifies long-term goals, strengths and challenges for meeting goals, and service goals including plan objectives, actions steps and expected outcomes. The case manager documents in the electronic case file the presence of two (2) or more ADvantage members residing in the same household and/or when the member and personal care provider reside together. The case manager identifies services, service provider, funding source units and frequency of service and service cost, cost by funding source and total cost for ADvantage services. The member signs and indicates review and agreement with the person-centered service plan by indicating acceptance or non-acceptance of the plans. The member, the member's legal guardian or legally authorized representative signs the person-centered service plan in the presence of the case manager. The signatures of two (2) witnesses are required when the member signs with a mark. When the member refuses to cooperate in development of the person-centered service plan or when the member refuses to sign the person-centered service plan, the case management agency refers the case to the AA for resolution. Based on the UCAT and/or case progress notes that document chronic uncooperative or disruptive behaviors, the OKDHS nurse or AA may identify members that require AA intervention through referral to the AA's Escalated Issues unit.

(A) For members that are uncooperative or disruptive, the case manager supports the member to develop an individualized person-centered service plan to overcome challenges to receiving services. This plan focuses on behaviors, both favorable and those that jeopardize the member's well-being and includes a design approach of incremental plans and addenda that allows the member to achieve stepwise successes in behavior modification.

(B) The AA may implement a person-centered service plan without the member's signature when mental health/behavioral issues prevent the member from controlling his or her behavior to act in his or her own interest. When the member, by virtue of level of care and the IDT assessment, needs ADvantage services to ensure his or her health and safety, the AA may authorize the person-centered service plan when the case manager demonstrates effort to work with and obtain the member's agreement. Should negotiations not result in agreement with the person-centered service plan, the member may withdraw his or her request for services or request a fair hearing.

(4) Consumer-Directed Personal Assistance Services and Supports (CDPASS) planning and supports coordination.

(A) CDPASS offers ADvantage members personal choice and control over the delivery of their in-home support service, including who provides the services and how services are provided. Members or their legal representatives have singular "employer authority" in decision-making and are responsible to recruit, hire, train, supervise and when necessary, terminate the individuals who furnish their services. They also have "budget authority" to determine how expenditures of their expense accounts are managed.

(B) Members who elect the CDPASS service option receive support from Consumer-Directed Agent/Case Manager (CDPASS CM) in directing their services. The CDPASS CM– liaison between the member and the program assists members, identifying potential requirements and supports as they direct their services and supports. ADvantage case management providers deliver required support and assign the CD-PASS members a case manager trained on the ADvantage CDPASS service option, independent living philosophy, person centered service planning, the role of the member as employer of record, the individual budgeting process and service plan

development guidelines. A case manager, who has completed specialized CDPASS training, is referred to as a CDPASS CM with respect to the service planning and support role when working with CDPASS members. The CDPASS CM educates the member about his or her rights and responsibilities as well as community resources, service choices and options available to the member to meet CDPASS service goals and objectives.

(C) The ADvantage case management provider is responsible for ensuring that case managers serving members who elect to receive or are receiving the CDPASS service option have successfully completed CDPASS certification training in its entirety and have a valid CDPASS CM certification issued by the AA.

(D) Consumer-directed, SoonerCare (Medicaid)-funded programs are regulated by federal laws and regulations setting forth various legal requirements with which states must comply. The ADvantage case management provider is responsible for ensuring that CDPASS CMs in their employment provide services to CDPASS members consistent with certification guidelines following federal, state, and Waiver requirements. Non-adherence may result in remediation for the case management provider, the case manager, or both, up to and including decertification.

(E) Members may designate a family member or friend as an authorized representative to assist in the service planning process and in executing member employer responsibilities. When the member chooses to designate an authorized representative, the designation and agreement, identifying the willing adult to assume this role and responsibility, is documented with dated signatures of the member, the designee, and the member's case manager, or AA staff.

(i) A person having guardianship or power of attorney or other court-sanctioned authorization to make decisions on behalf of the member has legal standing to be the member's designated authorized representative.

(ii) An individual hired to provide CDPASS services to a member may not be designated the authorized representative for the member.

(iii) The case manager reviews the designation of authorized representative, power of attorney, and legal guardian status on an annual basis and includes this in the reassessment packet to AA.

(F) The CDPASS CM provides support to the member in the person-centered CDPASS planning process. Principles of person-centered planning are listed in (i) through (v) of the subparagraph.

(i) The member is the center of all planning activities.

(ii) The member and his or her representative, or support team are given the requisite information to assume a controlling role in the development, implementation, and management of the member's services.

(iii) The member and those who know and care about him or her are the fundamental sources of information and decision-making.

(iv) The member directs and manages a planning process that identifies his or her strengths, capacities, preferences, desires, goals, and support needs.

(v) Person-centered planning results in personally-defined outcomes.

(G) The CDPASS CM encourages and supports the member, or as applicable his or her designated authorized representative, to lead, to the extent feasible, the CDPASS service planning process for personal services assistance. The CDPASS CM helps the

member define support needs, service goals, and service preferences including access to and use of generic community resources. Consistent with member-direction and preferences, the CDPASS CM provides information and helps the member locate and access community resources. Operating within the constraints of the Individual Budget Allocation (IBA) units, the CDPASS CM assists the member to translate the assessment of member needs and preferences into an individually tailored, person-centered service plan.

(H) To the extent the member prefers, the CDPASS CM develops assistance to meet member needs using a combination of traditional personal care and CDPASS Personal Service Assistant (PSA) services. However, the CDPASS IBA and the PSA unit authorization is reduced proportionally to agency personal care service utilization.

(I) The member determines with the PSA to be hired, a start date for PSA services. The member coordinates with the CDPASS CM to finalize the person-centered service plan. The start date must be after:

(i) authorization of services;

(ii) completion and approval of the background checks; and

(iii) completion of the member employee packets.

(J) Based on outcomes of the planning process, the CDPASS CM prepares an ADvantage person-centered service plan or plan amendment to authorize CDPASS personal service assistance units consistent with this individual plan and notifies existing duplicative personal care service providers of the end-date for those services.

(K) When the plan requires an Advanced Personal Service Assistant (APSA) to provide assistance with health maintenance activities, the CDPASS CM works with the member and, as appropriate, arranges for training by a skilled nurse for the member or member's family and the APSA to ensure that the APSA performs the specific health maintenance tasks safely and competently, when the member's APSA was providing Advanced Supportive Restorative Assistance to the member for the same tasks in the period immediately prior to being hired as the APSA, additional documentation of competence is not required.

(L) The CDPASS CM monitors the member's well-being and the quality of supports and services and assists the member in revising the PSA services plan as needed. When the member's need for services changes due to a change in health/disability status and/or a change in the level of support available from other sources to meet needs, the CDPASS CM, based upon an updated assessment, amends the person-centered service plan to modify CDPASS service units appropriately to meet the additional need and submits the plan amendment to the AA for authorization and update of the member's IBA.

(M) In the event of a disagreement between the member and CDPASS provider the following process is followed:

(i) either party may contact via the toll-free number to obtain assistance with issue resolution;

(ii) when the dispute cannot be resolved by AA protocol, it is heard by the Ethics of Care Committee. The Ethics of Care Committee makes a final determination regarding dispute settlement; or

(iii) at any step of this dispute resolution process the member may request a fair hearing to appeal the dispute resolution decision.

(N) The CDPASS CM and the member prepare an emergency backup response capability for CDPASS PSA/APSA services in the event a PSA/APSA services provider essential to the individual's health and welfare fails to deliver services. As part of the backup planning process, the CDPASS CM and member define what failure of service or neglect of service tasks constitutes a risk to health and welfare to trigger implementation of the emergency backup when (i) or (ii) may be used. Identification of:

(i) a qualified substitute provider of PSA/APSA services and preparation for their quick response to provide backup emergency services, including execution of all qualifying background checks, training, and employment processes; and/or

(ii) one (1) or more qualified substitute ADvantage agency service providers, adult day health, personal care, or nursing facility (NF) respite provider, and preparation for quick response to provide backup emergency services.

(O) To obtain authorizations for providers other than PSA and APSA identified as emergency backups, the CDPASS CM requests the AA authorize and facilitate member access to adult day health, agency personal care, or NF respite services.

(5) The CDPASS case manager submits the person-centered service plan to the CDPASS case management supervisor for review. The CDPASS case management supervisor conducts the review/approval of the plans from the CDPASS case manager or returns the plans to the CDPASS case manager with notations of errors, problems, and concerns to be addressed. The CDPASS case manager re-submits the corrected person-centered service plan to the CDPASS case management supervisor. The CDPASS case management supervisor returns the approved person-centered service plan to the CDPASS case manager. Within one-business (1-business) day of receiving supervisory approval, the case manager submits, the person-centered service plan to the AA. Only priority service needs and supporting documentation may be submitted to the AA as a "Priority" case with justification attached. "Priority" service needs are defined as services needing immediate authorization to protect the health and welfare of the member and/or avoid premature admission to the NF. Corrections to service conditions set by the AA are not considered a priority unless the health and welfare of the member would otherwise be immediately jeopardized and/or the member would otherwise require premature admission to a NF.

(6) Within one-business (1-business) day of notification of care plan and person-centered service plan authorization, the CDPASS case manager communicates with the service plan providers and member to facilitate service plan implementation. Within seven-business (7-business) days of notification of an initial person-centered service plan or a new reassessment service plan authorization, the CDPASS case manager visits the member, gives the member a copy of the person-centered service plan and evaluates the service plan implementation progress. The CDPASS case manager evaluates service plan implementation on the following minimum schedule:

(A) within thirty-calendar (30-calendar) days of the authorized effective date of the person-centered service plan or service plan amendment; and

(B) monthly after the initial thirty-calendar (30-calendar) days follow-up evaluation date.

(b) **Authorization of service plans and amendments to service plans**. The AA authorizes the individual person-centered service plan and all service plan amendments for each ADvantage member. When the AA verifies member ADvantage eligibility, service plan cost effectiveness

for service providers that are ADvantage authorized and SoonerCare contracted, and that the delivery of ADvantage services are consistent with the member's level of care need, the service plan is authorized.

(1) Except as provided by the process per Oklahoma Administrative Code (OAC) 317:30-5-761, family members may not receive payment for providing ADvantage waiver services. A family member is defined as an individual who is legally responsible for the member, such as the spouse or ~~or~~ legal guardian.

(2) When a complete service plan authorization or amendment request is received and the service plan is within cost-effectiveness guidelines, the AA authorizes or denies authorization within seven-business (7-business) days of receipt of the request. When the service plan is not within cost-effectiveness guidelines, the plan is referred for administrative review to develop an alternative cost-effective plan or assist the member to access services in an alternate setting or program. When the request packet is incomplete, the AA notifies the case manager immediately and puts a hold on authorization until the requirements are received from case management.

(3) The AA authorizes the service plan by entering the authorization date. Notice of authorization of the service plan is available through the appropriate designated software or web-based solution. AA authorization determinations are provided to case management within one-business (1-business) day of the authorization date. A person-centered service plan may be authorized and implemented with specific services temporarily denied. The AA communicates to case management the conditions for approval of temporarily denied services. The case manager submits revisions for denied services to AA for approval within seven-business (7-business) days.

(4) For audit purposes including Program Integrity reviews, the authorized service plan is documentation of service authorization for ADvantage waiver and State Plan Personal Care services. Federal or State quality review and audit officials may obtain a copy of specific person-centered service plans with original signatures by submitting a request to the member's case manager.

(c) **Change in service plan**. The process for initiating a change in the person-centered service plan is described in this subsection.

(1) The service provider initiates the process for an increase or decrease in service to the member's person-centered service plan. The requested changes and justification are documented by the service provider and, when initiated by a direct care provider, are submitted to the member's case manager. When in agreement, the case manager submits the service changes within seven-business (7-business) days of the assessed need. The AA authorizes or denies the person-centered service plan changes, per OAC 317:35-17-14.

(2) The member initiates the process for replacing personal care services with CDPASS services. The member may contact the AA to process requests for CDPASS services.

(3) A significant change in the member's physical condition or caregiver support, one that requires additional goals, deletion of goals or goal changes, or requires a four-hour (4-hour) or more adjustment in services per week, requires an updated UCAT reassessment by the case manager. The case manager develops and submits an amended or new person-centered service plan, as appropriate, for authorization.

(4) One (1) or more of the following changes or service requests require an Interdisciplinary Team review and service plan goals amendment:

(A) the presence of two (2) or more ADvantage members residing in the same household; or

(B) the member and personal care provider residing together; or

(C) a request for a family member or legal representative to be a paid ADvantage service provider.

(5) Based on the reassessment and consultation with the AA as needed, the member may, as appropriate, be authorized for a new person-centered service plan or be eligible for a different service program. When the member is significantly improved from the previous assessment and does not require ADvantage services, the case manager obtains the member's dated signature indicating voluntary withdrawal for ADvantage program services. When unable to obtain the member's consent for voluntary closure, the case manager requests AA assistance. The AA requests that the OKDHS nurse initiate a reconsideration of level of care.

(6) Providers of Home and Community Based Services (HCBS) for the member, or those who have an interest in or are employed by a provider of HCBS for the member, must not provide case management or develop the person-centered service plan, except when the State demonstrates the only willing and qualified entity to provide case management and develop person-centered service plans in a geographic area also provides HCBS.

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TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 55. MANAGED CARE

SUBCHAPTER 3. GENERAL PROGRAM INFORMATION

317:55-3-1. Mandatory, voluntary, and excluded populations

(a) **Mandatory populations.** The following SoonerCare Eligibles will be mandatorily enrolled with a CE and DBM under the SoonerSelect Dental and Medical program:

(1) Expansion adults;
(2) Parents and caretaker relatives;
(3) Pregnant women;
(4) Deemed newborns;
(5) Former foster children;
(6) Juvenile justice involved children;
(7) Foster care children;
(8) Children receiving adoption assistance; and
(9) Children.

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

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

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

(1) Dual-eligible individuals;
(2) Individuals enrolled in the Medicare Savings Program, including Qualified Medicare Beneficiaries (QMB), Specified Low Income Medicare Beneficiaries (SLMB), Qualified Disabled Workers (QDW) and Qualified Individuals (QI);
(3) Persons with a nursing facility or ICF-IID level of care, except for Enrollees with a pending level of care determination;
(4) Individuals during a period of presumptive eligibility;
(5) Individuals infected with tuberculosis Eligible for tuberculosis-related services under 42 C.F.R. § 435.215;
(6) Individuals determined Eligible for SoonerCare on the basis of needing treatment for breast or cervical cancer under 42 C.F.R. § 435.213;
(7) Individuals enrolled in a § 1915(c) Waiver;

(8) Undocumented persons Eligible for emergency services only in accordance with 42 C.F.R. § 435.139;
(9) Insure Oklahoma Employee Sponsored Insurance (ESI) dependent children in accordance with the Oklahoma Medicaid State Plan;
(10) Coverage of Pregnancy-Related Services under Title XXI for the benefit of unborn children ('Soon- to-be-Sooners'), as allowed by 42 C.F.R. § 457.10; and
(11) Individuals determined Eligible for Medicaid on the basis of age, blindness, or disability.
(12) Individuals enrolled in the SoonerPlan family planning program.

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

317:55-3-2. Enrollment and disenrollment process

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

(1) **Selection/auto assignment.** During the application process, at OHCA's discretion, an Applicant may have up to ~~sixty (60)~~thirty (30) days to select a contracted CE and DBM of their choice. Applicants who are Eligible to choose a CE and DBM and fail to make an election on the SoonerCare application, within the allotted timeframe, will be assigned to the CE and DBM that is due next to receive an auto assignment.

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

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

(i) The CE's maximum enrollment has been capped and actual enrollment has reached ninety-five percent (95%) of the cap;
(ii) The CE has been excluded from receiving new enrollment due to the application of non-compliance remedies; or
(iii) The CE has failed to meet readiness review requirements.

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

(i) The DBM's maximum enrollment has been capped and actual enrollment has reached ninety-five percent (95%) of the cap;
(ii) The DBM has been excluded from receiving new enrollment due to the imposition of administrative remedies; or
(iii) The DBM has failed to meet readiness review requirements.

(3) **Enrollment effective date**

(A) Eligibles, with the exception of deemed newborns, who select or are assigned to a CE and/or DBM from the first day of the month through the fifteenth day of the month shall be enrolled effective on the first day of the following month.
(B) Eligibles who select or are assigned to a CE and/or DBM on the sixteenth (16th) day of the month through the last day of the month will be enrolled effective on the first day of the second following month.

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

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

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

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

(A) The SoonerSelect Medical Enrollee:

(i) Is disenrolled due to loss of SoonerCare eligibility;

(ii) Becomes a foster child under custody of the state;

(iii) Becomes juvenile justice involved under the custody of the state;

(iv) Is a former foster care or child receiving adoption assistance and opts to enroll in the SoonerSelect Children's Specialty program;

(v) Demonstrates good cause under the following conditions:

(I) The Enrollee moves out of the service area;

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

(III) The plan does not cover the service the Enrollee seeks, because of moral or religious objections;

(IV) The Enrollee needs related services to be performed at the same time; not all related services are available within the CE's network; and the Enrollee's primary care provider or another provider determines that receiving the services separately would subject the Enrollee to unnecessary risk;

(V) For other reasons, including a filed and prevailed grievance related to poor quality of care, lack of access to services covered under the Contract, or lack of access to providers experienced in dealing with the Enrollee's oral health care needs or other matters deemed sufficient to warrant disenrollment; and

(VI) The Enrollee has been enrolled in error, as determined by the OHCA.

(vi) Experiences a temporary loss of eligibility or enrollment which caused the Enrollee to miss the annual disenrollment period, then the Enrollee may disenroll without cause upon reenrollment; or

(vii) The OHCA has imposed intermediate sanctions on the CE and allows Enrollees to disenroll without cause.

(B) The SoonerSelect Dental Enrollee:

(i) Is disenrolled due to loss of SoonerCare eligibility;

(ii) Demonstrates good cause under the following conditions:

(I) The Enrollee moves out of the service area;

(II) The plan does not cover the service the Enrollee seeks, because of moral or religious objections;

(III) The Enrollee needs related services to be performed at the same time; not all related services are available within the DBM's network; and the Enrollee's primary care dental provider or another provider determines that receiving the services separately would subject the Enrollee to unnecessary risk;

(IV) For other reasons, including a filed and prevailed grievance related to poor quality of care, lack of access to services covered under the Contract, or lack of access to providers experienced in dealing with the Enrollee's oral health care needs or other matters deemed sufficient to warrant disenrollment; and

(V) The Enrollee has been enrolled in error, as determined by the OHCA.

(iii) Experiences a temporary loss of eligibility or enrollment which caused the Enrollee to miss the annual disenrollment period, then the Enrollee may disenroll without cause upon reenrollment; or

(iv) The DBM is terminated.

(5) **Annual and special enrollment periods.** Sixty (60) days prior to the start of the Enrollee's annual open enrollment period, the Enrollee shall be notified of the option to maintain enrollment with the current CE and/or DBM or to enroll with a different CE and/or DBM. OHCA, at its sole discretion, may schedule a special open enrollment period, under the following circumstances:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) Loss of eligibility for Medicaid;

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

(iii) Enrollee becomes enrolled in Medicare;

(iv) Death;

(v) Enrollee becomes a foster child under the custody of the state;
(vi) Enrollee becomes juvenile justice involved under the custody of the state;
(vii) The Enrollee becomes an inmate of a public institution;
(viii) The Enrollee commits fraud or provides fraudulent information; or
(ix) Disenrollment is ordered by a hearing officer or court of law.

(B) The OHCA will initiate disenrollment of SoonerSelect Dental Enrollees under the following circumstances:
(i) Loss of eligibility for Medicaid;
(ii) Transition to a SoonerCare eligibility group excluded from the SoonerSelect Dental program;
(iii) Enrollee becomes enrolled in Medicare;
(iv) Death;
(v) The Enrollee becomes an inmate of a public institution;
(vi) The Enrollee commits fraud or provides fraudulent information; or
(vii) Disenrollment is ordered by a hearing officer or court of law.

(4) **Disenrollment effective date**. Consistent with 42 C.F.R. § 438.56(e), except as provided for below, and unless OHCA determines that a delay would have an adverse effect on an Enrollee's health, it is OHCA's intent that a disenrollment shall be effective no later than the first day of the second following month.

(A) Grievance resolution for poor quality of care, lack of access to services covered under the Contract or lack of access to providers experienced in dealing with the Enrollee's health care needs or other matters deemed sufficient to warrant disenrollment under (b)(2) of this Section must be completed within this timeframe. If the CE fails to complete the grievance process in time to permit disenrollment by OHCA, the disenrollment shall be considered approved for the effective date that would have been established had the CE complied with this timeframe. Disenrollment for any of the following reasons shall be effective as of the date that the Enrollee's SoonerSelect Medical program eligibility status changes:
(i) Loss of eligibility for Medicaid;
(ii) Transition to a SoonerCare eligibility group excluded from the SoonerSelect program;
(iii) Enrollee becomes a foster child under the custody of the state;
(iv) Enrollee becomes JJ Involved under the custody of the state;
(v) Enrollee becomes eligible for Medicare;
(vi) Death;
(vii) Enrollee becomes an inmate of a public institution;
(viii) Enrollee commits fraud or provides fraudulent information;
(ix) Disenrollment is ordered by a hearing officer or court of law; or
(x) Enrollee requiring long-term care.

(I) Enrollees requiring long-term care in a nursing facility or ICF-IID shall be disenrolled from the CE when the level of care determination is finalized.

(II) For additional information regarding nursing facility and ICF-IID stays, refer to the Contract.

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

(i) Loss of eligibility for Medicaid;

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

(iii) SoonerSelect Dental Enrollee becomes eligible for Medicare;

(iv) Death;

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

(vi) SoonerSelect Dental Enrollee commits Fraud or provides fraudulent information;

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

(viii) SoonerSelect Dental Enrollees requiring long-term care in a nursing facility or ICF-IID shall be disenrolled from the Contractor when the level of care determination being done by the SoonerSelect or SoonerSelect Children's Specialty CEs is complete.

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

(c) **Retroactive dual eligibility.** Dual eligibles are excluded from the SoonerSelect program. SoonerSelect Enrollees who become dual eligible individuals will be disenrolled as of their Medicare eligibility effective date.

(1) In the event a SoonerSelect Enrollee becomes retroactively Medicare eligible, the CE or DBM shall recover claims payments made to providers during the months of retroactive Medicare eligibility.

(2) The CE or DBM shall also notify the provider of the requirement to submit the claim to Medicare for reimbursement.

(3) OHCA will recoup the capitation payments paid for months of retroactive Medicare eligibility.

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

(e) **Eligibles voluntarily opting out of SoonerSelect Children's Specialty Program.** FFC and children receiving adoption assistance shall be enrolled in the SoonerSelect Children's Specialty Program. These Eligibles may opt-out of enrollment in the Children's Specialty Program; however, the legal guardian of the Eligible will be required to enroll the Eligible with a CE.

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

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PART 9. LONG TERM CARE

317:30-5-133.2. Ancillary services

~~(a)~~ Ancillary services are those items which are not considered routine services. Ancillary services may be billed separately to the SoonerCare program, unless reimbursement is available from Medicare or other insurance or benefit programs. ~~Coverage criteria, utilization controls and program limitations are specified in Part 17 of OAC 317:30-5. Ancillary services are limited to the following services:~~

~~(1) Services requiring prior authorization:~~

~~(A) External breast prosthesis and support accessories.~~

~~(B) Ventilators and supplies.~~

~~(C) Total Parenteral Nutrition (TPN), and supplies.~~

~~(D) Custom seating for wheelchairs.~~

~~(2) Services not requiring prior authorization:~~

~~(A) Permanent indwelling or male external catheters and catheter accessories.~~

~~(B) Colostomy and urostomy supplies.~~

~~(C) Tracheostomy supplies.~~

~~(D) Catheters and catheter accessories.~~

~~(E) Oxygen and oxygen concentrators.~~

~~(i) PRN Oxygen. Members in nursing facilities requiring oxygen PRN will be serviced by oxygen kept on hand as part of the per diem rate.~~

~~(ii) Billing for Medicare eligible members. Oxygen supplied to Medicare eligible nursing home members may be billed directly to OHCA. It is not necessary to obtain a denial from Medicare prior to filing the claim with OHCA.~~

~~(b) Items not considered ancillary, but considered routine and covered as part of the routine rate include but are not limited to:~~

~~(1) Diapers.~~

~~(2) Underpads.~~

~~(3) Medicine cups.~~

~~(4) Eating utensils.~~

~~(5) Personal comfort items.~~

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PART 3. HOSPITALS

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.
(14) For rapid whole genome sequencing, refer to OAC 317:30-5-47.7.

317:30-5-47.7 Rapid whole genome sequencing; inpatient hospitals

(a) **Coverage**. Rapid whole genome sequencing is covered for members who meet the following criteria. This service includes testing for the member and one or two biological parents.

(1) The member is under 21 years of age;
(2) The member has a complex or acute illness of unknown etiology, that is not confirmed to be an environmental exposure, toxic ingestion, infection with normal response to therapy, or trauma; and
(3) The member is receiving inpatient hospital services in an intensive care unit or other high acuity unit.

(b) **Billing**. Rapid whole genome sequencing must be billed on an outpatient claim. All rapid whole genome sequencing, including any parental testing, must be performed on behalf of a member who meets the criteria in (a) and should be filled under that member's SoonerCare member ID number.
(c) **Reimbursement**. Rapid whole genome sequencing may be reimbursed separately from the DRG pursuant to the Oklahoma Medicaid State Plan for members receiving services at an inpatient hospital. Services will be reimbursed according to the APC fee schedule.
(d) **Out-of-state hospitals**. Rapid whole genome sequencing provided to eligible members, when treated in out-of-state inpatient hospitals, may be reimbursed in the same manner as in-state hospitals. Out-of-state inpatient hospitals must meet applicable out-of-state conditions of payment set forth in OAC 317:30-3-89 through 317:30-3-92, and in the Oklahoma Medicaid State Plan.

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PART 19. CERTIFIED NURSE MIDWIVES

317:30-5-229. Reimbursement

In accordance with the Omnibus Budget Reconciliation Act of 1993, effective October 1, 1993, certified nurse midwife services include maternity services, as well as services outside the maternity cycle within the scope of their practice under state law.

~~(1) Medical verification of pregnancy is required. A written statement from the physician or certified nurse midwife verifying the applicant is pregnant and the expected date of delivery is acceptable. Pregnancy may also be verified by submission of a copy of a laboratory report indicating the individual is pregnant.~~

~~(2) Newborn charges billed on the mother's person code will be denied.~~

~~(3)~~(1) Providers must use ~~OKDHS Form FSS-NB-1 or the eNB1 application on the Secure Website to notify the county DHS office of the child's birth~~the NODOS/NB1 form (found on the OHCA website at https://oklahoma.gov/ohca/providers/forms.html) for a newborn child delivered by a SoonerCare member. A claim may then be filed for charges for the newborn under the case number and the newborn's name and assigned person code. Newborn charges billed on the mother's person code will be denied.

~~(4)~~(2) Obstetrical care should be billed using the appropriate CPT codes for Maternity Care and Delivery. The date of delivery should be used as the date of service for charges for total obstetrical care. Inclusive dates of care should be indicated on the claim form as part of the description. The date the patient was first seen must be on the claim form. Payment for total obstetrical care includes all routine care performed by the attending provider. For payment of total OB care, the provider must have provided care for more than one trimester. To bill for prenatal care only, the claim is filed after the member leaves the provider's care. Payment for routine or minor medical problems will not be made separately to the OB provider outside of antepartum visits. The antepartum care during the prenatal care period includes all care by the OB provider except major illness distinctly unrelated to the pregnancy.

PART 87. BIRTHING CENTERS

317:30-5-890. Eligible providers

Eligible providers are freestanding birthing centers that are not currently licensed as a hospital and meet the following requirements:

(1) Must be accredited by the Commission for the Accreditation of Birth Centers (CABC);

(2) Have a current contract with the Oklahoma Health Care Authority;

(3) Have a current written agreement with a board-certified Obstetrician-Gynecologist (OB-GYN) to provide coverage for consultation, collaboration, or referral services;

(4) Have a current SoonerCare-contracted clinical director who is a physician, certified nurse midwife (CNM), advanced practice registered nurse (APRN), or licensed midwife and is responsible for establishing patient protocols and other functions as defined in requirements for state licensure. This individual may, or may not, be the physician providing individual

patient coverage for consultation, collaborative, or referral service; and

(5) Have a written agreement with a referral hospital which is a Class II hospital. Class II hospital is defined as a facility with 24-hour availability of OB-GYN and capability of performing a C-section within 30 minutes of the decision to operate. The 30-minute timeframe is subject to each hospital's unique circumstance, logistical issues that include, but are not limited to, obtaining informed consent, transporting the patient, and any other potential problems that may arise.

317:30-5-890.1. Definitions

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

"Birthing center" means a freestanding facility, place, or institution, which is maintained or established primarily for the purpose of providing services of a licensed midwife, certified nurse-midwife, or licensed medical doctor to assist or attend a woman in delivery and birth, and where a woman is scheduled in advance to give birth following a normal, uncomplicated, low-risk pregnancy.

"Certified Midwife" means an individual with a non-nursing graduate degree, educated in midwifery, and certified by the American Midwifery Certification Board (AMCB) who is not a Nurse-Midwife.

"Certified Nurse Midwife" means a person educated in the discipline of nursing and midwifery, certified by the American College of Nurse-Midwives (ACNM), and licensed by the state to engage in the practice of midwifery and as an Advanced Practice Registered Nurse (APRN).

"Certified Professional Midwife" means an individual that graduated from an accredited midwifery program or apprenticeship and is certified by the North American Registry of Midwives (NARM).

"Licensed Midwife" means a Certified Professional Midwife or Certified Midwife who is licensed by the state under 59 O.S. § 3040.6 to engage in the practice of midwifery.

"Low-risk" means a normal, uncomplicated pregnancy with expectation of a normal, uncomplicated birth as defined by generally accepted criteria of maternal and fetal health.

"Newborn" means an infant during the first 28 days following birth.

"Normal" means, as applied to pregnancy, labor, delivery, the postpartum period, and the newborn period, circumstances under which a licensed provider has determined that the member does not have a condition that requires obstetrical intervention.

317:30-5-891. Coverage by category

(a) **Adults and children.** Birthing center services are covered and include admission to the birthing center of low-risk, normal, uncomplicated pregnancies, with an anticipated normal, spontaneous vaginal delivery for the period of labor and delivery.

(b) **Newborn.** Coverage for newborns includes those services within the scope of practice of the provider as defined by state law.

(c) **Individuals eligible for Part B of Medicare.** Birthing center services provided to Medicare eligible recipients should be billed directly to the fiscal agent.

317:30-5-892. Reimbursement

Birthing centers will be reimbursed a facility charge determined by the Ambulatory Payment

Classification (APC) fee schedule maintained by CMS. The facility charge represents payment in full for birthing center services. Separate payment will be made for lab services and midwife or physician obstetrical care, delivery, and postpartum care as appropriate.

317:30-5-893. Billing

Billing for birthing center services will be on UB-04. Claims must be submitted in accordance with guidelines found at OAC 317:30-3-11 and 317:30-3-11.1.

PART 114. DOULA SERVICES

317:30-5-1217. General coverage

(a) **Covered benefits.**

(1) **Prenatal/postpartum visits.** There is a total of eight (8) visits allowed for the member. The doula must work with the member to determine how best to utilize the benefit to meet the needs of the member.

(2) **Labor and delivery.** There is one (1) visit allowed, regardless of the duration.

(b) **Visit requirements.**

(1) The minimum visit length is sixty (60) minutes.

(2) Visits must be face-to-face.

(A) Prenatal and postpartum visits may be conducted via telehealth.

(B) Labor and delivery services may not be conducted via telehealth.

(c) **Service locations.**

(1) **Prenatal and postpartum.**

(A) Doulas must coordinate directly with the member and their family to determine the most appropriate service location for prenatal and postpartum visits.

(B) Service locations may include the following:

(i) Member's place of residence;

(ii) Doula's office;

(iii) Physician's office;

(iv) Hospital; or

(v) In the community.

(2) **Labor and delivery services.** There is no coverage for home birth(s).

(d) **Referral requirements.** Doula services must be recommended by a physician or other licensed practitioner of the healing arts who is operating within the scope of their practice under State law.

(1) The following providers may recommend doula services:

(A) Obstetricians;

(B) Certified Nurse ~~Midwifes~~Midwives;

(C) Physicians;

(D) Physician Assistants; ~~or~~

(E) ~~Certified Nurse Practitioners.~~Advanced Practice Registered Nurses; or

(F) Licensed Midwives.

(2) The SoonerCare Referral Form must be completed and submitted, noting the recommendation for doula services.

(e) **Prior authorization (PA) requirements.**

(1) A PA is not required to access the standard doula benefit package.

(2) A PA may be submitted, for members with extenuating medical circumstances, if there is need for additional visits beyond the eight (8) prenatal/postpartum visits.

(f) **Medical records requirements.** The medical record must include, but is not limited to, the following:

(1) Date of service;

(2) Person(s) to whom services were rendered;

(3) Start and stop time for the service(s);

(4) Specific services performed by the doula on behalf of the member;

(5) Member/family response to the service;

(6) Any new needs identified during the service; and

(7) Original signature of the doula, including the credentials of the doula.

(g) **Auditing review**. All doula services are subject to post-payment reviews and audits by the OHCA.

(h) **Reimbursement.**

(1) All doula services, that are outlined in Part 114 of this Chapter, are reimbursed per the methodology established in the Oklahoma Medicaid State Plan.

(2) There are no allotted incentive payments.

PART 116. LICENSED MIDWIVES

317:30-5-1235. Eligible Providers

Eligible Providers shall:

(1) Have and maintain one of the following midwifery certifications;

(A) Certified Midwife certification issued by the American Midwifery Certification Board (AMCB) or;

(B) Certified Professional Midwife issued by the North American Registry of Midwives (NARM).

(2) Have and maintain a current license by the Oklahoma State Department of Health as described in Section 3040.6 of Title 59 of Oklahoma Statutes and OAC 310:395-7-2; and

(3) Have a current contract with the Oklahoma Health Care Authority (OHCA).

317:30-5-1236. Covered Services

(a) **Adults and children**. OHCA covers medical services (as described in OAC 317:30-5, Part 1, Physicians) provided in a birthing center by a licensed midwife when rendered within their licensure and scope of practice as defined by state law and regulations. Coverage includes obstetrical care such as antepartum care, delivery, postpartum care, and care of the normal newborn.

(b) **Newborns**. OHCA covers medical services for newborns (as described in OAC 317:30-5, Part 1, Physicians) provided in a birthing center by a licensed midwife when rendered within their licensure and scope of practice as defined by state law and regulations. Services are covered for the newborn during the first six (6) weeks following birth, unless care is transferred to a physician or advanced practice registered nurse specializing in the care of infants and children.

(c) **Limitations**. Medical services rendered by licensed midwives are subject to the same limitations described in OAC 317:30-5, Part 1, Physicians. There is no coverage for home births.

317:30-5-1237. Reimbursement

(a) **Payment**. Payment for covered services (as described in OAC 317:30-5-1226) to eligible providers (as described in OAC 317:30-5-1225) shall be made when the same service would have been covered if ordered or performed by a physician. Payment to licensed midwives is made at 80% of the physician fee schedule for the rendered service. Payment for lab and imaging services ordered by licensed midwives is made at 100% of the physician fee schedule.

(b) **Billing**.

(1) **Adults and children**. Obstetrical care should be billed using the appropriate CPT codes for Maternity Care and Delivery. The date of delivery should be used as the date of service for charges for total obstetrical care. Inclusive dates of care should be indicated on the claim form as part of the description. The date the patient was first seen must be on the claim form. Payment for total obstetrical care includes all routine care performed by the attending provider. For payment of total OB care, the provider must have provided care for more than one trimester. To bill for prenatal care only, the claim is filed after the member leaves the provider's care. Payment for routine or minor medical problems will not be made separately to the OB provider outside of antepartum visits. The antepartum care during the prenatal care period includes all care by the OB provider except major illness distinctly unrelated to the pregnancy.

(2) **Newborns**. Providers must complete the NODOS/NB1 form (found on the OHCA website at https://oklahoma.gov/ohca/providers/forms.html) for a newborn child delivered by a SoonerCare member. A claim may then be filed for charges for the newborn under the case number and the newborn's name and assigned person code. Charges billed on the mother's person code for services rendered to the child will be denied.

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PART 35. RURAL HEALTH CLINICS

317:30-5-354. Definitions

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

"**APRN**" means advanced practice registered nurse.

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

"**CLIA**" means the Clinical Laboratory Improvement Amendments.

"**CMS**" means the Centers for Medicare and Medicaid Services.

"**CNM**" means certified nurse midwife.

"Core services" means outpatient services that may be covered when furnished to a patient at the rural health clinic (RHC) or other location, including the patient's place of residence. Services include those defined in OAC 317:30-5-355.2.

"**CP"** means clinical psychologist.

"**CPT**" means current procedural terminology.

"**CSW**" means clinical social worker.

"EPSDT" means the Early and Periodic Screening, Diagnostic and Treatment program for members under twenty-one (21)**.**

"FFS" means the current OHCA's fee-for-service reimbursement rate.

"**HCPCS**" means Healthcare Common Procedure Coding System.

"Marriage and family therapist" means the definition given to the same term in Section 1861(lll)(2) of the Social Security Act (42 U.S.C § 1395x(lll)(2)).

"Mental Health counselor" means the definition given to the same term in Section 1861(lll)(4) of the Social Security Act (42 U.S.C § 1395(lll)(4)).

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

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

"Other ambulatory services" means other outpatient health services covered under the Oklahoma Medicaid State Plan other than the core services listed in OAC 317:30-5-355.2.

"**PA**" means physician assistant.

"Physician" means:

(A) A doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which the function is performed or who is a licensed physician employed by the Public Health Service;

(B) Within limitations as to the specific services furnished, a doctor of dentistry or dental, a doctor of optometry when performing medical services that are reasonable and necessary for the diagnosis and treatment of illness or injury, ~~or~~ a doctor of podiatry when performing medical services that are reasonable and necessary for the diagnosis and treatment of illness or injury, or a chiropractor who meets the qualifications defined in 42 CFR 410.21 when performing the services described in 42 CFR 410.21(b).

"Physicians' services" means professional services that are performed by a physician at the RHC (or are performed away from the Center, excluding inpatient hospital services) whose

agreement with the RHC provides that he or she will be paid by the RHC for such services.

"PPS" means prospective payment system all-inclusive per visit rate method specified in the Oklahoma Medicaid State Plan.

"**RHC"** means rural health clinic.

"Visit" means a face-to-face encounter between a clinic patient and a physician, Physician Assistant (PA), Advanced Practice Registered Nurse (APRN), Certified Nurse Midwife (CMN), Clinical Psychologist (CP), ~~or~~ Clinical Social Worker (CSW), Marriage and Family Therapist (MFT), or Mental Health Counselor (MHC) whose services are reimbursed under the RHC PPS payment method. Encounters with more than one (1) health care professional and multiple encounters with the same health care professional that take place on the same day and at a single location constitute a single visit, except when the patient, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment. Services delivered via audio-only telecommunications and reimbursed pursuant to the fee-for-service (FFS) fee schedule do not constitute a visit and/or an encounter.

317:30-5-355.2. Covered services

The Rural Health Center benefit package, as described in 42 C.F.R. § 440.20, consists of RHC services and other ambulatory services.

(1) **RHC services.** RHC services are covered when medically necessary and furnished at the clinic or other outpatient setting, including the member's place of residence, delivered via telehealth, or via audio-only telecommunications pursuant to Oklahoma Administrative Code (OAC) 317:30-3-27 and OAC 317:30-3-27.1.

(A) **Core services.** RHC ~~"~~core~~"~~ services include, but are not limited to:

(i) Services furnished by a physician, Physician Assistant (PA), Advanced Practice Registered Nurse (APRN), Certified Nurse Midwife ~~(CMN)~~(CNM), Clinical Psychologist (CP), ~~or~~ Clinical Social Worker (CSW), Marriage and Family Therapist (MFT), or Mental Health Counselor (MHC).

(ii) Services and supplies incident to services provided by a physician, PA, APRN, CNM, CP, ~~or~~ CSW, MFT, or MHC are covered in accordance with 42 C.F.R §§ 405.2413 and 405.2415, if the service or supply is:

(I) Furnished in accordance with State law;

(II) A type commonly furnished in physicians' offices;

(III) A type commonly rendered either without charge or included in the RHC's bill;

(IV) Furnished as an incidental, although integral, part of a physician's professional services, PA, APRN, CNM, CP ~~or~~ CSW, MFT, or MHC; or

(V) Furnished under the direct supervision of a contracted physician, PA, APRN, or CNM; and

(VI) Drugs and biologicals which cannot be self-administered or are specifically covered by Medicare law, are included within the scope of RHC services. Drugs and biologicals commonly used in life saving procedures, such as analgesics, anesthetics (local), antibiotics, anticonvulsants, antidotes and emetics, serums and toxoids are not billed separately.

(iii) Visiting nurse services to the homebound are covered if:

(I) The RHC is located in an area in which the Secretary of Health and Human Services has determined there is a shortage of home health agencies;

(II) The services are rendered to members who are homebound;
(III) The member is furnished nursing care on a part-time or intermittent basis by a registered nurse, licensed practical nurse, or licensed vocational nurse who is employed by or receives compensation for the services from the RHC; and
(IV) The services are furnished under a written plan of treatment as required by 42 C.F.R § 405.2416.
(iv) Certain virtual communication services.

(B) **Preventive services.** In addition to the professional services of a physician, and services provided by an APRN, PA, and CNM which would be covered as RHC services under Medicare, certain primary preventive services are covered under the SoonerCare RHC benefit. The services must be furnished by or under the direct supervision of an RHC practitioner who is a clinic employee:
(i) Prenatal and postpartum care;
(ii) Screening examination under the EPSDT program for members under twenty-one (21);
(iii) Family planning services; and
(iv) Medically necessary screening mammography and follow-up mammograms.

(C) **Off-site services.** RHC services provided off-site of the clinic are covered if the RHC has a compensation arrangement with the RHC practitioner. SoonerCare reimbursement is made to the RHC and the RHC practitioner receives his or her compensation from the RHC. The RHC must have a written contract with the physician and other RHC "core" practitioners that specifically identify how the RHC services provided off-site are to be billed to SoonerCare. It is expected that services provided in off-site settings are, in most cases, temporary and intermittent, i.e., when the member cannot come to the clinic due to health reasons.

(2) **Other ambulatory services.** Other ambulatory services that may be provided by an RHC include non-primary care services covered by the Oklahoma Medicaid State Plan but are not included in the RHC's core services. These services are separately billable and may be provided by the RHC if the RHC meets the same standards as other contracted providers of those services.

(A) Other ambulatory services include, but are not limited to:
(i) Dental services for members under the age of twenty-one (21) provided by a qualified provider other than a licensed dentist;
(ii) Optometric services provided by a qualified provider other than a licensed optometrist;
(iii) Laboratory tests performed in the RHC lab, including the lab tests required for RHC certification;
(I) Chemical examinations of urine by stick or tablet method or both (including urine ketones);
(II) Hemoglobin or hematocrit;
(III) Blood glucose;
(IV) Examination of stool specimens for occult blood;
(V) Pregnancy tests; and
(VI) Primary culturing for transmittal to a certified laboratory.

(iv) Technical component of diagnostic tests such as x-rays and EKGs (interpretation of the test provided by the RHC physician is included in the encounter rate);
(v) Durable medical equipment;
(vi) Transportation by ambulance;
(vii) Prescribed drugs;
(viii) Prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags) and supplies directly related to colostomy care and the replacement of such devices;
(ix) Specialized laboratory services furnished away from the clinic;
(x) Inpatient services;
(xi) Outpatient hospital services; ~~and~~
(xii) Applied behavior analysis (ABA); and
(xiii) Diabetes self-management education and support (DSMES) services.

(B) Services listed in (2)(A) of this Section, furnished on-site, require a separate provider agreement(s) with the OHCA. Service item (2)(A)(iii) does not require a separate contract when furnished on-site, however, certain conditions of participation apply. (Refer to OAC 317:30-5-361 for conditions.)

317:30-5-356. Coverage for adults

Payment is made to RHCs for adult services as set forth in this Section.

(1) **RHC services.** Payment is made for one (1) encounter per member per day. Payment is also limited to four (4) visits per member per month. This limit may be exceeded if the SoonerCare Choice member has elected the RHC as his/her/their Patient Centered Medical Home/Primary Care Provider. Preventive service exceptions include:

(A) **Obstetrical care.** An RHC should have a written contract with its physician, PA, APRN, or CNM that specifically identifies how obstetrical care will be billed to SoonerCare, in order to avoid duplicative billing situations. The agreement should also specifically identify the physician's compensation for RHC and other ambulatory services.

(i) If the clinic compensates the physician, PA, APRN, or CNM to provide obstetrical care, then the clinic must bill the SoonerCare program for each prenatal visit using the appropriate CPT evaluation and management codes.
(ii) If the clinic does not compensate its practitioners to provide obstetrical care, then the independent practitioner must bill the OHCA for prenatal care according to the global method described in the SoonerCare provider specific rules for physicians, PAs, APRNs and CNMs (refer to OAC 317:30-5-22).
(iii) Under both billing methods, payment for prenatal care includes all routine or minor medical problems. No additional payment is made to the prenatal provider except in the case of a major illness distinctly unrelated to pregnancy.

(B) **Family planning services.** Family planning services are available only to members with reproductive capability. Family planning visits do not count as one (1) of the four (4) RHC visits per month.

(2) **Other ambulatory services.** These services are not considered a part of an RHC visit; therefore, these may be billed to the SoonerCare program by the RHC or service provider on the appropriate claim form. Refer to OAC 317:30-1, General Provisions, and OAC 317:30-3-

57, 317:30-5-59, and 317:30-3-60 for general coverage and exclusions under the SoonerCare program. Some specific limitations are applicable to other ambulatory services as set forth in specific provider rules and excerpted as follows:

~~(A) Coverage under optometrists for adults is limited to treatment of eye disease not related to refractive errors.~~

~~(B)~~(A) There is no coverage for eye exams for the purpose of prescribing eyeglasses, contact lenses or other visual aids. (See OAC 317:30-5-431.)

317:30-5-359.2. Reimbursement

(a) **Provider-based clinics.** Payments for provider-based clinics will be made for RHC ~~"~~core~~"~~ services listed in OAC 317:30-5-355.2 based on an all-inclusive visit fee established by one of the following:

(1) An interim rate established by calculating a statewide average rate for RHCs in the state; and

(2) The statewide average rate will be updated annually by the increase in the Medicare Economic Index (MEI); or

(3) An Alternative Payment Methodology (APM) established by the RHC periodic rate notification from the Medicare Fiscal Intermediary. In order to receive this rate, the RHC must submit a copy of the periodic rate notification letter for its most recent full cost reporting year received from the fiscal intermediary to the state. The APM rate cannot be lower than mentioned above in (a)(1) or (a)(2).

(b) **Independent clinics.** Payments for independent clinics will be made for RHC ~~"~~core~~"~~ services listed in OAC 317:30-5-355.2 based on an all-inclusive visit fee established by one of the following:

(1) An interim rate established by calculating a statewide average rate for RHCs in the state; and

(2) The statewide average rate will be updated annually by the increase in the MEI; or

(3) An APM established by the RHCs periodic rate notification from the Medicare Fiscal Intermediary. In order to receive this rate, the RHC must submit a copy of the periodic rate notification letter for its most recent full cost reporting year received from the fiscal intermediary to the state. The APM rate cannot be lower than mentioned above in (b)(1) or (b)(2).

PART 75. FEDERALLY QUALIFIED HEALTH CENTERS

317:30-5-659. Definitions

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

"**APRN**" means advanced practice registered nurse.

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

"**CLIA**" means the Clinical Laboratory Improvement Amendments.

"**CMS**" means the Centers for Medicare and Medicaid Services.

"**CNM**" means certified nurse midwife.

"Core services" means outpatient services that may be covered when furnished to a patient at the Center or other location, including the patient's place of residence. Services include those defined in OAC 317:30-5-661.1.

"**CPT**" means current procedural terminology.

"**CSW**" means clinical social worker.

"Encounter" or **"visit"** means a face-to-face contact between an approved health care professional as authorized in the FQHC pages of the Oklahoma Medicaid State Plan and an eligible SoonerCare member for the provision of defined services through a Health Center within a twenty-four (24) hour period ending at midnight, as documented in the patient's medical record.

"FFS" means the current OHCA's fee-for-service reimbursement rate.

"FQHC" means Federally Qualified Health Center.

"**HHS**" means the U.S. Department of Health and Human Services.

"**HRSA**" means the Health Resources and Services Administration.

"Licensed behavioral health professional (LBHP)" means any of the following practitioners:

(A) An allopathic or osteopathic physician with a current license and board certification in psychiatry or board eligible in the state in which services are provided, or a current resident in psychiatry practicing as described in OAC 317:30-5-2.

(B) A practitioner with a current license to practice in the state in which services are provided, within one (1) of the areas of practice listed in (i) through (vi).

(i) Psychology;

(ii) Social work (clinical specialty only);

(iii) Professional counselor;

(iv) Marriage and family therapist;

(v) Behavioral practitioner; or

(vi) Alcohol and drug counselor.

(C) An advanced practice registered nurse certified in a psychiatric mental health specialty, and licensed as a registered nurse (RN) with a current certification of recognition from the board of nursing in the state in which services are provided.

(D) A physician assistant who is licensed and in good standing in the state and has received specific training for and is experienced in performing mental health therapeutic, diagnostic, or counseling functions.

"Marriage and family therapist (MFT)" means the definition given to the same term in Section 1861(lll)(2) of the Social Security Act (42 U.S.C § 1395x(lll)(2)).

"Mental health counselor (MHC)" means the definition given to the same term in Section 1861(lll)(4) of the Social Security Act (42 U.S.C § 1395(lll)(4)).

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

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

"Other ambulatory services" means other health services covered under the Oklahoma Medicaid State Plan other than the core services listed in OAC 317:30-5-661.1.

"**PA**" means physician assistant.

"Physician" means:

(A) A doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which the function is performed or who is a licensed physician employed by the Public Health Service;

(B) Within limitations as to the specific services furnished, a doctor of dentistry or dental, a doctor of optometry when performing medical services that are reasonable and necessary for the diagnosis and treatment of illness or injury, ~~or~~ a doctor of podiatry when performing medical services that are reasonable and necessary for the diagnosis and

treatment of illness or injury, or a chiropractor who meets the qualifications defined in 42 CFR 410.21 when performing the services described in 42 CFR 410.21(b).

"Physicians' services" means professional services that are performed by a physician at the Health Center (or are performed away from the Center, excluding inpatient hospital services) whose agreement with the Center provides that he or she will be paid by the Health Center for such services.

"PPS" means prospective payment system all-inclusive per visit rate method specified in the Oklahoma Medicaid State Plan.

317:30-5-661.1. Coverage of core services

Health Center services are covered for SoonerCare adults and children as set forth in this Part, unless otherwise specified.

(1) Services furnished by a physician, PA, APRN, CNM, CP, ~~or~~ CSW, MFT, or MHC.

(2) Services and supplies incident to services provided by a physician, PA, APRN, CNM, CP, ~~or~~ CSW, MFT, or MHC are covered in accordance with 42 C.F.R '' 405.2413 and 405.2415, if the service or supply is:

(A) Furnished in accordance with State law;

(B) A type commonly furnished in physicians' offices;

(C) A type commonly rendered either without charge or included in the FQHC's bill;

(D) Furnished as an incidental, although integral, part of ~~a~~ physician, PA, APRN, CNM, CP ~~or~~ CSW, MFT, or MHC services; or

(E) Furnished under the direct supervision of a physician, PA, APRN, or CNM; and

(F) Drugs and biologicals which cannot be self-administered or are specifically covered by Medicare law, are included within the scope of FQHC services. Drugs and biologicals commonly used in life saving procedures, such as analgesics, anesthetics (local), antibiotics, anticonvulsants, antidotes and emetics, serums and toxoids are not billed separately.

(G) "Services and supplies incident to" include but are not limited to services such as minor surgery, reading x-rays, setting casts or simple fractures and other activities that involve evaluation or treatment of a patient's condition. They also include laboratory services performed by the Health Center, specimen collection for laboratory services furnished by an off-site CLIA certified laboratory and injectable drugs.

(3) Visiting nurse services to the homebound are covered if:

(A) The FQHC is located in an area in which the Secretary of Health and Human Services has determined there is a shortage of home health agencies;

(B) The services are rendered to members who are homebound;

(C) The member is furnished nursing care on a part-time or intermittent basis by a registered nurse, licensed practical nurse, or licensed vocational nurse who is employed by or receives compensation for the services from the FQHC; and

(D) The services are furnished under a written plan of treatment as required by 42 C.F.R ' 405.2416.

(4) Preventive primary services in accordance with 42 C.F.R ' 405.2448;

(5) Medical nutrition services in accordance with OAC 317:30-5-1075 through 317:30-5-1076; and

(6) Preventive primary dental services.

317:30-5-661.5. Health Center preventive primary care services

(a) Preventive primary care services, as described in 42 C.F.R ' 405.2448, are those health services that:

(1) A Health Center is required to provide as preventive primary health services under section 330 of the Public Health Service Act;

(2) Are furnished by or under the direct supervision of a physician, PA, APRN, CNM, CP, CSW, MFT, MHC or other approved health care professional as authorized in the approved FQHC State Plan pages;

(3) Are furnished by a member of the Health Center's health care staff who is an employee of the Center or provides services under arrangements with the Center; and

(4) Includes only drugs and biologicals that cannot be self-administered.

(b) Preventive primary care services which may be paid for when provided by Health Centers include:

(1) Medical social services;
(2) Nutritional assessment and referral;
(3) Preventive health education;
(4) Children's eye and ear examinations;
(5) Prenatal and post-partum care;
(6) Perinatal services;
(7) Well child care, including periodic screening (refer to OAC 317:30-3-65);
(8) Immunizations, including tetanus-diphtheria booster and influenza vaccine;
(9) Family planning services;
(10) Taking patient history;
(11) Blood pressure measurement;
(12) Weight;
(13) Physical examination targeted to risk;
(14) Visual acuity screening;
(15) Hearing screening;
(16) Cholesterol screening;
(17) Stool testing for occult blood;
(18) Dipstick urinalysis;
(19) Risk assessment and initial counseling regarding risks;
(20) Tuberculosis testing for high risk patients;
(21) Clinical breast exam;
(22) Referral for mammography; and
(23) Thyroid function test.
(24) Dental services (specified procedure codes).

(c) Primary care services do not include:

(1) Health education classes, or group education activities, including media productions and publications, group or mass information programs;

(2) Eyeglasses, hearing aids or preventive dental services (except under EPSDT);

(3) Screening mammography provided at a Health Center unless the Center meets the requirements as specified in OAC 317:30-5-900; and

(4) Vaccines covered by the Vaccines for Children program (refer to OAC 317:30-5-14).

317:30-5-664.3. FQHC encounters

(a) FQHC encounters that are billed to the Oklahoma Health Care Authority (OHCA) must meet the definition in this Section and are limited to services covered by OHCA. Only encounters provided by an authorized health care professional listed in the approved FQHC State Plan pages within the scope of their licensure trigger a Prospective Payment System (PPS) encounter rate.
(b) An encounter is defined as a face-to-face contact between a health care professional and a member for the provision of defined services through a FQHC within a twenty-four (24) hour period ending at midnight, as documented in the member's medical record. Services delivered via audio-only telecommunications do not constitute an encounter.
(c) An FQHC may bill for one (1) medically necessary encounter per twenty-four (24) hour period when the appropriate modifier is applied. Medical review will be required for additional visits for children. For information about multiple encounters, refer to Oklahoma Administrative Code (OAC) 317:30-5-664.4. Payment is limited to four (4) visits per member per month for adults. This limit may be exceeded if the SoonerCare Choice member has elected the FQHC as his/her/their Patient Centered Medical Home/Primary Care Provider.
(d) Services considered reimbursable encounters (including any related medical supplies provided during the course of the encounter) include:

(1) Medical;
(2) Diagnostic;
(3) Dental, medical and behavioral health screenings;
(4) ~~Vision~~Optometry;
(5) Physical therapy;
(6) Occupational therapy;
(7) Podiatry;
(8) Behavioral health;
(9) Speech;
(10) Hearing;
(11) Medically necessary FQHC encounters with a registered nurse or licensed practical nurse and related medical supplies (other than drugs and biologicals) furnished on a part-time or intermittent basis to home-bound members (refer to OAC 317:30-5-661.3); and
(12) Any other medically necessary health services (i.e. optometry and podiatry) are also reimbursable as permitted within the FQHCs scope of services when medically reasonable and necessary for the diagnosis or treatment of illness or injury, and must meet all applicable coverage requirements.

(e) Services and supplies incident to the services of a physician, PA, APRN, CNM, CP, ~~and~~ CSW, MFT, and MHC are reimbursable within the encounter, as described in 42 C.F.R § 405.2413 and OAC 317:30-5-661.1.
(f) Only drugs and biologicals which cannot be self-administered are included within the scope of this benefit.

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

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

(1) Services provided by an independently Clinical Laboratory Improvement Amendments certified and enrolled laboratory;
(2) Radiology services including nuclear medicine and diagnostic ultrasound services;
(3) Venipuncture for lab tests is considered part of the encounter and cannot be billed separately. When a member is seen at the clinic for a lab test only, use the appropriate Current Procedural Terminology code. A visit for "lab test only" is not considered a Center encounter;
(4) Medical supplies, equipment, and appliances not generally provided during the course of a Center visit such as diabetic supplies. However, gauze, band-aids, or other disposable products used during an office visit are considered as part of the cost of an encounter and cannot be billed separately under SoonerCare;
(5) Supplies and materials that are administered to the member are considered a part of the physician's or other health care practitioner's service;
(6) Drugs or medication treatments provided during a clinic visit are included in the encounter rate. For example, a member has come into the Center with high blood pressure and is treated at the Center with a hypertensive drug or drug samples provided to the Center free of charge are not reimbursable services and are included in the cost of an encounter. Prescriptions are not included in the encounter rate and must be billed through the pharmacy program by a qualified enrolled pharmacy;
(7) Administrative medical examinations and report services;
(8) Emergency services including delivery for pregnant members that are eligible under the Non-Qualified (ineligible) provisions of OAC 317:35-5-25;
(9) SoonerPlan family planning services;
(10) Long-acting reversible contraceptive devices (devices are not considered part of the FQHC encounter rate and can be billed separately);
(11) Optometry and podiatric services other than ~~for dual eligible for Part B of Medicare~~medical services that are reasonable and necessary for the diagnosis and treatment of illness or injury;
(12) Diabetes self-management education and support (DSMES) services (refer to OAC 317:30-5-1080 through 317:30-5-1084); and
(13) Other services that are not defined in this rule or the Oklahoma Medicaid State Plan.

(b) In addition, the following limitations and requirements apply to services provided by FQHCs:
(1) Physician services are not covered in a hospital; and
(2) Behavioral health case management and psychosocial rehabilitation services are limited to FQHCs enrolled under the provider requirements in OAC 317:30-5-240 and contracted with OHCA as an outpatient behavioral health agency.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 110. INDIAN HEALTH SERVICES, TRIBAL PROGRAMS, AND URBAN INDIAN CLINICS (I/T/Us)

317:30-5-1096. Off-site services

I/T/U covered services provided off-site or outside of the I/T/U setting, including but not limited to hospice services, mobile clinics, or places of residence, are compensable at the OMB rate ~~when billed by an I/T/U that has been designated as a Federally Qualified Health Center~~. The I/T/U must meet provider participation requirements listed in OAC 317:30-5-1088. I/T/U off-site services may be covered if the services rendered were within the provider's scope of practice and are of the same integrity of services rendered at the I/T/U facility.

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TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 61. HOME HEALTH AGENCIES

317:30-5-550. Paid Family Caregiver

Paid Family Caregiver (PFC) is a service that allows a family member of the qualifying child, i.e., parent, parent-in-law, sibling, grandparent, guardian, an individual related by blood and/or marriage, and any other individual with a close association that is the equivalent of a family relationship; to work for a home care agency, as a complex caregiver, to provide home care services to qualified children under the age of twenty-one (21). Individuals eligible to provide PFC services shall be employed by the home health agency as a complex caregiver. PFC services are provided:

(1) In the member's primary residence, unless it is medically necessary for the complex caregiver to accompany the individual in the community.

(2) In accordance with the Oklahoma Nursing Practice Act, § 567.3a, complex caregiver may provide care to qualifying members under the direction and supervision of a Registered Nurse or Licensed Practical Nurse, through a home care agency.

(A) The complex caregiver is prohibited from driving a vehicle during transportation.

(B) PFC services are not available for non-routine extended home absences unrelated to medically necessary treatment or medical care. [Refer to Oklahoma Administrative Code 317:30-5-558(4) and (13)].

(C) PFC hours authorized by OHCA and/or SoonerSelect may total up to forty (40) hours per week and are authorized concurrently with any PDN hours. PFC hours are not authorized in addition to PDN hours.

317:30-5-551. Eligible providers

(a) A home health agency that elects to employ and train complex caregivers and be reimbursed by SoonerCare for paid family caregiver (PFC) services must meet the following requirements prior to providing services to eligible SoonerCare members:

(1) The agency must be fully contracted with OHCA as a provider; and,

(2) The agency must meet the requirements of Oklahoma Administrative Code (OAC) 317:30-5-545; and,

(3) The agency must be licensed by the Oklahoma State Health Department (OSDH) as a home care agency.

(b) The complex caregiver must meet the following requirements:

(1) must be at least eighteen (18) years of age;

(2) must pass criminal and abuse registry background checks.

(c) The complex caregiver, employed by the agency, must receive eighty (80) hours of training, competency evaluation, and other qualification criteria as a complex caregiver, including but not limited to:

(1) Agency New Employee Orientation;

(2) Communicating with the Care Team;

(3) Documentation;

(4) Safety Care;
(5) Medications;
(6) Respiratory Care;
(7) Neurological care;
(8) Nutrition;
(9) Genitourinary care;
(10) Integumentary care; and
(11) Social Determinants of Health

317:30-5-552. Coverage by category

(a) **Adults.** SoonerCare does not cover adults [twenty-one (21) years of age and over] for paid family caregivers.

(b) **Children**. SoonerCare covers children [under twenty-one (21) years of age] if:

(1) The member is eligible for SoonerCare; and

(2) The Oklahoma Health Care Authority (OHCA) determines the service is medically necessary. Medical necessity is determined in accordance with Oklahoma Administrative Code (OAC) 317:30-5-560.1.

317:30-5-553. Paid Family Caregiver (PFC) coverage limitations

Coverage limitations at OAC 317:30-5-558 are applicable to all PFC services.

317:30-5-554. How Paid Family Caregiver (PFC) services are authorized

PFC services may be initiated after completion of steps outlined in OAC 317:30-5-559.

317:30-5-554.1. Treatment plan

(a) The treatment plan for a member receiving paid family caregiver services must meet requirements outlined in OAC 317:30-5-560.

(b) The treatment plan will be incorporated into the treatment plan request for members receiving PFC services.

317:30-5-554.2. Prior authorization requirements

Prior authorization requirements outlined in OAC 317:30-5-560.1 applicable to paid family caregiver services.

317:30-5-554.3. Record documentation

Documentation for paid family caregiver services must include the caregiver's credentials and meet all other requirements listed at OAC 317:30-5-560.2.

PART 62. PRIVATE DUTY NURSING

317:30-5-555. Private Duty Nursing (PDN)

PDN is medically necessary care provided on a regular basis by a licensed practical nurse or registered nurse. During any given period of service, a nurse may only provide care to the eligible member. PDN is the level of care that would routinely be provided by the nursing staff of a hospital or skilled nursing facility. PDN services are provided:

(1) In the member's primary residence, unless it is medically necessary for a nurse to accompany the individual in the community.

(A) The individual's place of residence is wherever the individual lives, whether the residence is the individual's own dwelling, a relative's home, or other type of living arrangement. The place of residence cannot include a hospital, nursing facility, or intermediate care facility for
individuals with intellectual disabilities (ICF/IID).

(B) The place of service in the community cannot include the residence or business location of the provider of PDN services unless the provider of PDN is a live-in caregiver.

(2) To assist during transportation to routine, Medicaid compensable health care appointments and/or to the nearest appropriate emergency room.

(A) The private duty nurse may not drive the vehicle during transportation.

(B) PDN services are not available for non-routine extended home absences unrelated to medically necessary treatment or medical care. [Refer to Oklahoma Administrative Code 317:30-5-558(4) and (13)].

317:30-5-556. Eligible providers

(a) A home health agency that desires to be reimbursed by SoonerCare or SoonerSelect for private duty nursing (PDN) must meet the following requirements prior to providing services to eligible SoonerCare members:

(1) The agency must be fully contracted with OHCA as a provider; and,

(2) The agency must meet the requirements of Oklahoma Administrative Code (OAC) 317:30-5-545, and it must be licensed by the Oklahoma State Health Department (OSDH) as a home care agency.

(b) The provider of PDN services, within the agency, must be a licensed practical nurse or a registered nurse who is currently licensed and in good standing in the state in which services are provided.

317:30-5-557. Coverage by category

(a) **Adults.** SoonerCare does not cover adults [twenty-one (21) years of age and over] for private duty nursing (PDN) with the exception of subsection (c).

(b) **Children.** SoonerCare or SoonerSelect does cover children [under twenty-one (21) years of age] if:

(1) The member is eligible for SoonerCare or SoonerSelect; and

(2) The Oklahoma Health Care Authority (OHCA), or OHCA's Contracted Entity, in its discretion, deems the services medically necessary. Medical necessity is determined in accordance with Oklahoma Administrative Code (OAC) 317:30-5-560.1.

(c) **Individuals eligible for Part B of Medicare**. Payment is made utilizing ~~the~~ SoonerCare allowable for comparable services.

(d) **1915(c) home and community-based services (HCBS) waivers.** If private duty nursing services are provided, they will be defined within each waiver and must be prior authorized.

317:30-5-558. Private duty nursing (PDN) coverage limitations

The following provisions apply to all PDN services and provide coverage limitations:

(1) All services must be prior authorized to receive payment from the Oklahoma Health Care Authority (OHCA), or through SoonerSelect. 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~~Recertification of a treatment plan is required at least every 60 days to request PDN services in accordance with OAC 317:30-5-560.1 and must:

(A) be signed by the physician [medical doctor (MD), or doctor of osteopathy, (DO)], a physician assistant (PA), or advanced practice registered nurse (APRN)]; and

(B) include documentation for Private Duty Nursing and/or Paid Family Caregiver services covering the previous ten (10) days for ongoing record review.

(3) An assessment by an OHCA ~~care management~~or SoonerSelect 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**. Audio-only telephonic communication;

(B) **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.** 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 week granted in the prior authorization is not SoonerCare compensable. Prior-authorized but unused service hours cannot be accumulated for use at a future date or time. If such hours or services are provided, they are not SoonerCare or SoonerSelect 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 or SoonerSelect compensate an organization for nursing staff time when sleeping.

(8) OHCA and SoonerSelect 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 or the SoonerSelect Contracted Entity 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 or SoonerSelect 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) or to the SoonerSelect Contracted Entity with the required data elements and the treatment plan;

(3) An assessment (telephonic, virtual, or face-to-face) has been conducted by an OHCA care management or SoonerSelect nurse, per OAC 317:30-5-558 (3); and

(4) An OHCA or SoonerSelect 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 PDN assessment.

317:30-5-560.1. Prior authorization requirements

(a) ~~Authorizations~~For children ages zero to three (0-3), authorizations are provided for a maximum period of six (6) months. For children ages three to twenty (3-20), authorizations are provided for a maximum period of one (1) year.

(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 or SoonerSelect 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 or SoonerSelect 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 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 7. PHARMACIES

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

(a) The 340B Drug Discount Program is a drug-pricing program established under section 256b of Title 42 of the United States Code (U.S.C) under which a manufacturer of covered outpatient drugs agrees that it will not charge a 340B covered entity more than the 340B price for a 340B covered outpatient drug.
(b) Covered entities participating in the 340B Drug Discount Program will adhere to the following provisions outlined in this Section and as defined in 42 U.S.C. §256b. Covered entities must:

(1) Notify the OHCA Pharmacy Department in writing within thirty (30) days of any changes in 340B Program participation, as well as any changes in name, address, National Provider Identification (NPI), SoonerCare Provider Number, etc.
(2) Maintain their status on the Health Resources & Services Administration (HRSA) Medicaid Exclusion File (MEF) and report any changes to the OHCA within thirty (30) days.
(3) Execute a contract addendum with the OHCA in addition to their provider contract.
(4) Drugs designated by OHCA as 340B Carve Out Drugs shall be prohibited from being dispensed or administered to Oklahoma Medicaid members if purchased at 340B prices. Drugs that may be designated by OHCA as 340B Carve Out Drugs are:

(A) Cell and gene therapies;
(B) Drugs currently under a value based agreement; or
(C) Brand Preferred Drugs where the cost to the Oklahoma Medicaid program is $500,000 or higher, annually.

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

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

(3) If a 340B covered entity fails to pay quarterly adjustments invoiced by OHCA within forty-five (45) days of receipt, it may result in a debt to the State of Oklahoma subject to applicable interest pursuant to prompt payment methodology at OAC 260:10-3-3.
(4) The quarterly adjustments invoiced, including applicable interest, must be paid regardless of any disputes made by the covered entity. If a covered entity fails to pay OHCA the adjustments invoiced within forty-five (45) days of receipt, the adjustments invoiced and applicable interest will be deducted from the facility's payment.

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

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

SUBCHAPTER 3. GENERAL PROVISIONS

PART 3. GENERAL MEDICAL PROGRAM INFORMATION

317:30-3-57. General SoonerCare coverage - categorically needy

The following are general SoonerCare coverage guidelines for the categorically needy:

(1) Inpatient hospital services.

(A) Adult coverage for inpatient hospital stays as described at Oklahoma Administrative Code (OAC) 317:30-5-41.

(B) Coverage for members under twenty-one (21) years of age is not limited. All admissions must be medically necessary. All psychiatric admissions require prior authorization for an approved length of stay.

(2) Emergency department services.

(3) Dialysis in an outpatient hospital or freestanding dialysis facility.

(4) Outpatient therapeutic radiology or chemotherapy for proven malignancies or opportunistic infections.

(5) Outpatient surgical services - facility payment for selected outpatient surgical procedures to hospitals which have a contract with the Oklahoma Health Care Authority (OHCA).

(6) Outpatient mental health services for medical and remedial care including services provided on an outpatient basis by certified hospital-based facilities that are also qualified mental health clinics.

(7) Rural health clinic services and other ambulatory services furnished by rural health clinic.

(8) Optometrists' services - only as listed in Subchapter 5, Part 45, Optometrist specific rules of this Chapter.

(9) Maternity clinic services.

(10) Outpatient diagnostic x-rays and lab services. Other outpatient services provided to adults, not specifically addressed, are covered only when prior authorized by the Agency's Medical Authorization Unit.

(11) Medically necessary screening mammography. Additional follow-up mammograms are covered when medically necessary.

(12) Long-term care facility services (other than services in an institution for tuberculosis or mental diseases).

(13) Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) are available for members under twenty-one (21) years of age to provide access to regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth. Federal regulations also require that diagnosis and treatment be provided for conditions identified during a screening whether or not they are covered under the State Plan, as long as federal funds are available for these services. These services must be necessary to ameliorate or correct defects and physical or mental illnesses or conditions and require prior authorization. EPSDT/OHCA child-health services are outlined in OAC 317:30-3-65.2 through 317:30-3-65.12.

(A) EPSDT screening examinations for eligible children by a medical or osteopathic physician, physician assistant, or advanced practice nurse practitioner.

(B) Diagnostic x-rays, lab, and/or injections when prescribed by a provider.
(C) Immunizations.
(D) Outpatient care.
(E) Dental services as outlined in OAC 317:30-3-65.8.
(F) Optometrists' services. The EPSDT periodicity schedule provides for at least one (1) visual screening and glasses each twelve (12) months. In addition, payment is made for glasses for children with congenital aphakia or following cataract removal. Interperiodic screenings and glasses at intervals outside the periodicity schedule for optometrists are allowed when a visual condition is suspected. Payment is limited to two (2) glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.
(G) Hearing services as outlined in OAC 317:30-3-65.9.
(H) Prescribed drugs.
(I) Outpatient psychological services as outlined in OAC 317:30-5-275 through 317:30-5-278.
(J) Inpatient psychiatric services as outlined in OAC 317:30-5-94 through 317:30-5-97.
(K) Transportation. Provided when necessary in connection with examination or treatment when not otherwise available.
(L) Inpatient hospital services.
(M) Medical supplies, equipment, appliances, orthotics and prosthetics.
(N) EPSDT services furnished in a qualified child health center.

(14) Family planning services and supplies for members of child-bearing age, including counseling, insertion of intrauterine device, implantation of subdermal contraceptive device, and sterilization for members twenty-one (21) years of age and older who are legally competent, not institutionalized and have signed the "Consent Form" at least thirty (30) days prior to procedure. Reversal of sterilization procedures for the purposes of conception is not covered. Reversal of sterilization procedures are covered when medically indicated and substantiating documentation is attached to the claim.

(15) Physicians' services whether furnished in the office, the member's home, a hospital, a long-term care facility, intermediate care facilities for individuals with intellectual disabilities (ICF/IID), or elsewhere. For adults, payment is made for compensable hospital days described at OAC 317:30-5-41. ~~Office visits for adults are limited to four (4) per month except when in connection with conditions as specified in OAC 317:30-5-9(b).~~

(16) Medical care and any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law. See applicable provider section for limitations to covered services for:

(A) Podiatrists' services;
(B) Optometrists' services;
(C) Psychologists' services;
(D) Certified registered nurse anesthetists;
(E) Certified nurse midwives;
(F) Advanced practice registered nurses; and
(G) Anesthesiologist assistants.

(17) Freestanding ambulatory surgery centers.

(18) Prescribed drugs not to exceed a total of six (6) prescriptions with a limit of two (2) brand name prescriptions per month. Exceptions to the six (6) prescription limit are:

(A) Unlimited medically necessary monthly prescriptions for:

(i) Members under the age of twenty-one (21) years; and

(ii) Residents of long-term care facilities or ICF/IID.

(B) Seven (7) medically necessary generic prescriptions per month in addition to the six (6) covered under the State Plan (including three (3) brand name prescriptions) are allowed for adults receiving services under the 1915(c) home and community-based services (HCBS) waivers. These additional medically necessary prescriptions beyond the three (3) brand name or thirteen (13) total prescriptions are covered with prior authorization.

(19) Rental and/or purchase of medical supplies, equipment, and appliances.

(20) Adaptive equipment, when prior authorized, for members residing in private ICF/IID's.

(21) Dental services for members residing in private ICF/IID's in accordance with the scope of dental services for members under age twenty-one (21).

(22) For non-expansion adults, prosthetic devices are limited to catheters and catheter accessories, colostomy and urostomy bags and accessories, tracheostomy accessories, nerve stimulators, hyperalimentation and accessories, home dialysis equipment and supplies, external breast prostheses and support accessories, oxygen/oxygen concentrator equipment and supplies, respirator or ventilator equipment and supplies, and those devices inserted during the course of a surgical procedure. There is no coverage for orthotic devices for adults.

(23) Orthotics and prosthetics, including prosthetic hearing implants and ocular prosthetics, are covered for expansion adult members, above the limitations within (22) of this Section, when prescribed by the treating provider (physician, physician assistant, or an advanced practice registered nurse) and medical necessity is documented in accordance with OAC 317:30-5-211.13.

(24) Standard medical supplies.

(25) Eyeglasses under EPSDT for members under age twenty-one (21). Payment is also made for glasses for children with congenital aphakia or following cataract removal. Payment is limited to two (2) glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.

(26) Blood and blood fractions for members when administered on an outpatient basis.

(27) Inpatient services for members age sixty-five (65) or older in institutions for mental diseases, limited to those members whose Medicare, Part A benefits are exhausted for this particular service and/or those members who are not eligible for Medicare services.

(28) Long-term care facility services, limited to members preauthorized and approved by OHCA for such care.

(29) Inpatient psychiatric facility admissions for members are limited to an approved length of stay with provision for requests for extensions.

(30) Transportation and subsistence (room and board) to and from providers of medical services to meet member's needs (ambulance or bus, etc.), to obtain medical treatment.

(31) Extended services for pregnant women including all pregnancy-related and postpartum services to continue to be provided, as though the women were pregnant, for twelve (12) months after the pregnancy ends regardless of the reason, beginning on the last date of pregnancy.

(32) Long-term care facility services for members under twenty-one (21) years of age.

(33) Personal care in a member's home, prescribed in accordance with a plan of treatment and rendered by a qualified person under supervision of a registered nurse (RN).

(34) Medicare Part A, Part B, and Part C deductibles, coinsurance, and copays.
(35) HCBS for the intellectually disabled.
(36) Home health services can be provided without a PA for the first thirty-six (36) visits. A PA will be required beyond the 36th ~~36th~~ visit. The visits are limited to any combination of RN and nurse aide visits.
(37) Medically necessary solid organ and bone marrow/stem cell transplantation services for children and adults are covered services based upon the conditions listed in (A)-(D) of this paragraph:

(A) All transplantation services, except kidney and cornea, must be prior authorized;

(B) All transplant procedures are reviewed and prior authorization is based upon appropriate medical criteria;

(C) All organ transplants must be performed at a Medicare approved transplantation center;

(D) Procedures considered experimental or investigational are not covered. For more information regarding experimental or investigational including clinical trials, see OAC 317:30-3-57.1; and

(E) Donor search and procurement services are covered for transplants consistent with the methods used by the Medicare program for organ acquisition costs.

(38) HCBS for intellectually disabled members who were determined to be inappropriately placed in a long-term care facility (Alternative Disposition Plan - ADP).
(39) Case management services for the chronically and/or seriously mentally ill.
(40) Emergency medical services, including emergency labor and delivery for undocumented or ineligible aliens.
(41) Services delivered in Federally Qualified Health Centers (FQHCs). Payment is made on an encounter basis.
(42) Early intervention services for children ages zero (0) to three (3).
(43) Residential behavior management in therapeutic foster care setting.
(44) Case management services through the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS).
(45) HCBS for aged or physically disabled members.
(46) Outpatient ambulatory services for members infected with tuberculosis.
(47) Smoking and tobacco use cessation counseling for children and adults.
(48) Services delivered to American Indians/Alaskan Natives (AI/AN) in Indian Health Services, Tribal Programs, and Urban Indian Clinics (I/T/Us). Payment is made on an encounter basis.
(49) OHCA contracts with designated agents to provide disease state management for individuals diagnosed with certain chronic conditions. Disease state management treatments are based on protocols developed using evidence-based guidelines.
(50) Residential substance use disorder (SUD) services.
(51) Medication-assisted treatment (MAT) services.
(52) Diabetes self-management education and support (DSMES).

317:30-3-59. General program exclusions - adults

The following are excluded from SoonerCare coverage for adults:
(1) Inpatient admission for diagnostic studies that could be performed on an outpatient basis.
(2) Services or any expense incurred for cosmetic surgery.

(3) Services of two (2) physicians for the same type of service to the same member on the same day, except when supplemental skills are required and different specialties are involved.
(4) Refractions and visual aids.
(5) Pre-operative care within twenty-four (24) hours of the day of admission for surgery and routine post-operative care as defined under the global surgery guidelines promulgated by Current Procedural Terminology (CPT) and the Centers for Medicare and Medicaid Services (CMS).
(6) Sterilization of members who are under twenty-one (21) years of age, mentally incompetent, or institutionalized or reversal of sterilization procedures for the purposes of conception.
(7) Non-therapeutic hysterectomies.
(8) Induced abortions, ~~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~~ except as authorized pursuant to OAC 317:30-5-50.
(9) Medical services considered experimental or investigational. For more information regarding coverage of clinical trials, see Oklahoma Administrative Code (OAC) 317:30-3-57.1.
(10) Services of a certified surgical assistant.
(11) Services of a chiropractor. Payment is made for chiropractor services on crossover claims for coinsurance and/or deductible only.
(12) Services of an independent licensed physical therapist and/or licensed physical therapist assistant. Per OAC 317:30-5-291.
(13) Services of an independent licensed occupational therapist and/or occupational therapist assistant. Per OAC 317:30-5-296.
(14) Services of a psychologist.
(15) Services of an independent licensed speech-language pathologist, speech-language pathology assistant (SLPA), and/or speech-language clinical fellow. Per OAC 317:30-5-675.
~~(16) Payment for more than four (4) outpatient visits per month (home or office) per member, except those visits in connection with family planning or related to emergency medical conditions.~~
~~(17) Payment for more than two (2) long-term care facility visits per month.~~
~~(18)~~(16) More than one (1) inpatient visit per day per physician.
~~(19)~~(17) Payment for removal of benign skin lesions.
~~(20)~~(18) 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.
~~(21)~~(19) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.
~~(22)~~(20) Payment for the services of social workers, licensed family counselors, registered nurses or other ancillary staff, except as specifically set out in the Oklahoma Health Care Authority (OHCA) rules.
~~(23)~~(21) Mileage.
~~(24)~~(22) A routine hospital visit on the date of discharge unless the member expired.

~~(25)~~(23) Direct payment to perfusionist as this is considered part of the hospital reimbursement.
~~(26)~~(24) Fertility treatment.
~~(27)~~(25) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.

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) Outpatient physician services including primary care, specialty care, and direct physician services in a nursing facility.

~~(G) Physician services on an outpatient basis include:~~

~~(i) A maximum of four (4) visits per member per month, including primary care or specialty care, 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)~~(H) Diagnostic x-ray and laboratory services.

~~(J)~~(I) Mammography screening and additional follow-up mammograms as per current guidelines.

~~(K)~~(J) Obstetrical care.

~~(L)~~(K) Pacemakers and prostheses inserted during the course of a surgical procedure.

~~(M)~~(L) 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)~~(M) 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)~~(N) 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)~~(O) Genetic counseling.
~~(Q)~~(P) Laboratory testing.
~~(R)~~(Q) Payment for ultrasounds for pregnant women as specified in Oklahoma Administrative Code (OAC) 317:30-5-22.
~~(S)~~(R) 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)~~(S) 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)~~(T) 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)~~(U) 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)~~(V) Screening and follow up pap smears as per current guidelines.
~~(X)~~(W) 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)~~(X) 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)~~(Y) Total parenteral nutritional (TPN) therapy for identified diagnoses and when prior authorized.

~~(AA)~~(Z) Ventilator equipment.

~~(BB)~~(AA) Home dialysis equipment and supplies.

~~(CC)~~(BB) 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)~~(CC) 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)~~(DD) Immunizations as specified by the Advisory Committee on Immunization Practices (ACIP) guidelines.

~~(FF)~~(EE) 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.

(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)~~(J) More than one (1) inpatient visit per day per physician.
~~(M)~~(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.
~~(N)~~(L) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.
~~(O)~~(M) 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)~~(N) 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)~~ as authorized pursuant to OAC 317:30-5-50.
~~(Q)~~(O) Speech and hearing services.
~~(R)~~(P) Mileage.
~~(S)~~(Q) A routine hospital visit on the date of discharge unless the member expired.
~~(T)~~(R) Direct payment to perfusionist as this is considered part of the hospital reimbursement.
~~(U)~~(S) Inpatient chemical dependency treatment.
~~(V)~~(T) Fertility treatment.
~~(W)~~(U) 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)~~as authorized pursuant to OAC 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.

317:30-5-9. Medical services

(a) **Use of medical modifiers.** The physicians' Current Procedural Terminology (CPT) and the second level Healthcare Common Procedure Coding System (HCPCS) provide for 2-digit medical modifiers to further describe medical services. Modifiers are used when appropriate.

(b) **Covered office services.**

~~(1) Payment is made for four (4) office visits (or home) per month per member, for adults [over age twenty-one (21)], regardless of the number of physicians involved. Additional visits per month are allowed for services related to emergency medical conditions.~~

~~(2) Visits for the purpose of family planning are excluded from the four (4) per month limitation.~~

~~(3)~~(1) Payment is allowed for the insertion and/or implantation of contraceptive devices in addition to the office visit.

~~(4)~~(2) Separate payment will be made for the following supplies when furnished during a physician's office visit.

(A) Casting materials;

(B) Dressing for burns;

(C) Contraceptive devices; and

(D) IV fluids.

~~(5)~~(3) Medically necessary office lab and X-rays are covered.

~~(6)~~(4) Hearing exams by physician for members between the ages of twenty one (21) and sixty five (65) are covered only as a diagnostic exam to determine type, nature and extent of hearing loss.
~~(7)~~(5) Hearing aid evaluations are covered for members under twenty one (21) years of age.
~~(8)~~(6) IPPB (Intermittent Positive Pressure Breathing) is covered when performed in physician's office.
~~(9)~~(7) Payment is made for an office visit in addition to allergy testing.
~~(10)~~(8) Separate payment is made for antigen.
~~(11)~~(9) Eye exams are covered for members between ages twenty one (21) and sixty five (65) for medical diagnosis only.
~~(12)~~(10) If a physician personally sees a member on the same day as a dialysis treatment, payment can be made for a separately identifiable service unrelated to the dialysis.
(11)~~(13)~~ Separate payment is made for the following specimen collections:
(A) Catheterization for collection of specimen; and
(B) Routine venipuncture.
(12)~~(14)~~ The Professional Component for electrocardiograms, electroencephalograms, electromyograms, and similar procedures are covered on an inpatient basis as long as the interpretation is not performed by the attending physician.
(13)~~(15)~~ Cast removal is covered only when the cast is removed by a physician other than the one who applied the cast.
(14)~~(16)~~ Payment may be made for medication-assisted treatment (MAT) medications prescribed and/or administered by a physician.

(c) **Non-covered office services.**

(1) Payment is not made separately for an office visit and rectal exam, pelvic exam or breast exam. Office visits including one of these types of exams should be coded with the appropriate office visit code.
(2) Payment cannot be made for prescriptions or medication dispensed by a physician in his office.
(3) Payment will not be made for completion of forms, abstracts, narrative reports or other reports, separate charge for use of office or telephone calls.
(4) Additional payment will not be made for mileage.
(5) Payment is not made for an office visit where the member did not keep appointment.
(6) Refractive services are not covered for persons between the ages of twenty-one (21) and sixty-five (65).
(7) Removal of stitches is considered part of post-operative care.
(8) Payment is not made for a consultation in the office when the physician also bills for surgery.
(9) Separate payment is not made for oxygen administered during an office visit.

(d) **Covered inpatient medical services.**

(1) Payment is allowed for inpatient hospital visits for all SoonerCare covered admissions. Psychiatric admissions must be prior authorized.
(2) Payment is allowed for the services of two physicians when supplemental skills are required and different specialties are involved.
(3) Certain medical procedures are allowed in addition to office visits.
(4) Payment for critical care is all-inclusive and includes payment for all services that day. Payment for critical care, first hour is limited to one unit per day.

(e) **Non-covered inpatient medical services.**

(1) For inpatient services, all visits to a member on a single day are considered one service except where specified. Payment is made for only one (1) visit per day.

(2) A hospital admittance or visit and surgery on the same day would not be covered if post-operative days are included in the surgical procedure. If there are no post-operative days, a physician can be paid for visits.

(3) Drugs administered to inpatients are included in the hospital payment.

(4) Payment will not be made to a physician for an admission or new patient work-up when the member receives surgery in out-patient surgery or ambulatory surgery center.

(5) Payment is not made to the attending physician for interpretation of tests on his own patient.

(f) **Other medical services.**

(1) Payment will be made to physicians providing Emergency Department services.

(2) Payment is made for ~~two (2)~~ nursing facility visits ~~per month. The~~when the appropriate CPT code is used.

(3) When payment is made for evaluation of arrhythmias or evaluation of sinus node, the stress study of the arrhythmia includes inducing the arrhythmia and evaluating the effects of drugs, exercise, etc. upon the arrhythmia.

(4) When the physician bills twice for the same procedure on the same day, it must be supported by a written report.

317:30-5-10. Ophthalmology services

(a) **Covered services for adults.**

(1) Payment can be made for medical services that are reasonable and necessary for the diagnosis and treatment of illness or injury ~~up to the patient's maximum number of allowed office visits per month~~.

(2) There is no provision for routine eye exams, examinations for the purpose of prescribing glasses or visual aids, determination of refractive state or treatment of refractive errors, or purchase of lenses, frames, or visual aids. Payment is made for treatment of medical or surgical conditions which affect the eyes. Providers must notify members in writing of services not covered by SoonerCare prior to providing those services. Determination of refractive state or other non-covered service may be billed to the patient if properly notified.

(3) The global surgery fee allowance includes preoperative evaluation and management services rendered the day before or the day of surgery, the surgical procedure, and routine postoperative period. Co-management for cataract surgery is filed using appropriate CPT codes, modifiers and guidelines. If an optometrist has agreed to provide postoperative care, the optometrist's information must be in the referring provider's section of the claim.

(b) **Covered services for children.**

(1) Eye examinations are covered when medically necessary. Determination of the refractive state is covered when medically necessary.

(2) Payment is made for certain corrective lenses and optical supplies when medically necessary. Refer to OAC 317:30-5-432.1. for specific guidelines.

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

(d) **Procedure codes.**

(1) The appropriate procedure codes used for billing eye care services are found in the Current Procedural Terminology (CPT) and HCPCS Coding Manuals.

(2) Vision screening is a component of all eye exams performed by ophthalmologists or optometrists and is not billed separately.

317:30-5-11. Psychiatric services

(a) Payment is made for procedure codes listed in the psychiatry section of the most recent edition of the American Medical Association Current Procedural Terminology (CPT) codebook. The codes in this service range are accepted services within the SoonerCare program for children and adults with the following exceptions:

(1) Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes.

(2) Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist the patient.

(3) Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purposes) for other physicians, agencies, or insurance carriers.

(4) Unlisted psychiatric service or procedure.

(b) All services must be medically necessary and appropriate and include at least one (1) diagnosis from the most recent version of the Diagnosis and Statistical Manual of Mental Disorders (DSM).

(c) Services in the psychiatry section of the CPT manual must be provided by a board eligible or board certified psychiatrist or a physician, physician assistant, or nurse practitioner with additional training that demonstrates the knowledge to conduct the service performed.

(d) Psychiatric services performed via telemedicine are subject to the requirements found in Oklahoma Administrative Code (OAC) 317:30-3-27.

~~(e) With the exception of the two (2) allowable direct physician services in a nursing facility (refer to OAC 317:30-5-2), reimbursement~~Reimbursement ~~for psychiatric services to members residing in a nursing facility is not allowed. Provision of these services is the responsibility of the nursing facility and reimbursement is included within the all-inclusive per diem payment that nursing facilities receive for the member's care.~~

317:30-5-15. Chemotherapy injections

(a) **Outpatient.**

(1) Outpatient chemotherapy is compensable only when a malignancy is indicated or for the diagnosis of Acquired Immune Deficiency Syndrome (AIDS). Outpatient chemotherapy treatments are unlimited. ~~Outpatient visits in connection with chemotherapy are limited to four per month.~~

(2) Payment for administration of chemotherapy medication is made under the appropriate National Drug Code (NDC) and HCPCS code as stated in OAC 317:30-5-14(b). Payment is made separately for office visit and administration under the appropriate CPT code.

(3) When injections exceed listed amount of medication, show units times appropriate quantity, i.e., injection code for 100 mgm but administering 300, used 100 mgm times 3 units.

(4) Glucose - fed through IV in connection with chemotherapy administered in the office is covered under the appropriate NDC and HCPCS code.

(b) **Inpatient.**

(1) Inpatient hospital supervision of chemotherapy administration is non-compensable. The hospital visit in connection with chemotherapy could be allowed within our guidelines if otherwise compensable, but must be identified by description.
(2) Hypothermia - Local hypothermia is compensable when used in connection with radiation therapy for the treatment of primary or metastatic cutaneous or subcutaneous superficial malignancies. It is not compensable when used alone or in connection with chemotherapy.
(3) The following are not compensable:
(A) Chemotherapy for Multiple Sclerosis;
(B) Efudex;
(C) Oral Chemotherapy;
(D) Photochemotherapy;
(E) Scalp Hypothermia during Chemotherapy; and
(F) Strep Staph Chemotherapy.

PART 3. HOSPITALS

317:30-5-42.4. Clinic/treatment room services; urgent care

(a) An outpatient hospital clinic is a non-emergency service providing diagnostic, preventive, curative and rehabilitative services on a scheduled basis.
(b) Urgent care payment is made for services provided in non-emergency clinics operated by a hospital. This payment does not include the professional charges of the treating physician, nurse practitioner, physician assistant or charges for diagnostic testing. A facility charge is also allowed when drug and/or blood are administered outpatient.
(c) Urgent Care services will not require a referral for SoonerCare Choice members however other claims will deny without a referral.
~~(d) Adults are limited to four clinic visits per month.~~

PART 23. PODIATRISTS

317:30-5-261. Coverage by category

Payment is made to podiatrists as set forth in this Section:
(1) **Adults.** Payment is made for medically necessary surgical procedures, x-rays, and outpatient visits. Procedures which are generally considered as preventative foot care, i.e. cutting or removal of corns, warts, callouses, or nails, are not covered unless the diagnoses on the claim, i.e. diabetes, multiple sclerosis, cerebral vascular accident, peripheral vascular disease establishes the medical necessity for the service. The patient must be under the active care of a doctor of medicine or osteopathy who documents the condition. All services must be medically appropriate and related to systemic disease for which foot care is viewed as preventative in nature. Nursing home visits must be ordered by the attending physician. The nursing home record must contain appropriate documentation that the visit was not performed for screening purposes. A specific foot ailment, symptom or complaint must be documented. In instances where the examination is performed in response to specific symptoms or complaints which suggests the need for care, the visit is compensable regardless of the resulting diagnosis. ~~All outpatient visits are subject to existing visit limitations.~~

(2) **Children.** Coverage of podiatric services for children is the same as for adults. Refer to OAC 317:30-3-57 (13) for additional coverage under the Early and Periodic Screening, Diagnosis and Treatment Program.
(3) **Individuals eligible for Part B of Medicare.** Payment for podiatric services is made utilizing the Medicaid allowable for comparable services.

PART 45. OPTOMETRISTS

317:30-5-431. Coverage by category

Payment is made to optometrists as set forth in this Section.
(1) **Adults.** Payment can be made for medical services that are reasonable and necessary for the diagnosis and treatment of illness or injury ~~up to the patient's maximum number of allowed office visits per month~~.

(A) There is no provision for routine eye exams, examinations for the purpose of prescribing glasses or visual aids, determination of refractive state, treatment of refractive errors, or purchase of lenses, frames, or visual aids. Payment is made for treatment of medical or surgical conditions which affect the eyes. Prior to providing noncovered services, providers must notify members in
writing of those services not covered by SoonerCare. Determination of refractive state or other non-covered services may be billed to the patient if properly notified.
(B) The global surgery fee allowance includes preoperative evaluation and management services rendered the day before or the day of surgery, the surgical procedure, and routine postoperative period. Co-management for cataract surgery is filed using appropriate CPT codes, modifiers and guidelines. If an optometrist has agreed to provide postoperative care, the surgeon's information must be in the referring provider's section of the claim.
(C) Payment for laser surgery to optometrist is limited to those optometrists certified by the Board of Optometry as eligible to perform laser surgery.

(2) **Children.** Eye examinations are covered when medically necessary. Determination of the refractive state is covered when medically necessary.
(3) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the Medicaid allowable for comparable services.

PART 35. RURAL HEALTH CLINICS

317:30-5-356. Coverage for adults

Payment is made to RHCs for adult services as set forth in this Section.
(1) **RHC services.** Payment is made for one (1) encounter per member per day. ~~Payment is also limited to four (4) visits per member per month. This limit may be exceeded if the SoonerCare Choice member has elected the RHC as his/her/their Patient Centered Medical Home/Primary Care Provider. Preventive service exceptions include:~~

(A) **Obstetrical care.** An RHC should have a written contract with its physician, PA, APRN, or CNM that specifically identifies how obstetrical care will be billed to SoonerCare, in order to avoid duplicative billing situations. The agreement should also specifically identify the physician's compensation for RHC and other ambulatory services.

(i) If the clinic compensates the physician, PA, APRN, or CNM to provide obstetrical care, then the clinic must bill the SoonerCare program for each prenatal visit using the appropriate CPT evaluation and management codes.

(ii) If the clinic does not compensate its practitioners to provide obstetrical care, then the independent practitioner must bill the OHCA for prenatal care according to the global method described in the SoonerCare provider specific rules for physicians, PAs, APRNs and CNMs (refer to OAC 317:30-5-22).

(iii) Under both billing methods, payment for prenatal care includes all routine or minor medical problems. No additional payment is made to the prenatal provider except in the case of a major illness distinctly unrelated to pregnancy.

~~(B) **Family planning services.** Family planning services are available only to members with reproductive capability. Family planning visits do not count as one (1) of the four (4) RHC visits per month.~~

(2) **Other ambulatory services.** These services are not considered a part of an RHC visit; therefore, these may be billed to the SoonerCare program by the RHC or service provider on the appropriate claim form. Refer to OAC 317:30-1, General Provisions, and OAC 317:30-3-57, 317:30-5-59, and 317:30-3-60 for general coverage and exclusions under the SoonerCare program. Some specific limitations are applicable to other ambulatory services as set forth in specific provider rules and excerpted as follows: There is no coverage for eye exams for the purpose of prescribing eyeglasses, contact lenses or other visual aids. (See OAC 317:30-5-431.)

~~(A) Coverage under optometrists for adults is limited to treatment of eye disease not related to refractive errors.~~

~~(B) There is no coverage for eye exams for the purpose of prescribing eyeglasses, contact lenses or other visual aids. (See OAC 317:30-5-431.)~~

317:30-5-361. Billing

(a) **Encounters.** Payment is made for one (1) encounter per member per day. Encounters with more than one (1) health professional and multiple encounters with the same health professional that takes place on the same day and a single location, constitute a single visit except when the member, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment. Medical review will be required for additional visits~~ for children. Payment is also limited to four (4) visits per member per month for adults. This limit may be exceeded if the SoonerCare Choice member has elected the RHC as his/her/their Patient Centered Medical Home/Primary Care Provider~~. RHCs must bill the combined fees of all "core" services provided during an encounter on the appropriate claim form. Claims must include reasonable and customary charges.

(1) **RHC.** The appropriate revenue code is required. No HCPCS or CPT code is required.

(2) **Mental health.** Mental health services must include a revenue code and a HCPCS code.

(3) **Obstetrical care.** The appropriate revenue code and HCPCS code are required. The date the member is first seen is required. The primary pregnancy diagnosis code is also required. Secondary diagnosis codes are used to describe complications of pregnancy. Delivery must be billed by the independent practitioner who has a contract with the OHCA.

(4) **Family planning.** Family planning encounters require a revenue code, HCPCS code, and a family planning diagnosis.

(5) **EPSDT screening.** EPSDT screenings must be billed by the attending provider using the appropriate Preventative Medicine procedure code from the CPT Manual. Payment is made directly to the RHC on an encounter basis for on-site dental services by a licensed dentist for members under the age of twenty-one (21).

(6) **Dental.** Dental services for children must be billed on the appropriate dental claim form.

(A) **EPSDT dental screening.** An EPSDT dental screening includes oral examination, prophylaxis and fluoride treatment, charting of needed treatment, and, if necessary, x-rays (including two bite wing films). This service must be filed on claim form ADM-36-D for EPSDT reporting purposes.

(B) **Dental encounter.** A dental encounter consists of all dental treatment other than a dental screening. This service must be billed on the ADM-36-D.

(7) **Visual analysis.** Visual analysis services for a child with glasses, or a child who needs glasses, or a medical eye exam. This includes the refraction and medical eye health evaluation. Visual analysis services are billed using the appropriate revenue code and a HCPCS code. Payment is made directly to the RHC on an encounter basis for on-site optometric services by a licensed optometrist for members under the age of twenty-one (21).

(b) **Services billed separately from encounters.**

(1) Other ambulatory services and preventive services itemized separately from encounters must be billed using the appropriate revenue, HCPC and/or CPT codes. Claims must include reasonable and customary charges from the physical location where services were rendered/performed.

(A) **Laboratory.** The RHC must be CLIA certified for specialized laboratory services performed. Laboratory services must be itemized separately using the appropriate CPT or HCPCS code.

(B) **Radiology.** Radiology must be identified using the appropriate CPT or HCPC code with the technical component modifier. Radiology services are paid at the technical component rate. The professional component is included in the encounter rate.

(C) **Immunizations.** The administration fee for immunizations provided on the same day as the EPSDT exam is billed separately.

(D) **Contraceptives.** Contraceptives are billed independently from the family planning encounter. A revenue code and the appropriate CPT or HCPC codes are required.

(E) **Eyeglasses.** Eyeglasses prescribed by a licensed optometrist are billed using the appropriate revenue code and HCPCS code. Payment is limited to two eyeglasses per year. Any eyeglasses beyond this limit must be prior authorized and determined to be medically necessary.

(2) Other ambulatory services provided off-site by independent practitioners (through subcontracting agreements or arrangements for services not available at the clinic) must be billed to the SoonerCare program by the provider rendering the service. Independent practitioners must meet provider eligibility criteria and must have a current contract with the OHCA.

PART 75. FEDERALLY QUALIFIED HEALTH CENTERS

317:30-5-664.3. FQHC encounters

(a) FQHC encounters that are billed to the Oklahoma Health Care Authority (OHCA) must meet the definition in this Section and are limited to services covered by OHCA. Only encounters

provided by an authorized health care professional listed in the approved FQHC State Plan pages within the scope of their licensure trigger a Prospective Payment System (PPS) encounter rate.
(b) An encounter is defined as a face-to-face contact between a health care professional and a member for the provision of defined services through a FQHC within a twenty-four (24) hour period ending at midnight, as documented in the member's medical record. Services delivered via audio-only telecommunications do not constitute an encounter.
(c) An FQHC may bill for one (1) medically necessary encounter per twenty-four (24) hour period when the appropriate modifier is applied. Medical review will be required for additional visits for children. For information about multiple encounters, refer to Oklahoma Administrative Code (OAC) 317:30-5-664.4. ~~Payment is limited to four (4) visits per member per month for adults. This limit may be exceeded if the SoonerCare Choice member has elected the FQHC as his/her/their Patient Centered Medical Home/Primary Care Provider.~~
(d) Services considered reimbursable encounters (including any related medical supplies provided during the course of the encounter) include:

(1) Medical;
(2) Diagnostic;
(3) Dental, medical and behavioral health screenings;
(4) Optometry;
(5) Physical therapy;
(6) Occupational therapy;
(7) Podiatry;
(8) Behavioral health;
(9) Speech;
(10) Hearing;
(11) Medically necessary FQHC encounters with a registered nurse or licensed practical nurse and related medical supplies (other than drugs and biologicals) furnished on a part-time or intermittent basis to home-bound members (refer to OAC ~~317:30-5-661.3~~317:30-5-661.1); and
(12) Any other medically necessary health services (i.e. optometry and podiatry) are also reimbursable as permitted within the FQHCs scope of services when medically reasonable and necessary for the diagnosis or treatment of illness or injury, and must meet all applicable coverage requirements.

(e) Services and supplies incident to the services of a physician, PA, APRN, CNM, CP, CSW, MFT, and MHC are reimbursable within the encounter, as described in 42 C.F.R § 405.2413 and OAC 317:30-5-661.1.
(f) Only drugs and biologicals which cannot be self-administered are included within the scope of this benefit.

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-27. Telehealth

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

(1) **"Distant site"** means the location of the provider of the professional service being performed via telehealth.

(2) **"Originating site"** means the location of the SoonerCare member at the time a telehealth service is being performed by an eligible contracted provider.

~~(1)~~(3) **"Remote patient monitoring"** means the use of digital technologies to collect medical and other forms of health data (e.g., vital signs, weight, blood pressure, blood sugar) from individuals in one (1) location and electronically transmit that information securely to health care providers in a different location for assessment and recommendations.

(2) **"School-based services"** means medically necessary health-related and rehabilitative services that are provided by a qualified school provider to a student under the age of twenty-one (21), pursuant to an Individualized Education Program (IEP), in accordance with the Individuals with Disabilities Education Act. See Oklahoma Administrative Code (OAC) 317:30-5-1020.

~~(3)~~(4) **"Store and forward technologies"** means the transmission of a patient's medical information from an originating site to the health care provider at the distant site; provided, photographs visualized by a telecommunications system shall be specific to the patient's medical condition and adequate for furnishing or confirming a diagnosis or treatment plan. Store and forward technologies shall not include consultations provided by telephone audio-only communication, electronic mail, text message, instant messaging conversation, website questionnaire, nonsecure video conference, or facsimile transmission.

~~(4)~~(5) **"Telehealth"** means the practice of health care delivery, diagnosis, consultation, evaluation and treatment, transfer of medical data or exchange of medical education information by means of a two-way, real-time interactive communication, not to exclude store and forward technologies, between a patient and a healthcare provider with access to and reviewing the patient's relevant clinical information prior to the telemedicine visit. Telehealth shall not include consultations provided by telephone audio-only communication, electronic mail, text message, instant messaging conversation, website questionnaire, nonsecure video conference, or facsimile transmission. For audio-only health service delivery, see OAC 317:30-3-27.1.

(5) **"Telehealth medical service"** means, for the purpose of the notification requirements of OAC 317:30-3-27(d)(2), telehealth services that expressly do not include physical therapy, occupational therapy, and/or speech and hearing services.

(b) **Applicability and scope.** The purpose of this Section is to implement telehealth policy that improves access to healthcare services, while complying with all applicable state and federal laws and regulations. Telehealth services are not an expansion of SoonerCare-covered services, but an option for the delivery of certain covered services. However, if there are technological difficulties in performing an objective, thorough medical assessment, or problems in the member's understanding of telehealth, hands-on-assessment and/or in-person care must be provided for the member. Any service delivered using telehealth technology must be appropriate for telehealth delivery and be of the same quality and otherwise on par with the same service delivered in person. A telehealth encounter must maintain the confidentiality and security of protected health information in accordance with applicable state and federal law, including, but not limited to, 42 Code of Federal Regulations (CFR) Part 2, 45 CFR Parts 160 and 164, and 43A Oklahoma Statutes (O.S.) § 1-109. For purposes of SoonerCare reimbursement, telehealth is the use of interactive audio, video, or other electronic media for the purpose of diagnosis, consultation, or treatment that occurs in real-time and when the member is actively participating during the transmission.

(c) **Requirements.** The following requirements apply to all services rendered via telehealth.

(1) Interactive audio and video telecommunications must be used, permitting encrypted, real-time communication between the physician or practitioner and the SoonerCare member. The telecommunication service must be secure and adequate to protect the confidentiality and integrity of the telehealth information transmitted. As a condition of payment the member must actively participate in the telehealth visit.

(2) The telehealth equipment and transmission speed and image must be technically sufficient to support the service billed. If a peripheral diagnostic scope is required to assess the member, it must provide adequate resolution or audio quality for decision making. Staff involved in the telehealth visit need to be trained in the use of the telehealth equipment and competent in its operation.

(3) The medical or behavioral health related service must be provided at an appropriate site for the delivery of telehealth services. An appropriate telehealth site is one that has the proper security measures in place; the appropriate administrative, physical, and technical safeguards should be in place that ensures the confidentiality, integrity, and security of electronic protected health information. The location of the room for the encounter at both ends should ensure comfort, privacy, and confidentiality. Both visual and audio privacy are important, and the placement and selection of the rooms should consider this. Appropriate telehealth equipment and networks must be used considering factors such as appropriate screen size, resolution, and security. Providers and/or members may provide or receive telehealth services outside of Oklahoma when medically necessary; however, prior authorization may be required, per OAC 317:30-3-89 through 317:30-3-91.

(4) The provider must be contracted with SoonerCare and appropriately licensed or certified, in good standing. Services that are provided must be within the scope of the practitioner's license or certification. If the provider is outside of Oklahoma, the provider must comply with all laws and regulations of the provider's location, including health care and telehealth requirements.

(5) If the member is a minor, the provider must obtain the prior written consent of the member's parent or legal guardian to provide services via telehealth, that includes, at a

minimum, the name of the provider; the provider's permanent business office address and telephone number; an explanation of the services to be provided, including the type, frequency, and duration of services. Written consent must be obtained annually, or whenever there is a change in the information in the written consent form, as set forth above. The parent or legal guardian need not attend the telehealth session unless attendance is therapeutically appropriate. The requirements of subsection OAC 317:30-3-27(c)(5), however, do not apply to telehealth services provided in a primary or secondary school setting.

(6) If the member is a minor, the telehealth provider shall notify the parent or legal guardian that a telehealth service was performed on the minor through electronic communication whether a text message or email.

(7) The member retains the right to withdraw at any time.

(8) All telehealth activities must comply with Oklahoma Health Care Authority (OHCA) policy, and all other applicable State and Federal laws and regulations, including, but not limited to, 59 O.S. § 478.1.

(9) The member has access to all transmitted medical information, with the exception of live interactive video as there is often no stored data in such encounters.

(10) There will be no dissemination of any member images or information to other entities without written consent from the member or member's parent or legal guardian, if the member is a minor.

(11) A telehealth service is subject to the same SoonerCare program restrictions, limitations, and coverage which exist for the service when not provided through telehealth; provided, however, that only certain telehealth codes are reimbursable by SoonerCare. For a list of the SoonerCare-reimbursable telehealth codes, refer to the OHCA's Behavioral Health Telehealth Services and Medical Telehealth Services, available on OHCA's website, www.okhca.org.

(12) Where there are established service limitations, the use of telehealth to deliver those services will count towards meeting those noted limitations. Service limitations may be set forth by Medicaid and/or other third-party payers.

(d) **Additional requirements specific to telehealth services in a school setting.** In order for OHCA to reimburse medically necessary telehealth services provided to SoonerCare members in a primary or secondary school setting, all of the requirements in (c) above must be met, with the exception of (c)(5), as well as all of the requirements shown below, as applicable.

(1) **Consent requirements.** Advance parent or legal guardian consent for telehealth services must be obtained for minors, in accordance with 25 O.S. §§ 2004 through 2005. Additional consent requirements shall apply to school-based services provided pursuant to an IEP, per OAC 317:30-5-1020.

(2) **Notification requirements.** For telehealth medical services provided in a primary or secondary school setting, the telehealth practitioner must provide a summary of the service, including, but not limited to, information regarding the exam findings, prescribed or administered medications, and patient instructions, to:

(A) The SoonerCare member, if he or she is an adult, or the member's parent or legal guardian, if the member is a minor; or

(B) The SoonerCare member's primary care provider, if requested by the member or the member's parent or legal guardian.

(3) **Requirements specific to physical therapy, occupational therapy, and/or speech and hearing services.** Even though physical therapy, occupational therapy, and/or speech and hearing services are not subject to the notification requirements of OAC 317:30-3-27(d)(2), said services must still comply with all other State and Federal Medicaid requirements, in order to be reimbursable by Medicaid. Accordingly, for those physical therapy, occupational therapy, and/or speech and hearing services that are provided in a primary or secondary school setting, but that are not school-based services (i.e., not provided pursuant to an IEP), providers must adhere to all state and federal requirements relating to prior authorization and prescription or referral, including, but not limited to, 42 C.F.R. § 440.110, OAC 317:30-5-291, 317:30-5-296, and 317:30-5-676.

(e) Additional requirements for originating sites.

(1) The host facility must provide a suitable physical space with adequate privacy, necessary telecommunications technology and equipment, on-site staff support during the telehealth visit, and adequate medical staff to oversee and coordinate with specialty care.

(2) **Physical Space.** Telehealth visits must be conducted in an enclosed room or designated clinical area that supports privacy, confidentiality, and safety comparable to an in-person visit. The space must:

(A) Allow conversations to occur without being overheard by unauthorized individuals;

(B) Provide adequate lighting and visibility for clinical assessment;

(C) Be accessible to members with disabilities; and

(D) Have procedures for responding to medical or behavioral emergencies during telehealth visits.

(3) **Staffing.** When billing an originating site facility fee, the originating site must have at least one trained staff member on-site during the telehealth encounter to:

(A) Verify member identity and confirm the member’s physical location;

(B) Assist the member with use of the telehealth equipment and connection, including troubleshooting;

(C) Provide clinical support within the staff member’s scope of practice, when required by the service (e.g., obtaining vital signs, assisting with examination maneuvers); and

(D) Implement emergency procedures consistent with facility policy.

(E) Staff must receive training on telehealth workflows, privacy, equipment operation, and emergency escalation.

(4) **Equipment and Technology.** The originating site must maintain telecommunications equipment sufficient to support real-time, two-way interactive telehealth services, including:

(A) Reliable internet connectivity;

(B) A camera, microphone, speakers or headset, and display screen suitable for clinical interaction;

(C) Peripheral clinical devices, when required by the service; and

(D) Telehealth software configured to comply with HIPAA privacy and security standards.

(E) Equipment must be maintained in good working order, and the originating site must have procedures for testing functionality and resolving technical issues.

(5) **Documentation.** The originating site must document in the member's medical record:

(A) The date of service and confirmation that the member was physically present at the originating site;

(B) The name and credentials of the distant-site practitioner and the telehealth modality used; and

(C) The name and role of the on-site staff supporting the encounter.

~~(e)~~(f) **Reimbursement.**

(1) Health care services delivered by telehealth such as Remote Patient Monitoring, Store and Forward, or any other telehealth technology, must be compensable by OHCA in order to be reimbursed.

(2) Services provided by telehealth must be billed with the appropriate modifier.

(3) If the technical component of an X-ray, ultrasound or electrocardiogram is performed during a telehealth transmission, the technical component can be billed by the provider that provided that service. The professional component of the procedure and the appropriate visit code should be billed by the provider that rendered that service.

(4) The cost of telehealth equipment and transmission is not reimbursable by SoonerCare.

(5) For reimbursement of audio-only health service delivery, see OAC 317:30-3-27.1.

(6) Originating site facility fee.

(A) The originating site facility fee will reimburse eligible facilities for hosting an appropriate space for telehealth services furnished by a physician, advanced practice registered nurse, or physician assistant when those services are not otherwise reasonably accessible.

(B) Reimbursement will be made to the site where the member is located during the telehealth visit, when the appropriate telehealth facility fee code is billed. The facility fee shall be paid in accordance with the SoonerCare fee schedule and is separate from the professional service billed by the distant-site provider.

(C) The facility fee code may only be billed once per day, per member and must be directly associated with the provision of a SoonerCare covered service provided by a physician/practitioner.

(D) Eligible originating sites include hospitals, outpatient hospital departments, skilled nursing facilities, physician and practitioner offices, rural health clinics (RHCs), federally qualified health centers (FQHCs), Indian health/tribal/urban Indian (I/T/U) clinics, and public health clinics.

(E) OHCA may request documentation substantiating appropriate capabilities of the originating site as required in these rules prior to initiating payment. OHCA may also require substantiation of the distant site service rendered as a condition of payment or during post-payment review.

(F) The facility fee is not reimbursable when the member's home or school is the originating site or when no staff or facility resources are used to host the telehealth encounter. The facility fee shall not be billed for services available at or in reasonable proximity to the originating site, or for other instances in which telehealth does not provide more timely access to care.

(G) Equipment and transmission costs remain non-reimbursable under paragraph (4) of this subsection.

~~(f)~~(g) **Documentation.**

(1) Documentation must be maintained by the rendering provider to substantiate the services rendered.

(2) Documentation must indicate the services were rendered via telehealth, and the location of the services.

(3) All other SoonerCare documentation guidelines apply to the services rendered via telehealth. Examples include but are not limited to:

(A) Chart notes;

(B) Start and stop times;

(C) Service provider's credentials; and

(D) Provider's signature.

~~(g)~~(h) **Final authority.** The OHCA has discretion and the final authority to approve or deny any telehealth services based on agency and/or SoonerCare members' needs.

317:30-3-27.1 Audio-only health service delivery

(a) **Definition. "Audio-only health service delivery"** means the delivery of healthcare services through the use of audio-only telecommunications, permitting real-time communication between a patient and the provider, for the purpose of diagnosis, consultation, and/or treatment. Audio-only health service delivery does not include the use of facsimile, email, or health care services that are customarily delivered by audio-only telecommunications and not billed as separate services by the provider, such as the sharing of laboratory results. This definition includes health services delivered via audio-only when audio-visual is unavailable or when a member chooses audio-only.

(b) **Purpose.** Health services delivered via audio-only telecommunications are intended to improve access to healthcare services, while complying with all applicable state and federal laws and regulations. Audio-only telecommunications is an option for the delivery of certain covered services and is not an expansion of SoonerCare-covered services.

(c) **Applicability and scope.**

(1) Health service delivery via audio-only telecommunications is applicable to medically necessary covered primary care and other approved health services. Refer to the Oklahoma Health Care Authority (OHCA) website~~, www.okhca.org~~, for a complete list of the SoonerCare-reimbursable audio-only health services codes.

(2) If there are technological difficulties in performing medical assessment through audio-only telecommunications, then hands-on-assessment and/or in-person care must be provided for the member. Any service delivered using audio-only telecommunications must be appropriate for audio-only delivery and be of the same quality and otherwise on par with the same service delivered in person.

(3) Confidentiality and security of protected health information in accordance with applicable state and federal law, including, but not limited to, 42 Code of Federal Regulations (CFR) Part 2, 45 CFR Parts 160 and 164, and 43A Oklahoma Statutes (O.S.) § 1-109, must be maintained in the delivery of health services by audio-only telecommunications.

(4) For purposes of SoonerCare reimbursement, audio-only health service delivery is the use of interactive audio technology for the purpose of diagnosis, consultation, and/or

treatment that occurs in real-time and when the member is actively participating during the transmission.

(d) **Requirements.** The following requirements apply to all services rendered via audio-only health service delivery:

(1) Interactive audio telecommunications must be used, permitting real-time communication between the physician or practitioner and the SoonerCare member. As a condition of payment, the member must actively participate in the audio-only telecommunications health service visit.

(2) The audio telecommunications technology used to deliver the services must meet the standards required by state and federal laws governing the privacy and security of protected health information (PHI).

(3) The provider must be contracted with SoonerCare and appropriately licensed and/or certified, and in good standing. Services that are provided must be within the scope of the practitioner's license and/or certification.

(4) Either the provider or the member must be located at the freestanding clinic that is providing services pursuant to 42 CFR § 440.90 and Oklahoma Administrative Code (OAC) 317:30-5-575.

(5) If the member is a minor, the provider must obtain the prior written consent of the member's parent or legal guardian to provide services via audio-only telecommunications, that includes, at a minimum, the name of the provider; the provider's permanent business office address and telephone number; and an explanation of the services to be provided, including the type, frequency, and duration of services. Written consent must be obtained annually, or whenever there is a change in the information in the written consent form, as set forth above. The parent or legal guardian need not attend the audio-only telecommunications session unless attendance is therapeutically appropriate.

(6) The member retains the right to withdraw at any time.

(7) All audio-only health service delivery activities must comply with Oklahoma Health Care Authority (OHCA) policy, and all other applicable State and Federal laws and regulations.

(8) A health service delivered via audio-only telecommunications is subject to the same SoonerCare program restrictions, limitations, and coverage which exist for the service when not delivered via audio-only telecommunications.

(9) A health service delivered by audio-only telecommunications must be designated for reimbursement by SoonerCare.

(10) Where there are established service limitations, the use of audio-only telecommunications to deliver those services will count towards meeting those noted limitations. Service limitations may be set forth by Medicaid and/or other third-party payers.

(e) **Reimbursement.**

(1) Health care services delivered via audio-only telecommunications must be compensable by OHCA in order to be reimbursed.

(2) Services delivered via audio-only telecommunications must be billed with the appropriate modifier.

(3) Health care services delivered via audio-only telecommunications are reimbursed pursuant to the fee-for-service fee schedule approved under the Oklahoma Medicaid State Plan.
(4) An RHC and an FQHC shall be reimbursed for services delivered via audio-only telecommunications at the fee-for-service rate per the fee-for-service fee schedule.
(5) An I/T/U shall be reimbursed for services delivered via audio-only telecommunications at the Office of Management and Budget (OMB) all-inclusive rate.
(6) The cost of audio-only telecommunication equipment and other service related costs are not reimbursable by SoonerCare.

(f) **Documentation.**
(1) Documentation must be maintained by the rendering provider to substantiate the services rendered.
(2) Documentation must indicate the services were rendered via audio-only telecommunications, and the location of the services.
(3) All other SoonerCare documentation guidelines apply to the services rendered via audio-only telecommunications. Examples include but are not limited to:
(A) Chart notes;
(B) Start and stop times;
(C) Service provider's credentials; and
(D) Provider's signature.

(g) **Final authority.** The OHCA has discretion and final authority to approve or deny any services delivered via audio-only telecommunications based on agency and/or SoonerCare members' needs.

OPERATIONAL METRICS

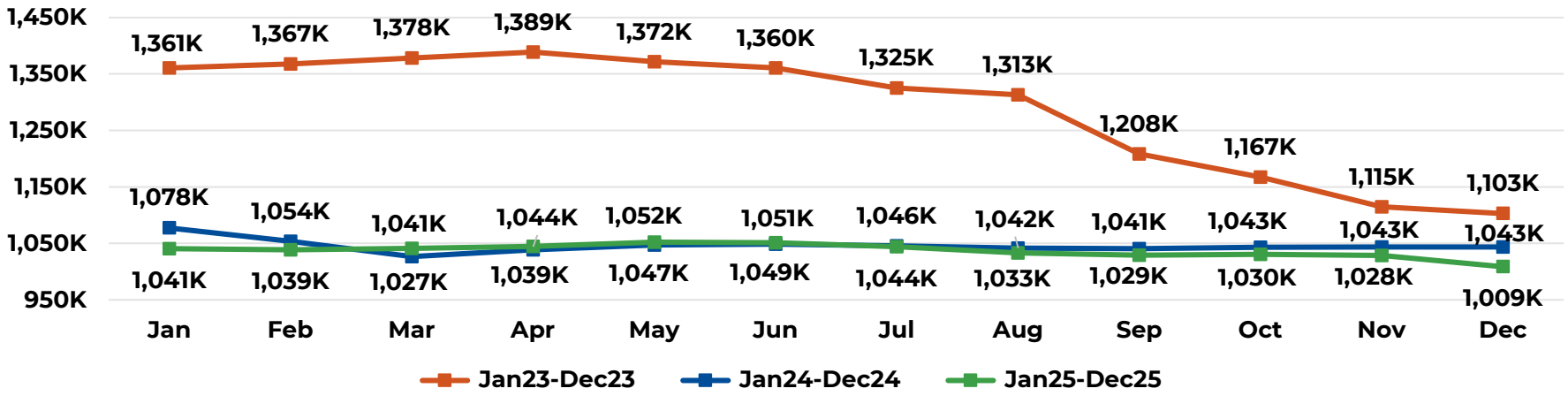
January 2026 Board Meeting

OKLAHOMA HEALTH CARE AUTHORITY

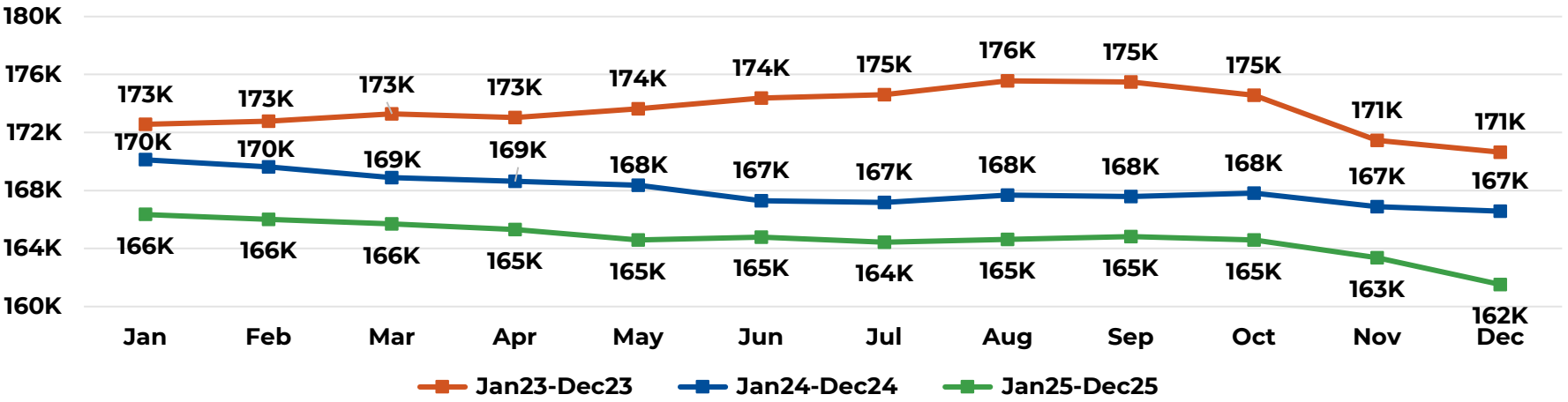
4345 N. LINCOLN BLVD. | OKHCA.ORG |

Enrollment & Utilization

Total Enrolled Members

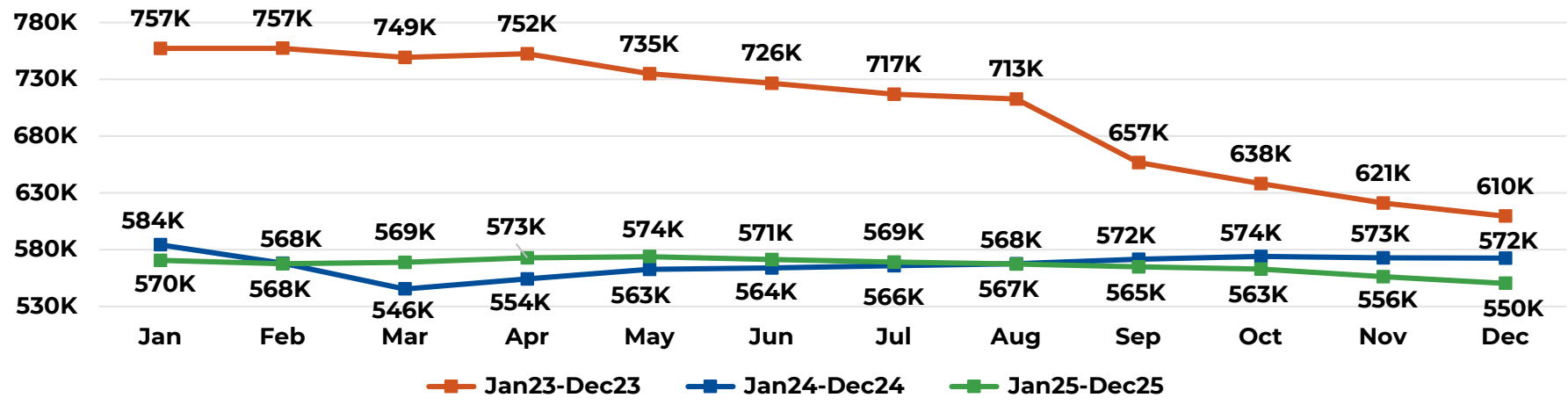


Aged/Blind/Disabled Enrolled Members

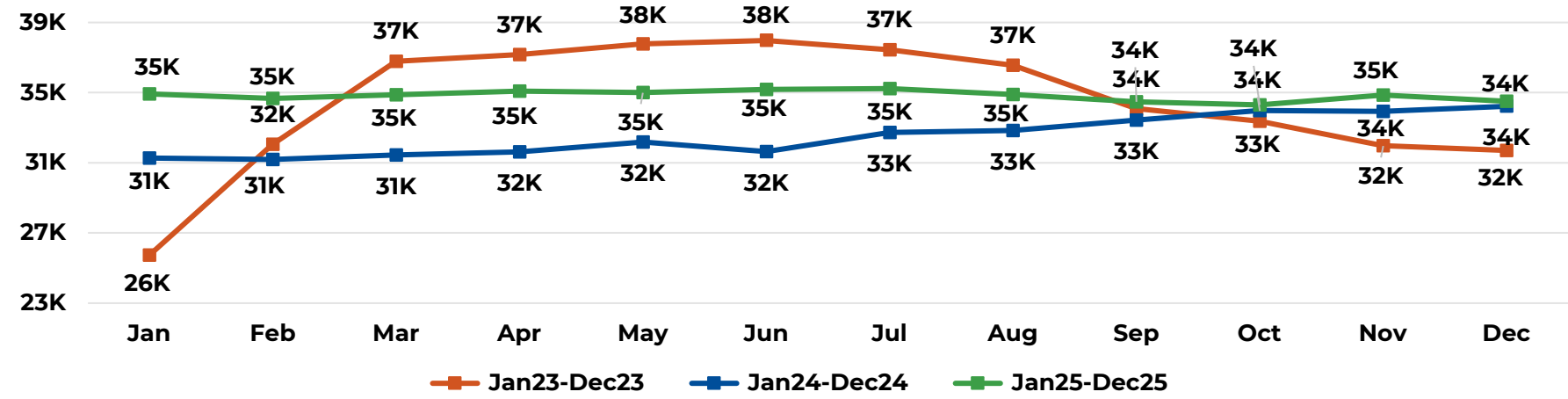


Enrollment & Utilization (Cont.)

Children & Parent/Caretaker Enrolled Members

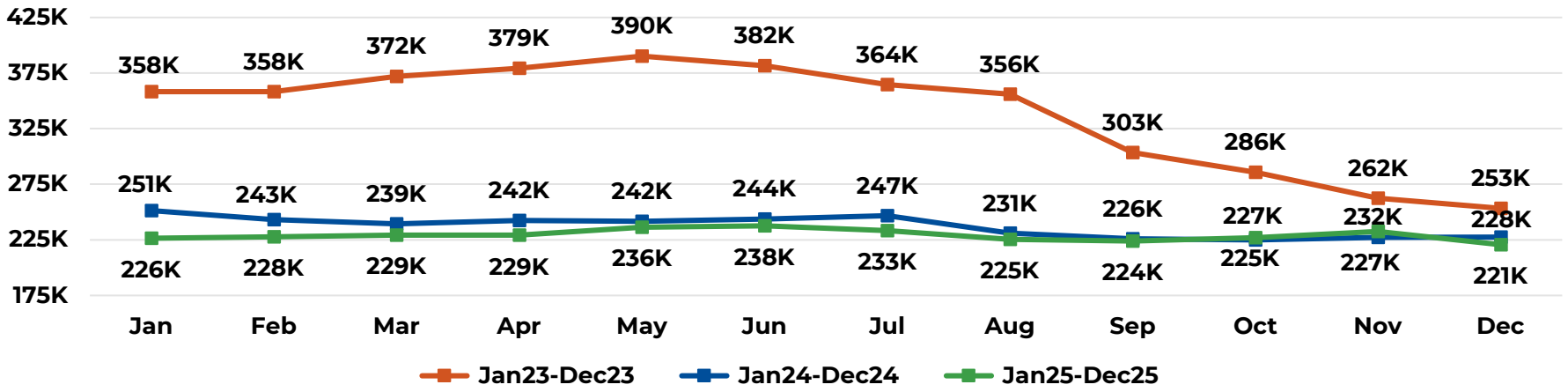


Pregnant (Full Scope) Enrolled Members

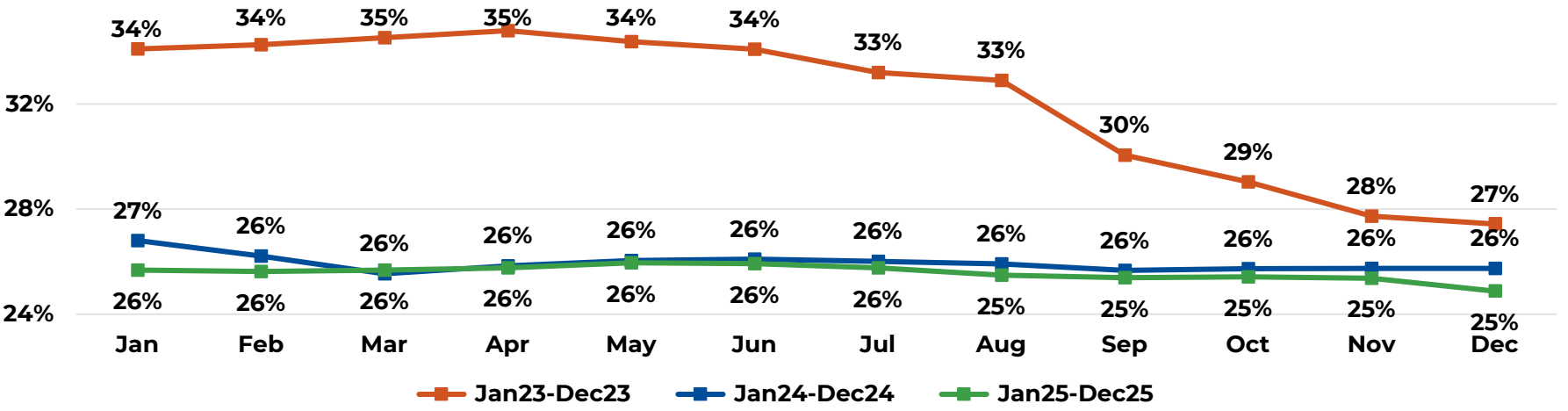


Enrollment & Utilization (Cont.)

Expansion Enrolled Members

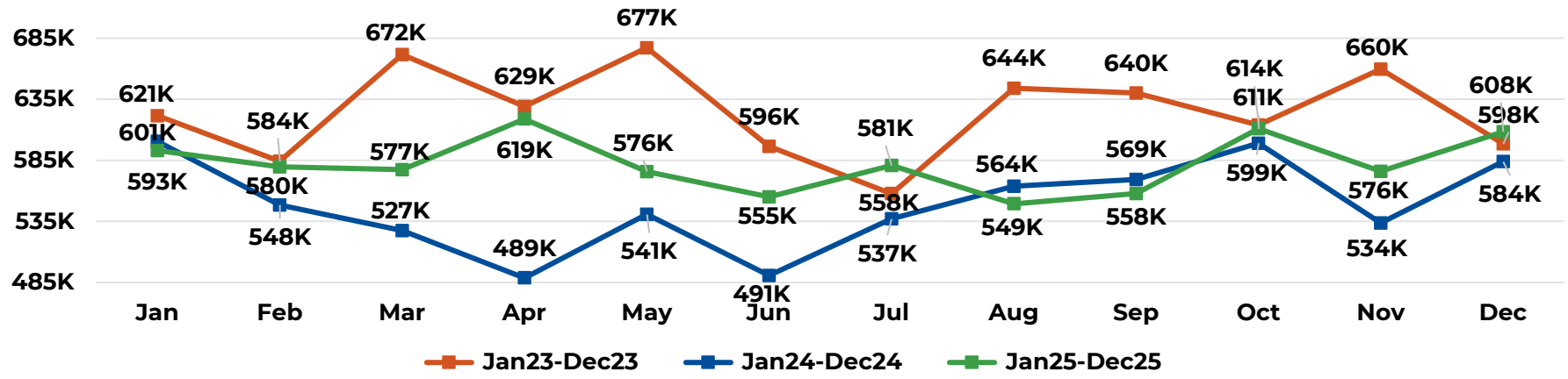


Percent of OK Population Enrolled Members

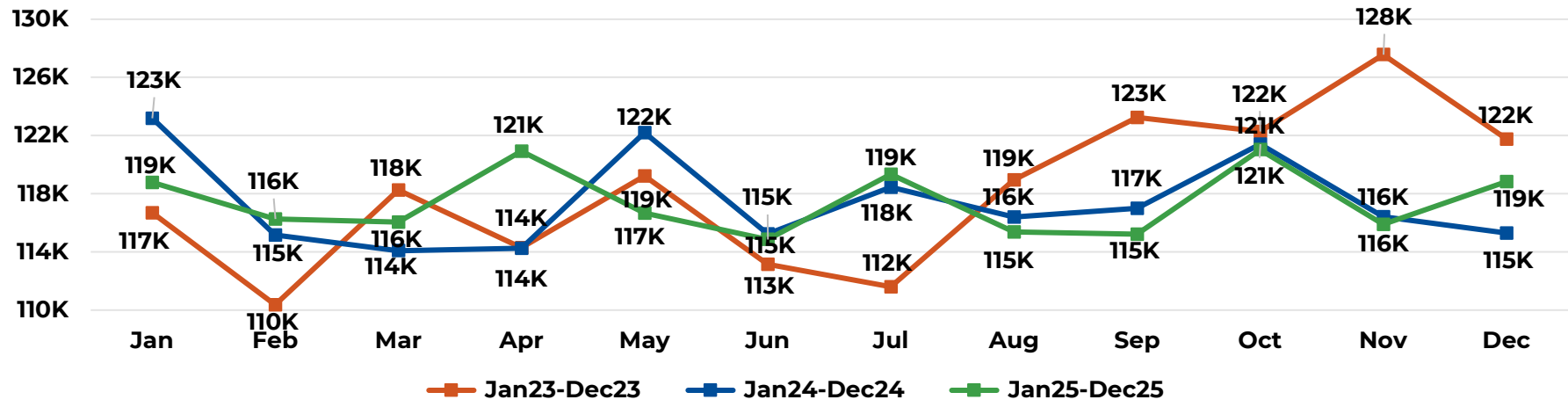


Enrollment & Utilization (Cont.)

Total Members Served

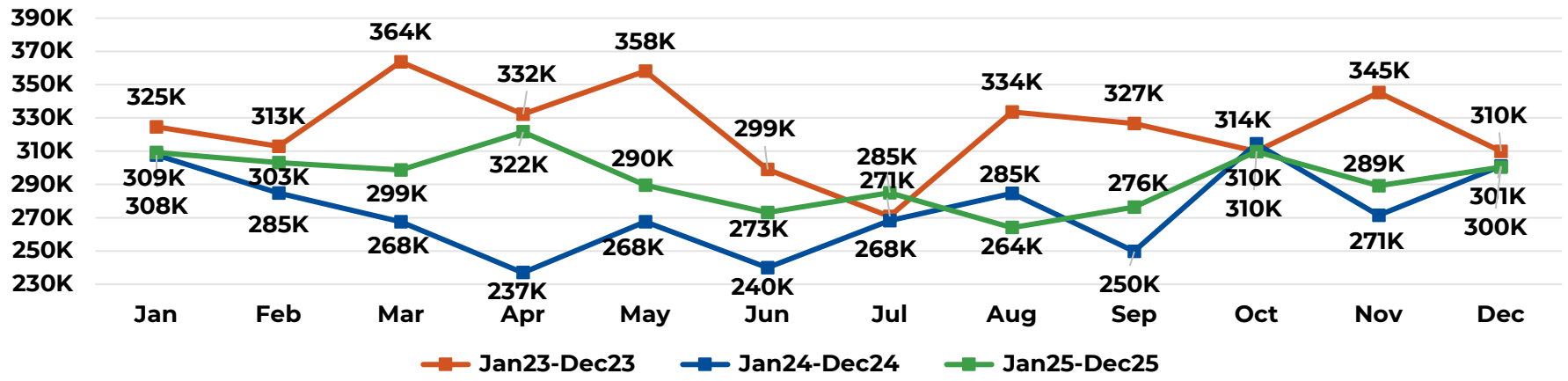


Aged/Blind/Disabled Members Served

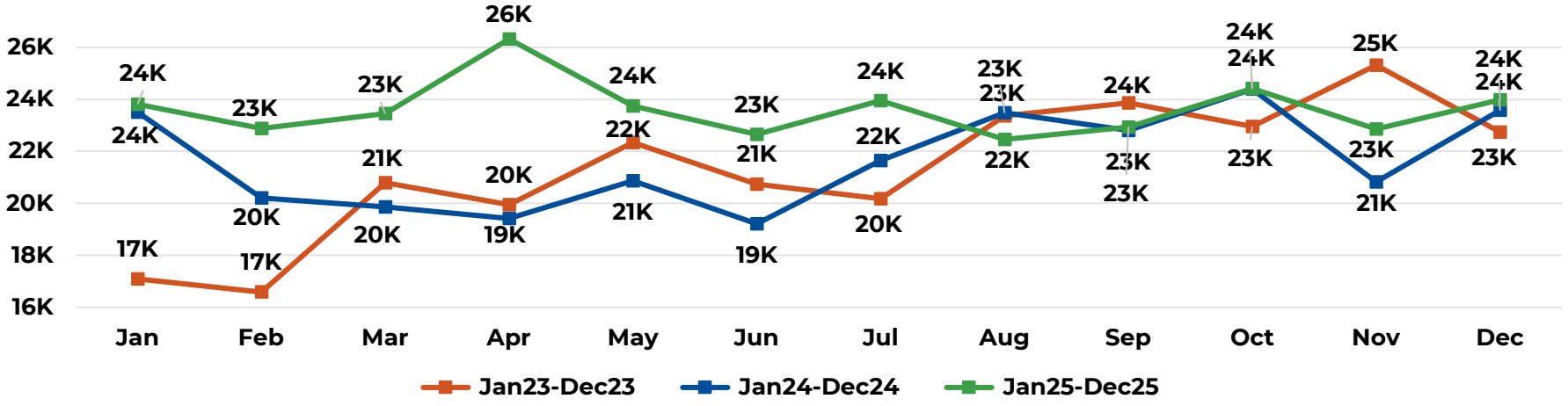


Enrollment & Utilization (Cont.)

Children & Parent/Caretaker Members Served

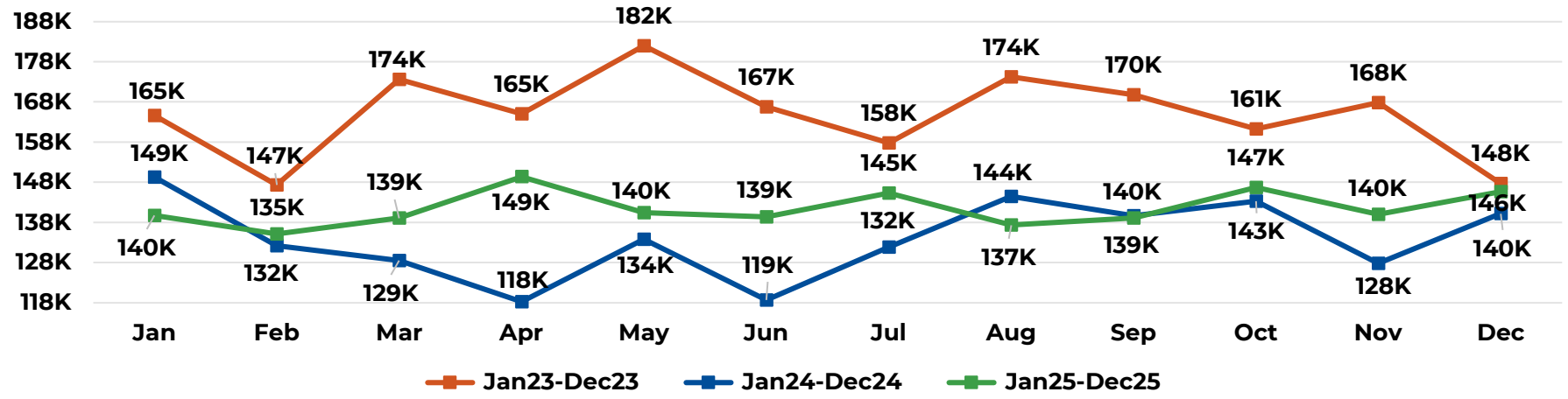


Pregnant (Full Scope) Members Served

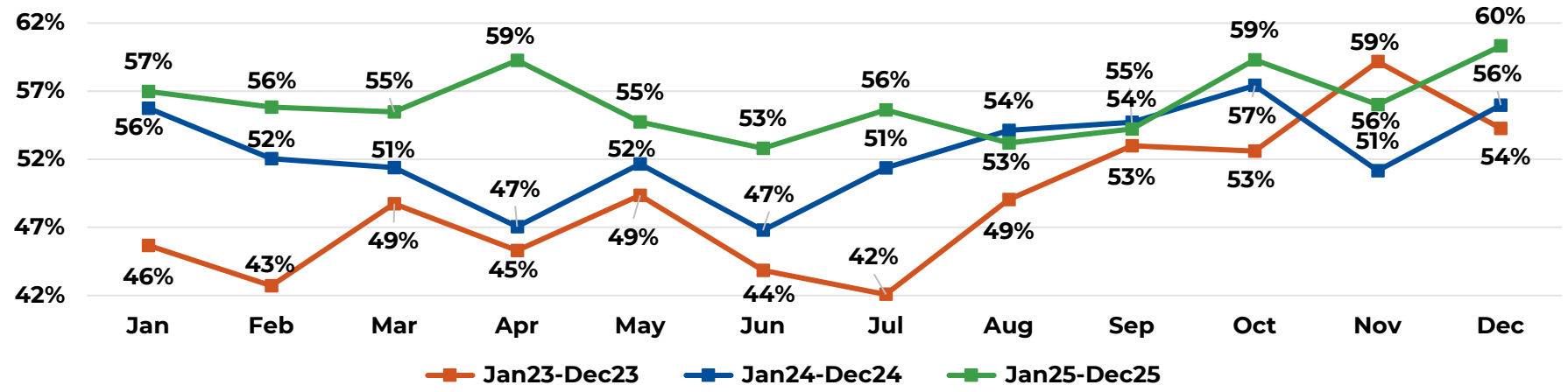


Enrollment & Utilization (Cont.)

Expansion Members Served

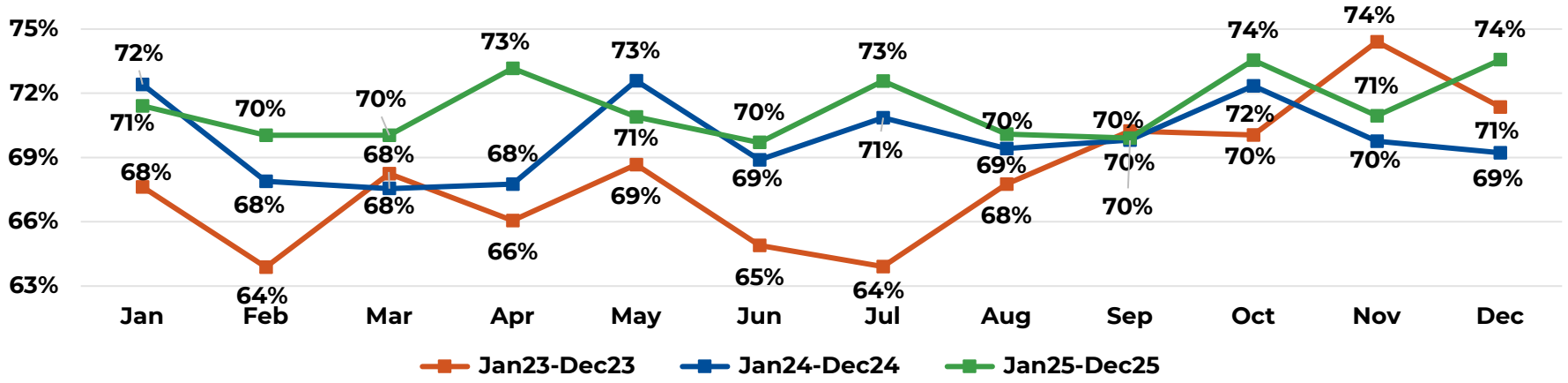


Percent of Total Enrolled Members Served

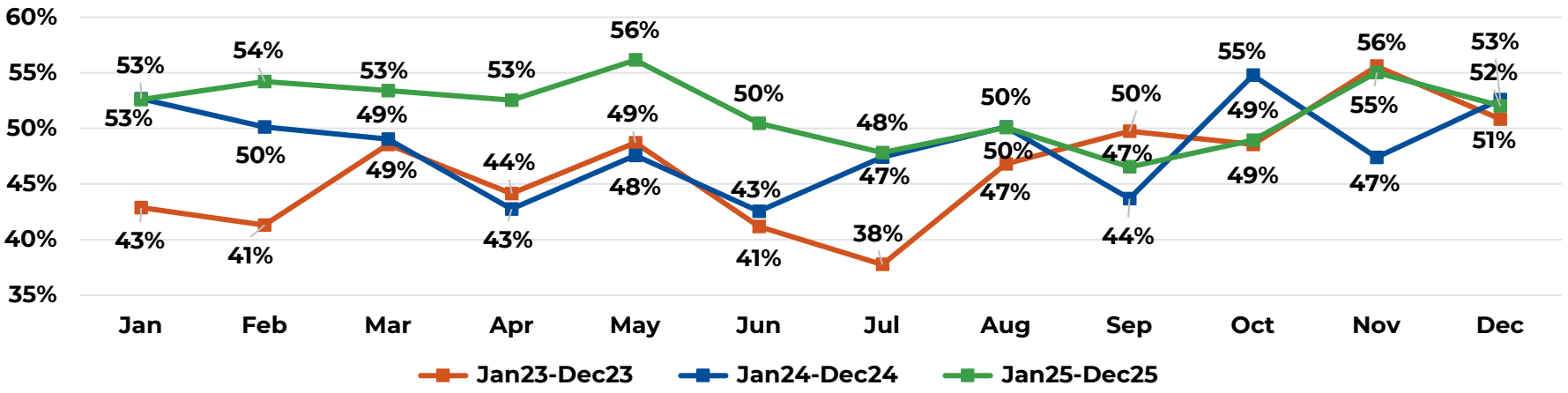


Enrollment & Utilization (Cont.)

Percent of Aged/Blind/Disabled Enrolled Members Served

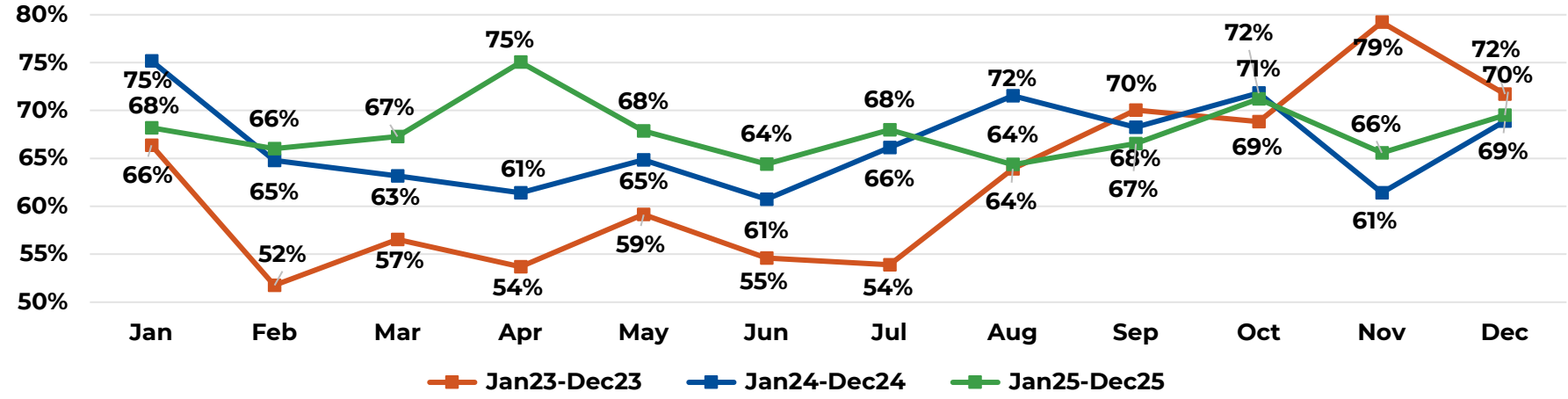


Percent of Children & Parent/Caretaker Enrolled Members Served

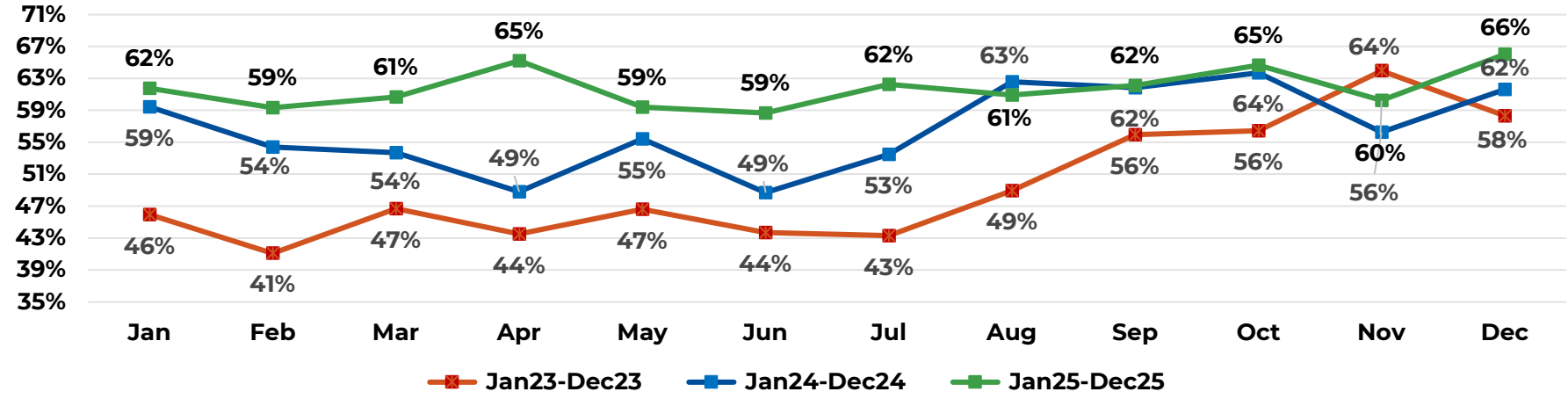


Enrollment & Utilization (Cont.)

Percent of Pregnant (Full Scope) Enrolled Members Served

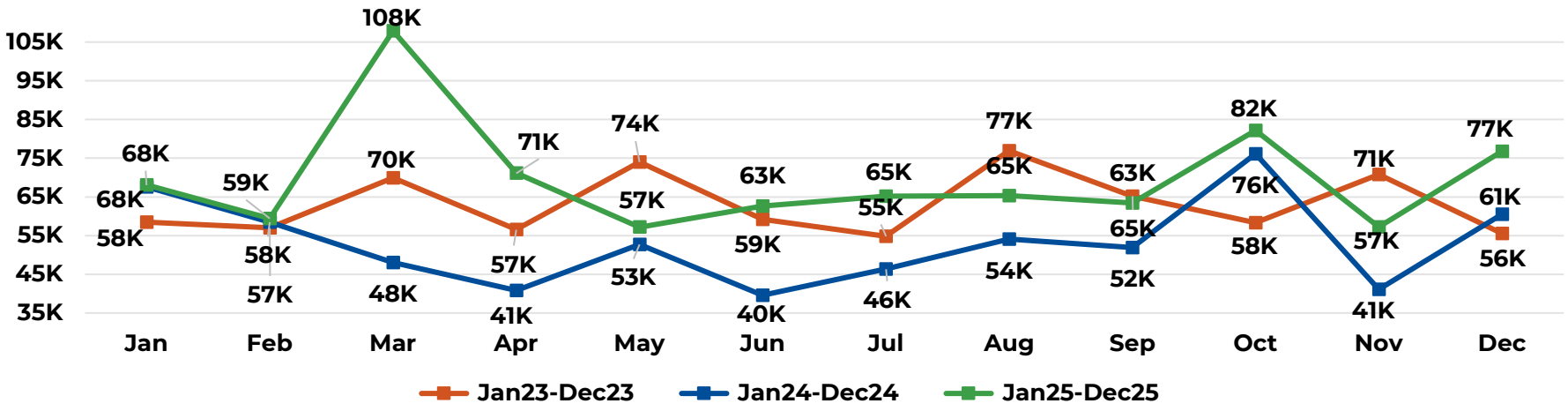


Percent of Expansion Enrolled Members Served

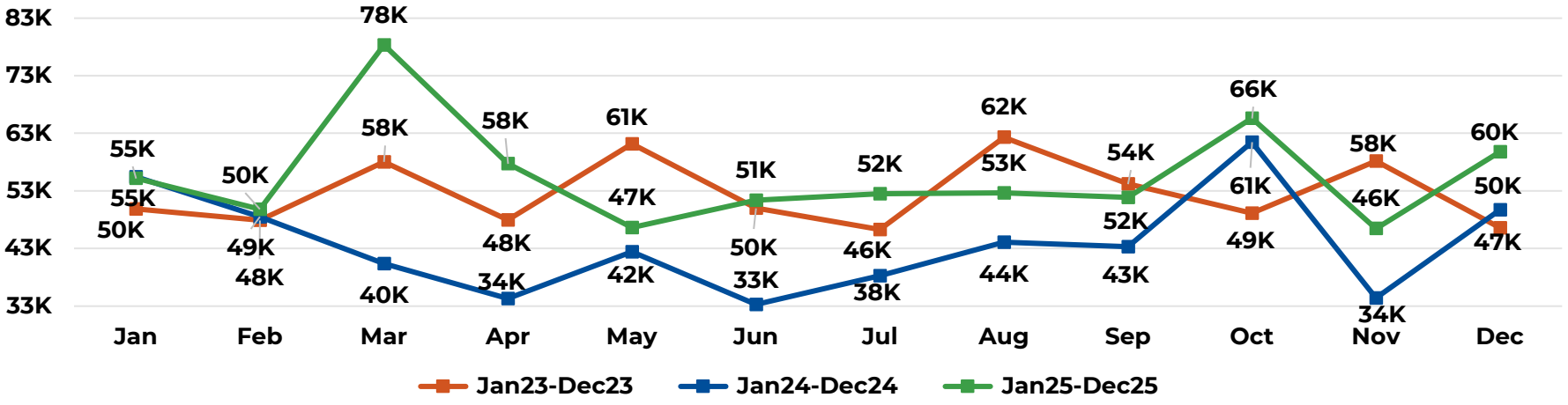


Utilization

Emergency Department - Visits (Claims)

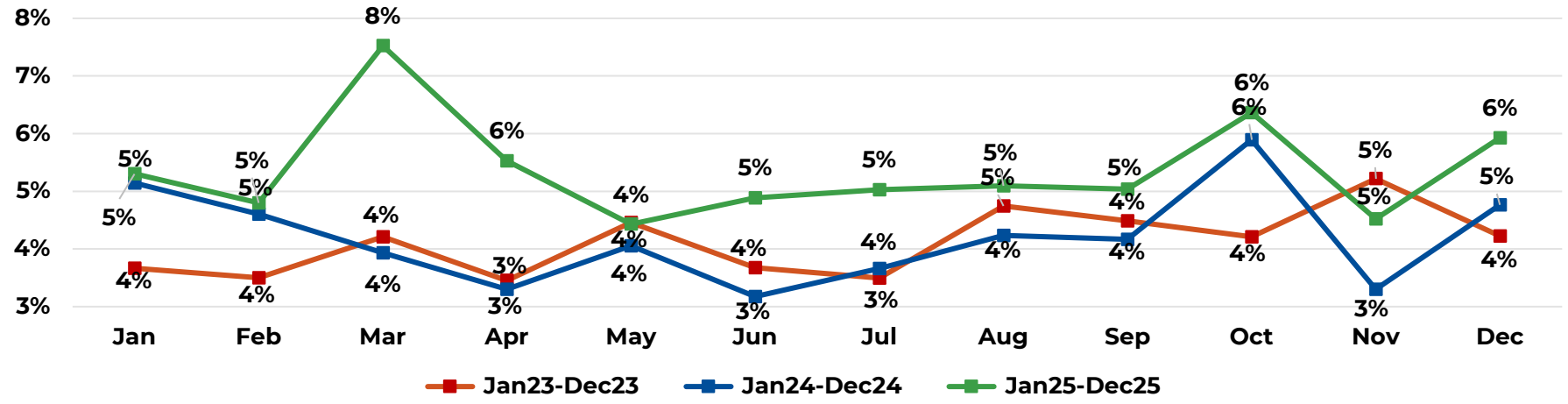


Emergency Department - Members Served



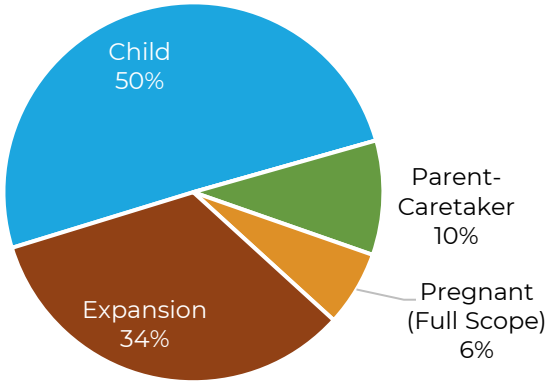
Utilization (Cont.)

Emergecy Department - Percent Total Enrolled Members Served

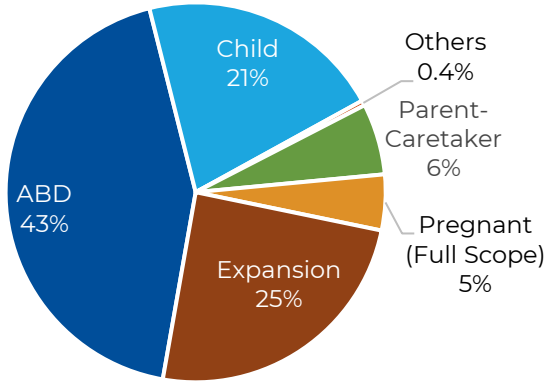


Emergency Department - Members Served By Qualifying Group (Dec2025)

MCE

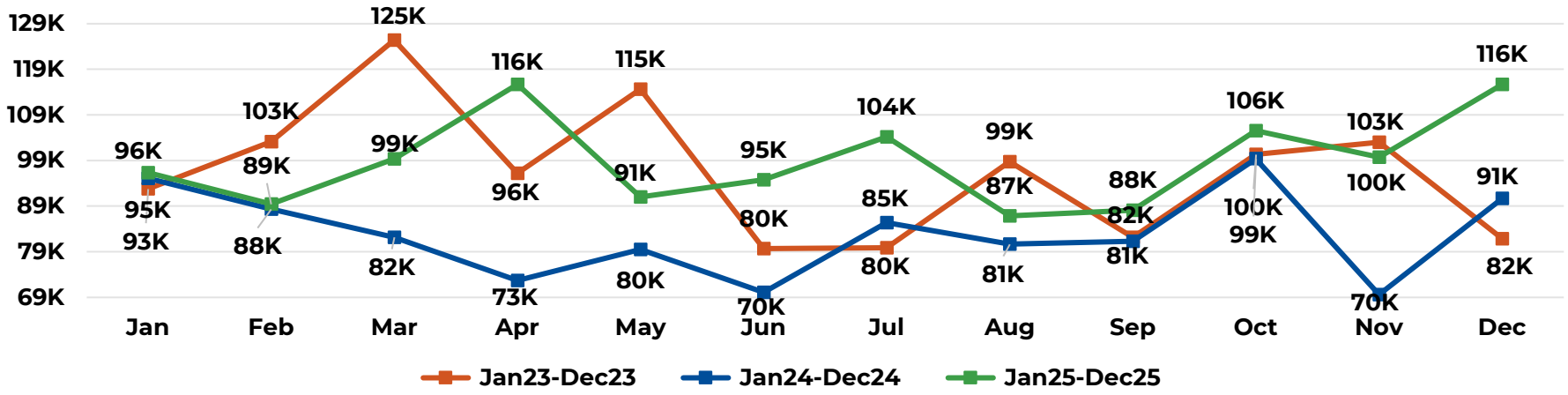


FFS

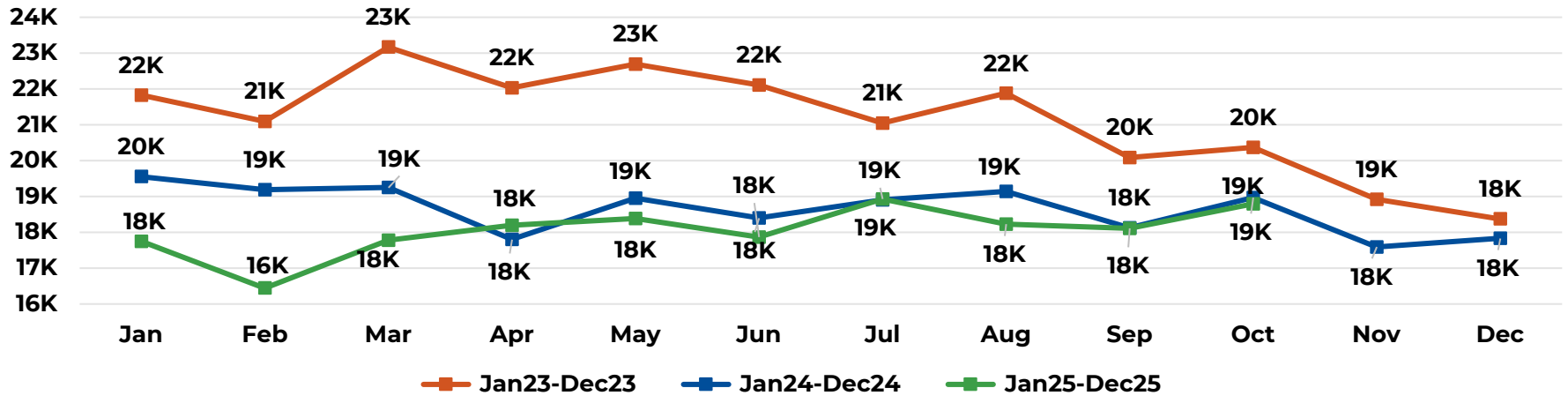


Utilization (Cont.)

Telemedicine - Total Visits (Claims)

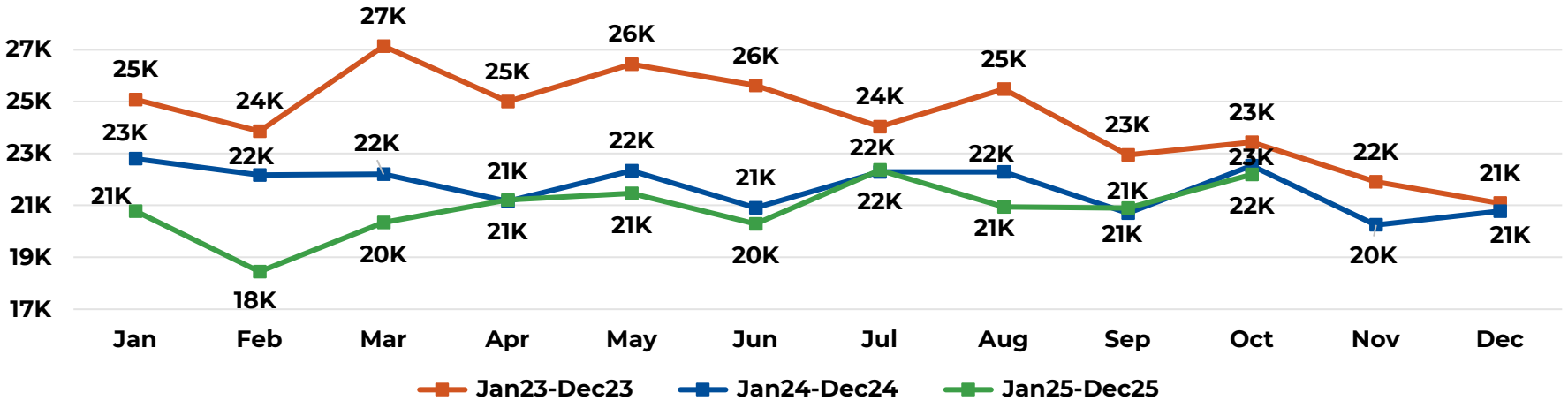


Opioid Claims - Members Served



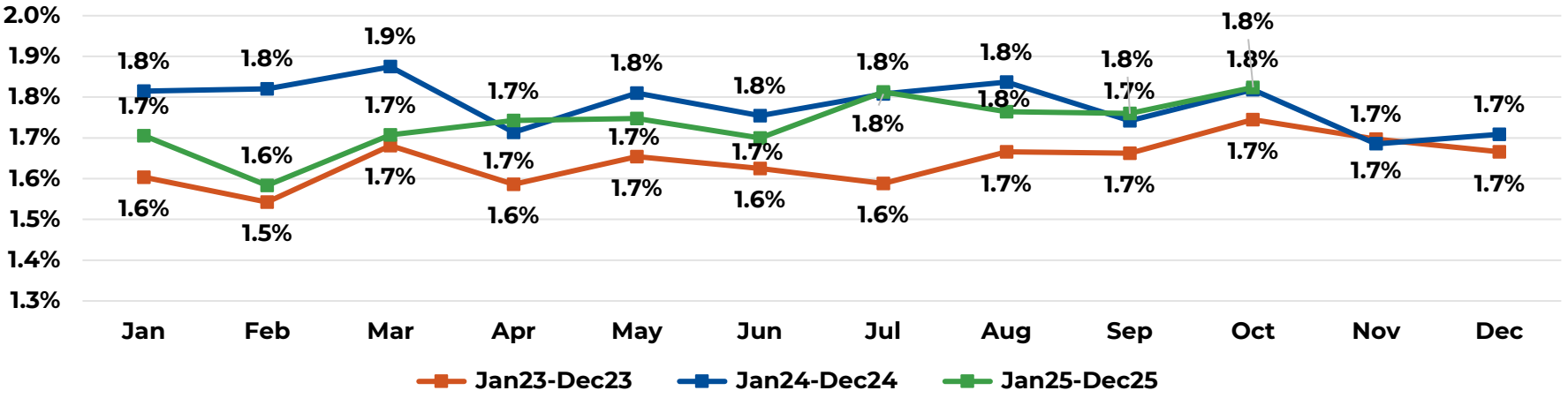
Utilization (Cont.)

Opioid Claims - Total Claims

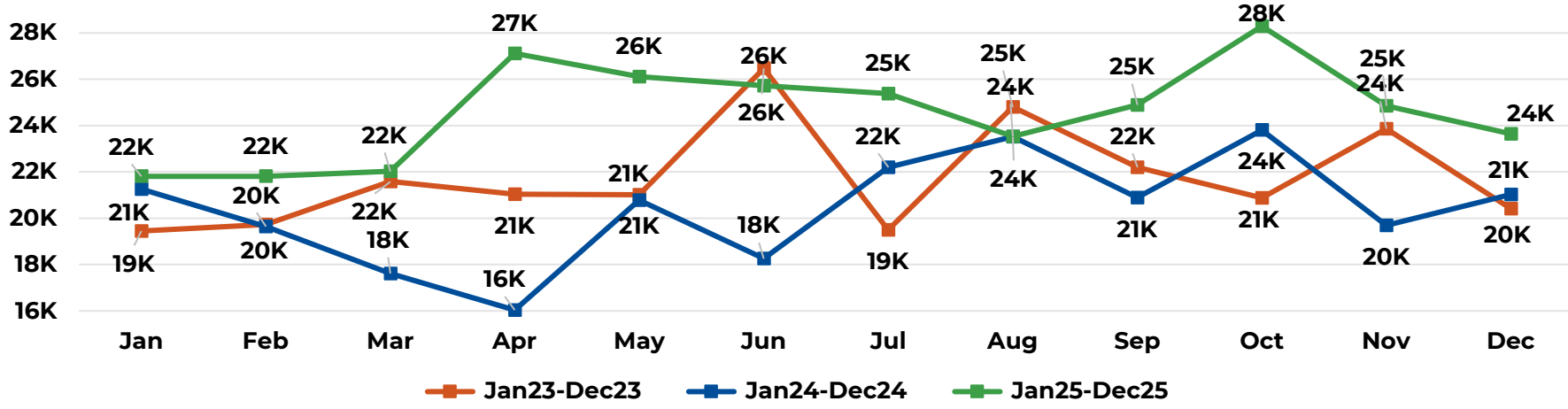


Utilization (Cont.)

Opioid Claims - Percent Total Enrolled With Opioid Claims



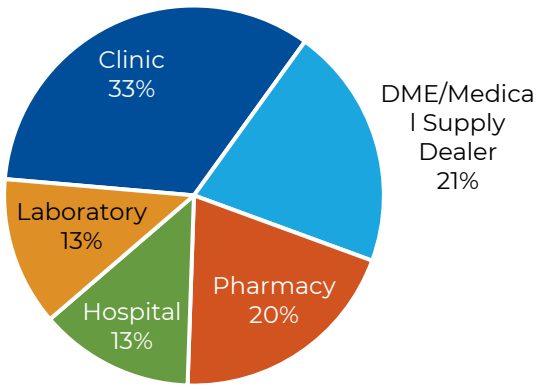
Out of State Services (Non Border County) - Total Members Served



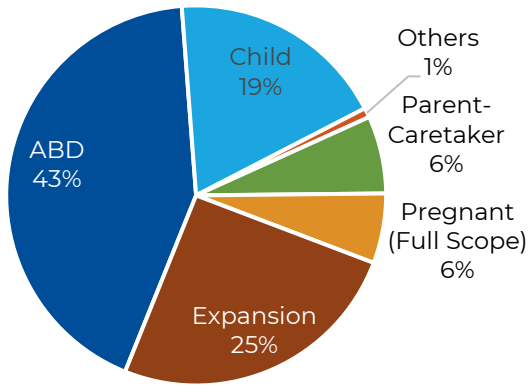
Utilization (Cont.)

Out of State Services (Non Border County) - Total Members Served By Provider Type & Qualifying Group (Dec2025)

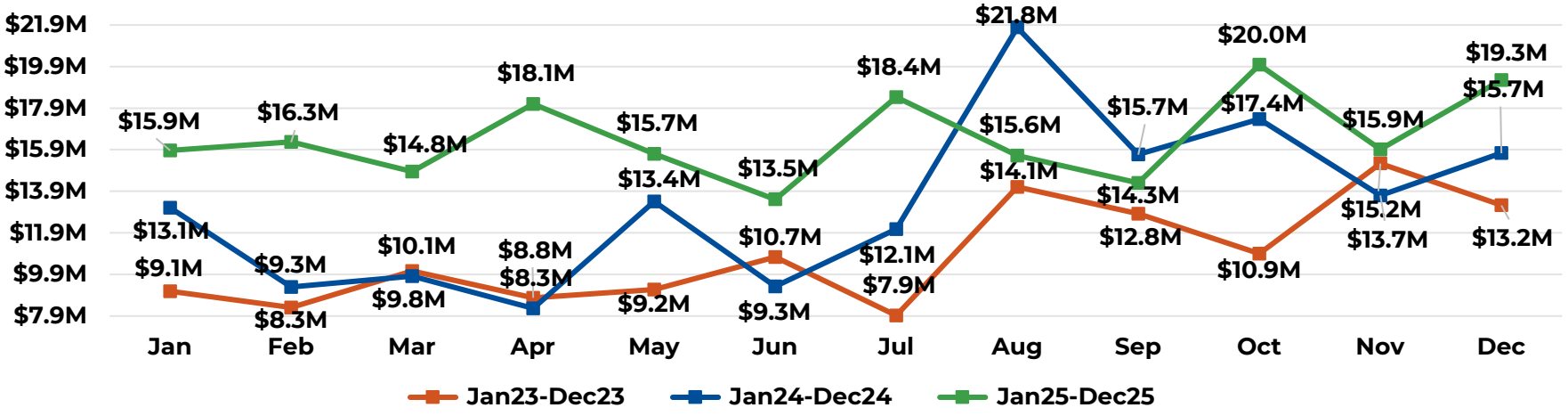
Provider Type (Top 5)



Qualifying Group (All Members)

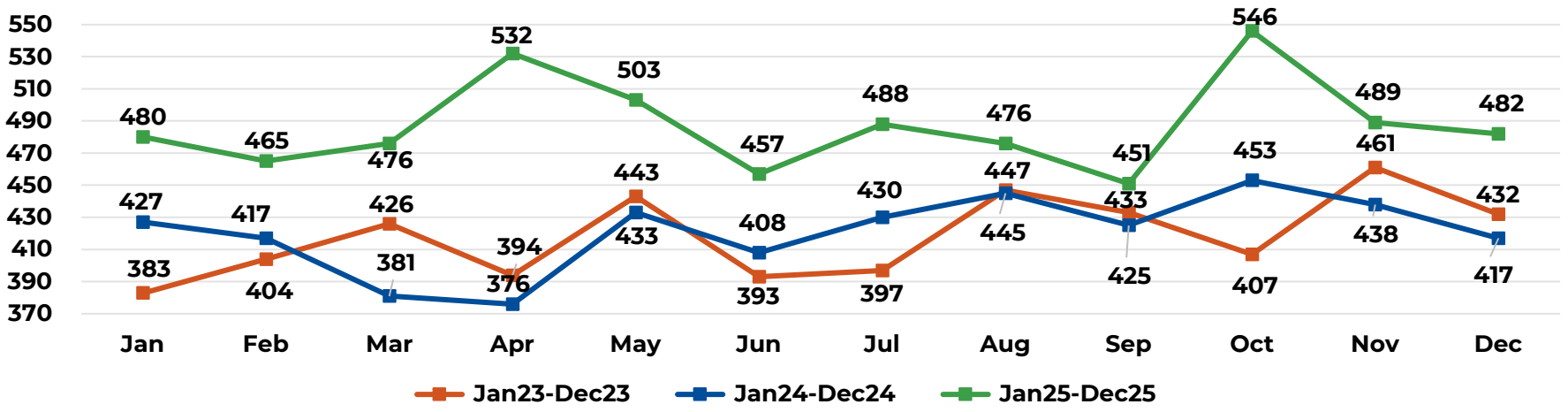


Out of State Services (Non Border County) - Total Expenditures

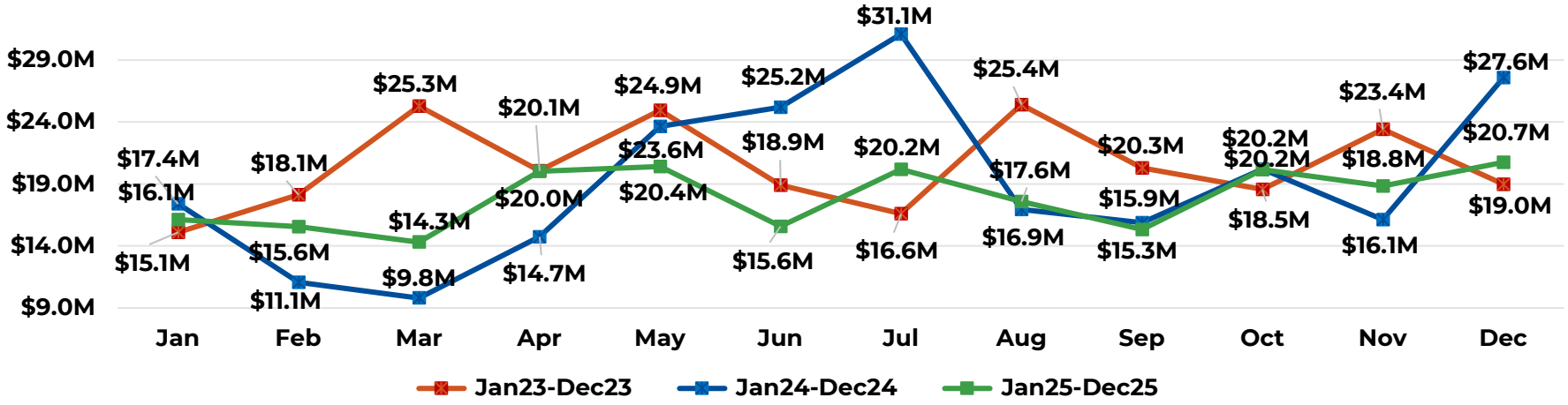


Utilization (Cont.)

Out of State Services (Non Border County) - Total Active Billing Providers

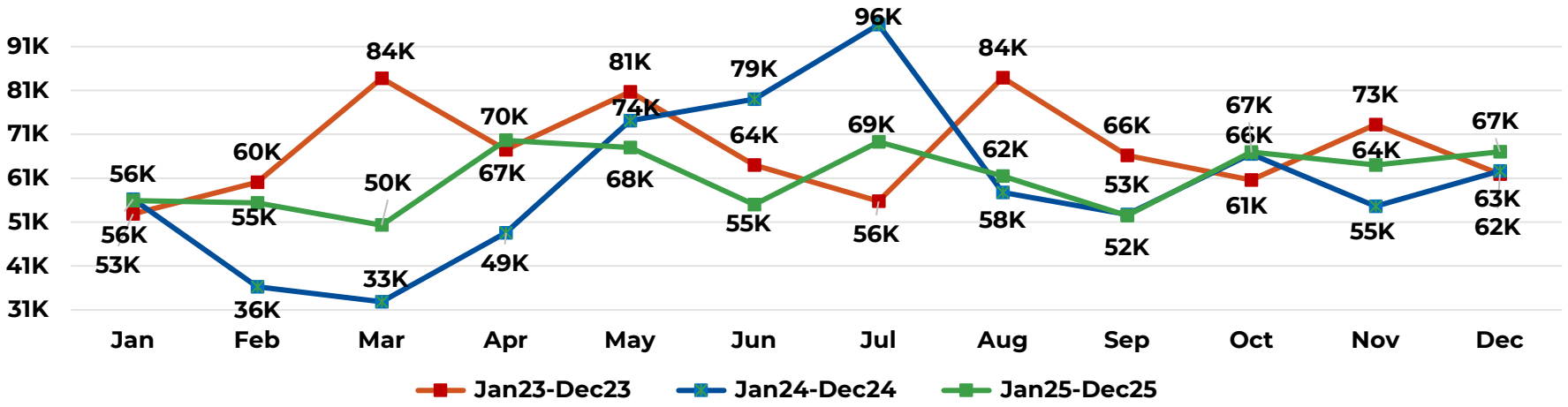


Dental Claims - Expenditures

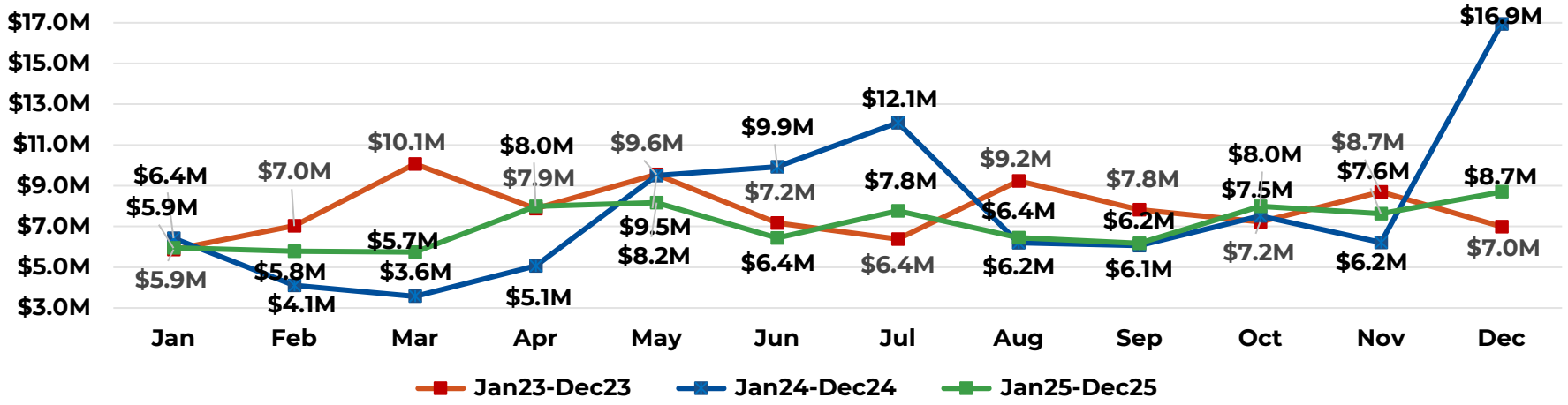


Utilization (Cont.)

Dental Claims - Members Served

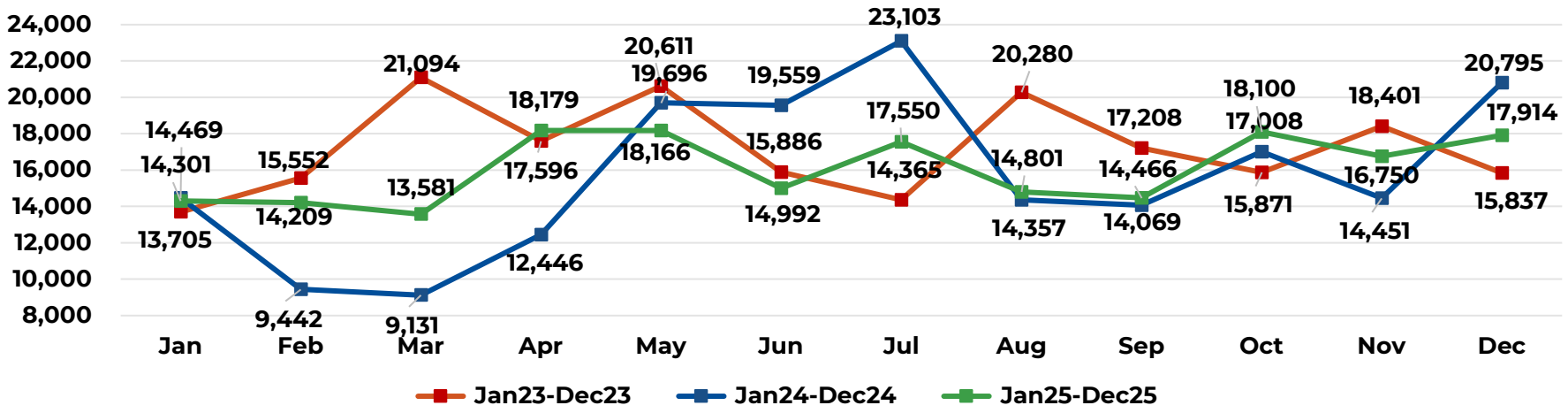


Adult Dental Claims (21 & Over) - Expenditures

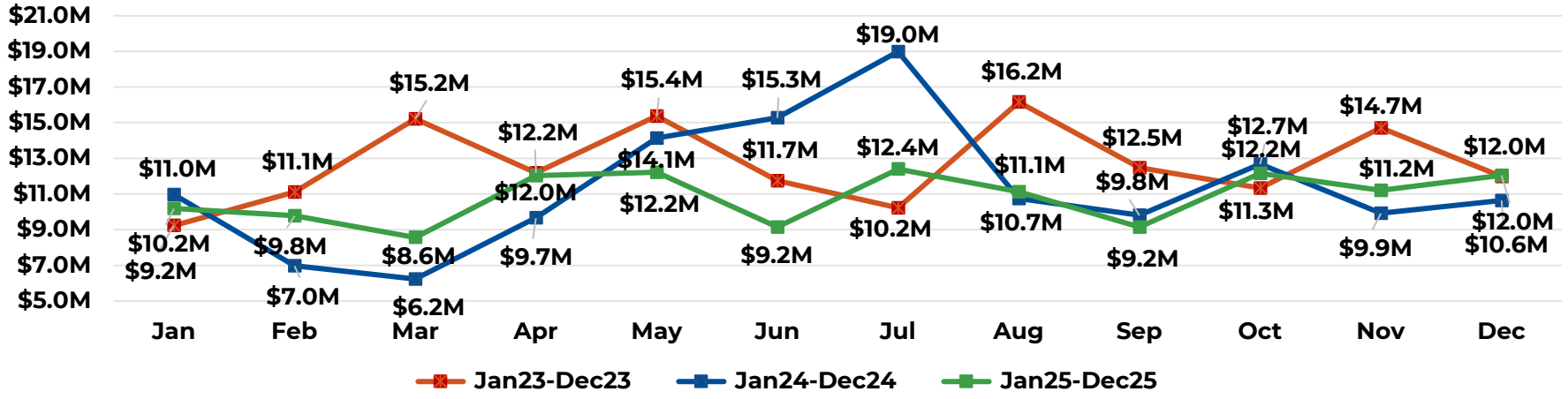


Utilization (Cont.)

Adult Dental Claims (21 & Over) - Members Served

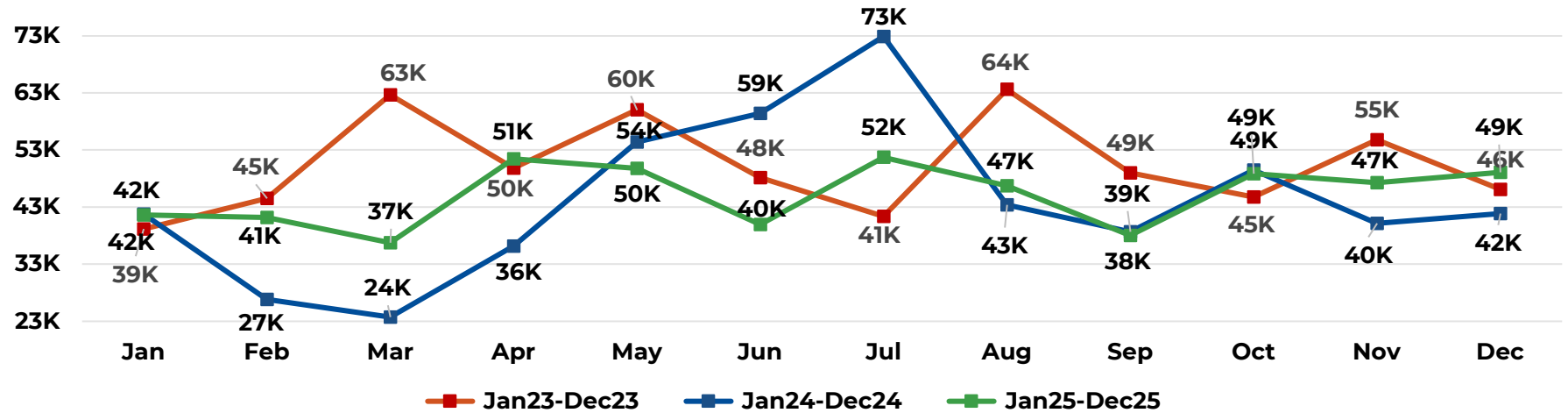


Children Dental Claims (Under 21) - Expenditures

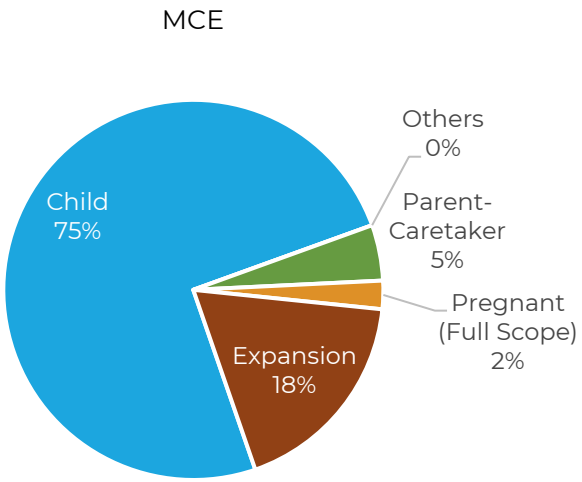


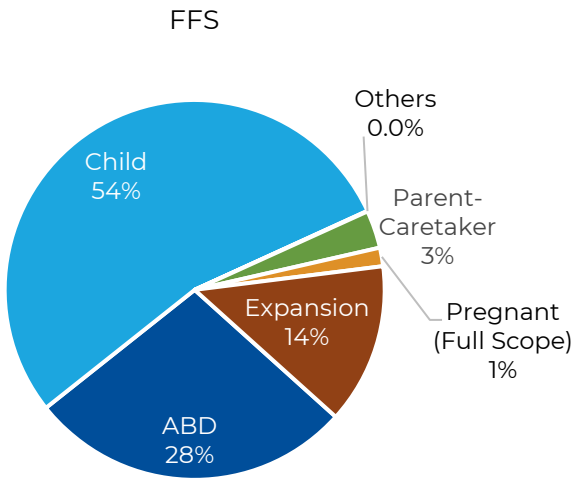
Utilization (Cont.)

Children Dental Claims (Under 21) - Members Served



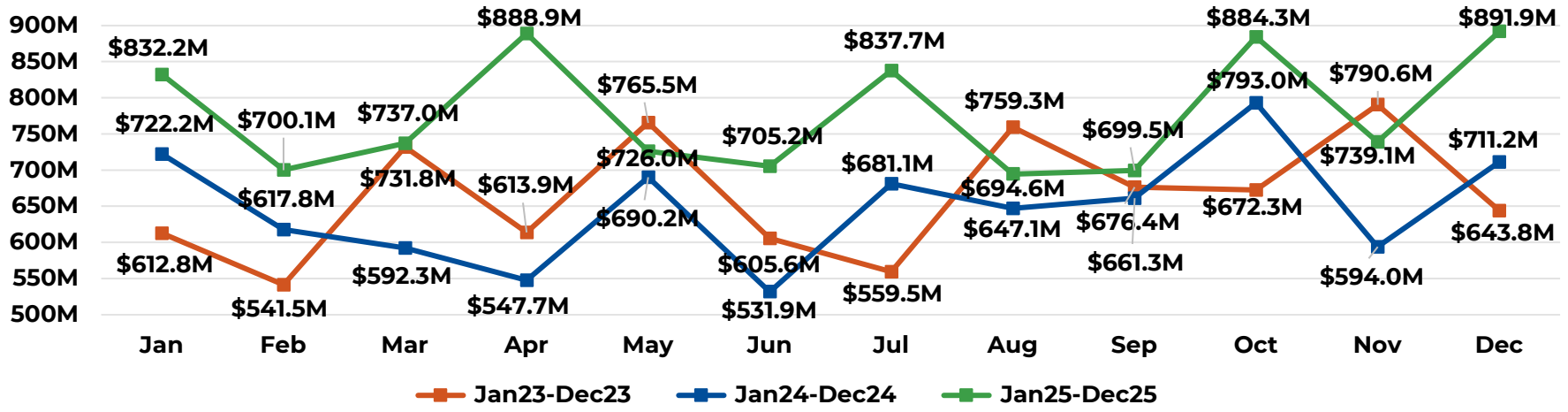
Dental Claims - Members Served By Qualifying Group (Dec2025)





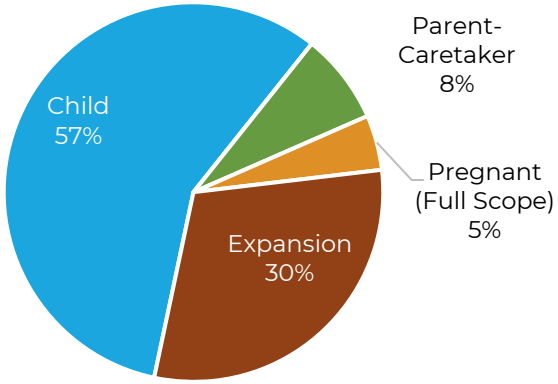
Financials

Total Agency Expenditures

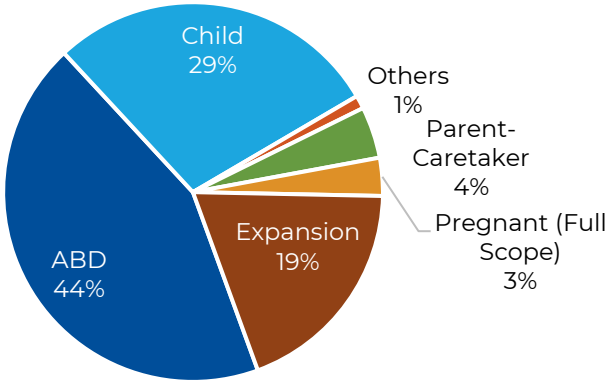


Total Agency Utilization - Members Served By Qualifying Group (Dec2025)

MCE

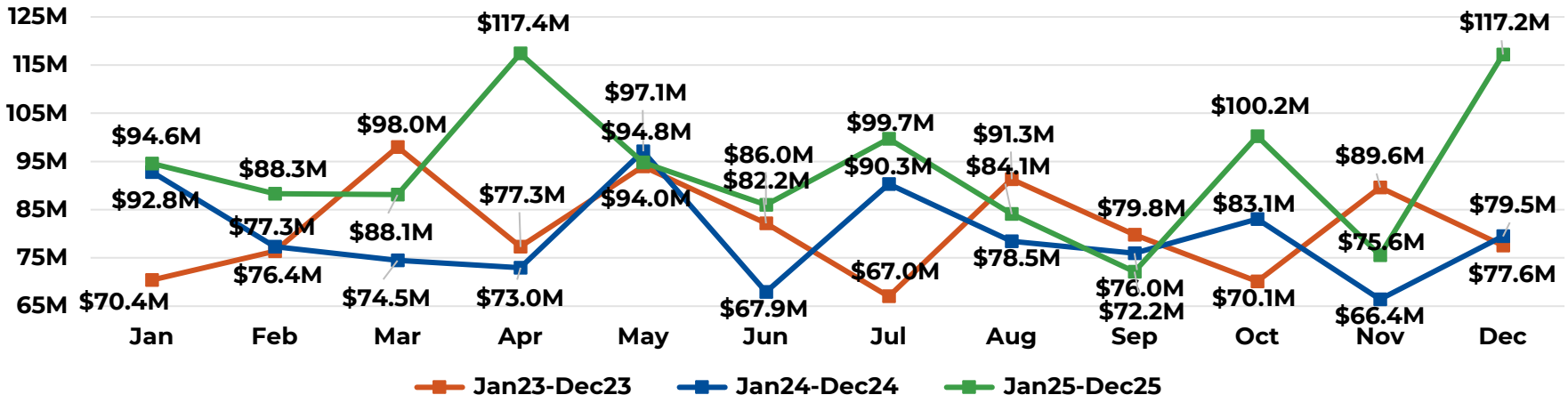


FFS



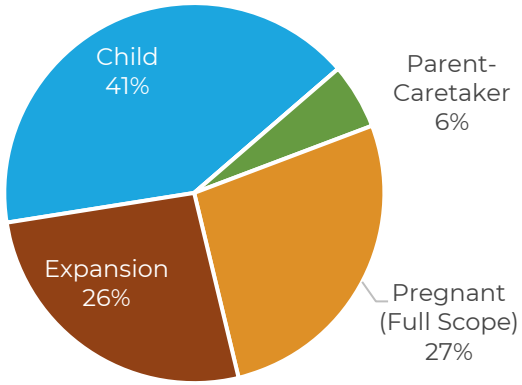
Financials (Cont.)

Inpatient Services - Expenditures

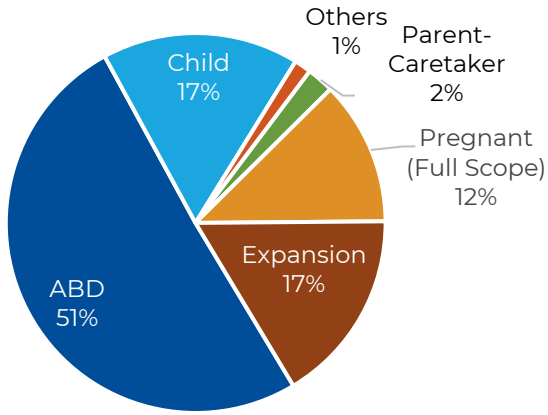


Inpatient Services - Members Served by Qualifying Group (Dec2025)

MCE

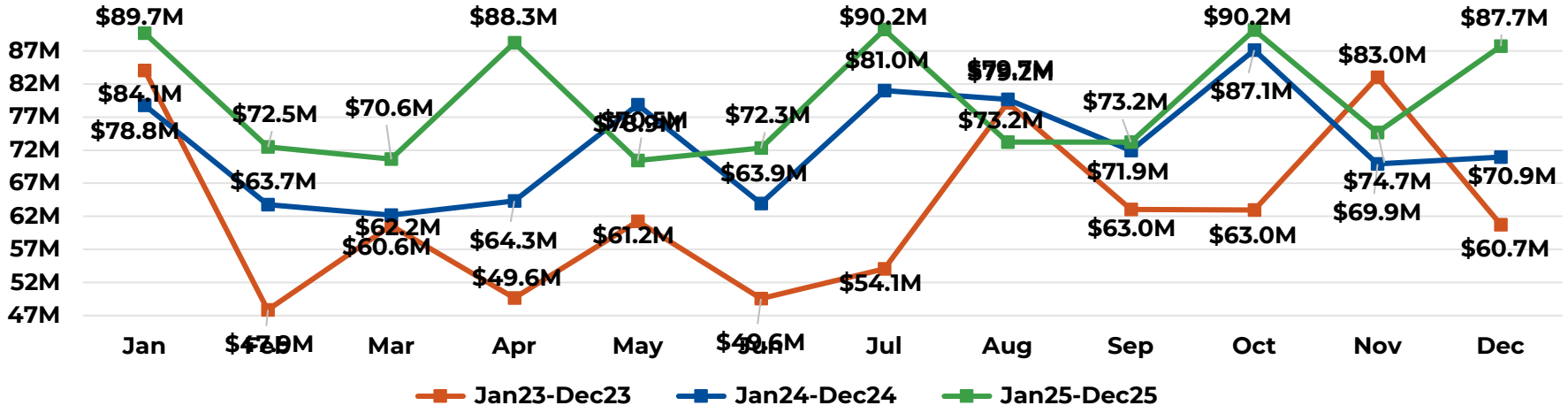


FFS

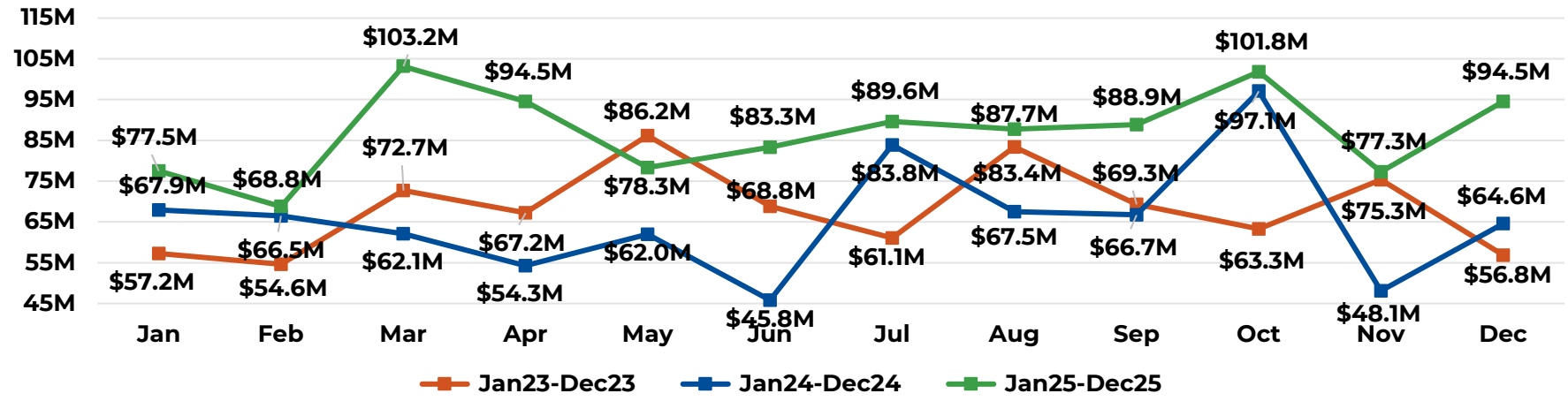


Financials (Cont.)

Nursing Facility Services - Expenditures

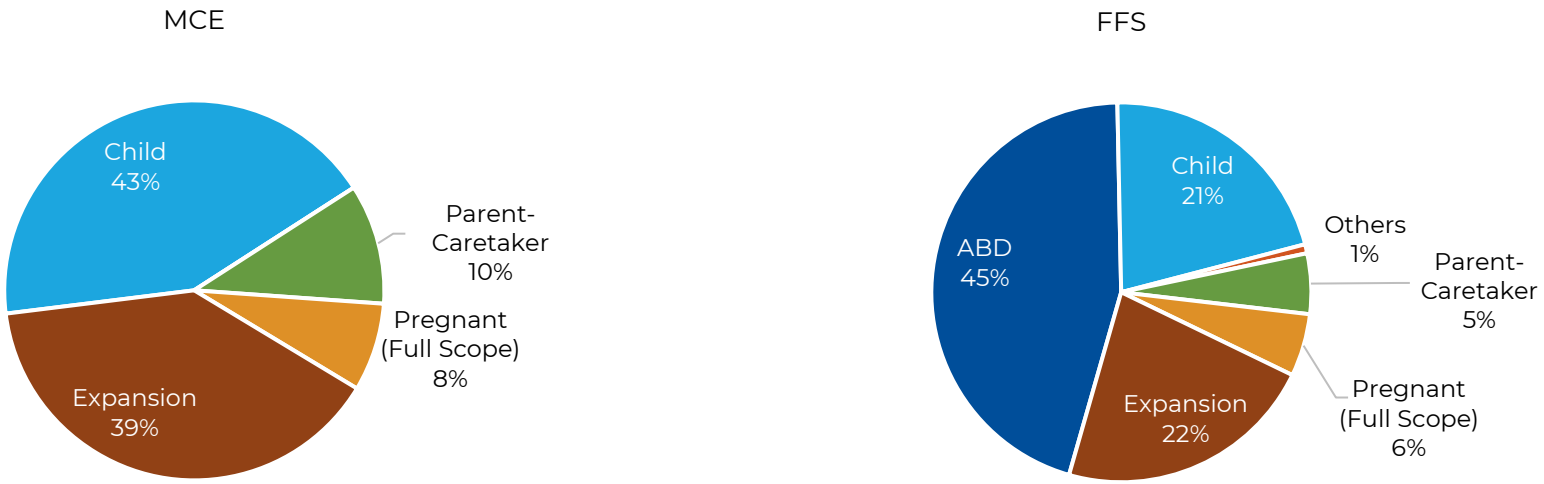


Outpatient Hospital Services - Expenditures

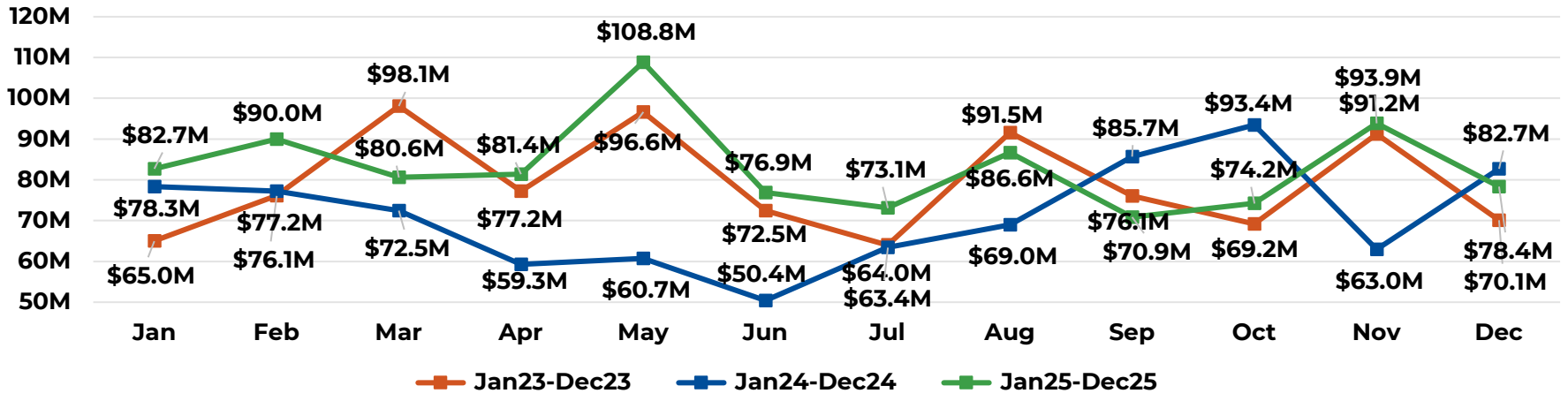


Financials (Cont.)

Outpatient Hospital Services - Members Served By Qualifying Group (Dec2025)



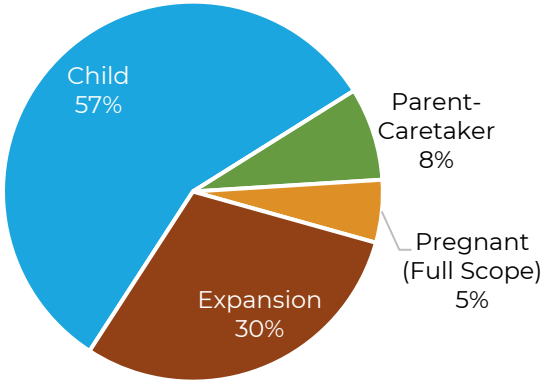
Physician Services - Expenditures



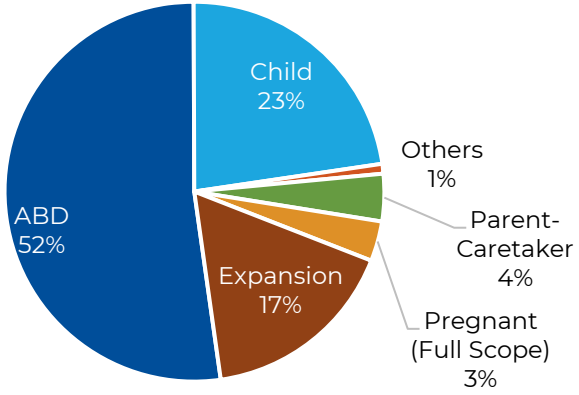
Financials (Cont.)

Physician Services - Members Served By Qualifying Group (Dec2025)

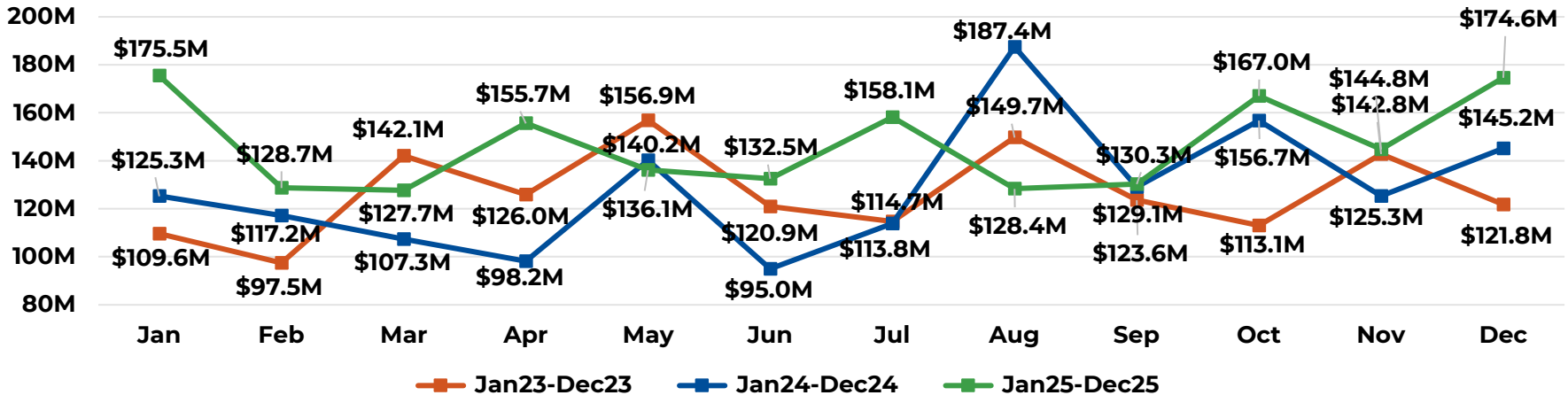
MCE



FFS



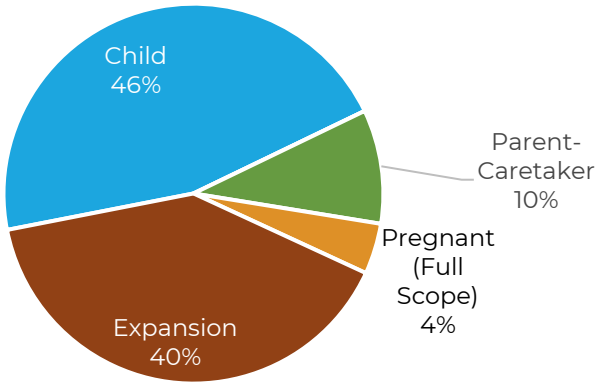
Prescribed Drugs - Expenditures



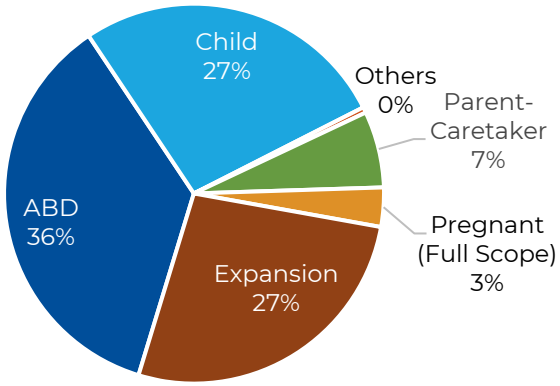
Financials (Cont.)

Prescribed Drugs - Members Served By Qualifying Group (Dec2025)

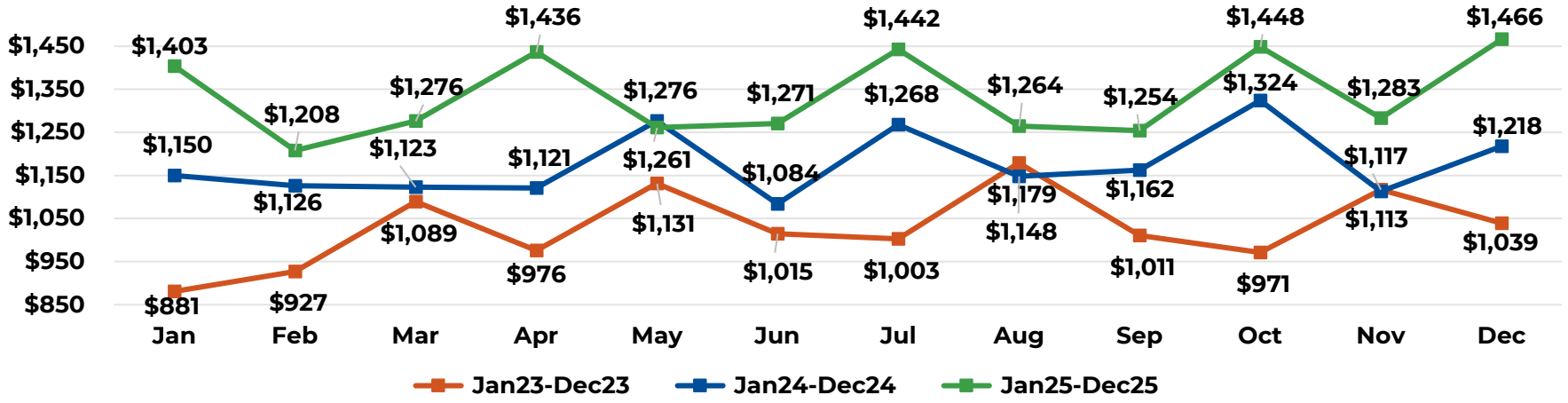
MCE



FFS

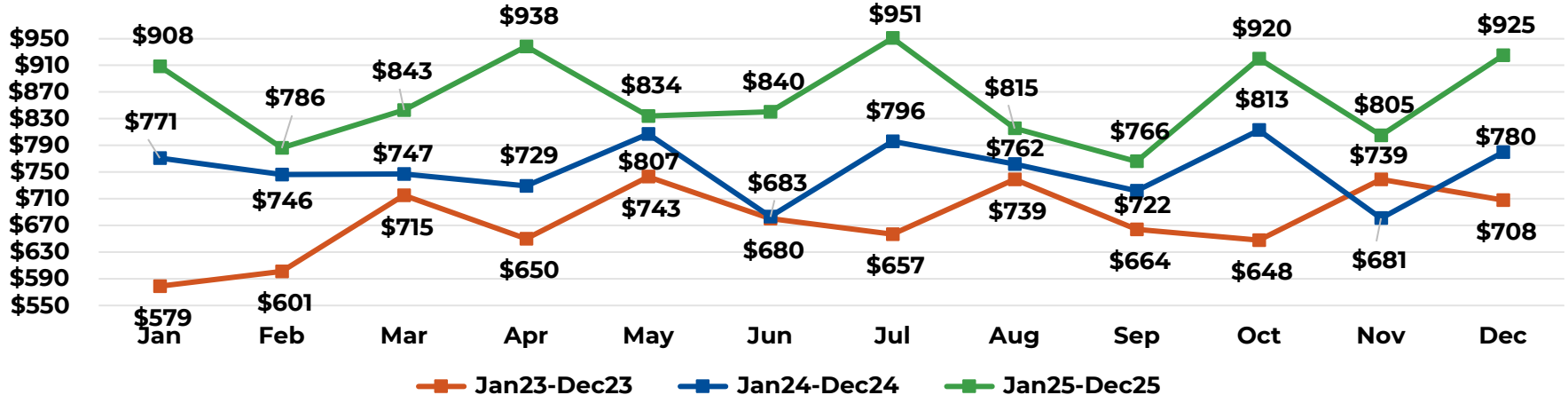


Average Expenditure Per Total Members Served

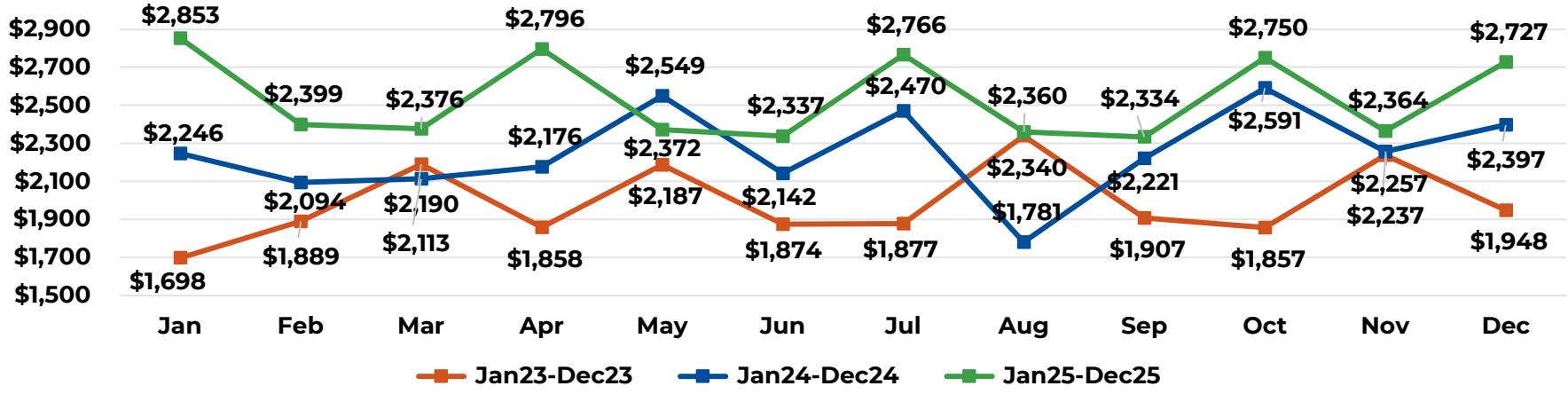


Financials (Cont.)

Average Expenditure Per Child (Under 21) Member Served

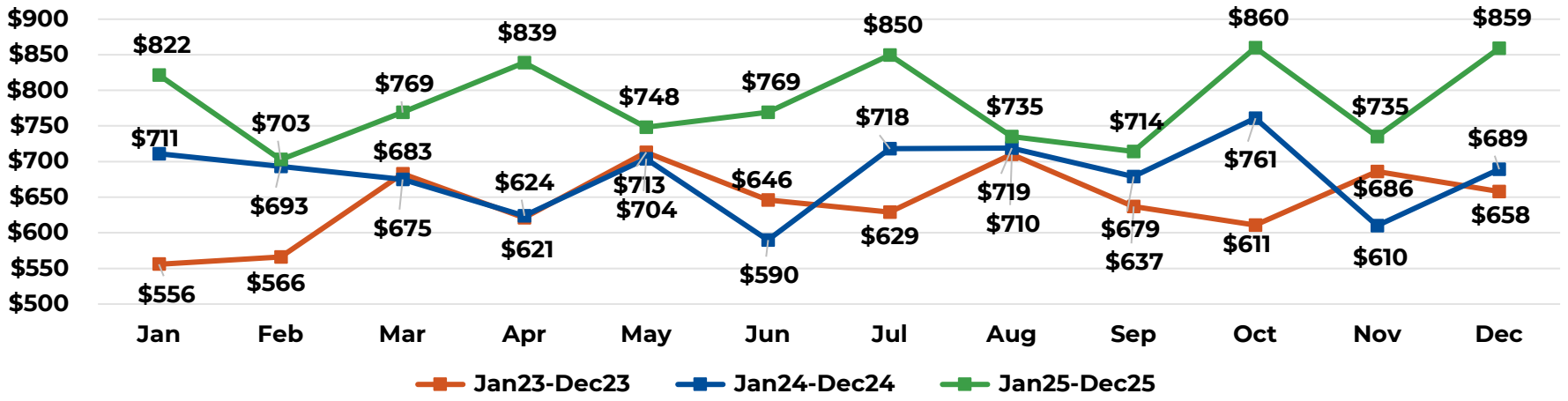


Average Expenditure Per Aged/Blind/Disabled Member Served

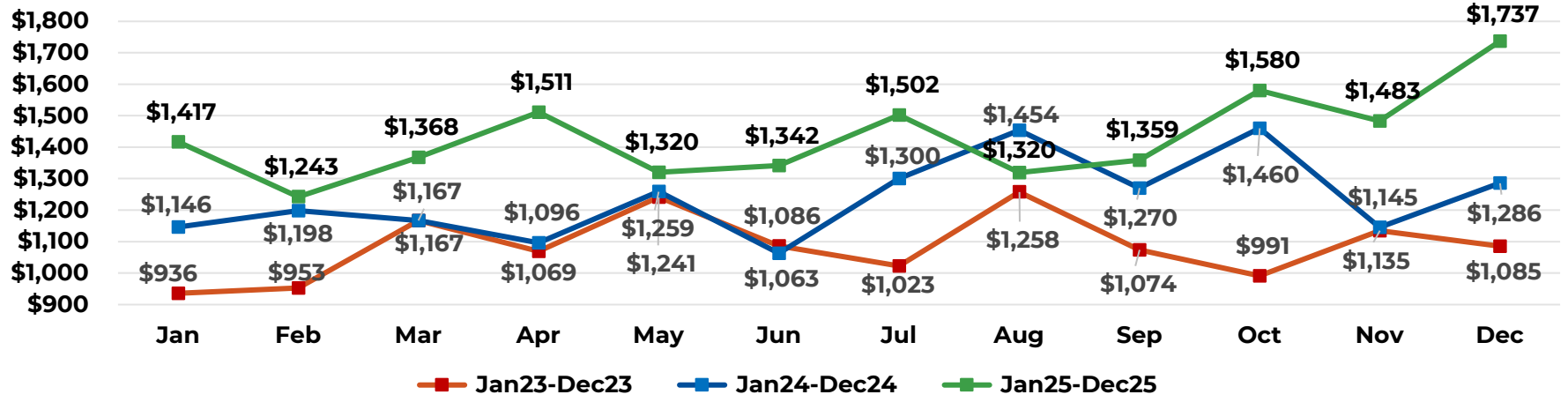


Financials (Cont.)

Average Expenditure Per Children & Parent/Caretaker Member Served

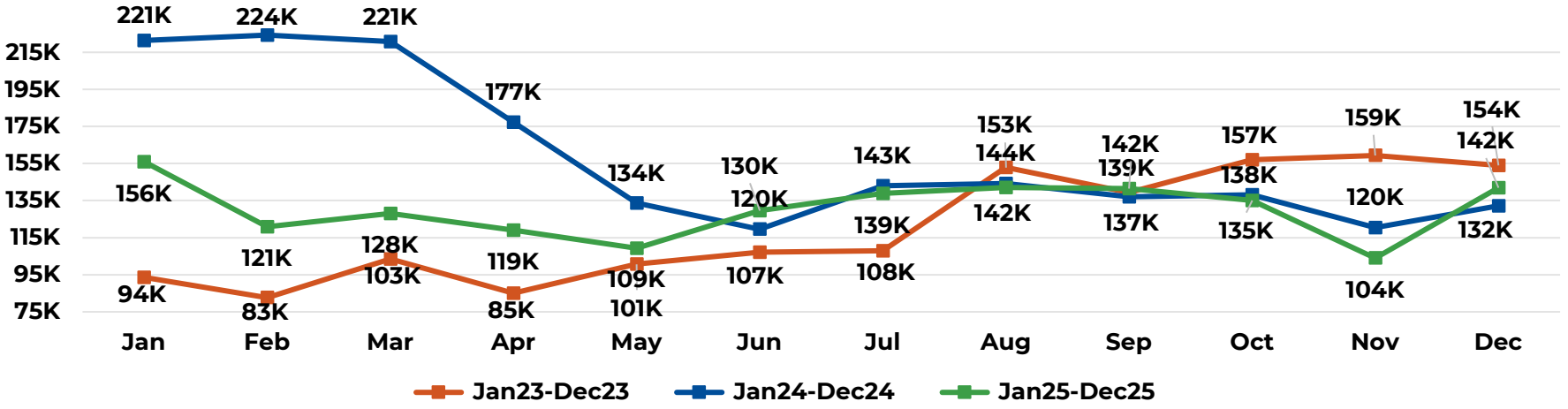


Average Expenditure Per Expansion Member Served

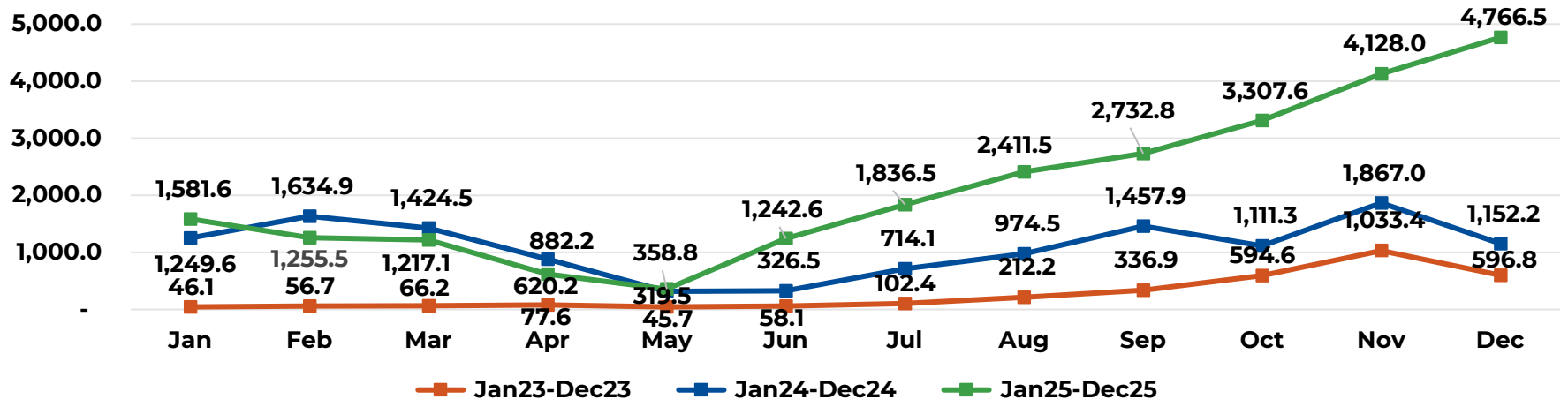


Call Center

Call Center - Member Calls Answered

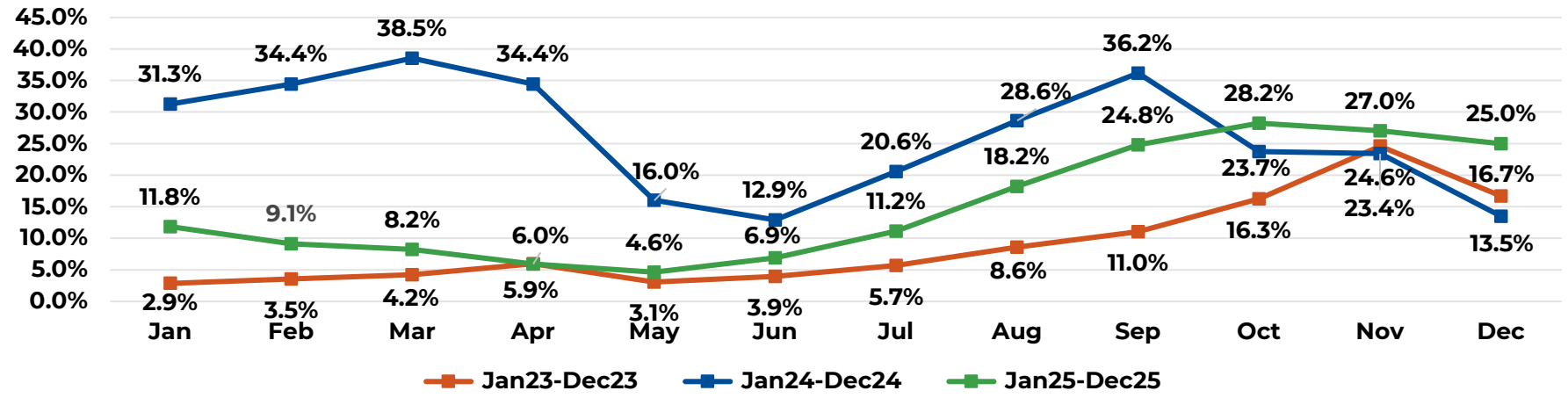


Call Center - Average Wait Time (In Seconds)



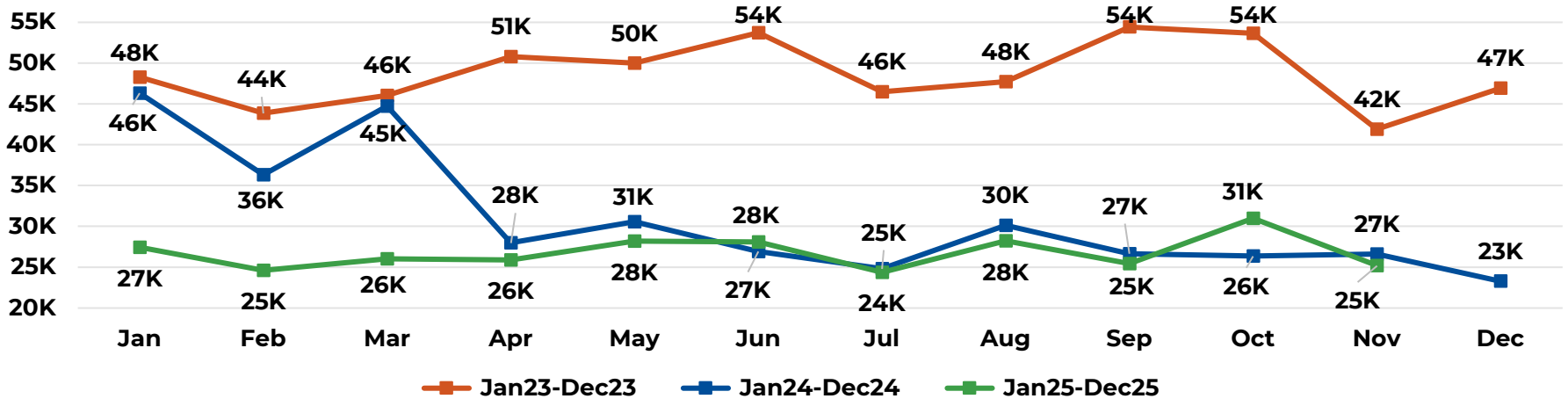
Call Center (Cont.)

Call Center - Abandoned Call Rate



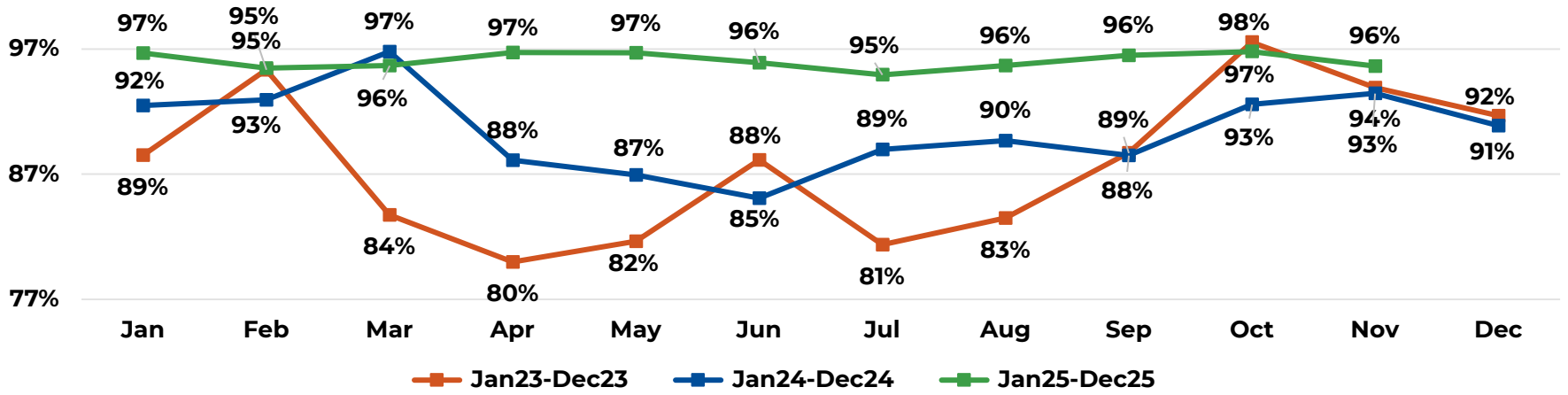
Prior Authorization

Fee-For-Service Prior Authorization - Total Combined - Total Completed PA Volume



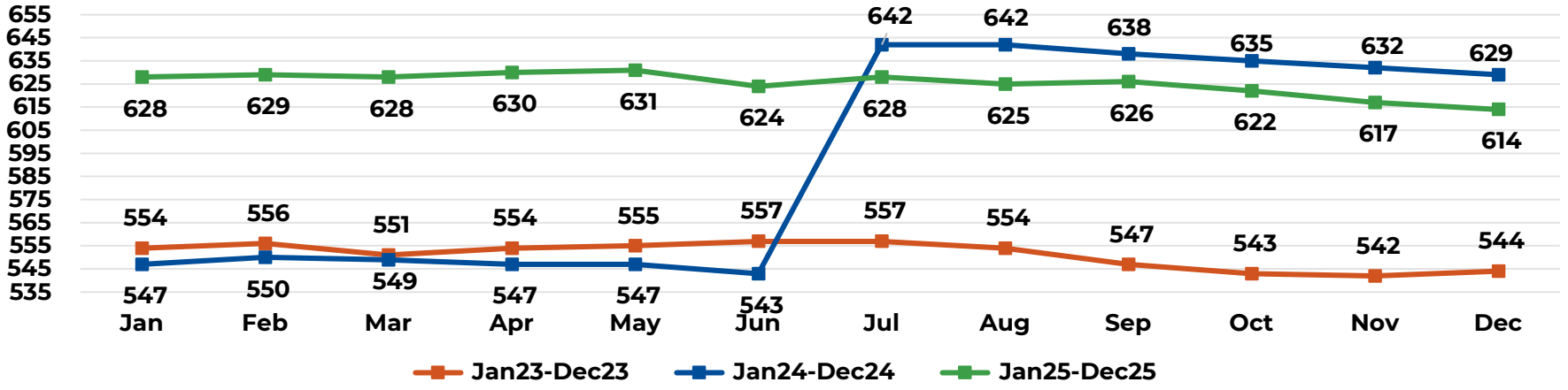
Prior Authorization (Cont.)

Fee-For-Service Prior Authorization - Total Combined - Total Percent Completed 0-6 Days



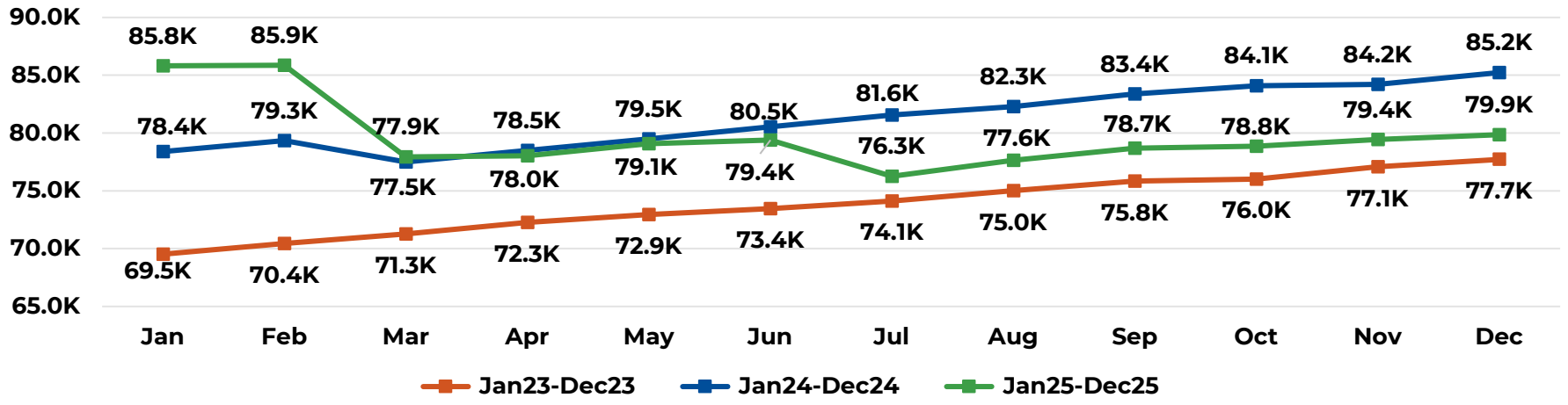
Agency Stats & Provider Network

OHCA Admin - Number of FTEs

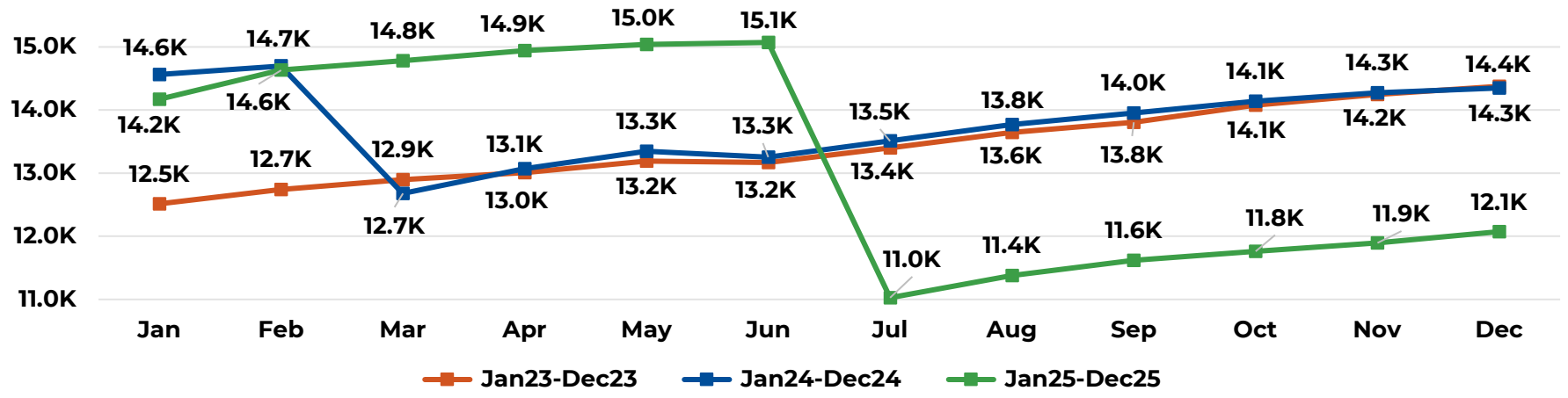


Agency Stats & Provider Network (Cont.)

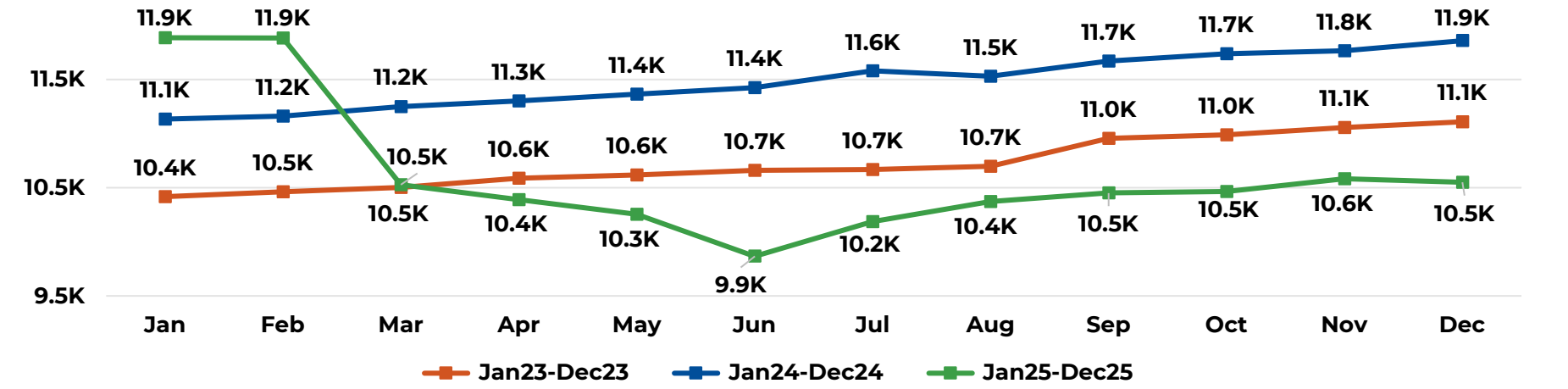
Total Providers Enrolled



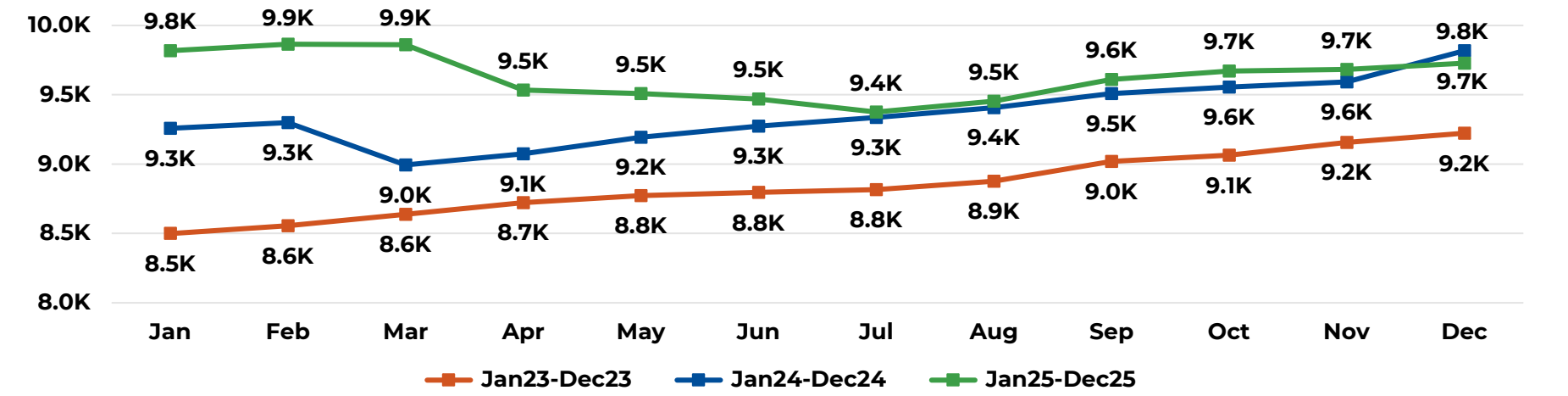
Mental Health Providers Enrolled (In-State Only)



Physicians Enrolled (In-State Only)

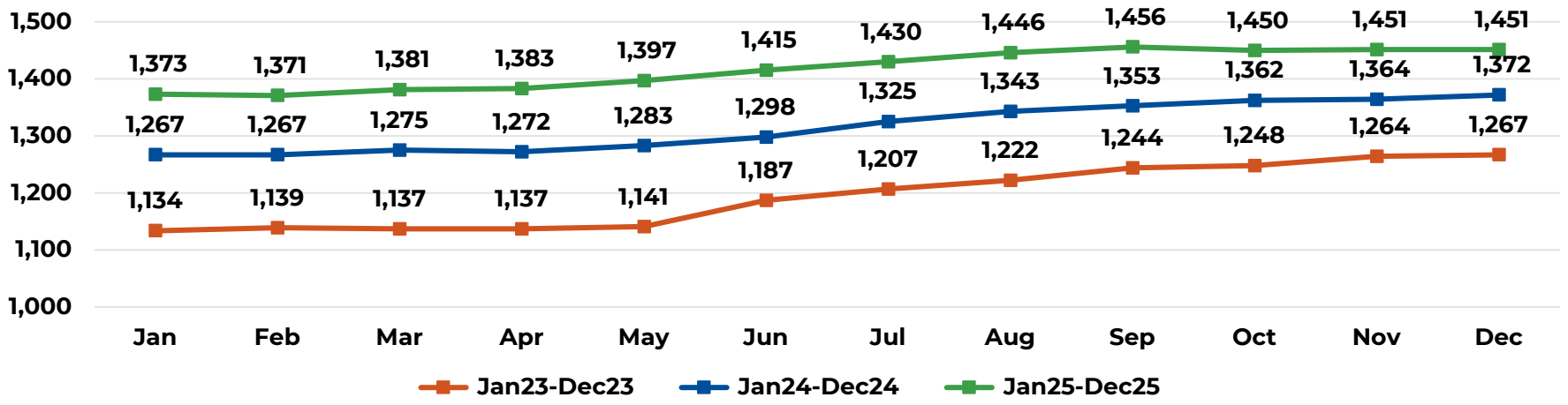


Primary Care Providers Enrolled (In-State Only)

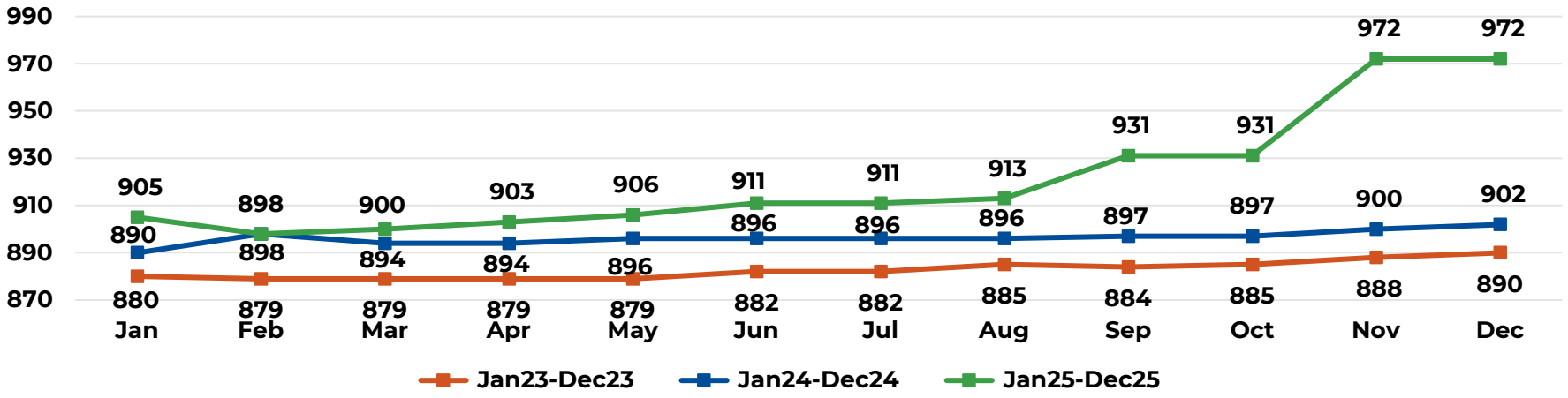


Agency Stats & Provider Network (Cont.)

Dentists Enrolled (In-State Only)

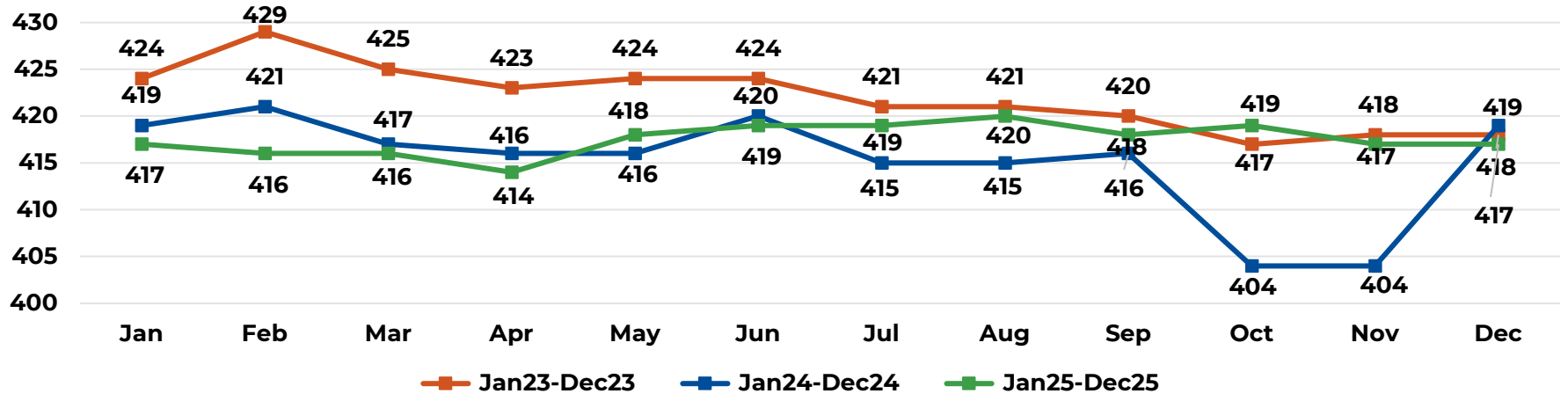


Pharmacy Enrolled (In-State Only)

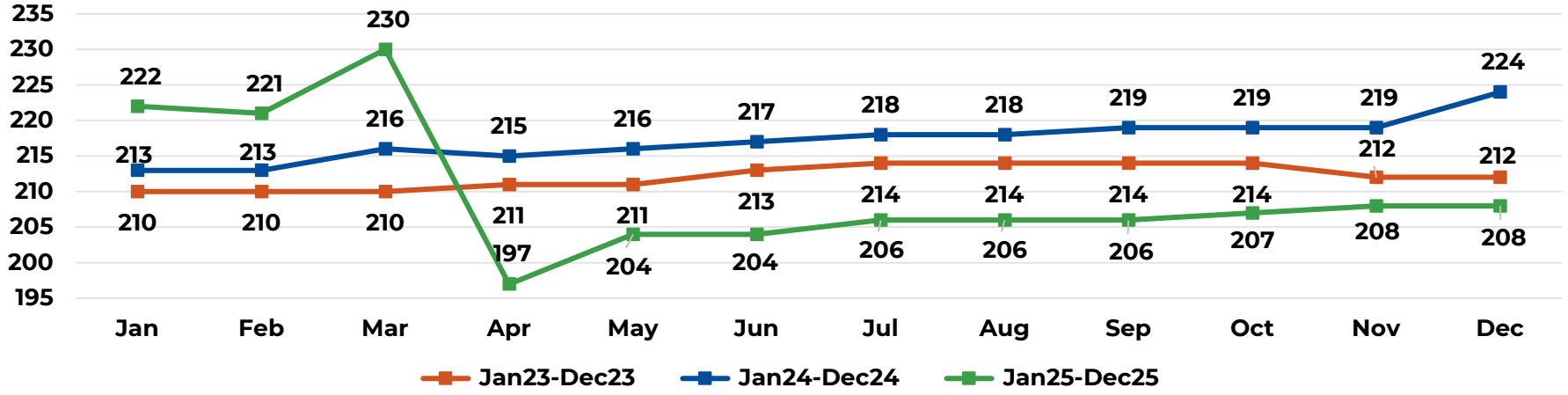


Agency Stats & Provider Network (Cont.)

Extended Care Facilities Enrolled (In-State Only)

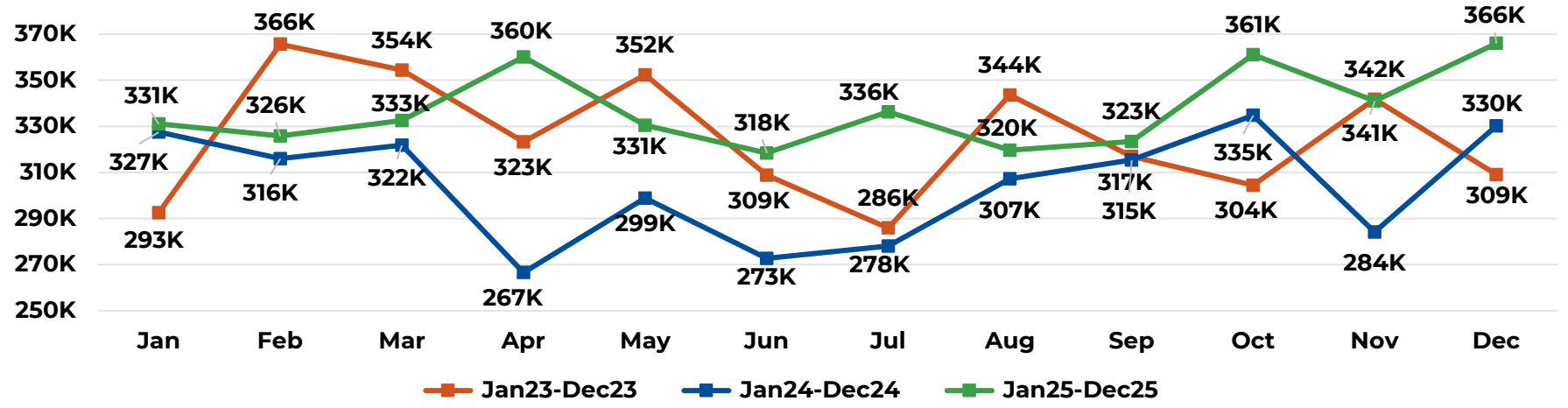


Hospitals Enrolled (In-State Only)



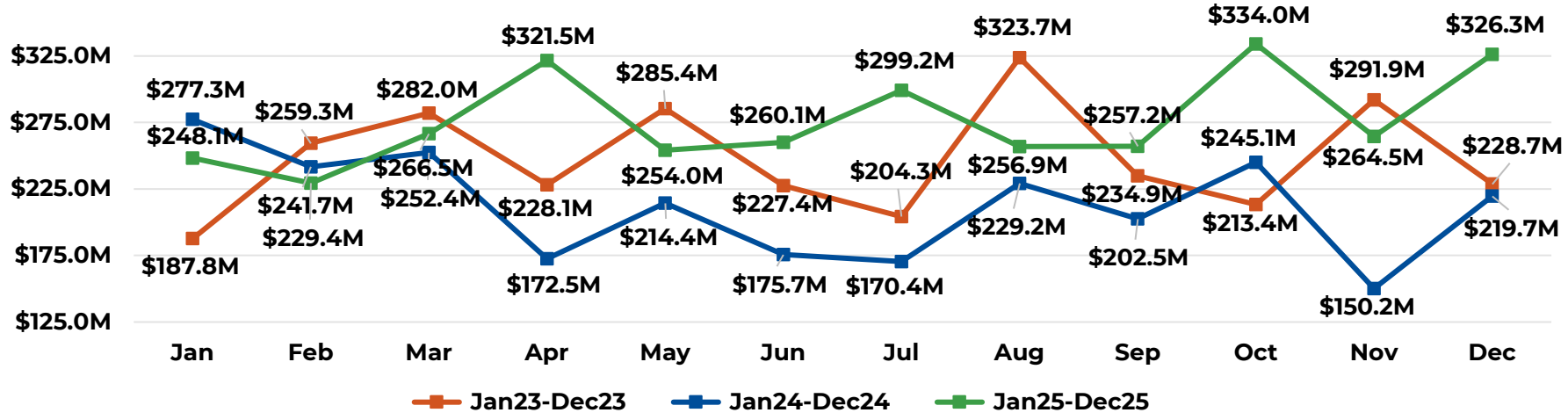
MCE Utilization

Total MCE Members Served - Medical & Dental (All MCEs)



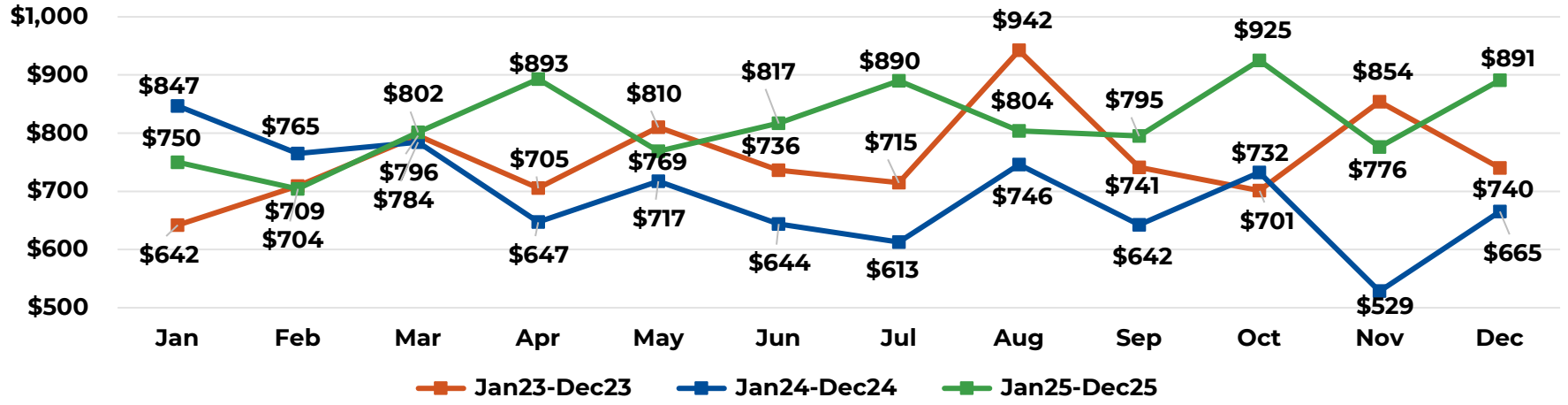
For MCE members served, expenditures and average per member, the data through June 2024 is MCE comparable group which is non ABD members eligible for MCE (Expansion, Parent/Caretaker, Non ABD Children, Full Scope Pregnant, etc.). Excludes tribal members since had low MCE opt-in. Data starting July 2024 is MCE claims based on MCE claim region codes (30, 68).

Total MCE Expenditures - Medical & Dental (All MCEs)

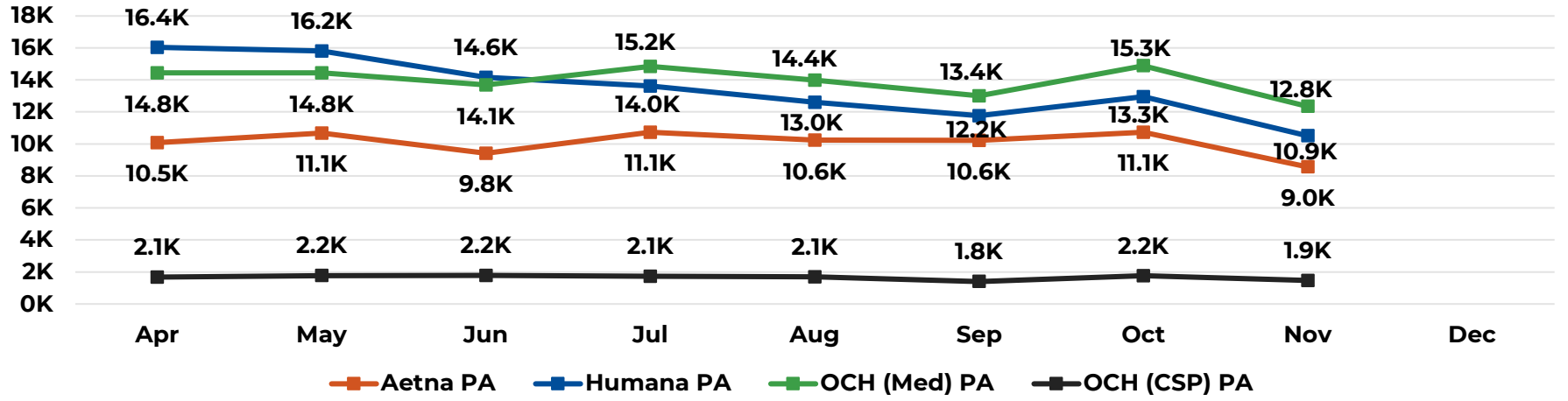


MCE Utilization (Cont.)

Average Expenditure Per Total MCE Members Served - Medical & Dental (All MCEs)

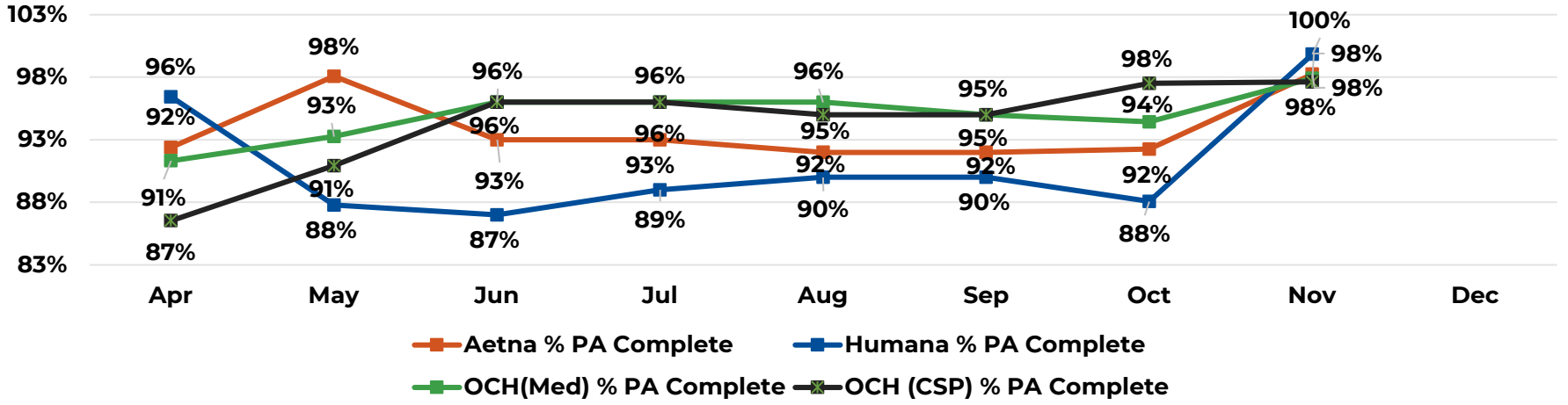


MCE Expedited & Standard Prior Authorization (Medical) - Overall PA Count

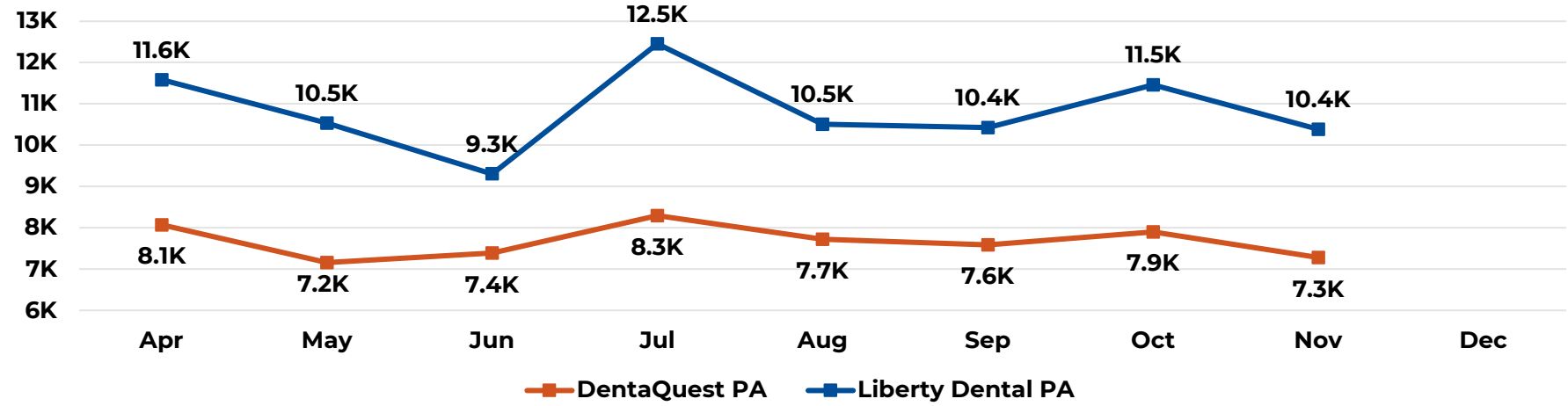


MCE Utilization (Cont.)

MCE Expedited & Standard Prior Authorization (Medical) - % Completed Within Contractually Allotted Base Time

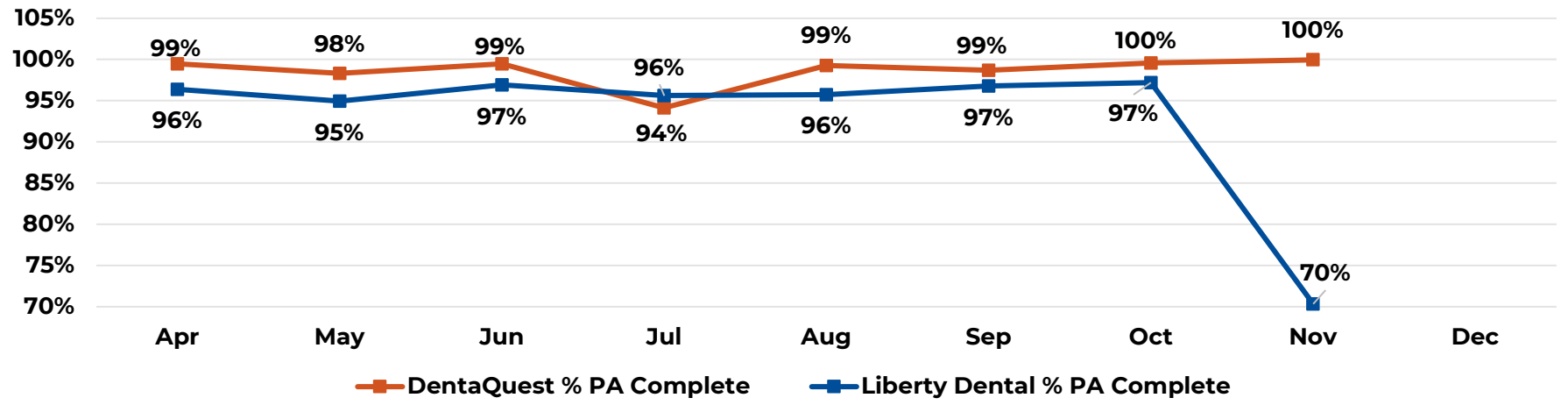


MCE Expedited & Standard Prior Authorization (Dental) - Overall PA Count



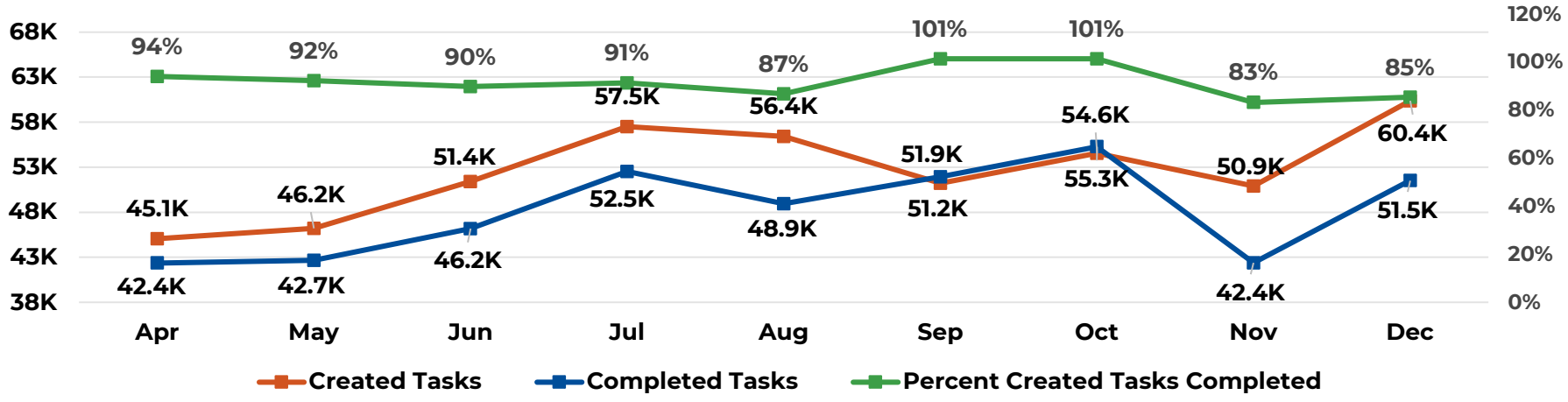
MCE Utilization (Cont.)

MCE Expedited & Standard Prior Authorization (Dental) - Percent Processed Within Contractually Allotted Base Time



Workflow - Productivity

Created & Completed Tasks



Operational Metrics Query Notes:

Enrollment is any point in time and any length of time enrolled during a month.

Enrollment group (Expansion, ABD, etc.) is based on aid category at time of service.

Payment cycles (number of payment processing weeks) is the main driver of most monthly variances.

Paid claims based on paid dates (FFS or MCE paid claim).

Type of claim (Inpatient, Outpatient, etc.) is based on the claim's category of service.

Emergency department claims based on paid facility claims based on paid dates with revenue codes between 450 and 459.

Opioid data is from the Opioid dashboard MME Calculations files.

Out of state is paid claims based on paid dates. Billing provider is not in OK, and address type is service. Results are filtered to just border counties (within 50 miles of border). Data excludes non border county results and specialty pharmacy.

Telemedicine is paid claims based on paid dates. Claim includes procedure codes: Q3014;99441;99442;99443;98966;98967;98968;D9995, or procedure code modifiers GT or 95 or place of service was 02 – telehealth or 10 – telehealth (patients home).

Call center data from Call Center Data_Call Volume Change XLSX (Call Center_Member Calls tab).

Fee-For-Service Prior Authorization data includes Medical, Therapy, Dental and DME PAs. They are based on traditional path PAs. Accelerated path PAs are excluded. Counts include all PA line items (amendments, system added modifiers, etc) and are point in time. Completed PAs are Approved, Cancelled, System Cancelled and Denied. Monthly totals are calculated from the first day of the month to the last Sunday of the month; therefore, monthly totals may not reflect an entire month.

FTE counts from the latest available org chart or from last for a month. Uses agency count OHCA filled number.

For MCE members served, expenditures and average per member, the data through June 2024 is MCE comparable group which is non ABD members eligible for MCE (Expansion, Parent/Caretaker, Non ABD Children, Full Scope Pregnant, etc.). Excludes tribal members since had low MCE opt-in. Data starting July 20247 is MCE claims based on MCE claim region codes (30, 68).

MCE Prior Authorization data is from SEL-0500 and DEN-0700.