PUBLIC HEARING FOR THE CONSIDERATION OF PERMANENT RULEMAKING UNDER THE OKLAHOMA AMINISTRATIVE PROCEDURES ACT

PLACE OF HEARING: BUSINESS OFFICE OF THE OKLAHOMA HEALTH CARE AUTHORITY (Charles Ed McFall Board Room)
4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

TIME OF HEARING: 1:00 PM

DATE OF HEARING: January 18, 2022

AGENDA FOR THE MEETING

1. INTRODUCTIONS AND PURPOSE OF MEETING

2. RULES TO BE CONSIDERED

A-1. **APA WF # 21-02A ADvantage Waiver Services and State Plan Personal Care Services** — The proposed revisions will align policy with the recently approved 1915c ADvantage waiver renewal and current State Plan Personal Care services authority. The revisions will provide clarity surrounding eligible provider certification and will modify procedures to reflect current business practices. Finally, revisions will correct formatting and grammatical errors.

The Oklahoma Administrative Code (OAC) section that will be affected by these changes is 317:30-5-761.

A-2. **APA WF # 21-02B ADvantage Waiver Services and State Plan Personal Care Services** — The proposed revisions will add language to establish guidelines and criteria regarding how an ADvantage member and/or provider are to report critical and non-critical incidents. Additional revisions will align policy with the recently approved 1915c ADvantage waiver renewal and current State Plan Personal Care services authority, which will modify procedures to reflect current business practices. Finally revisions will correct grammatical errors.

The OAC sections that will be affected by these changes are 317:35-15-1, 317:35-15-2, 317:35-15-3, 317:35-15-4, 317:35-15-5, 317:35-15-6, 317:35-15-7, 317:35-15-8, 317:35-15-8.1, 317:35-15-8.2, 317:35-15-9, 317:35-15-10, 317:35-15-12, 317:35-15-13.1, 317:35-15-13.2, 317:35-15-14, 317:35-15-15, 317:35-17-5, 317:35-17-16, and 317:35-17-27.

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

The OAC sections that will be affected by these changes are 317:45-1-1, 317:45-1-2, 317:45-1-3, 317:45-1-4, 317:45-7-5, 317:45-9-1, 317:45-11-1, 317:45-11-2, 317:45-11-10, 317:45-11-11, 317:45-11-20, 317:45-11-21, 317:45-11-21.1, 317:45-11-22, 317:45-11-23, 317:45-11-24, 317:45-11-26, 317:45-11-27, and 317:45-11-28.

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

The OAC section that will be affected by these changes is 317:30-5-58.

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

The OAC sections that will be affected by these changes are 317:10-1-1, 317:10-1-2, 317:10-1-12, 317:10-1-16, 317:10-1-21, 317:10-1-22, 317:10-1-23, 317:10-1-24, 317:10-1-25, 317:10-1-25.1, 317:10-1-26, 317:10-1-27, 317:10-1-28, 317:10-1-29, 317:10-1-30, 317:10-1-31,

317:10-1-32, and 317:10-1-33.

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

The OAC section that will be affected by these changes is 317:25-7-12.

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

The OAC section that will be affected by these changes is 317:35-5-4.

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

The OAC sections that will be affected by these changes are 317:30-5-95.22, 317:30-5-95.29, 317:30-5-95.30, 317:30-5-95.33, 317:30-5-95.34, 317:30-5-95.37, and 317:30-5-95.38.

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

The OAC sections that will be affected by these changes are 317:30-3-65.12, 317:30-5-310, 317:30-5-311, 317:30-5-312, 317:30-5-313, 317:30-5-314, 317:30-5-315, and 317:30-5-316.

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

The OAC section that will be affected by these changes is 317:30-5-87.

J. **APA WF 21-34 Reimbursement Methodology for Providers of Certified Community Behavioral Health (CCBH) Services —** The proposed revisions will update and clarify language regarding covered CCBH services. The revisions will update language regarding reimbursement of CCBH services in alignment with changes to the Oklahoma Medicaid State Plan. These changes included language related to rebasing frequency and scope updates to the Prospective Payment System (PPS) rates. Other revisions will clarify the definition of "Client Assessment Record (CAR)."

The OAC sections that will be affected by these changes are 317:30-5-240.1, 317:30-5-266, and 317:30-5-267.

A-1.
TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 85. ADVANTAGE PROGRAM WAIVER SERVICES
317:30-5-761 [AMENDED]
(REFERENCE APA WF # 21-02A)

317:30-5-761. Eligible providers

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

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

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

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

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

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

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

~~Supports (CD-PASS), and NF respite services do not have a programmatic evaluation after the initial certification.~~

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

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

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

(i) ~~no~~No provider included on the Certified Agency Report (CAR) or in the member's service area, has available staffing~~;~~. ~~This is as evidenced by supportive documentation, which~~Documentation also affirms ~~no provider within the members service area can staff and~~ all area providers attempt to employ staff to serve; or

(ii) ~~the~~The member's needs are so complex that unless the spouse or legal guardian provides the care, the member's risk level would increase; and

(iii) ~~it~~It is mentally or physically detrimental for someone other than the spouse or legal guardian to provide care. This is evidenced by ~~the~~ documentation from a qualified clinician or medical provider, such as a physician or licensed psychologist.

(B) The service ~~must~~:

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

(ii) ~~be~~Is necessary to avoid institutionalization;

(iii) ~~be~~Is a ~~service/support~~service or support specified in the person-centered service plan;

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

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

(vi) ~~not be~~Is not an activity the spouse or legal guardian would ordinarily perform or is responsible to perform.

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

(i) ~~providing~~Providing no more than forty (40) service hours of services in a ~~seven-day (7-day)~~seven (7) day period;

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

(iii) ~~maintaining~~Maintaining and submitting time sheets and other required documentation for hours paid; and

(iv) ~~the~~The person-centered service plan as the member's care provider.

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

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

(9) ~~DHS AS~~OKDHS CAP periodically performs a programmatic audit of: ~~adult day health, assisted living, case management, home care (providers of skilled nursing, personal care, in-home respite, and advanced supportive/restorative assistance and therapy services) and CD-PASS providers. When due to a programmatic audit, a provider Plan of Correction (POC) is required, the AA may stop new cases and referrals to the provider until the (POC) is approved, implemented, and follow-up review occurs. Depending on the nature and severity of problems discovered during a programmatic audit and at the discretion of the DHS AS, members determined to be at risk for health or safety may be transferred from a provider requiring a POC to another provider.~~

(A) Adult day health;

(B) Assisted living;

(C) Case Management;

(D) Home care:

(i) Skilled nursing;

(ii) Personal care;

(iii) In-home respite; and

(iv) Advanced supportive or restorative assistance; and

(v) Therapy services; and

(E) CD-PASS providers.

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

A-2.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
SUBCHAPTER 15. STATE PLAN PERSONAL CARE SERVICES
317:35-15-1 [AMENDED]
317:35-15-2 [AMENDED]
317:35-15-3 [AMENDED]
317:35-15-4 [AMENDED]
317:35-15-5 [AMENDED]
317:35-15-6 [AMENDED]
317:35-15-7 [AMENDED]
317:35-15-8 [AMENDED]
317:35-15-8.1 [AMENDED]
317:35-15-8.2 [REVOKED]
317:35-15-9 [AMENDED]
317:35-15-10 [AMENDED]
317:35-15-12 [AMENDED]
317:35-15-13.1 [AMENDED]
317:35-15-13.2 [AMENDED]
317:35-15-14 [AMENDED]
317:35-15-15 [AMENDED]
SUBCHAPTER 17. ADVANTAGE WAIVER SERVICES
317:35-17-5 [AMENDED]
317:35-17-16 [AMENDED]
317:35-17-27 [NEW]
(REFERENCE APA WF # 21-02B)

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

~~Long-term medical care for the categorically needy includes care in a nursing facility (refer to OAC 317:35-19), public and private intermediate care facility for individuals with intellectual disabilities (refer to OAC 317:35-9), persons age 65 years or older in mental health hospitals (refer to OAC 317:35-9), Home and Community Based Waiver Services for the Intellectually Disabled (refer to OAC 317:35-9), Home and Community Based Waiver Services for the ADvantage program (refer to OAC 317:35-17), and Personal Care services (refer to this subchapter). Personal Care provides services in the member's own home. Any time an individual is certified as eligible for SoonerCare coverage of long-term care, the individual is also eligible for other SoonerCare services. Another application is not required. Any time an aged, blind, or disabled individual is determined eligible for long-term care, a separate determination must be made to see if eligibility conditions as a Qualified Medicare Beneficiary Plus (QMBP) or Specified Low-Income Medicare Beneficiary (SLMB) are met. Another application for QMBP or SLMB benefits is not required.~~

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

(1) Care in a nursing facility, per Oklahoma Administrative Code (OAC) 317:35-19;

(2) Public and private intermediate care facility for individuals with intellectual disabilities (ICF/IID), per OAC 317:35-9;

(3) Persons age sixty-five (65) years or older in mental health hospitals, per OAC 317:35-9;

(4) Home and Community-Based Waiver Services for the Intellectually Disabled, per OAC 317:35-9;

(5) Home and Community-Based Waiver Services for the ADvantage program, per OAC 317:35-17; and

(6) State Plan Personal Care services, per OAC 317:35-15.

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

317:35-15-2. State Plan Personal ~~care~~Care (SPPC) services

(a) ~~Personal care~~SPPC services ~~is assistance to an individual~~assist a member in carrying out Activities of Daily Living (ADLs) or ~~in carrying out~~ Instrumental Activities of Daily Living (IADLs) directly related to the member's personal care needs ~~to prevent~~. SPPC services prevent or minimize physical health regression or deterioration. ~~Personal care service requires~~SPPC services require a skilled nursing assessment to: ~~of need, development of a care plan to meet identified personal care needs, care plan oversight, and periodic re-assessment and updating, of the care plan, when necessary. Personal care services do not include technical services, such as suctioning, tracheal care, gastrostomy-tube feeding or care, specialized feeding due to choking risk, application of compression stockings, bladder catheterization, colostomy irrigation, wound care, application of prescription lotions or topical ointments, range of motion exercises, or the operation of equipment of a technical nature, such as a patient lift or oxygen equipment.~~

(1) Assess a member's needs;

(2) Develop a care plan to meet the member's identified personal care needs;

(3) Manage care plan oversight; and

(4) Periodically reassess and update the care plan when necessary.

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

(1) Suctioning;

(2) Tracheal care;

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

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

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

(A) Licensed facilities, such as a:
(i) Hospital;
(ii) Nursing facility;
(iii) Licensed residential care facility; or
(iv) Licensed assisted living facility; or

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

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

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

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

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

plan.

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

(1) ~~be~~Are at least ~~18~~eighteen (18) years of age;

(2) ~~have~~Have no pending notation related to abuse, neglect, or exploitation as reported by the Oklahoma State Department of Health Nurse Aide Registry;

(3) ~~not be~~Are not included in the ~~DHS~~OKDHS Community Services Worker Registry;

(4) ~~not be~~Are not convicted of a crime ~~or~~and do not have ~~any~~a criminal background history or registry listings that prohibit employment per ~~O.S. Title 63, Section 1-1950.1;~~Title 63 of the Oklahoma Statutes Section 1-1944 through 1-948;

(5) ~~demonstrate~~Demonstrate the ability to understand and carry out assigned tasks;

(6) ~~not be~~Are not a legally responsible family member~~, such as a spouse, legal guardian, or parent of a minor child~~ of the member being served, such as a spouse, legal guardian, or a minor child's parent~~ exceptions may be made for a legal guardian to provide services only with prior approval from DHS Aging Services~~;

(7) ~~have~~Have a verifiable work history ~~and/or~~or personal references, and verifiable identification; and

(8) ~~meet~~Meet any additional requirements outlined in the contract and certification requirements with OHCA.

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

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

(a) **Requests for ~~Personal Care.~~SPPC services.** ~~A request for Personal Care is made to the local OKDHS office or ADvantage Administration (AA).~~ The SPPC application process initiates when an online application is completed for SPPC services. A written financial application is not required for an ~~individual~~applicant who has an active SoonerCare case. A financial application for ~~Personal Care~~SPPC services is initiated when there is no active SoonerCare case. The Medicaid application is signed by the

applicant, parent, spouse, guardian or someone ~~else~~ acting on the applicant's behalf. All financial eligibility conditions ~~of financial eligibility must be~~are verified and documented in the case record. When current available information ~~already available in the local office~~ establishes eligibility, the information may be used by recording source and date of information. If the applicant also wishes to apply for a State Supplemental Payment, either the applicant or ~~his/her~~his or her guardian, or a person acting on the applicant's behalf, such as an authorized representative or power-of-attorney, ~~must sign~~signs the application form.

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

~~(1) The date of applications is:~~

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

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

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

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

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

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

(a) **Eligibility.** The Oklahoma ~~Department of~~ Human Services ~~(DHS)~~(OKDHS) ~~area nurse~~Health Care Management Nurse (HCMN) III determines medical eligibility for ~~personal care~~SPPC services based on the Uniform Comprehensive Assessment Tool (UCAT) ~~Part III~~ and the determination that the member has unmet care needs that require personal care ~~services.~~assistance. ~~Personal care~~SPPC services are initiated to support the regular care provided in the member's home. ~~Personal care~~SPPC services are not intended to take the place of regular care, ~~and~~ general maintenance tasks, or meal preparation

~~shared or done for one another~~provided by natural supports, such as spouses or other adults who live in the same household. Additionally, ~~personal care~~SPPC services are not furnished when they principally benefit the family unit. To be eligible for ~~personal care~~SPPC services, the ~~individual must:~~applicant:

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

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

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

(2) ~~require a plan of care involving the planning and administration of services delivered under the supervision of professional personnel;~~Requires a care plan for planning and administering services delivered under a professional personnel's supervision;

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

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

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

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

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

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

(A) ~~bathing;~~Bathing;

(B) ~~eating;~~Eating;

(C) ~~dressing;~~Dressing;

(D) ~~grooming;~~Grooming;

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

(F) ~~mobility;~~Mobility;

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

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

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

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

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

(5) **"~~Consumer~~Applicant or Member support moderate ~~need~~"** means the UCAT ~~Part III Consumer~~applicant or member score is fifteen (15), ~~which~~this indicates, in the UCAT ~~Part III~~ assessor's clinical judgment, the formal and informal support is available, but overall, it is inadequate, changing, fragile, or otherwise problematic. The applicant or member requires additional assistance that usually includes personal care assistance with one (1) or more ADLs not available through Medicare, the Veterans Administration, or other federal entitlement programs. ~~Support provided by informal caregivers is of questionable reliability due to one (1) or more of the following:~~Informal caregiver support is considered questionable or unreliable due to one (1) or more criteria in (A) through (D) of this paragraph:

(A) ~~care~~Care or support is required continuously with no

relief or backup available;

(B) ~~informal~~Informal support lacks continuity due to conflicting responsibilities such as work or child care;

(C) ~~care or support is provided by persons~~Persons with advanced age or disability~~; or~~ provide care; or

(D) ~~institutional~~Institutional placement can reasonably be expected with any loss of existing support.

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

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

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

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

(A) ~~shopping;~~Shopping;

(B) ~~cooking;~~Cooking;

(C) ~~cleaning;~~Cleaning;

(D) ~~managing~~Managing money;

(E) ~~using~~Using a phone;

(F) ~~doing~~Doing laundry;

(G) ~~taking~~Taking medication; and

(H) ~~accessing~~Accessing transportation.

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

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

one (1) or more other IADLs.

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

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

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

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

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

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

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

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

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

~~definition. A follow-up is required by the DHS county worker with (SSA) to ensure the SSA disability decision is also the LOCEU decision.~~

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

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

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

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

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

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

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

(5) During the assessment visit, the ~~DHS nurse~~OKDHS HCMN I or II completes the UCAT ~~Part III~~ and reviews rights to privacy, fair

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

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

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

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

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

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

(B) The ~~DHS area nurse~~OKDHS HCMN III assigns a medical certification period of not more than thirty-six (36) months

for persons eighteen (18) years of age and older or not more than twelve (12) months for persons younger than eighteen (18) years of age. The service plan period ~~under the Service Authorization Model (SAM)~~ is for ~~a period of~~ twelve (12) months~~ and is provided by the DHS nurse~~.

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

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

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

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

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

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

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

standards.

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

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

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

(2) **Financial ~~eligibility/categorically~~eligibility or categorically related to ~~ABD.~~Aged, Blind, and Disabled.** In determining income and resources for the ~~individual~~member related to ABD, the "family" includes the individual and spouse, if any. To be categorically needy, the countable income ~~must be~~is less than the categorically needy standard as shown on the OKDHS form 08AX001E (Appendix C-1), Schedule VI ~~(QMBP standard).~~Qualified Medicare Beneficiary Plus standard. If ~~an individual and~~a member and his or her spouse cease to live together for reasons other than institutionalization or receipt of the ADvantage waiver or ~~HCBW/MR~~a Home and Community Based Waiver, ADvantage or Developmental Disabilities services, income and resources are considered available to each other through the month in which they are separated. Mutual consideration ceases with the month after the month in which the separation occurs. Any amounts ~~which are actually contributed~~ to the spouse after the mutual consideration has ended are considered.

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

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

(a) **State Plan Personal Care (SPPC) certification period.** The first month of the ~~Personal Care~~SPPC certification period ~~must be~~is the first month the member ~~was~~is determined financially and medically eligible for ~~Personal Care,~~SPPC~~ both financially and medically~~. When eligibility or ineligibility for ~~Personal Care~~SPPC is established, the local OKDHS office updates the computer-generated ~~form~~notice and the appropriate notice is mailed to the member.

(b) **Financial certification period.** The financial certification period for ~~Personal Care~~SPPC services is ~~12~~twelve (12) months. ~~Redetermination of eligibility~~Eligibility redetermination is completed according to the categorical relationship.

(c) **Medical certification period.** A medical certification period of not more than thirty-six (36) months is assigned for ~~an~~a ~~individual~~member who is approved for ~~Personal Care.~~SPPC. The certification period for ~~Personal Care~~SPPC services is based on the

Uniform Comprehensive Assessment Tool ~~(UCAT)~~ evaluation and clinical judgment of the Oklahoma ~~Department of~~ Human Services ~~(DHS) area nurse or designee.~~HCMN III.

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

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

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

(2) ~~02AG030E, Personal Care Planning Schedule/Service Plan;~~SPPC-Service Planning; and

(3) ~~02AG029E, Personal Care Plan.~~SPPC Member Service Agreement.

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

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

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

(8).

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

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

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

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

(4) Annually, or more frequently when the member's needs change, the provider agency nurse re-assesses the member's ~~need's~~needs and develops a new ~~SAM packet~~plan to meet the member's needs. The provider agency nurse ~~conducts a home visit and~~ completes and submits the annual reassessment documents to the ~~DHS nurse~~OKDHS HCMN I or II no sooner than ~~60-calendar~~sixty (60) calendar days before the existing service plan end-date, and no later than ~~14-calendar~~fourteen (14) calendar days prior to service.

(5) When the member is unstaffed, the provider agency nurse or staff communicates with the member and makes efforts to re-staff. ~~It is recommended the provider agency contacts unstaffed members weekly by phone to actively monitor the health and safety of the member and documents ongoing efforts to provide staff.~~When consecutively unstaffed for seven (7) calendar days, or fewer depending on the member's needs, the provider agency nurse or staff contacts the unstaffed member weekly by phone to actively monitor the member's health and safety and documents ongoing efforts to provide staff using the electronic system.

When the member is unstaffed for ~~30-calendar~~thirty (30) days, the provider agency notifies the ~~DHS nurse on Form 02AG032E, Provider Communication Form.~~OKDHS HCMN I or II via the Case Note for SPPC thirty (30) day unstaffed note in the electronic system. The DHS nurse The HCMN I or II contacts the member and when the member chooses, initiates a member transfer ~~of the member~~ to another provider agency that can provide staff.

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

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

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

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

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

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

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

and associated service planning per ~~SAM~~ nursing visit.

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

(2) **Issue resolution.**

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

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

(3) **Persons ineligible to serve as ~~PCAs.~~a PCA.** Payment from SoonerCare funds for ~~personal care~~SPPC services may not be made to an individual who is a legally responsible family member of the member, such as a spouse, legal guardian, or parent of a minor child, ~~to whom he/she~~when he or she is providing ~~personal care~~SPPC services ~~(exceptions may be made for legal guardians with prior approval from the Department of Human Services/Aging Services (DHS/AS)~~.

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

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

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

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

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

~~(2) The service must:~~

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

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

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

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

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

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

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

~~(A) Providing no more that forty (40) hours of services in a seven (7) calendar day period;~~

~~(B) Planned work schedules that must be available in advance for the member's home care agency. Variations to the schedule must be noted and supplied to the home care agency two (2) weeks in advance unless the change is due to an emergency;~~

~~(C) Utilization of the Electronic Visit Verification System (EVV) also known as the Interactive Voice Response Authentication (IVRA) system; and~~

~~(D) Being identified and monitored by the home care agency.~~

~~(4) The home care agency is required to submit a request and obtain approval for eligible provider exceptions to OKDHS AS prior to employing a legal guardian as a member's personal care assistant (PCA). Eligible provider exceptions require the home care agency to:~~

~~(A) Provide monitoring and complete the Eligible Provider Exception Six Month Review document, when in the member's home completing the six-month Nurse Evaluation document in the Medicaid waiver information system; and~~

~~(B) Annually complete the Eligible Provider Exception Request and submit it with the annual Service Authorization Model (SAM) documentation no later than forty-five (45) calendar days prior to the previous eligible provider exception service authorization end date.~~

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

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

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

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

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

(c) **Change in amount of units or tasks.** When the ~~personal care~~SPPC provider agency determines a need for a change in the amount of units or tasks ~~within the personal care~~in the service, a ~~new Service Authorization Model (SAM) packet~~care plan is completed and submitted to ~~DHS~~OKDHS within five (5) business days of identifying the assessed need. The OKDHS HCMN III approves or denies the change ~~is approved or denied by the DHS area nurse or designee,~~ prior to implementation.

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

(e) **Resuming personal care services.** When a SPPC member approved for ~~personal care~~SPPC services is without ~~personal care~~ services for less than ~~ninety-calendar (90-calendar)~~ninety (90) calendar days, but the member has current medical and SoonerCare (Medicaid) financial eligibility approval, ~~personal care~~SPPC services may be

resumed using the member's previously approved ~~SAM packet.~~plan. The personal care provider agency nurse contacts the member to determine when changes in health or service needs occurred. When changes are identified, the provider agency nurse ~~makes a home~~completes an assessment visit and submits ~~a personal care~~a SPPC services skilled nursing need re-assessment ~~of need~~ within ~~ten-business (10-business)~~ten (10) business days of the resumed plan start date~~, using the State Plan Personal Care Progress Notes, DHS Form 02AC044E~~. When the member's needs dictate, the personal care provider agency may submit a request for a change in authorized ~~personal care services~~SPPC service units ~~with a SAM packet to DHS~~. When no changes occur, the agency nurse documents the contact ~~on State Plan Personal Provider Communication Form 02AC032E and forwards it to the DHS nurse within ten-business (10-business)~~in the electronic system for the OKDHS HCMN I or II ten (10) business days of the resumed plan start date.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(H) ~~the~~The member refuses to select ~~and/or~~or accept ~~the services of~~ a provider agency or ~~personal care assistant~~

~~(PCA)~~Personal Care Assistant (PCA) service for ~~ninety-consecutive (90-consecutive)~~ninety (90) consecutive days as ~~supported by~~ professional or credible documentation~~.~~ supports.

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

317:35-15-12. Case changes

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

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

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

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

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

units allocated. Requests for changes in the units authorized in the care plan ~~must be~~are approved by the ~~DHS area nurse or designee,~~HCMN III prior to implementation~~ of the changed number of units~~.

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

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

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

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

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

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

(iii) The contractor payment fee covers all ~~personal care~~SPPC services included on the service and care plans ~~developed by the DHS nurse.~~the OKDHS HCMN I or II develops. Payment is only made for eligible members'

direct services and care ~~of the eligible member(s) only~~. The ~~area nurse, or designee,~~OKDHS HCMN III, authorizes the number of ~~units of~~ service units the member receives.

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

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

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

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

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

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

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

manage services for a member whose IPCA is ~~a~~his or her family member~~ of the DHS nurse~~.

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

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

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

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

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

(D) ~~the~~The effective service date ~~was~~is established~~,~~;

(E) ~~all~~All registries ~~were~~are checked and the IPCA's name is not listed~~,~~;

(F) ~~the Oklahoma State Department of Health~~OSDH Nurse Aide Registry ~~was~~is checked and no notations ~~were~~are found~~,~~; and

(G) ~~the~~ OSBI background check ~~was~~is completed.

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

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

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

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

(i) ~~an IPCA's performance is such that his or her continued participation in the program could pose~~Performance poses a threat to the member's health and

safety ~~of the member~~ or to others; or
(ii) ~~the IPCA failed~~Failed to comply with ~~the expectations outlined in the~~ PCA Provider Agreement expectations and counseling is not appropriate or ~~was not~~ effective; or
(iii) ~~an IPCA's name~~Name appears on the ~~DHS~~OKDHS Community Services Worker Registry~~,~~ or any ~~of the registries~~registry listed in ~~Section 1-1947 of Title~~O.S. 63 ~~of the Oklahoma Statutes,~~ § 1-1947, even ~~though his or her name may not have appeared on the Registry~~when his or her name is not on the registry at the time of application or hiring.

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

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

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

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

in the event of an EVV system failure, the provider documents time in accordance with internal provider agency policy and procedures backup plan. This documentation is sufficient to account for both in-home and in-office services. The provider agency's backup procedures are only permitted when the EVV system is unavailable.

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

In many situations, members ~~who are~~ receiving medical services through SoonerCare (Medicaid) need social services. The OKDHS ~~nurse~~HCMN I or II may make referrals for social services to the OKDHS ~~worker~~social services specialist (SSS) in the local office. In addition to these referrals, a member, or another individual acting on the member's behalf, may initiate a social services request~~ for social services may be initiated by a member or by another individual acting upon behalf of a member~~.

(1) ~~The~~ OKDHS ~~Social Services Specialist~~SSS ~~is responsible for providing~~provides the indicated services, or ~~for referral~~makes referrals to the appropriate ~~resource outside the Department~~outside resources if the services are not available within ~~the Department.~~OKDHS.

(2) ~~Among the~~OKDHS SSS provided services~~ provided by the OKDHS Social Services Specialist are:~~

(A) ~~Services that will enable individuals~~Enable members to attain ~~and/or~~or maintain ~~as~~ good physical and mental health ~~as possible~~;

(B) ~~Services to assist patients~~Assist members who ~~are receiving~~receive care outside their own homes in planning for and returning to their own homes or to other alternate care;

(C) ~~Services to encourage~~Encourage the development and maintenance of family and community ~~interest~~interests and ties;

(D) ~~Services to promote~~Promote member's maximum independence in ~~the management of~~managing their own affairs;

(E) ~~Protective~~Include protective services~~, including evaluation of~~ that evaluate the need for and ~~arranging for~~arrange guardianship; and

(F) ~~Appropriate~~Offer family planning services, ~~which include assisting the~~including family assistance in acquiring means to responsible parenthood. Services are offered in making the necessary referral and follow-up.

SUBCHAPTER 17. ADVANTAGE WAIVER SERVICES

317:35-17-5. ADvantage program medical eligibility determination

The Oklahoma ~~Department~~ of Human Services ~~(DHS)~~OKDHS area nurse or nurse designee, makes the medical eligibility determination utilizing professional judgment, the Uniform Comprehensive Assessment Tool (UCAT) ~~Parts I and III~~, and any other available medical information.

(1) When ADvantage care services are requested or the ~~UCAT I~~application is received~~ in the county office~~, the:

(A) ~~DHS~~OKDHS nurse ~~is responsible for completing~~completes the UCAT~~ III~~; and

(B) ~~social service~~Social services specialist (SSS) ~~is responsible for contacting~~contacts the applicant within three (3) business days to initiate the financial eligibility application process.

(2) Categorical relationship ~~must be~~is established for ADvantage services eligibility determination~~ of eligibility for ADvantage services~~. When a member's categorical relationship to a disability ~~was~~is not established, the local ~~social service specialist~~SSS submits the same information, per Oklahoma Administrative Code (OAC) 317:35-5-4(2) to the Level of Care Evaluation Unit (LOCEU) of the Oklahoma Health Care Authority to request a medical categorical relationship eligibility determination~~ of eligibility for categorical relationship~~. LOCEU ~~renders a decision~~decides on the categorical relationship to ~~the person with~~ the disability using the Social Security Administration (SSA) definition. ~~A~~An SSS follow-up with SSA is required ~~by the DHS social service specialist with SSA~~ to ensure the disability decision agrees with the LOCEU decision.

(3) Community agencies and waiver service applicants may complete the ~~UCAT I,~~application and forward ~~the form~~ to ~~the county office.~~OKDHS. ~~When the UCAT I indicates the applicant does not qualify for Medicaid long-term care services, the applicant is referred to appropriate community resources. Members may call the care line at 1-800-435-4711.~~

(4) ~~The DHS~~When an applicant is Medicaid eligible at the request time, an OKDHS nurse completes the UCAT ~~III~~ assessment ~~visit~~ with the ~~member~~applicant within ~~10-business~~ten (10) business days of referral receipt ~~of the referral~~ for ADvantage services ~~for an applicant who is Medicaid eligible at the time of the request~~. The ~~DHS~~OKDHS nurse completes the UCAT ~~III~~ assessment ~~visit~~ within ~~20-business~~twenty (20) business days of the date the Medicaid application is completed for new applicants.

(5) For initial level of care (LOC), the OKDHS nurse assesses the applicant through an electronic format such as phone or video conference, using the UCAT unless there are limiting factors which necessitate a face-to-face assessment.

(A) The OKDHS nurse determines LOC based upon the assessment outcome unless the applicant is medically ineligible. In this case, a face-to-face visit is scheduled to either validate the initial electronic format assessment or to provide additional documentation to support the applicant meeting medical LOC.

(B) Applicants are not denied access to the waiver solely based on an assessment completed through an electronic format.

~~(5)~~(6) During the UCAT ~~III~~ assessment~~ visit~~, the ~~DHS~~OKDHS nurse informs the applicant of medical eligibility criteria and provides information about the different long-term care service options. ~~When there are multiple household members applying for the ADvantage program, the UCAT assessment is done for them during the same visit.~~ The ~~DHS~~OKDHS nurse documents whether the ~~member~~applicant chooses nursing facility program services or ADvantage program services and makes ~~a level of care~~an LOC and service program recommendation.

~~(6)~~(7) The ~~DHS~~OKDHS nurse informs the ~~member~~applicant and family of agencies certified to deliver ADvantage case management and in-home care services in the local area to obtain the applicant's primary and secondary informed ~~choices,~~provider choice, ensuring adherence to conflict free case management requirements.

(A) ~~Providers of~~ ADvantage ~~services for the member,~~providers, or ~~for~~ those who have an interest in~~,~~ or are employed by an ADvantage provider, ~~for the member must not~~do not provide case management or develop the person-centered service plan~~,~~. ~~except~~The only exception is when the ADvantage Administration ~~(AA)~~ demonstrates ~~the only~~there are no more than two (2) willing and qualified ~~entity~~entities to provide case management ~~and/or~~and develop person-centered service plans in a geographic area, and those agencies also ~~provides~~provide other ADvantage services.

(B) When the ~~member and/or~~applicant or family declines to make a provider choice, the ~~DHS~~OKDHS nurse documents the decision on ~~Form 02CB001, Member Consents and Rights.~~the consents and rights document.

(C) ~~The AA~~OKDHS uses a rotating system to select ~~an agency~~agencies for the ~~member~~applicant from a list of all local, certified case management and in-home care ~~agencies,~~providers, ensuring adherence to conflict free case management requirements.

~~(7)~~(8) The ~~DHS~~OKDHS nurse documents ~~the~~chosen agency names~~ of the chosen agencies~~, or the choice to decline to select agencies, and the applicant's agreement ~~of the member, by dated signature,~~ to receive waiver services~~ provided by the agencies~~.

~~(8)~~(9) When the ~~member's~~applicant's needs require an immediate interdisciplinary team (IDT) meeting with the case manager and home ~~health~~care provider agency nurse participation to develop a person-centered service plan, the ~~DHS~~OKDHS nurse documents the priority processing need~~ for priority processing~~.

~~(9)~~(10) The ~~DHS~~OKDHS nurse ~~scores the UCAT III. The DHS nurse~~ forwards the completed UCAT ~~III and documentation of financial eligibility, documentation of the member's case management and in-home care agency choices~~ to the area nurse or nurse designee for medical eligibility determination.

~~(10)~~(11) When ~~based upon the information obtained during~~the

OKDHS nurse determines the UCAT ~~the~~ assessment~~, the DHS nurse determines~~indicates the member ~~may be~~health and safety are at risk~~ for health and safety~~, ~~DHS~~OKDHS Adult Protective Services staff is notified immediately and the referral is documented on the UCAT.

~~(11)~~(12) Within ~~10-business~~ten (10) business days of receipt of a complete ADvantage application, the area nurse or nurse designee determines medical eligibility using nursing facility ~~level of care~~LOC criteria and service eligibility criteria, per OAC 317:35-17-2 and 317:35-17-3, and enters the medical decision on the system.

~~(12)~~(13) Upon SSS financial eligibility notification ~~of financial eligibility from the social service specialist, medical eligibility,~~ and medical eligibility approval for ADvantage entry from the area nurse or nurse designee, ~~the~~ AA communicates with the case management provider to begin care and service plan development. ~~The AA communicates to the case management provider, the member's name, address, case number, Social Security number,~~AA provides the member's demographic and assessment information, and the number of ~~units of~~ case management and ~~the number of units of~~ home care ~~agency~~ nurse evaluation units authorized for service plan development. When the member requires an immediate home visit to develop a person-centered ~~within 24 hours, the~~plan, AA contacts the case management provider directly to confirm availability and request IDT priority~~ electronically sends the new case packet information to the case management provider~~.

~~(13)~~(14) When ~~the~~a member is being discharged from a nursing facility or hospital and transferred home, services ~~must be~~are in place to ensure the member's health and safety~~ of the member upon discharge to the home from the nursing facility or hospital, a~~. The member's chosen case manager ~~from an ADvantage case management provider selected by the member and referred by the AA~~ follows the ADvantage ~~institution~~institutional transition~~,~~ case management procedures for care, and service plan development and implementation.

~~(14)~~(15) A new medical ~~level of care~~LOC determination is required when a member requests any ~~changes~~change in service ~~program,~~setting, from:

(A) State Plan Personal Care (SPPC) services to ADvantage services;

(B) ADvantage to ~~State Plan Personal Care~~SPPC services;

(C) ~~nursing~~Nursing facility to ADvantage services; or

(D) ADvantage to nursing facility services.

~~(15)~~(16) A new medical ~~level of care~~LOC determination is not required when a member requests ADvantage services re-activation ~~of ADvantage services~~ after ~~a short-term stay of 90-calendar~~staying ninety (90) calendar days or less in a nursing facility when the member had previous ADvantage services and the

ADvantage certification period has not expired~~.~~ by the date the member is discharged.

~~(16)~~(17) When a UCAT assessment ~~was~~is completed more than ~~90-calendar~~ninety (90) calendar days prior to submission to the area nurse or nurse designee for a medical decision, a new assessment is required.

317:35-17-16. Member annual level of care re-evaluation and annual service plan reauthorization

(a) The ADvantage case manager reassesses the member's needs annually using the Uniform Comprehensive Assessment Tool (UCAT) ~~Parts I and III~~, then evaluates the member's progress ~~of the member~~ toward person-centered service plan goals and objectives. The ADvantage case manager develops the annual person-centered service plan with the member and interdisciplinary team and submits the person-centered service plan to the ADvantage Administration (AA) for authorization. The ADvantage case manager initiates the UCAT reassessment and ~~development of~~develops the annual person-centered service plan at least forty (40) calendar days, but not more than sixty (60) calendar days, prior to the existing plan's end date~~ of the existing person-centered service plan~~. The ADvantage case manager provides AA the ~~reassessment~~ person-centered service plan ~~packet~~reassessment documents no less than thirty (30) calendar days prior to the existing plan's end date~~ of the existing plan~~. The reassessment ~~person-centered service plan packet includes~~documents include the person-centered service plan, UCAT ~~Parts I and III~~, Nursing Assessment and Monitoring Tool and supporting documentation.

(b) For medical eligibility reassessment, ~~The~~ Oklahoma ~~Department of~~ Human Services ~~(DHS)~~(OKDHS) recertification nurse reviews the UCAT ~~Parts I and III~~the ADvantage case manager submitted~~ by the ADvantage case manager for a level of care redetermination~~. When policy defined criteria for nursing facility ~~level of care~~LOC cannot be determined or justified from available documentation or through direct contact with the ADvantage case manager, the member is referred to the local OKDHS nurse. ~~UCAT Parts I and IIIare completed in the member's home by the DHS nurse. The DHS nurse submits the UCAT evaluation to the area nurse or nurse designee, to make the medical eligibility level of care determination.~~The OKDHS nurse then re-assesses the applicant using the UCAT through an electronic format such as a phone and video conference, unless there are limiting factors which necessitate a face-to-face assessment.

(1) The OKDHS nurse determines LOC based on the assessment's outcome unless the applicant is determined to be medically ineligible. In this case, a face-to-face visit is scheduled to either validate the electronic format assessment or provide additional documentation to support the applicant meeting medical LOC.

(2) Applicants are not medically denied access to the waiver solely based on an assessment completed through an electronic format.

(c) When medical eligibility redetermination is not made prior to the current medical eligibility expiration, the existing medical eligibility certification is automatically extended.

(1) For members who are not receiving inpatient~~,~~ acute care, long term acute care, rehab or skilled nursing services, the existing medical eligibility certification is extended for a maximum of sixty (60) calendar days from the date of the previous medical eligibility expiration date.

(2) For members who are receiving inpatient~~,~~ acute care, long term acute care, rehab or skilled nursing services, the existing medical eligibility certification is extended for thirty (30) calendar days from the facility discharge date, ~~of discharge from the facility~~ or ~~the~~for sixty (60)calendar days from the previous medical eligibility's date~~ of the previous medical eligibility date~~, whichever is longer.

(3) When the medical eligibility redetermination is not made by the applicable extended deadline, the member ~~is determined to~~ no longer ~~meet~~meets medical eligibility. The area nurse or nurse designee updates the system's medical eligibility end date~~ and simultaneously notifies AA electronically~~.

(d) When ~~DHS~~OKDHS determines a member no longer meets medical eligibility~~,~~ to receive waiver services, the:

(1) ~~area~~Area nurse or nurse designee updates the medical eligibility end date~~ and notifies the AA electronically~~;

(2) AA communicates to the member's ADvantage case manager that the member ~~was determined to~~ no longer ~~need~~meets medical eligibility for ADvantage as of the eligibility determination effective date~~ of the eligibility determination~~; and

(3) ADvantage case manager communicates with the member and when requested, assists with access to other services.

317:35-17-27 Incident reporting

(a) **Reporting requirement.** Certified ADvantage provider staff should report critical and non-critical incidents involving the health and welfare of ADvantage Waiver members to the Oklahoma Human Services Medicaid Services Unit (MSU).

(b) **Critical incidents.** Critical incidents are events with potential to cause significant risk or serious harm to an ADvantage member's safety or well-being. Critical Incidents Reports (CIR) are completed for:

(1) Suspected maltreatment including abuse, neglect, or exploitation, per Section 10-103 of Title 43A of the Oklahoma Statutes (43A O.S. § 10-103);

(2) Attempted suicide or suicidal ideation exhibition;

(3) Unexpected or questionable death;

(4) Falls or injuries requiring medical attention;

(5) Residence loss due to disaster;
(6) An interruption of needed medical supports;
(7) Lost or missing members;
(8) A medication error requiring medical attention;
(9) Use of physical restraints; or
(10) Allegations related to Personal Care Assistant (PCA) or Personal Service Assistant (PSA).

(c) **Non-critical incidents.** Non-critical incidents are events with potential to cause risk to an ADvantage member's safety and well-being, but do not rise to the critical incident level. Non-critical incidents include:
(1) Falls or injuries that do not require medical attention;
(2) Theft allegations;
(3) Threatening or inappropriate behavior;
(4) Substance abuse or use;
(5) Serious allegations related to a provider agency; and
(6) Law enforcement involvement due to challenging behaviors.

(d) **Incident notification requirements.** The reporting provider documents and submits to MSU incidents included in (b) and (c) of this Section in the electronic system on the CIR document, within one business day of becoming aware of the incident. The reporting provider notifies other persons or entities as required by law or regulation, including:
(1) When a service recipient dies, per OAC 340:100-3-35; and
(2) Investigative authorities immediately in cases of suspected maltreatment, as applicable, including:
(A) Local law enforcement;
(B) The Office of Client Advocacy when the alleged perpetrator is a community service worker, per OAC 340:2-3-33; and
(C) Adult Protective Services when the alleged perpetrator is not a community service worker per 43A O.S. § 10-104.

(e) **Internal Investigation.** The provider completes an internal investigation of all critical incidents, unless directed otherwise by an authorized government entity.
(1) All provider investigative reports are submitted to the MSU within ten (10) working days after the initial CIR is completed.
(2) The provider coordinates internal critical incident investigation and response efforts with governmental investigative authorities as required by law.
(3) Provider supervisory staff run a monthly report from the electronic system to review all critical incidents submitted to the MSU. Doing so ensures proper handling and dispensation occurs, as required by the Centers for Medicare and Medicaid Services.

(f) **Escalated issues.** The Escalated Issues (EI) team reviews all CIR and determines whether the appropriate response occurred. EI coordinates their investigation and response efforts with governmental investigative authorities as required by law. For

non-critical incident reports, EI reviews and works with the member, the member's informal support, provider, and others to verify appropriate actions are taken to identify barriers to service, prevent future incidents, and assure continued member health and welfare. Investigation results are communicated to the member, legal guardian, or next of kin as appropriate.

(g) **Members and their representatives.** Upon entry into the program and at least annually, each member is provided with resources and contact information to self-report complaints, abuse, neglect, exploitation, or other issues.

B.
TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 45. INSURE OKLAHOMA
SUBCHAPTER 1. GENERAL PROVISIONS
317:45-1-1 [AMENDED]
317:45-1-2 [AMENDED]
317:45-1-3 [AMENDED]
317:45-1-4 [AMENDED]
SUBCHAPTER 7. INSURE OKLAHOMA ESI EMPLOYER ELIGIBILITY
317:45-7-5 [AMENDED]
SUBCHAPTER 9. INSURE OKLAHOMA ESI EMPLOYEE ELIGIBILITY
317:45-9-1 [AMENDED]
SUBCHAPTER 11. INSURE OKLAHOMA IP [REVOKED]
PART 1. INDIVIDUAL PLAN PROVIDERS [REVOKED]
317:45-11-1 [REVOKED]
317:45-11-2 [REVOKED]
PART 3. INSURE OKLAHOMA IP MEMBER BENEFITS [REVOKED]
317:45-11-10 [REVOKED]
317:45-11-11 [REVOKED]
PART 5. INSURE OKLAHOMA IP MEMBER ELIGIBILITY [REVOKED]
317:45-11-20 [REVOKED]
317:45-11-21 [REVOKED]
317:45-11-21.1 [REVOKED]
317:45-11-22 [REVOKED]
317:45-11-23 [REVOKED]
317:45-11-24 [REVOKED]
317:45-11-26 [REVOKED]
317:45-11-27 [REVOKED]
317:45-11-28 [REVOKED]
(REFERENCE APA WF # 21-06)

317:45-1-1. Purpose and general program provisions

The purpose of this Chapter is to provide rules, in compliance with all applicable federal and state regulations, for the Insure Oklahoma program that establishes access to affordable health coverage for low-income working adults~~,~~ their dependents, and their spouses; foster parents; and qualified college students.

317:45-1-2. Program limitations

(a) The Insure Oklahoma program is contingent upon federal waiver approval and sufficient funding that is collected and dispersed through a revolving fund within the State Treasury designated as the "Health Employee and Economy Improvement Act (HEEIA) Revolving Fund". This fund is a continuing fund, not subject to fiscal year limitations.

(1) All monies accruing to the credit of the fund are budgeted and expended by the ~~OHCA~~Oklahoma Health Care Authority (OHCA) to implement the program.

(2) The program is funded through a portion of monthly proceeds

from the Tobacco Tax, ~~Okla. Stat. § 68-302-5~~Title 68 of the Oklahoma Statutes (O.S.) § 302-5 et seq., collected and dispersed through the HEEIA revolving fund, pursuant to ~~Title 68, Section 302-5 (B.1. and D.1.) and Section 402-3 (B.1 and C.1.) of the Oklahoma Statutes~~68 O.S. §§ 302-5 (B)(1) & (C)(1) and 402-3 (B)(1) & (D)(1).

(3) The program is limited in scope such that available funding is not exceeded. Available funding includes the estimated annual deposits from tax collections, accrued interest, federal matching funds and any other revenue source deposited in the HEEIA Revolving Fund for the purpose of this program. If at any time it becomes apparent there is risk the available funding may be exceeded, OHCA must take action to ensure the Insure Oklahoma program continues to operate within its fiscal capacity.

(A) Insure Oklahoma may limit eligibility based on:

(i) ~~the federally-approved Health Insurance Flexibility and Accountability (HIFA) Waiver/1115 Waiver~~The 1115 Waiver;

(ii) Tobacco ~~Tax~~tax collections; and

(iii) ~~the~~The State Child Health Plan for the State Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act.

(B) The Insure Oklahoma program may limit eligibility when the utilization of services is projected to exceed the spending authority, or, may suspend new eligibility determinations instead, establishing a waiting list.

(i) Applicants, not previously enrolled and participating in the program, submitting new applications for the Insure Oklahoma program ~~are~~may be placed on a waiting list. Applications, with the exception of college students, are identified by region ~~and Insure Oklahoma program~~. Regions are established based on population density statistics as determined through local and national data and may be periodically adjusted to assure statewide availability. Insure Oklahoma program size is determined by OHCA and may be periodically adjusted.

(ii) The waiting list utilizes a "first in - first out" method of selecting eligible applicants by region and program.

(iii) When an applicant is determined eligible and moves from the waiting list to active participation, the applicant must submit a new application.

(iv) Enrolled applicants who are currently participating in the program are not subject to the waiting list.

(v) For approved employers, if the employer hires a new employee after the employer's program eligibility begins, the new employee is allowed to participate.

(vi) For approved employers, if the employer has an employee who has a qualifying event after the employer's

program eligibility begins, the employee is allowed to make changes pertaining to the qualifying event.

(b) College student eligibility and participation in the Insure Oklahoma program is contingent upon sufficient funding from the Oklahoma legislature. This funding is separate from the funding described in subsection (a) of this Section.

317:45-1-3. Definitions

The following words or terms, when used in this Chapter, will have the following meanings unless the context clearly indicates otherwise:

"Carrier" means:

(A) ~~an~~An insurance company, insurance service, insurance organization, or group health service, which is licensed to engage in the business of insurance in the State of Oklahoma and is subject to State law which regulates insurance, or Health Maintenance Organization (HMO) which provides or arranges for the delivery of basic health care services to enrollees on a prepaid basis, except for copayments or deductibles for which the enrollee is responsible, or both and is subject to State law which regulates Health Maintenance Organizations (HMOs);

(B) ~~a~~A Multiple Employer Welfare Arrangement (MEWA) licensed by the Oklahoma Insurance Department;

(C) ~~a~~A domestic MEWA exempt from licensing pursuant to Title 36 ~~O.S., Section~~of the Oklahoma Statutes (O.S.) § 634(B) that otherwise meets or exceeds all ~~of~~ the licensing and financial requirements of MEWAs as set out in ~~Article 6A of Title 36~~Title 36 O.S.; or

(D) ~~any~~Any entity organized pursuant to the Interlocal Cooperation Act, ~~Section 1001 et seq. of Title 74 of the Oklahoma Statutes~~74 O.S. § 1001 et seq. as authorized by ~~Title 36 Section 607.1 of the Oklahoma Statutes~~36 O.S. § 607.1 and which is eligible to qualify for and hold a certificate of authority to transact insurance in this State and annually submits on or before March 1st a financial statement to the Oklahoma Insurance Department in a form acceptable to the Insurance Commissioner covering the period ending December 31st of the immediately preceding fiscal year.

"Child ~~Care Center~~care center" means a facility licensed by the Oklahoma Department of Human Services (DHS) which provides care and supervision of children and meets all the requirements in OAC ~~340:110-3-1 through OAC 340:110-3-33.3~~340:110-3-275 through 340:110-3-311.

"College ~~Student~~student" means an Oklahoma resident between the age of nineteen (19) through twenty-two (22) that is a full-time student at an Oklahoma accredited ~~University~~university or ~~College~~college.

~~**"DHS"** means the Oklahoma Department of Human Services.~~

"Dependent" means the spouse of the approved applicant and/or child under nineteen (19) years of age or his or her child nineteen (19) years through twenty-two (22) years of age who is attending an Oklahoma qualified institution of higher education and relying upon the insured employee or member for financial support.

"Eligibility period" means the period of eligibility extending from an approval date to an end date.

"Employee" means a person who works for an employer in exchange for earned income. This includes the owners of a business.

"Employer" means the business entity that pays earned income to employees.

"Employer Sponsored Insurance (ESI)" means the program that provides premium assistance to qualified businesses for approved applicants.

"Explanation of Benefit (EOB)" means a statement issued by a carrier that indicates services rendered and financial responsibilities for the carrier and Insure Oklahoma member.

"Full-time ~~Employer~~employer" means the employer who employs an employee per Federal and State regulations, to perform work in exchange for wages or salary.

"Full-time ~~Employment~~employment" means a normal work week per Federal and State regulations.

~~**"Individual Plan (IP)"** means the safety net program for those qualified individuals who do not have access to Insure Oklahoma ESI.~~

"In-network" means providers or health care facilities that are part of a benefit plan's network of providers with which it has negotiated a discount, and services provided by a physician or other health care provider with a contractual agreement with the insurance company paid at the highest benefit level.

"Insure Oklahoma (IO)" means a benefit plan purchasing strategy in which the State uses public funds to pay for a portion of the costs of benefit plan coverage for eligible populations.

"Member" means an individual enrolled in the Insure Oklahoma ESI ~~or IP~~ program.

"Modified Adjusted Gross Income (MAGI)" means the financial eligibility determination methodology established by the Patient Protection and Affordable Care Act (PPACA) in 2009.

"OAC" means the Oklahoma Administrative Code.

"OESC" means the Oklahoma Employment Security Commission.

"OHCA" means the Oklahoma Health Care Authority.

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

"Premium" means a monthly payment to a carrier for benefit plan coverage.

"Primary ~~Care Provider~~care provider (PCP)" means a provider under contract with the OHCA to provide primary care services,

including all medical necessary referrals.

"Professional ~~Employer Organization~~employer organization (PEO)" means any person engaged in the business of providing professional employer services shall be subject to registration under the Oklahoma Professional Employer Organization Recognition and Registration Act as provided in ~~Title 40, Chapter 16 of Oklahoma Statutes, Section 600.1 et. seq~~40 O.S. § 600.1 et. seq.

"Qualified ~~Benefit Plan~~benefit plan (QBP)" means a benefit plan that has been approved by the OHCA for participation in the Insure Oklahoma program.

"Qualifying ~~Event~~event" means the occurrence of an event that permits individuals to join a group benefit plan outside of the "open enrollment period" and/or that allows individuals to modify the coverage they have had in effect. Qualifying events are defined by the employer's benefit plan and meet federal requirements under Public Law 104-191 (HIPAA), and 42 U.S.C. 300bb-3.

"State" means the State of Oklahoma, acting by and through the OHCA.

317:45-1-4. Reimbursement for out-of-pocket expenses

(a) Out-of-pocket expenses for all approved and eligible members (and/or their approved and eligible dependents) will be limited to five (5) percent of their annual gross household income. The OHCA will provide reimbursement for out-of-pocket expenses in excess of the five (5) percent annual gross household income. An expense must be for an allowed and covered service by a ~~qualified benefit plan (QBP)~~QBP to be eligible for reimbursement. For the purpose of this Section, an allowed and covered service is defined as an in-network service covered in accordance with a QBPs benefit summary and policies. For instance, if a QBP has multiple in-network reimbursement percentage methodologies (~~80%~~eighty (80) percent for level 1 provider and ~~70%~~seventy (70) percent for level 2 provider) the OHCA will only reimburse expenses related to the highest percentage network.

(b) For all eligible expenses as defined above in OAC 317:45-1-4(a), the member must submit the OHCA required form and all OHCA required documentation to support that the member incurred and paid the out-of-pocket expense. The OHCA required documentation must substantiate that the member actually incurred and paid the eligible out-of-pocket expense. The OHCA may request additional documentation at any time to support a member's request for reimbursement of eligible out-of-pocket expenses.

SUBCHAPTER 7. INSURE OKLAHOMA ESI EMPLOYER ELIGIBILITY

317:45-7-5. Reimbursement

In order to receive a premium subsidy, the employer must submit all pages of the current benefit plan invoice. Due to timely filing requirements, subsidy payments will not be paid on invoices older

than six (6) months.

SUBCHAPTER 9. INSURE OKLAHOMA ESI EMPLOYEE ELIGIBILITY

317:45-9-1. Employee eligibility requirements

(a) Employees must complete and submit the OHCA required forms and application to be considered for participation in the program.
(b) The eligibility determination will be processed within thirty (30) days from the date the application is received. The employee will be notified in writing of the eligibility decision.
(c) All eligible employees described in this section must be enrolled in their employer's qualified benefit plan. Eligible employees must:

(1) ~~have~~Have countable income at or below the appropriate standard according to the family size on the Insure Oklahoma ESI Income Guidelines form;

(A) ~~Effective January 1, 2016, financial~~Financial eligibility for Insure Oklahoma ESI benefits is determined using the MAGI methodology. Unless questionable, the income of applicants does not require verification. See OAC 317:35-6-39 through ~~OAC 317:35-6-54~~317:35-6-55 for the applicable MAGI rules for determining household composition and countable income.

(B) Income is evaluated on a monthly basis for all individuals included in the case for Insure Oklahoma ESI Benefits.

(2) ~~be~~Be a US citizen or alien as described in OAC 317:35-5-25;
(3) ~~be~~Be Oklahoma residents;
(4) ~~furnish~~Furnish, or show documentation of an application for, a Social Security number at the time of application for Insure Oklahoma ESI benefits;
(5) ~~not~~Not be receiving benefits from SoonerCare or Medicare;
(6) ~~be~~Be employed with a qualified employer at a business location in Oklahoma;
(7) ~~be~~Be age nineteen (19) through age sixty-four (64);
(8) ~~be~~Be eligible for enrollment in the employer's ~~qualified benefit plan~~QBP;
(9) ~~not~~Not have full-time employment with any employer who does not meet the eligible employer guidelines listed in OAC 317:45-7-1(a)(1)-(2);
(10) ~~select~~Select one of the ~~qualified benefit plans~~QBPs the employer is offering; and
(11) ~~provide~~Provide in a timely manner any and all documentation that is requested by the Insure Oklahoma program by the specified due date.

(d) An employee's dependents are eligible when:

(1) ~~the~~The employer's benefit plan includes coverage for dependents;
(2) ~~the~~The employee is eligible;
(3) ~~if~~If employed, the spouse may not have full-time employment

with any employer who does not meet the eligible employer guidelines listed in OAC 317:45-7-1 (a) (1)-(2); and

(4) ~~the~~The dependents are enrolled in the same benefit plan as the employee.

(e) If an employee or their dependents are eligible for multiple ~~qualified benefit plans~~QBPs, each may receive a subsidy under only one benefit plan.

(f) College students may enroll in the Insure Oklahoma ESI program as dependents. ~~Effective January 1, 2016, financial~~Financial eligibility for Insure Oklahoma ESI benefits for college students is determined using the MAGI methodology. See OAC 317:35-6-39 through ~~OAC 317:35-6-54~~317:35-6-55 for the applicable MAGI rules for determining household composition and countable income. Dependent college students must enroll under their parents and all annual gross household income (including parent income) must be included in determining eligibility. Independent college students may apply on their own without parent income included in the household. College student status as dependent or independent is determined by the student's current Free Application for Federal Student Aid (FAFSA) or the university's financial aid office. College students must also provide a copy of their current student schedule to prove full-time student status.

(g) Working dependent children must have countable income at the appropriate standard according to the family size on the Insure Oklahoma ESI Income Limits Guidelines form. ~~Effective January 1, 2016, financial~~Financial eligibility for Insure Oklahoma ESI benefits is determined using the MAGI methodology. See OAC 317:35-6-39 through ~~OAC 317:35-6-54~~317:35-6-55 for the applicable MAGI rules for determining household composition and countable income. Children found to be eligible for SoonerCare may not receive coverage through Insure Oklahoma.

(h) ESI approved individuals must notify the OHCA of any changes, including household status and income, that might impact individual and/or dependent eligibility in the program within ten (10) days of the change.

(i) When the agency responsible for determining eligibility for the member becomes aware of a change in the member's circumstances, the agency will promptly redetermine eligibility for all household members whose eligibility is affected by the change.

SUBCHAPTER 11. INSURE OKLAHOMA IP [REVOKED]

PART 1. INDIVIDUAL PLAN PROVIDERS [REVOKED]

317:45-11-1. Insure Oklahoma Individual Plan providers [REVOKED]

~~Insure Oklahoma Individual Plan (IP) providers must comply with existing SoonerCare rules found at 317:25 and 317:30. In order to receive reimbursement, the IP provider:~~

~~(1) must enter into a SoonerCare contract; and~~

~~(2) must complete Insure Oklahoma IP addendum if provider wants to provide primary care services as a PCP.~~

317:45-11-2. Insure Oklahoma Individual Plan (IP) provider payments [REVOKED]

~~Payment for covered benefits rendered to Insure Oklahoma IP members is made to contracted Insure Oklahoma IP healthcare providers for medical and surgical services within the scope of OHCA's medical programs, provided the services are medically necessary as defined in Oklahoma Administrative Code 317:30-3-1(f).~~

~~(1) Coverage of certain services requires prior authorization and may be based on a determination made by a medical consultant in individual circumstances; and~~

~~(2) The provider may collect the member's co-payment in addition to the SoonerCare reimbursement for services provided.~~

PART 3. INSURE OKLAHOMA IP MEMBER BENEFITS [REVOKED]

317:45-11-10. Insure Oklahoma IP adult benefit [REVOKED]

~~(a) All IP adult benefits are subject to rules delineated in OAC 317:30 except as specifically set out in this Section. The scope of IP adult benefits described in this Section is subject to specific non-covered services listed in OAC 317:45-11-11.~~

~~(b) A PCP referral is required to see any other provider with the exception of the following services:~~

~~(1) behavioral health services;~~

~~(2) prenatal and obstetrical supplies and services, meaning prenatal care, delivery and 60 days of postpartum care;~~

~~(3) family planning supplies and services, meaning an office visit for a comprehensive family planning evaluation, including obtaining a Pap smear;~~

~~(4) women's routine and preventive health care services;~~

~~(5) emergency medical condition as defined in OAC 317:30-3-1; and~~

~~(6) services delivered to American Indians at Indian Health Service, tribal, or urban Indian clinics.~~

~~(c) IP covered adult benefits for in-network services and limits are listed in this subsection. Member cost sharing related to premium and co-payments cannot exceed federal maximums with the exception of emergency room visits, in which case the State establishes the maximum for member cost share. Native American adults providing documentation of ethnicity who receive items and services furnished by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services are exempt from co-payments. Coverage for IP services includes:~~

~~(1) Anesthesia/Anesthesiologist Standby. Covered in accordance with OAC 317:30-5-7. Eligible services are covered for covered illness or surgery including services provided by a Certified~~

~~Registered Nurse Anesthetist (CRNA) or Anesthesiologist Assistant (AA).~~

~~(2) Blood and Blood Products. Processing, storage, and administration of blood and blood products in inpatient and outpatient settings.~~

~~(3) Chelation Therapy. Covered for heavy metal poisoning only.~~

~~(4) Diagnostic X-ray, including Ultrasound. Covered in accordance with OAC 317:30-5-22(b)(2). PCP referral is required.~~

~~(5) Emergency Room Treatment, services and supplies for treatment in an emergency. Contracted provider services are subject to a $30 co-pay per occurrence. The emergency room co-pay will be waived if the member is admitted to the hospital or death occurs before admission.~~

~~(6) Inpatient Hospital Benefits. Covered in accordance with OAC 317:30-5-41, OAC 317:30-5-47 and OAC 317:30-5-95.~~

~~(7) Preventive Office Visit. For services of evaluation and medical management (wellness exam); one visit per year. This visit counts as an office visit.~~

~~(8) Office Visits/Specialist Visits. Covered in accordance with OAC 317:30-5-9, OAC 317:30-5-10, and OAC 317:30-5-11. For services of evaluation and medical management; up to four visits are covered per month; PCP referral required for specialist visits.~~

~~(9) Outpatient Hospital/Facility Services.~~

~~(A) Includes hospital surgery services in an approved outpatient facility including outpatient services and diagnostic services. Prior authorization required for certain procedures.~~

~~(B) Therapeutic radiology or chemotherapy on an outpatient basis without limitation to the number of treatments per month for persons with proven malignancies or opportunistic infections.~~

~~(C) Physical, Occupational and Speech Therapy services. Coverage is limited to one evaluation/re-evaluation visit (unit) per discipline per calendar year and 15 visits (units) per discipline per date of service per calendar year. Must be hospital based.~~

~~(10) Maternity (Obstetric). Covered in accordance with OAC 317:30-5-22.~~

~~(11) Laboratory/Pathology. Covered in accordance with OAC 317:30-5-20.~~

~~(12) Mammogram (Radiological or Digital). Covered in accordance with OAC 317:30-5-901.~~

~~(13) Immunizations. Covered in accordance with OAC 317:30-5-2.~~

~~(14) Assistant Surgeon. Covered in accordance with OAC 317:30-5-8.~~

~~(15) Dialysis, Kidney dialysis, and services and supplies, either at home or in a facility.~~

~~(16) Oral Surgery. Services are limited to the removal of tumors~~

~~or cysts.~~

~~(17) Behavioral Health (Mental Health and Substance Abuse) Treatment (Inpatient). Covered in accordance with OAC 317:30-5-95.1.~~

~~(18) Behavioral Health (Mental Health and Substance Abuse) Treatment (Outpatient). Outpatient benefits are limited to 48 visits per calendar year. Additional visits may be approved as medically necessary.~~

~~(A) Agency services. Covered in accordance with OAC 317:30-5-241 and OAC 317:30-5-596.~~

~~(B) Individual provider services. Licensed Behavioral Health Professionals (LBHPs) are defined as follows for the purpose of Outpatient Behavioral Health Services and Outpatient Substance Abuse Treatment:~~

~~(i) Allopathic or Osteopathic Physicians with a current license and board certification in psychiatry or board eligible in the state in which services are provided, or a current resident in psychiatry practicing as described in OAC 317:30-5-2.~~

~~(ii) Practitioners with a license to practice in the state in which services are provided.~~

~~(I) Psychology,~~

~~(II) Social Work (clinical specialty only),~~

~~(III) Professional Counselor,~~

~~(IV) Marriage and Family Therapist,~~

~~(V) Behavioral Practitioner, or~~

~~(VI) Alcohol and Drug Counselor.~~

~~(iii) Advanced Practice Nurse (certified in a psychiatric mental health specialty), licensed as a registered nurse with a current certification of recognition from the board of nursing in the state in which services are provided.~~

~~(iv) A Physician's Assistant who is licensed in good standing in this state and has received specific training for and is experienced in performing mental health therapeutic, diagnostic, or counseling functions.~~

~~(v) LBHPs must have a valid Insure Oklahoma contract in order to bill for services rendered.~~

~~(vi) LBHP services require prior authorization and are limited to four (4) therapy services per month per member and eight (8) testing units per year per member.~~

~~(19) Durable Medical Equipment and Supplies. Covered in accordance with OAC 317:30-5-210 through OAC 317:30-5-218. A PCP referral and prior authorization is required for certain items.~~

~~(20) Diabetic Supplies. Covered in accordance with OAC 317:30-5-211.15.~~

~~(21) Oxygen. Covered in accordance with OAC 317:30-5-211.11 through OAC 317:30-5-211.12.~~

~~(22) Pharmacy. Covered in accordance with OAC 317:30-5-72.1 and~~

~~OAC 317:30-5-72. Prenatal vitamins and smoking cessation products do not count against monthly prescription limits.~~
~~(23) Smoking Cessation Products. Products do not count against monthly prescription limits. Covered in accordance with OAC 317:30-5-72.1.~~
~~(24) Nutrition Services. Covered in accordance with OAC 317:30-5-1076.~~
~~(25) External Breast Prosthesis, Bras and Prosthetic Garments. Covered in accordance with OAC 317:30-5-211.13.~~
~~(26) Surgery. Covered in accordance with OAC 317:30-5-8.~~
~~(27) Home Dialysis. Covered in accordance with OAC 317:30-5-211.13.~~
~~(28) Parenteral Therapy. Covered in accordance with OAC 317:30-5-211.14.~~
~~(29) Family Planning Services and Supplies, including Sterilizations. Covered in accordance with OAC 317:30-3-57.~~
~~(30) Home Health and Medications, Intravenous (IV) Therapy and Supplies. Covered in accordance with OAC 317:30-5-211.15 and OAC 317:30-5-42.16(b)(3).~~
~~(31) Fundus photography.~~
~~(32) Emergency ground ambulance transportation. Covered in accordance with OAC 317:30-5-336.~~

317:45-11-11. Insure Oklahoma IP adult non-covered services [REVOKED]

~~Certain health care services are not covered in the Insure Oklahoma IP adult benefit package listed in OAC 317:45-11-10. These services include, but are not limited to:~~
~~(1) services not considered medically necessary;~~
~~(2) any medical service when the member refuses to authorize release of information needed to make a medical decision;~~
~~(3) organ and tissue transplant services;~~
~~(4) weight loss intervention and treatment including, but not limited to, bariatric surgical procedures or any other weight loss surgery or procedure, drugs used primarily for the treatment of weight loss including appetite suppressants and supplements, and/or nutritional services prescribed only for the treatment of weight loss;~~
~~(5) procedures, services and supplies related to sex transformation;~~
~~(6) supportive devices for the feet (orthotics) except for the diagnosis of diabetes;~~
~~(7) cosmetic surgery, except as medically necessary and as covered in OAC 317:30-3-59(19);~~
~~(8) over-the-counter drugs, medicines and supplies except contraceptive devices and products, and diabetic supplies;~~
~~(9) experimental procedures, drugs or treatments;~~
~~(10) dental services (preventive, basic, major, orthodontia,~~

~~extractions or services related to dental accident);~~
~~(11) vision care and services (including glasses), except services treating diseases or injuries to the eye;~~
~~(12) physical medicine including chiropractic and acupuncture therapy;~~
~~(13) hearing services;~~
~~(14) non-emergency transportation and emergency air transportation;~~
~~(15) allergy testing and treatment;~~
~~(16) hospice regardless of location;~~
~~(17) Temporomandibular Joint Dysfunction (TMD) (TMJ);~~
~~(18) genetic counseling;~~
~~(19) fertility evaluation/treatment/and services;~~
~~(20) sterilization reversal;~~
~~(21) Christian Science Nurse;~~
~~(22) Christian Science Practitioner;~~
~~(23) skilled nursing facility;~~
~~(24) long-term care;~~
~~(25) stand by services;~~
~~(26) thermograms;~~
~~(27) abortions (for exceptions, refer to OAC 317:30-5-6);~~
~~(28) services of a Lactation Consultant;~~
~~(29) services of a Maternal and Infant Health Licensed Clinical Social Worker;~~
~~(30) enhanced services for medically high risk pregnancies as found in OAC 317:30-5-22.1;~~
~~(31) ultraviolet treatment-actinotherapy;~~
~~(32) private duty nursing;~~
~~(33) payment for removal of benign skin lesions;~~
~~(34) sleep studies;~~
~~(35) prosthetic devices; and~~
~~(36) continuous positive airway pressure devices (CPAP).~~

PART 5. INSURE OKLAHOMA IP MEMBER ELIGIBILITY [REVOKED]

317:45-11-20. Insure Oklahoma IP eligibility requirements [REVOKED]

~~(a) Oklahoma employed working adults not eligible to participate in an employer's qualified benefit plan, employees of non-participating employers, self-employed, unemployed seeking work, workers with a disability, and qualified college students may apply for the Individual Plan. Applicants, unless a qualified college student, must be: considered "employed" in accordance with State law, including, but not limited to, Title 40 O.S. § 1-210; engaged in routine, for-profit activity, if self-employed; or considered "unemployed" in accordance with State law, including, but not limited to Title 40 O.S. § 1-217. Applicants cannot obtain IP coverage if they are eligible for ESI.~~
~~(b) The eligibility determination will be processed within thirty~~

~~(30) days from the date the complete application is received. The applicant will be notified of the eligibility decision.~~

~~(c) In order to be eligible for the IP, the applicant must:~~

~~(1) choose a valid PCP according to the guidelines listed in OAC 317:45-11-22, at the time he/she completes application;~~

~~(2) be a US citizen or alien as described in OAC 317:35-5-25;~~

~~(3) be an Oklahoma resident;~~

~~(4) furnish, or show documentation of an application for, a Social Security number at the time of application for Insure Oklahoma IP benefits;~~

~~(5) be not currently enrolled in, or have an open application for SoonerCare or Medicare;~~

~~(6) be age 19 through 64;~~

~~(7) make premium payments by the due date on the invoice;~~

~~(8) not have full-time employment with any employer who does not meet the eligible employer guidelines listed in OAC 317:45-7-1(a) (1)-(2);~~

~~(9) be not currently covered by a private insurance policy or plan; and~~

~~(10) provide in a timely manner any and all documentation that is requested by the Insure Oklahoma program by the specified due date.~~

~~(d) If employed and working for an approved Insure Oklahoma employer who offers a qualified benefit plan, the applicant must meet the requirements in subsection (c) of this Section and:~~

~~(1) have countable income at or below the appropriate standard according to the family size on the Insure Oklahoma IP Income Guidelines form.~~

~~(A) Effective January 1, 2016, financial eligibility for Insure Oklahoma IP benefits is determined using the MAGI methodology. Unless questionable, the income of applicants do not require verification. See OAC 317:35-6-39 through OAC 317:35-6-54 for the applicable MAGI rules for determining household composition and countable income.~~

~~(B) Income is evaluated on a monthly basis for all individuals included in the case for Insure Oklahoma IP Benefits;~~

~~(2) be ineligible for participation in their employer's qualified benefit plan due to number of hours worked.~~

~~(e) If employed and working for an employer who does not offer a qualified benefit plan, the applicant must meet the requirements in subsection (c) of this Section and have countable income at or below the appropriate standard according to the family size on the Insure Oklahoma IP Income Guidelines form.~~

~~(1) Effective January 1, 2016, financial eligibility for Insure Oklahoma IP benefits is determined using the MAGI methodology. Unless questionable, the income of applicants does not require verification. See OAC 317:35-6-39 through OAC 317:35-6-54 for the applicable MAGI rules for determining household composition~~

and countable income.

(2) Income is evaluated on a monthly basis for all individuals included in the case for Insure Oklahoma IP Benefits.

(f) If self-employed, the applicant must meet the requirements in subsection (c) of this Section and:

(1) have countable income at or below the appropriate standard according to the family size on the Insure Oklahoma IP Income Guidelines form.

(A) Effective January 1, 2016, financial eligibility for Insure Oklahoma IP benefits is determined using the MAGI methodology. Unless questionable, the income of applicants does not require verification. See OAC 317:35-6-39 through OAC 317:35-6-54 for the applicable MAGI rules for determining household composition and countable income.

(B) Income is evaluated on a monthly basis for all individuals included in the case for Insure Oklahoma IP Benefits.

(2) must not have full-time employment with any employer who does not meet the eligible employer guidelines listed in OAC 317:45-7-1(a)(1)-(2).

(3) must verify self-employment by completing and submitting to Insure Oklahoma the Self-Employment Attestation Form. In addition,

(A) for any applicant who filed a Federal tax return for the tax year immediately preceding the date of application, he or she must provide a copy of such tax return with all supporting schedules and forms, or

(B) for any applicant exempt from filing a Federal tax return for the previous tax year in accordance with Federal law, including, but not limited to, 26 Code of Federal Regulation, Section 1.6017-1, he or she must submit a completed 12-Month Profit and Loss Worksheet to Insure Oklahoma, as well as any other information requested by Insure Oklahoma that could reasonably be used to substantiate the applicant's regular, for-profit business activity.

(g) If unemployed seeking work, the applicant must meet the requirements in subsection(c) of this Section and the following:

(1) Applicants must have countable income at or below the appropriate standard according to the family size on the Insure Oklahoma IP Income Guidelines form.

(2) Effective January 1, 2016, financial eligibility for Insure Oklahoma IP benefits is determined using the MAGI methodology. Unless questionable, the income of applicants does not require verification. See OAC 317:35-6-39 through OAC 317:35-6-54 for the applicable MAGI rules for determining household composition and countable income.

(3) Income is evaluated on a monthly basis for all individuals included in the case for Insure Oklahoma IP Benefits. Applicant must verify eligibility by providing a most recent copy of their

~~monetary OESC determination letter and a most recent copy of at least one of the following:~~

~~(A) A OESC eligibility letter;~~

~~(B) A OESC weekly unemployment payment statement, or;~~

~~(C) A bank statement showing state treasurer deposit.~~

~~(h) If working with a disability, the applicant must meet the requirements in subsection (c) of this Section and the following:~~

~~(1) Applicants must have countable income at or below the appropriate standard according to the family size on the Insure Oklahoma IP Income Guidelines form.~~

~~(2) Applicants may need to verify eligibility of their enrollment in the Ticket to Work program.~~

~~(3) Effective January 1, 2016, financial eligibility for Insure Oklahoma IP benefits is determined using the MAGI methodology. Unless questionable, the income of applicants does not require verification. See OAC 317:35-6-39 through OAC 317:35-6-54 for the applicable MAGI rules for determining household composition and countable income.~~

~~(4) Income is evaluated on a monthly basis for all individuals included in the case for Insure Oklahoma IP Benefits.~~

~~(i) IP approved individuals must notify the OHCA of any changes, including household status and income, that might impact individual and/or dependent eligibility in the program within 10 days of the change.~~

~~(j) When the agency responsible for determining eligibility for the member becomes aware of a change in the member's circumstances, the agency will promptly redetermine eligibility for all household members whose eligibility is affected by the change.~~

~~(k) College students may enroll in the Insure Oklahoma IP program as dependents. Effective January 1, 2016, financial eligibility for Insure Oklahoma IP benefits for college students is determined using the MAGI methodology. See OAC 317:35-6-39 through OAC 317:35-6-54 for the applicable MAGI rules for determining household composition and countable income. Dependent college students must enroll under their parents and all annual gross household income (including parent income) must be included in determining eligibility. Independent college students may apply on their own without parent income included in the household. College student status as dependent or independent is determined by the student's current Free Application for Federal Student Aid (FAFSA) or the university's financial aid office. College students must also provide a copy of their current student schedule to prove full-time student status.~~

~~(l) Any misleading or false representation, or omission of any material fact or information required or requested by OHCA as part of the Insure Oklahoma application process, may result in, among other things, closure of eligibility pursuant to OAC 317:45-11-27.~~

317:45-11-21. Dependent eligibility [REVOKED]

~~(a) If the spouse of an Insure Oklahoma IP approved individual is eligible for Insure Oklahoma ESI, they must apply for Insure Oklahoma ESI. Spouses cannot obtain Insure Oklahoma IP coverage if they are eligible for Insure Oklahoma ESI.~~
~~(b) The employed or self-employed spouse of an approved applicant must meet the guidelines listed in 317:45-11-20 (a) through (g) to be eligible for Insure Oklahoma IP.~~
~~(c) The dependent of an applicant approved according to the guidelines listed in 317:45-11-20(h) does not become automatically eligible for Insure Oklahoma IP.~~
~~(d) The applicant and the dependents' eligibility are tied together. If the applicant no longer meets the requirements for Insure Oklahoma IP, then the associated dependent enrolled under that applicant is also ineligible.~~
~~(e) College students may enroll in the Insure Oklahoma IP program. Effective January 1, 2016, financial eligibility for Insure Oklahoma IP benefits for college students' are determined using the MAGI methodology. See OAC 317:35-6-39 through OAC 317:35-6-54 for the applicable MAGI rules for determining household composition and countable income.~~
~~(f) IP approved individuals must notify the OHCA of any changes, including household status and income, that might impact individual and/or dependent eligibility in the program within 10 days of the change.~~
~~(g) When the agency responsible for determining eligibility for the member becomes aware of a change in the dependents circumstances, the agency will promptly redetermine eligibility for all household members whose eligibility is affected by the change.~~

317:45-11-21.1. Certification of newborn child deemed eligible [REVOKED]

~~(a) A newborn child is deemed eligible on the date of birth for SoonerCare benefits when the child is born to a member of Insure Oklahoma Individual Plan (IP) and the annual gross household income does not exceed SoonerCare requirements. The newborn child is deemed eligible for SoonerCare benefits through the last day of the month the child attains the age of one (1) year.~~
~~(b) The newborn child's SoonerCare eligibility is not dependent on the mother's continued eligibility in Insure Oklahoma IP. The child's SoonerCare eligibility is based on the original eligibility determination of the mother for Insure Oklahoma IP and consideration is not given to any income or resource changes that occur during the deemed eligibility period.~~
~~(c) The newborn child's certification period for SoonerCare is shortened only in the event the child:~~
~~(1) Loses Oklahoma residence; or~~
~~(2) Expires.~~
~~(d) No other conditions of eligibility are applicable, including social security number enumeration and citizenship and identity~~

~~verification. However, it is recommended that social security number enumeration be completed as soon as possible after the child's birth.~~

317:45-11-22. Primary Care Physician (PCP) choices [REVOKED]

~~(a) The applicant and any covered dependent(s) are required to select a valid PCP.~~

~~(b) The applicant and any covered dependent(s) must make a PCP selection though their mysoonercare.org account.~~

~~(c) After initial enrollment in Insure Oklahoma Individual Plan the applicant any covered dependent(s) may change their PCP selection through their mysoonercare.org account or by calling the Insure Oklahoma helpline.~~

~~(d) To ensure members have access to their Patient Centered Medical Home, Insure Oklahoma staff may facilitate enrollment as applicable.~~

317:45-11-23. Member eligibility period [REVOKED]

~~(a) The rules in this subsection apply to member's eligibility according to OAC 317:45-11-20(a) through (e).~~

~~(1) The member's eligibility period begins only after approval of the application and receipt of the premium payment.~~

~~(A) If the application is approved and the premium payment is made by the last day of the same month, eligibility will begin the first day of the next month.~~

~~(B) If the application is approved and the premium payment is made between the first and 15th day of the next month, eligibility will begin the first day of the second consecutive month.~~

~~(C) If the application is approved and the premium payment is not made within 45 days, eligibility will not begin.~~

~~(2) Employee eligibility is contingent upon the employer meeting the program guidelines.~~

~~(3) The employee's eligibility is determined using the eligibility requirements listed in OAC 317:45-9-1 or OAC 317:45-11-20 (a) through (e).~~

~~(4) If the employee is determined eligible for Insure Oklahoma IP, he/she is approved for a period not greater than 12 months.~~

~~(b) The rules in this subsection apply to applicants eligible according to OAC 317:45-11-20(a) through (c) and OAC 317:45-11-20(f) through (h).~~

~~(1) The applicant's eligibility is determined using the eligibility requirements listed in OAC 317:45-11-20(a) through (c) and OAC 317:45-11-20(f) through (h).~~

~~(2) If the applicant is determined eligible for Insure Oklahoma IP, he/she is approved for a period not greater than twelve (12) months.~~

~~(3) The applicant's eligibility period begins only after receipt of the premium payment.~~

317:45-11-24. Member cost sharing [REVOKED]

~~(a) Members are given monthly invoices for their benefit plan premiums. IP health plan premiums are established by the OHCA. The premiums are due monthly and must be paid in full.~~

~~(1) Members are responsible for their monthly premiums, in an amount not to exceed four percent (4%) of their monthly gross household income.~~

~~(2) Working disabled individuals are responsible for their monthly premiums in an amount not to exceed four percent~~ (4%) ~~of their monthly gross household income, based on a family size of one and capped at one-hundred percent (100%) of the Federal Poverty Level.~~

~~(3) Cost-sharing, including premium payments and copayments, are not required of American Indian and Alaska Native members, as is established in the federally-approved Oklahoma Medicaid State Plan.~~

~~(b) IP coverage is not provided until the premium and any other amounts due are paid in full. Other amounts due may include but are not limited to any fees, charges, or other costs incurred as a result of returned payments.~~

317:45-11-26. Reviews [REVOKED]

~~Members participating in the Insure Oklahoma program are subject to reviews related to their eligibility, subsidy payments, premium payments and out-of-pocket reimbursements. Eligibility may be reversed at any time if inconsistencies are found. Any monies paid in error will be subject to recoupment.~~

317:45-11-27. Closure [REVOKED]

~~(a) Members are mailed a notice 10 days prior to closure of eligibility.~~

~~(b) The employer and employees' eligibility are tied together. If the employer no longer meets the requirements for Insure Oklahoma then eligibility for the associated employees enrolled under that employer are also ineligible.~~

~~(c) The employee's certification period may be terminated when:~~

~~(1) the member requests closure;~~

~~(2) the member moves out-of-state;~~

~~(3) the covered member dies;~~

~~(4) the employer's eligibility ends;~~

~~(5) a review indicates a discrepancy that makes the member or employer ineligible;~~

~~(6) the employer is terminated from Insure Oklahoma;~~

~~(7) the member fails to pay their premium;~~

~~(8) the qualified benefit plan or carrier no longer meets the requirements set forth in this chapter;~~

~~(9) the member begins receiving SoonerCare or Medicare benefits;~~

~~(10) the member begins receiving coverage by a private benefit~~

~~policy or plan;~~

~~(11) the member or employer reports any change affecting eligibility; or~~

~~(12) the member no longer meets the eligibility criteria set forth in this Chapter.~~

~~(d) This subsection applies to applicants eligible according to 317:45-11-20(a) through (c) and 317:45-11-20(f) through (h). The member's certification period may be terminated when:~~

~~(1) the member requests closure;~~

~~(2) the member moves out-of-state;~~

~~(3) the covered member dies;~~

~~(4) the employer's eligibility ends;~~

~~(5) a review indicates a discrepancy that makes the member or employer ineligible;~~

~~(6) the member fails to pay their premium;~~

~~(7) the member becomes eligible for SoonerCare or Medicare;~~

~~(8) the member begins receiving coverage by a private benefit policy or plan;~~

~~(9) the member or employer reports any change affecting eligibility; or~~

~~(10) the member no longer meets the eligibility criteria set forth in this Chapter.~~

317:45-11-28. Appeals [REVOKED]

~~Member appeal procedures based on denial of eligibility due to income are described at 317:2-1-2.~~

C.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 3. HOSPITALS
317:30-5-58 [AMENDED]
(REFERENCE APA WF # 21-09)

317:30-5-58. Supplemental Hospital Offset Payment Program

(a) **Purpose.** The Supplemental Hospital Offset Payment Program (SHOPP) is a hospital assessment fee that is eligible for federal matching funds when used to reimburse SoonerCare services in accordance with Section 3241.1 of Title 63 of the Oklahoma Statutes (O.S.).

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

(1) **"Base Year"** means a hospital's fiscal year ending in 2009, as reported in the Medicare Cost Report or as determined by the Oklahoma Health Care Authority (OHCA) if the hospital's data is not included in a Medicare Cost Report.

(2) **"Directed payments"** means payment arrangements allowed under 42 Code of Federal Regulations (C.F.R.) Section (§) 438.6(c) that permit states to direct specific payments made by managed care plans to providers under certain circumstances and can assist states in furthering the goals and priorities of their Medicaid programs.

~~(2)~~(3) **"Fee"** means supplemental hospital offset assessment pursuant to Section (§) 3241.1 of Title 63 of the ~~Oklahoma Statutes~~O.S.

~~(3)~~(4)**"Hospital"** means an institution licensed by the State Department of Health as a hospital pursuant to ~~Section~~§ 1-701.1 of Title 63 of the ~~Oklahoma Statutes~~O.S. maintained primarily for the diagnosis, treatment, or care of patients.

~~(4)~~(5)**"Hospital Advisory Committee"** means the Committee established for the purposes of advising the OHCA and recommending provisions within and approval of any state plan amendment or waiver affecting the Supplemental Hospital Offset Payment Program.

~~(5)~~(6) **"NET hospital patient revenue"** means the gross hospital revenue as reported on Worksheet G-2 (Columns 1 and 2, Lines "Total inpatient routine care services", "Ancillary services", "Outpatient services") of the Medicare ~~Cost Report~~cost report, multiplied by hospital's ratio of total net to gross revenue, as reported on Worksheet G-3(Column 1, Line 3)"Net patient revenues"~~)~~ and Worksheet G-2 (Part I, Column 3, Line "Total patient revenues").

~~(6)~~(7) **"Medicare ~~Cost Report~~cost report"** means the ~~Hospital Cost Report~~hospital cost report, Form CMS-2552-96 or subsequent

versions.

~~(7)~~(8) **"Upper payment limit"(UPL)"** means the maximum ceiling imposed by ~~42 C F R §§~~42 C.F.R. §§ 447.272 and 447.321 on hospital Medicaid reimbursement for inpatient and outpatient services, other than to hospitals owned or operated by state government.

~~(8)~~(9) **"Upper payment limit gap"** means the difference between the upper payment limit and SoonerCare payments not financed using hospital assessments.

(c) **Supplemental Hospital Offset Payment Program.**

(1) Pursuant to 63 ~~Okla. Stat.~~O.S. §§ 3241.1 through 3241.6 the ~~Oklahoma Health Care Authority (OHCA)~~OHCA is mandated to assess hospitals licensed in Oklahoma, unless exempted under (c) (2) of this Section, a supplemental hospital offset payment fee.

(2) The following hospitals are exempt from the SHOPP fee:

(A) ~~a~~A hospital that is owned or operated by the state or a state agency, or the federal government, as determined by OHCA, using most recent Medicare cost report worksheet S-2, column 1, line 18 or other line that indicates ownership, or by a federally recognized Indian tribe or Indian Health Services, as determined by OHCA, using the most recent IHS/Tribal facility list for Oklahoma as updated by the Indian Health Service Office of Resource Access and Partnerships in Partnership with the Centers for Medicare and Medicaid Services and ~~State~~state operations.

(B) ~~a~~A hospital that provides more than fifty percent (50%) of its inpatient days under a contract with a state agency other than the OHCA, as determined by OHCA, using data provided by the hospital;

(C)~~a~~A hospital for which the majority of its inpatient days are for any one of the following services, as determined by OHCA, using the Inpatient Discharge Data File published by the Oklahoma State Department of Health, or in the case of a hospital not included in the Inpatient Discharge Data File, using substantially equivalent data provided by the hospital:

(i) ~~treatment~~Treatment of a neurological injury;

(ii) ~~treatment~~Treatment of cancer;

(iii) ~~treatment~~Treatment of cardiovascular disease;

(iv) ~~obstetrical~~Obstetrical or childbirth services; or

(v) ~~surgical~~Surgical care except that this exemption will not apply to any hospital located in a city of less than five hundred thousand (500,000) population and for which the majority of inpatient days are for back, neck, or spine surgery.

(D) ~~a~~A hospital that is certified by the Centers for Medicare and Medicaid Services (CMS) as a long term acute hospital, according to the most recent list of LTCH's published on the CMS http://www.cms.gov/LongTermCareHospitalPPS/08download.asp or as a children's hospital; and

(E) ~~a~~A hospital that is certified by CMS as a critical access hospital, according to the most recent list published by Flex Monitoring Team for Critical Access Hospital (CAH) Information at http://www.flexmonitoring.org/cahlistRA.cgi, which is based on CMS quarterly reports, augmented by information provided by state Flex Coordinators.

(d) **The ~~Supplemental Hospital Offset Payment Program~~SHOPP Assessment.**

(1) The SHOPP assessment is imposed on each hospital, except those exempted under (c) (2) of this Section, for each calendar year in an amount calculated as a percentage of each hospital's net hospital patient revenue. ~~The assessment rate until December 31, 2012, is two and one-half percent (2.5%). At no time in subsequent years will the assessment rate exceed four percent (4%).~~The SHOPP assessment is imposed on each hospital, except those exempted under (c) (2) of this Section, in an amount calculated as a percentage of each hospital's net hospital patient revenue. At no time will the assessment rate exceed four percent (4%). For the calendar year ending December 31, 2022, the assessment rate shall be fixed at three percent (3%). For the calendar year ending December 31, 2023, the assessment rate shall be fixed at three and one-half percent (3.5%). For the calendar year ending December 31, 2024 and for all subsequent calendar years shall, the assessment rate exceed shall be fixed at four percent (4%).

~~(2) OHCA will review and determine the amount of annual assessment in December of each year.~~

~~(3)~~(2) A hospital may not charge any patient for any portion of the SHOPP assessment.

~~(4)~~(3) The ~~Method~~method of collection is as follows:

(A) The OHCA will send a notice of assessment to each hospital informing the hospital of the assessment rate, the hospital's net hospital patient revenue calculation, and the assessment amount owed by the hospital for the applicable year.

(B) The hospital has thirty (30) days from the date of its receipt of a notice of assessment to review and verify the hospital's net patient revenue calculation, and the assessment amount.

(C) New hospitals will only be added at the beginning of each calendar year.

(D) The annual assessment imposed is due and payable on a quarterly basis. Each quarterly installment payment is due and payable by the fifteenth day of the first month of the applicable quarter (i.e. January 15th, April 15th, etc.)

(E) Failure to pay the amount by the 15th or failure to have the payment mailing postmarked by the 13th ~~will~~may result in a debt to the State of Oklahoma and is subject to penalties of ~~5%~~five percent (5%) of the amount ~~and interest of 1.25%one~~

~~and a quarter percent (1.25%) per month~~.

(F) If a hospital fails to timely pay the full amount of a quarterly assessment, OHCA ~~will~~may add to the assessment:

(i) ~~a~~A penalty assessment equal to five percent (5%) of the quarterly amount not paid on or before the due date, and

(ii) ~~on~~On the last day of each quarter after the due date until the assessed amount and the penalty imposed under section (i) of this paragraph are paid in full, an additional five percent (5%) penalty assessment on any unpaid quarterly and unpaid penalty assessment amounts.

(iii) ~~the~~The quarterly assessment including applicable penalties and interest must be paid regardless of any appeals action requested by the facility. If a provider fails to pay the OHCA the assessment within the time frames noted on the invoice to the provider, the assessment~~,~~ and applicable penalty~~, and interest~~ will be deducted from the facility's payment. Any change in payment amount resulting from an appeals decision in which a recoupment or additional allocation is necessary will be adjusted in future payments in accordance with ~~OAC~~Oklahoma Administrative Code (OAC) 317:2-1-15 SHOPP appeals.

(iv) If additional allocation or recoupment resulting from an appeal is for the current calendar year and another SHOPP payment is scheduled for the calendar year, an adjustment to the next payment will be calculated. If additional allocation or recoupment is for a prior calendar year, a separate payment/account receivable (AR) will be issued.

(G) The SHOPP assessments excluding penalties and interest are an allowable cost for cost reporting purposes.

(e) **~~Supplemental Hospital Offset Payment Program~~SHOPP Cost Reports.**

(1) The report referenced in paragraph (b)(6) must be signed by the preparer and by the Owner, authorized Corporate Officer or Administrator of the facility for verification and attestation that the reports were compiled in accordance with this section.

(2) The Owner or authorized Corporate Officer of the facility must retain full accountability for the report's accuracy and completeness regardless of report submission method.

(3) Penalties for false statements or misrepresentation made by or on behalf of the provider are provided at 42 ~~U.S.C.~~United States Code (U.S.C.) Section 1320a-7b which states, in part, "Whoever...(2) at any time knowingly and willfully makes or causes to be made any false statement of a material fact for use in determining rights to such benefits or payment...shall (i) in the case of such statement, representation, failure, or conversion by any person in connection with furnishing (by the person) of items or services for which payment is or may be under this title (42 U.S.C. § 1320 et seq.), be guilty of a

felony and upon conviction thereof fined not more than ~~$25,000~~twenty-five thousand dollars ($25,000) or imprisoned for not more than five (5) years or both, or (ii) in the case of such a statement, representation, concealment, failure or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than ~~$10,000~~ten thousand dollars ($10,000) or imprisoned for not more than one year, or both."

(4) Net hospital patient revenue is determined using the data from each hospital's applicable Medicare ~~Cost Report~~cost report contained in the Centers for Medicare and Medicaid Services' Healthcare Cost Report Information System (HCRIS) file. The base year for assessment shall be the hospital's fiscal year that ended two years prior (e.g. calendar year 2022 will use 2020 fiscal year cost reports), as contained in the HCRIS file dated June 30 of each year.

~~(A) Through 2013, the base year for assessment shall be the hospital's fiscal year that ended in 2009, as contained in the HCRIS file dated December 31, 2010;~~

~~(B) For years 2014 and 2015, the base year for assessment shall be the hospital's fiscal year that ended in 2012, as contained in the HCRIS file dated June 30, 2013; and~~

~~(C) For subsequent two-year periods the base year for assessment shall be the hospital's fiscal year that ended two years prior (e.g.,2016 & 2017 – 2014 fiscal year; 2018 & 2019 – 2016 fiscal year), as contained in the HCRIS file dated June 30 of the following year.~~

(5) If a hospital's applicable Medicare ~~Cost Report~~cost report is not contained in the Centers for Medicare and Medicaid Services' HCRIS file, the hospital will submit a copy of the hospital's applicable Medicare ~~Cost Report~~cost report to the ~~Oklahoma Health Care Authority (OHCA)~~OHCA in order to allow the OHCA to determine the hospital's net hospital patient revenue for the base year.

(6) If a hospital commenced operations after the due date for a Medicare ~~Cost Report~~cost report, the hospital will submit its initial Medicare ~~Cost Report~~cost report to ~~Oklahoma Health Care Authority (OHCA)~~OHCA in order to allow the OHCA to determine the hospital's net patient revenue for the base year.

(7) Partial year reports may be prorated for an annual basis. Hospitals whose assessments were based on partial year cost reports will be reassessed the following year using a cost report that contains a full year of operational data.

(8) In the event that a hospital does not file a uniform cost report under 42 U.S.C., Section 1396a(a)(40), the OHCA will provide a data collection sheet for such facility.

(f) **Closure, merger and new hospitals.**

(1) If a hospital ceases to operate as a hospital or for any reason ceases to be subject to the fee, the assessment for the

year in which the cessation occurs is adjusted by multiplying the annual assessment by a fraction, the numerator of which is the number of days in the year during which the hospital is subject to the assessment and denominator of which is 365. Within ~~30~~thirty (30) days of ceasing to operate as a hospital, or otherwise ceasing to be subject to the assessment, the hospital will pay the assessment for the year as so adjusted, to the extent not previously paid.

(2) Cost reports required under (e)(5),(e)(6),or (e)(8) of this subsection for assessment calculation must be submitted to OHCA by September 30 of each year.

(g) **Disbursement of payment to hospitals.**

(1) All in-state inpatient hospitals are eligible for hospital access payments each year as set forth in this subsection except for those listed in OAC 317:30-5-58 (c) (2):

(A) In addition to any other funds paid to inpatient critical access hospital for services provided to SoonerCare members, each critical access hospital will receive hospital access payments equal to the amount by which the payment for these services was less than one hundred one percent (101%) of the hospital's cost of providing these services.

(B) In addition to any other funds paid to hospitals for inpatient hospital services to SoonerCare members, each eligible hospital will receive inpatient hospital access payments each year equal to the hospital's pro rata share of the inpatient supplemental payment pool as reduced by payments distributed in paragraph (1) (A) of this Section. The pro rata share will be based upon the hospital's SoonerCare payment for inpatient services divided by the total SoonerCare payments for inpatient services of all eligible hospitals within each class of hospital and cannot exceed the UPL for the class.

(C) Directed payments paid through a managed care organization (MCO) as approved in the CMS-approved 438.6(c) directed payment pre-prints.

(2) All in-state outpatient hospitals are eligible for hospital access payments each year as set forth in this subsection except for those listed in OAC 317:30-5-58 (c) (2):

(A) In addition to any other funds paid to outpatient critical access hospital for services provided to SoonerCare members, each critical access hospital will receive hospital access payments equal to the amount by which the payment for these services was less than one hundred one percent (101%) of the hospital's cost of providing these services.

(B) In addition to any other funds paid to hospitals for outpatient hospital services to SoonerCare members, each eligible hospital will receive outpatient hospital access payments each year equal to the hospital's pro rata share of the outpatient supplemental payment pool as reduced by

payments distributed in paragraph (2) (A) of this Section. The pro rata share will be based upon the hospital's SoonerCare payment for outpatient services divided by the total SoonerCare payments for outpatient services of all eligible hospitals within each class of hospital and cannot exceed the UPL for the class.

(C) Directed payments paid through a managed care organization (MCO) as approved in the CMS-approved 438.6(c) directed payment pre-prints.

(3) Medicaid payments to a group of facilities within approved categories may not exceed the upper payment limit in accordance with 42 ~~CFR~~C.F.R. 447.272 (b) (2) and 42 ~~CFR~~C.F.R 447.321 (b) (2). If any audit determines that a class of hospitals has exceeded the inpatient and/or outpatient UPL the overpayment will be recouped and redistributed based on the following methods:

(A) If it is determined prior to issuance of hospital access payments that the pool of hospitals would exceed the upper payment limit estimate of that pool, the amount above the UPL estimate will be allocated to another pool of hospitals that does not exceed the upper payment limit estimate of that pool. The reallocation can be applied to multiple pools if necessary.

(B) If the overpayment cannot be redistributed due to all classes being paid at their UPL, the overpayment will be deposited in to the SHOPP fund.

(4) ~~In order to ensure sufficient funds to make payments effective July 1, 2013 OHCA shall reduce the next quarterly payment by 1.4% (OHCA will pay out 23.6% of the assessment rather than 25%). This reduction will be distributed in the fourth (4th) quarter of the year as soon as all assessments are received. This payment will also be increased by penalties collected within the year as long as the penalties do not cause the payment to exceed the UPL estimate. If all assessments are received prior to the 4th quarterly payment being processed the 4th quarter may be adjusted to pay out 26.4% plus accrued penalties.~~

~~(5)~~ Effective for all subsequent calendar years the OHCA will distribute payments in the following quarterly percentages: 23.6%, 25%, 25%, 25%. A ~~5th~~fifth (5th) payment of 1.4% in the fourth (4th) quarter of each calendar year will also be made as soon as all assessments are received. ~~This payment will also be increased by any penalties collected within the year as long as the penalties do not cause the payment to exceed the UPL estimate. If all assessments are received prior to the 4th quarterly payment being processed the 4th quarter payment may be adjusted to pay out 26.4% plus accrued penalties.~~

D.
TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 10. PURCHASING
317:10-1-1 [AMENDED]
317:10-1-2 [AMENDED]
317:10-1-12 [AMENDED]
317:10-1-16 [AMENDED]
317:10-1-21 [NEW]
317:10-1-22 [NEW]
317:10-1-23 [NEW]
317:10-1-24 [NEW]
317:10-1-25 [NEW]
317:10-1-25.1 [NEW]
317:10-1-26 [NEW]
317:10-1-27 [NEW]
317:10-1-28 [NEW]
317:10-1-29 [NEW]
317:10-1-30 [NEW]
317:10-1-31 [NEW]
317:10-1-32 [NEW]
317:10-1-33 [NEW]
(REFERENCE APA WF # 21-12)

317:10-1-1. Purpose
~~(a) The purpose of this Chapter is to describe the rules governing the contracting and purchasing requirements of the Oklahoma Health Care Authority (OHCA). The Contracts and Purchasing Divisions are internal divisions of the OHCA. These divisions provide the mechanism for the acquisition of goods, equipment, non-professional and professional services for the operation of the OHCA. These rules are superseded by the Office of Management and Enterprise Services (OMES) Purchasing rules (OAC 260:115) whenever OMES has final authority on an acquisition.~~
~~(b) Different rules apply depending on which of the above three entities is making the acquisition and whether the purchase is for professional services or non-professional services and products. When an acquisition is made by OMES, the OMES Purchasing rules at OAC 260:115 apply. When an acquisition is made by OHCA, these rules must be read in conjunction with the OMES rules.~~
(a) The purpose of this Chapter is to describe the rules governing the contracting and purchasing requirements of the Oklahoma Health Care Authority (OHCA), as directed by 74 O.S. § 85.39. OHCA maintains two (2) internal units that are responsible for the acquisition of goods, equipment, non-professional services, and professional services for the operation of OHCA.
(b) The rules of this Chapter are superseded by the Office of Management and Enterprise Services (OMES) [Oklahoma Administrative Code (OAC) 260:115,] as amended from time to time, whenever OMES has final authority on an acquisition. When an acquisition is made

by OMES, the OMES purchasing rules at OAC 260:115 apply. When an acquisition is made by OHCA, the rules of this Chapter should be read in conjunction with the OMES rules.

317:10-1-2. Definitions

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

~~**"Authority Board"** means the board designated by the Oklahoma Legislature to establish policies and adopt and promulgate rules for the OHCA.~~

~~**"Chief Executive Officer"** or **"CEO"** means the highest ranking administrator at the OHCA.~~

"Acquisition" means items, products, materials, supplies, services, and equipment that OHCA acquires by purchase, lease-purchase, lease with option to purchase, or rental.

"Administrative review" means the process by which OHCA ensures that a bid submission is complete and accurate; confirms that the bidder understood the solicitation specifications; and ascertains that all materials and any required signatures are submitted.

"Award" or **"contract award"** means the process by which OHCA formally notifies a bidder that OHCA has accepted the bidder's bid or offer.

"Best and final offer" or **"BAFO"** means a final offer submitted in writing by a bidder initially or after negotiations are completed and containing the bidder's most favorable terms for price, service, and/or products to be delivered.

"Best price" means the lowest available price for the goods and/or services that are subject of a solicitation.

"Best value" means evaluation criteria which may include but is not limited to the acquisition's operational cost a state agency would incur; the quality of the acquisition, or its technical competency; the reliability of the bidder's delivery and implementation schedules; the acquisition's facilitation of data transfer and systems integration; the acquisition's warranties and guarantees and the bidder's return policy; the bidder's financial stability; the acquisition's adherence to the state agency's planning documents and announced strategic program; the bidder's industry and program experience and record of successful past performance with acquisitions of this complexity; the anticipated acceptance by user groups; and the acquisition's use of proven development methodology, and innovative use of current technologies.

"Bid" means any response to a solicitation, including any and all required forms; required documents and information; and supplemental documents and information.

"Bidder" means an individual, entity, or service vendor that submits a bid in response to a solicitation.

"Bid evaluation" means the process of conducting any evaluative

activity that could reasonably be expected to result in determining the value, nature, character, or quality of a bid.

"Bid evaluator" means an employee or officer of the State of Oklahoma who is actively engaged in Oklahoma Health Care Authority's (OHCA) process to evaluate, score, or select a bid, regardless of whether a contract is awarded to the bid evaluated and/or scored by that employee or officer.

"Bid specifications" means the information OHCA will use for bid evaluation, when such information is exactly detailed within a solicitation and is based on the subject matter of the solicitation, the type of solicitation, and the needs to be met by the supplier(s) awarded a contract from the solicitation.

"Central Purchasing Division" means the Central Purchasing Division of the Office of Management and Enterprise Services (OMES).

"Certification" means the process of a bidder providing OHCA with an official document attesting to a status or level of achievement in response to a solicitation.

"Certified Procurement Officer" or **"CPO"** means a state agency procurement official certified as a procurement officer or analyst by the State Purchasing Director under the provisions of the Oklahoma Central Purchasing Act.

"C.F.R." means the Code of Federal Regulations as may be amended from time to time.

"Chief Executive Officer" or **"CEO"** means the highest-ranking administrator at the OHCA.

"Chief Information Officer" means the chief administrative officer of the Information Services Division of the Office of Management and Enterprise Services.

"Clarification" means a bidder's explanation of all or part of a bid that does not change, alter, or supplement the bid.

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

"Closing date/time" means the date and Central Time a solicitation specifies responses must be received by OHCA.

"Competitive solicitation" or **"solicitation"** means an invitation to bid for the provision of goods or services through specified documents submitted to the Central Purchasing Division or a state agency pursuant to terms, conditions, and other requirements of a solicitation. The competitive solicitation process may be electronic when the terms of the solicitation expressly permit electronic submission and the requirements of applicable statutes and rules are met. When used in this chapter, "competitive solicitation" is synonymous with "invitation to bid," "request for proposal," "request for information," or "request for quotation."

"Conflict plan" means the written statement detailing the accommodations and/or remedies associated with a specific OHCA employee's or officer's conflict of interest in the procurement process or resulting contract.

"Conflict of interest" means a situation in which a person is in

a position to derive personal benefit from actions or decisions made in their official capacity, a situation in which the concerns or aims of two (2) different parties are incompatible, a situation prohibited or constrained by law, or a situation that would appear inappropriate to a reasonable individual.

"Contract" means the written and binding agreement between OHCA and the bidder resulting from the competitive solicitation.

"Contracting official" or **"contracting officer"** means the OHCA CEO or the OHCA officer or employee to whom contracting authority has been delegated by the OHCA CEO, unless specified otherwise.

"Contractor" means any individual or entity contracted with OHCA for the provision of any goods or services. A bidder becomes a contractor upon contract award and execution.

"Days" means calendar days unless otherwise specified.

"Debar" or **"debarment"** means action taken by the State Purchasing Director to exclude any business entity from inclusion on the Supplier List, bidding, offering to bid, receiving an award of contract with the state of Oklahoma for acquisitions by state agencies, or a contract the OMES awards or administers. Debarment may also result in cancellation of existing contracts with the State of Oklahoma.

"Employee" or **"officer"** means a natural person that works for OHCA, unless otherwise specified, regardless of title or designation and regardless of manner of appointment, election, or hiring. "Employee or officer" does not mean a member of the Authority Board in the member's capacity as a board member.

"Enrollment activities" means activities performed or conducted by OHCA related to distributing, collecting, or processing enrollment materials, taking enrollments by technological device or in person, or enrolling or disenrolling, including by algorithm, Medicaid beneficiaries with respect to any health plan or managed care services contract.

"Fiscal year" means the period of time from July 1 of a calendar year through June 30 of the succeeding calendar year.

"Former employee" means a natural person whose work as an employee or officer for OHCA ended by any means at some point prior to the currently referenced moment.

"Health plan" means any person or entity that is licensed as a health maintenance organization (HMO) by the state of Oklahoma to provide or arrange for the delivery of basic health care services to enrollees on a prepaid basis, except for copayments or deductibles for which the enrollee is responsible, or both, that meets the definition of an HMO as delineated in the Oklahoma Medicaid State Plan and that contracts with the State to provide services to enrollees.

"Invoice" means an accounting document issued by an individual or entity that details the goods and/or services provided and the amount of money owed for the goods and/or services when the document conforms to all invoicing provisions of the contract and

that records the details of the transaction.

"Managed care entity" or **"MCE"** means any entity permitted under 42 C.F.R. Part 438 to contract with a state for services provided under a risk contract or a nonrisk contract within the state's Medicaid managed care program, including but not limited to managed care organization (MCO), primary care case management (PCCM), primary care case management entity (PCCM entity), prepaid ambulatory health plan (PAHP), and prepaid inpatient health plan (PIHP).

"Managed care organization" or **"MCO"** means the same in these rules as defined at 42 C.F.R. § 438.2.

"Managed care program" or **"managed care"** or **"MCP"** means a health care delivery system organized to manage cost, utilization, and quality that is operated by a state as authorized under sections 1915(a), 1915(b), 1932(a), or 1115(a) of the Social Security Act and relevant state law.

"Mandatory specification" means any specification of a solicitation when the terms "shall", "must", "will", or "is required" are used to describe, define, or announce the specification. This definition refers only to the use of such words in a solicitation and does not refer to the use of such words in this chapter.

"Material deficiency" or **"material deviation"** means a bidder's failure to provide information necessary to evaluate a competitive solicitation.

"Medicaid" means the medical assistance program jointly administered by the federal and state governments and authorized by 42 U.S.C. § 1396a to provide health care benefits for certain low-income persons.

"Minor deficiency" or **"minor informality"** means an immaterial defect in a bid or variation in a bid from the exact requirements of a competitive solicitation that may be corrected or waived without prejudice to other bidders. A minor deficiency or informality does not affect the price, quantity, quality, delivery, or conformance to specifications and is negligible in comparison to the total cost or scope of the acquisition.

"Multi-award" means the process by which OHCA formally, by written determination, notifies two or more bidders that OHCA has accepted the bidders' bid to furnish an indefinite quantity or category of item, where more than one supplier is needed to meet the contract requirements for quantity, delivery, service, or product compatibility.

"Non-collusion certification" means a certification submitted by a bidder with any competitive bid or contract executed by the state for goods or services in accordance with 74 O.S. § 85.22.

"Nonresponsive" means a bid or proposal that has been determined not to conform to essential requirements of a solicitation.

"OAC" means the Oklahoma Administrative Code as may be amended from time to time.

"Office of Management and Enterprise Services" or **"Office"** or **"OMES"** means the Oklahoma Office of Management and Enterprise Services.

"Oklahoma Central Purchasing Act" means 74 O.S. §§ 85.1 et seq.

"Oklahoma Health Care Authority" or **"OHCA"** or **"Authority"** means the single state agency designated to administer the medical programs which make available appropriate medical services to eligible individuals through the Title XIX Medicaid Program and which has authority to procure, administer and monitor contracts, issue performance deficiency notices, and assess non-compliance damages.

"OHCA Board" means the board designated by the Oklahoma Legislature to establish policies and adopt and promulgate rules for the OHCA.

"Oklahoma Information Technology (IT) Accessibility Standards" or **"IT Accessibility Standards"** means the accessibility standards adopted by the Office of Management and Enterprise Services (Reference OAC 250:15) to address all technical standard categories of Section 508 of the Rehabilitation Act (Reference 29 U.S.C. § 794d), as amended by the Workforce Investment Act of 1998 (Reference P.L. 105-220, August 7, 1998) and adopted at 62 O.S. §§ 34.28, 34.29, 34.30, and 34.16, to be used by each state agency in procuring, maintaining, or using information technology, and in the development and implementation of custom-designed information technology systems, web sites, and other emerging information technology systems.

"Oral presentation evaluation" means the process, through the bidder's participation in an interactive dialogue or non-interactive presentation, by which OHCA assesses a bidder's capability, past performance, work plans or approaches, staffing resources, transition plans, sample tasks, or fit with the OHCA.

"O.S." or **"Okla. Stat."** means the Oklahoma Statutes as may be amended from time to time.

"Permissible specification" means any specification in a solicitation when the terms "can", "may", or "should" are used to describe, define, or announce the specification. This definition refers only to the use of such words in a solicitation and does not refer to the use of such words in this chapter.

"Privatize" means to enter into contract for the performance of a duty or function which is currently being performed by a state employee.

"Procurement" means buying, purchasing, renting, leasing, or otherwise acquiring any goods or services. The term also means all functions that pertain to the obtaining of any goods or services, including but not limited to the description of requirements, selection, and solicitation of sources, preparation and award of contracts, and all phases of contract administration.

"Professional services" means services which are predominantly advisory or intellectual in character, involve privatized

functions, or involve support rather than supplying equipment, supplies, or other merchandise. Professional services include those services requiring special, usually advanced, education, or skill.

"Prejudice" means the effect on an affected bidder's substantial rights when a procurement decision related to a different bidder, if such decision is found to be in error, would yield a more favorable result for the affected bidder if the decision error were corrected.

"Purchasing" means the Purchasing Department of the Oklahoma Health Care Authority.

"Purchasing manager" means the Purchasing Manager of the Oklahoma Health Care Authority.

"Registered supplier" means a supplier that registers with the Central Purchasing Division pursuant to 74 O.S. § 85.33.

"Remedy" means to cure, alter, correct, or change.

"Request for information" or **"RFI"** means a non-binding procurement practice used to obtain information, comments, and feedback from interested parties or potential suppliers prior to issuing a solicitation.

"Request for proposal" or **"RFP"** means a type of solicitation OHCA or the State Purchasing Director issues to suppliers to request submission of proposals for acquisitions.

"Request for quotation" or **"RFQ"** means a simplified written or oral solicitation OHCA or the State Purchasing Director issues to suppliers to request submission of a quote for acquisitions.

"Requisition number" means an identifier OHCA or OMES assigns to a requisition.

"Responsible supplier" means a supplier who demonstrates capabilities, in all respects, to fully perform the requirements of a contract and which will ensure good faith performance, including but not limited to finances, credit history, experience, integrity, perseverance, reliability, capacity, facilities and equipment, and performance history.

"Responsive" means a bid or proposal that has been determined to conform to the essential requirements of a solicitation.

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

"Sole brand acquisition" means an acquisition that by specification restricts the acquisition to one manufacturer or brand name.

"Sole source acquisition" means an acquisition that by specification restricts the acquisition to one supplier.

"Split purchase" means dividing a known quantity or failing to consolidate a known quantity of an acquisition for the purpose of

evading a competitive bidding requirement.

"State Purchasing Director" means the director of the Central Purchasing Division of the Office of Management and Enterprise Services appointed by the OMES Director and includes any employee or agent of the State Purchasing Director, acting within the scope of delegated authority. (Reference 74 O.S. § 85.2) Unless otherwise stated, the term includes employees of the Central Purchasing Division and state agency purchasing officials certified by the State Purchasing Director to which the State Purchasing Director has lawfully delegated authority to act on his or her behalf. In regard to the procurement of information technology or telecommunications, the term means the Chief Information Officer of the Office of Management and Enterprise Services.

"Statement of work" or **"scope of work"** means a detailed description of the work which OHCA requires a contractor or supplier to perform or accomplish.

"Supplier" or **"vendor"** means an individual or business entity that sells or desires to sell acquisitions, including goods and/or services to OHCA. (Reference 74 O.S. § 85.2)

"Supplier list" means a list of individuals or business entities that have registered with the Central Purchasing Division in order to receive notification of solicitations for commodities specified in their registration application.

"Supplier performance evaluation" means information a state agency or OMES Procurement provides to the State Purchasing Director, in a manner the OMES Director prescribes, that documents the quality of service or products provided by a supplier.

"Supplier registration" means a process a supplier uses to register with the Central Purchasing Division to automatically receive solicitations based on a commodity class for a specified period of time.

"Technical proposal evaluation" means the process, based on established criteria and reliant on evaluators' expertise in assessing the strengths and weaknesses of multiple bids, by which OHCA measures the extent to which a bid will meet OHCA's needs.

"U.S.C." means the United States Code as may be amended from time to time.

"Value based" or **"value-based purchasing"** means the intentional linking of cost to the OHCA's perception of the value of goods or services. In a health plan or managed care contract, these terms refer to provider payments made by the health plan or managed care entity based on improved performance by health care providers.

317:10-1-12. Protest of award

(a) Protests of awards made by ~~the Authority~~OHCA under 74 Okla. Stat. § ~~85.5T~~85.5N are addressed at OAC 317:2-1-1 et seq.

(b) Bidders who wish to protest any other award shall follow the process outlined in the ~~Office of Management and Enterprise Services~~OMES rules at OAC 260:115-3-19.

317:10-1-16. Delegation of authority

The authority to procure needed products and services for ~~the Authority~~OHCA has been delegated to ~~the Authority~~OHCA from the Office of Management and Enterprise Services, Central Purchasing Division. The ~~Authority~~OHCA Board delegates authority for expenditure of funds to the CEO and other ~~Authority~~OHCA officers and personnel according to the dollar limits and types of products stated in (1), (2) and (3) of this Section. Within this authority, the CEO may delegate in writing to other specific individuals the responsibility for the performance of the procurement duties.

(1) **Supply and non-professional services acquisitions.** Each division director or supervisor may initiate any supply or non-professional services acquisition which is within his or her authorized division budget and approved by the CEO or designee. ~~Any single acquisition of this kind over $5,000 up to $500,000 must be approved by the CEO, Executive Staff or designee.~~ Any single acquisition of this kind over ~~$500,000~~$1,000,000 must be approved by the ~~Authority~~OHCA Board. A contract amendment that would increase the total original contract acquisition cost to an amount that equals or exceeds ~~$500,000~~$1,000,000 for a supply or non-professional services contract must be prior approved by the ~~Authority~~OHCA Board. Any amendment to a contract that would result in a ~~10 percent~~ten percent (10%) or greater increase in the total acquisition cost originally approved by the OHCA Board must be submitted to the OHCA Board for prior approval.

(2) **Professional service contracts.** Acquisitions of professional services must be approved by the CEO or designee. All professional service contracts over ~~$125,000~~$1,000,000 must be approved by the ~~Authority~~OHCA Board. A contract amendment that would increase the total original contract acquisition cost to an amount that equals or exceeds ~~$125,000~~$1,000,000 for a professional service contract must be prior approved by the ~~Authority~~OHCA Board. Any amendment to a contract that would result in a ~~25 percent~~twenty-five percent (25%) or greater increase or a ~~$250,000~~$1,000,000 or greater increase in the total acquisition cost originally approved by the ~~Authority~~OHCA Board must be submitted to the ~~Authority~~OHCA Board for prior approval. Board approval is not required if the increase in total contract acquisition cost results from the exercise of a price increase methodology, option for additional work, or option to renew that was contained in the previously approved contract.

(3) **Interagency/intergovernmental agreements.** All agreements with another state agency or public agency must be approved by the CEO or designee~~,~~ but are exempt from the ~~Authority~~OHCA Board approval.

317:10-1-21. Procurement ethics, prohibited conduct

(a) **Standard of conduct.** The Oklahoma Central Purchasing Act, State Ethics Commission rules, and other state laws contain regulations, prohibitions, and penalties governing procurement ethics. Transactions relating to the public expenditure of funds require the highest degree of public trust and impeccable standards of conduct.

(b) **One (1) year prohibition on certain contracts.** For one (1) year after the employment termination date of any employee or officer, OHCA is prohibited from entering into a sole source contract, a professional service contract, or a contract for the services of that employee or officer. Refer to 74 O.S. § 85.42(A). An agency may enter into a sole source contract or a contract for professional services at any time with a person who is a qualified interpreter for the deaf. Reference to 74 O.S. § 85.42(D).

(c) **Supplier gratuities.** Employees or officers of the Purchasing and Contracts Development unit, acting within the scope of delegated authority, or any member of their immediate family, under the Oklahoma Central Purchasing Act shall not accept any gift, donation, or gratuity for himself or any member of his immediate family from any supplier or prospective supplier of any acquisition covered by the Oklahoma Central Purchasing Act. This subsection shall not apply to exceptions to the definition of "anything of value" established in rules promulgated by the Oklahoma Ethics Commission.

(d) **State requirement for one (1) year prohibition on certain state officers' or employees' employment with a supplier.** For a period of one (1) year from the date that any contract to privatize is awarded by OHCA, any state officer or employee who exercised discretionary or decision-making authority in awarding a specific contract to privatize is prohibited from becoming an officer or employee of a business organization which is party to that specific contract to privatize. If, within the prohibited period and in violation of state law, any state officer or employee who exercised discretionary or decision-making authority in awarding a specific contract to privatize becomes an officer or employee of a business organization which is party to that specific contract to privatize, then the business organization is prohibited from contracting with OHCA for one (1) year from the date of the violation of state law. Refer to 74 O.S. § 590.

(e) **Agency contract or agreement open for legislative inspection.** Upon request, a contract or any other form of agreement made by OHCA will be open for inspection to any member of the Legislature. OHCA will not direct, put in a contract, or in any way disallow a vendor, client, employer or independent contractor, person, or any other entity from contacting or communicating with any member of the Legislature. Refer to 74 O.S. § 464.1.

(f) **Federal requirement for conflict-of-interest safeguards pertaining to any contract for health plan or managed care services.** Any contract awarded for health plan or managed care services and subject to 42 C.F.R. Part 438 necessitates state conflict-of-interest safeguards at least as effective as those specified at section 27 of the Office of Federal Procurement Policy Act. Refer to 42 C.F.R. § 438.58, citing 41 U.S.C. § 423. In addition to this subsection, OAC 317:10-1-22 describes processes pertaining to the conflict-of-interest safeguards in this section.

(1) The following person(s) shall not, except as provided by law, knowingly disclose a contractor bid or proposal information or source selection information before the award of an OHCA procurement contract to which the information relates:

(A) When such person is:

(i) A present or former employee or officer;

(ii) Acting or has acted for or on behalf of OHCA with respect to a procurement; or

(iii) Advising or has advised OHCA with respect to a procurement; and

(B) By virtue of that office, employment, or relationship has or had access to contractor bid or proposal information or source selection information.

(2) A person shall not, other than as provided by law, knowingly obtain contractor bid or proposal information or source selection information before the award of an OHCA procurement contract to which the information relates.

(3) If an employee or officer who is personally and substantially participating in a procurement under this Section, contacts or is contacted by a procurement bidder regarding possible non-OHCA employment, the employee or officer shall promptly report the contact in writing to the employee's or official's supervisor and to the designated OHCA ethics official (or designee) and either:

(A) Reject the possibility of non-OHCA employment; or

(B) Disqualify himself or herself from further personal and substantial participation in that procurement until such time as OHCA has authorized the employee or official to resume participation in such procurement on the grounds that:

(i) The bidder is no longer a participant in the procurement; or

(ii) All discussions with the bidder regarding possible non-OHCA employment have terminated without an agreement or arrangement for employment.

(4) A former employee or officer shall not accept compensation from a contract-awarded bidder as an employee, officer, director, or consultant of that bidder within a period of one (1) year after such former employee or officer functioned within the scope of employment as:

(A) The procuring contracting officer, the source selection authority, a member of an evaluation committee, or the chief of a financial or technical evaluation team in a procurement in which that contract-awarded bidder was selected for award of a contract in excess of $10,000,000;
(B) A program manager, deputy program manager, or administrative contracting officer for a contract in excess of $10,000,000 awarded to that contract-awarded bidder; or
(C) A primary decision maker who personally made one (1) or more of the following decisions on behalf of OHCA:
(i) To award a contract, subcontract, modification of a contract or subcontract, or a task order or delivery order for that contract-awarded bidder valued in excess of $10,000,000;
(ii) To establish overhead or other rates applicable to a contract or contracts for that contract-awarded bidder valued in excess of $10,000,000;
(iii) To approve issuance of a contract payment or payments to that contract-awarded bidder valued in excess of $10,000,000; or
(iv) to pay or settle a claim in excess of $10,000,000 with that contract-awarded bidder.

(5) A former employee or officer who accepts compensation from any division or affiliate of a contract-awarded bidder that does not produce the same or similar products or services as the entity of the contract-awarded bidder that is responsible for the contract does not violate this section.
(6) With regard to any current or former employee or officer or any bidder who violates this subsection (f), OHCA may take any administrative action and pursue any penalty allowed by state or federal law.
(7) Any employee or officer or former employee or officer may request advice from the appropriate designated OHCA ethics official regarding whether the employee or officer or former employee or officer is or would be precluded by subsection (f)(4) of this section from accepting compensation from a particular contractor.

317:10-1-22. Conflicts of interest

(a) **Types of conflicts of interest.** Three (3) types of conflict-of-interest forms may be used for OHCA to clear conflicts related to procurement.
(1) **General conflicts of interest.** OHCA requires all employees or officers to sign general conflict-of-interest forms annually.
(2) **Contract-specific conflicts of interest.** OHCA requires specific employees or officers, as described within this subsection, to sign a contract-specific conflict-of-interest form related to a specific contract when deemed appropriate to

meet any applicable federal or state law or regulation and to avoid impropriety or the appearance of impropriety in connection with the procurement process or the administration of the specific contract. The contract-specific conflict-of-interest form will inform the employee or officer of rights and responsibilities related of role as related to a specific contract, including any potential restrictions on future employment or other business connections with the contractor or with OHCA, and will record any conflicts that pre-date the signing of the form or that arise at any point in time thereafter until the contract is terminated.

(3) **Evaluator-specific conflicts of interest.** OHCA requires employees or officers of any agency or department of the State to sign an evaluator-specific conflict-of-interest form, whenever the employee or officer is appointed, selected, or approved as a bid evaluator or performs any duty of a bid evaluator for a specific contract. The evaluator-specific conflict-of-interest form will inform the employee or officer of rights and responsibilities related to the role of bid evaluator, including any potential restrictions on future employment or other business connection with the contractor or with OHCA, and will record any conflicts that pre-date the signing of the form or that arise at any point in time thereafter until the evaluation is complete and closed. If a bid evaluator is removed from the bid evaluation for any reason, including potential conflict of interest, a substitute bid evaluator with similar expertise will be added to the bid evaluation after signing an evaluator-specific conflict-of-interest form.

(b) **Forms meet or exceed legal standards.** All conflict-of-interest forms shall meet or exceed the applicable legal standards controlling the type of contract and/or type of employee or officer involvement in procurement or administration of a contract, including but not limited to 74 O.S. § 85.42(A), 74 O.S. § 590, and 41 U.S.C. § 423.

(c) **Identification of conflicts of interest.** OHCA will identify conflicts of interest, plan any accommodation, and manage any employee disciplinary action.

(1) The OHCA contracting officer will identify all employee or officer positions required to sign a specific conflict-of-interest form or an evaluator-specific conflict of interest form. For any solicitation for health plan or managed care services, the contracting officer will identify, at minimum, all employees or officers engaged in enrollment activities, when those employees or officers are internally titled manager or above, and all employees and officers engaged as bid evaluators.

(2) OHCA's Human Resources (HR) Department will obtain conflict-of-interest forms:

(A) For general conflict-of-interest forms, from each employee or officer at the time of hiring and annually thereafter.
(B) For contract-specific conflict-of-interest forms, from each employee or officer in an identified position prior to the employee's or officer's participation in contract- or solicitation-specific activities.
(C) For evaluator-specific conflict-of-interest forms, from each employee or officer identified as an evaluator prior to the employee's or officer's participation in evaluation-specific activities.
(3) OHCA HR and OHCA's Legal Department will review the executed conflict-of-interest forms.
(4) If a potential conflict is identified, a conflict plan will be presented to the employee or officer. The conflict plan will include, at minimum, guidelines that the employee or officer must follow to avoid an actual conflict.
(5) The employee or officer will determine if the conflict plan can be accommodated and respond accordingly.
(6) If the accommodation does not resolve the issue, then the employee or officer will face disciplinary action up to and including termination of employment.
(d) Each employee or officer has a responsibility to notify OHCA HR within one (1) business day of becoming aware of a potential conflict, regardless of whether the employee or officer previously executed a conflict-of-interest form. Upon notification, OHCA HR will take appropriate action to identify the potential conflict in writing, either as part of the existing conflict-of-interest form or as a new conflict-of-interest form; develop a conflict plan; and present the conflict plan to the employee or officer.

317:10-1-23. Value-based purchasing

(a) Unless otherwise prohibited by law, OHCA may engage in value-based purchasing with regard to any contract for goods, services, or professional services.
(b) Unless otherwise prohibited by law, OHCA may include in any contract for health plan or managed care services any concept of value-based purchasing as to the transaction between OHCA and the health plan or managed care entity.
(c) Unless otherwise prohibited by law, OHCA may include in any contract for health plan or managed care services any concept of value-based purchasing as to the transaction underlying the provision of health care services or items by providers contracted with any health plan or managed care entity.

317:10-1-24. Bidder obligations arising from bid submission

(a) **One (1) bid.** Bidders may submit only one bid in response to any solicitation. Except as requested by OHCA, no bid may be changed after the response due date and time. If the bidder needs to change a submitted bid prior to the response due date and time, the bidder will withdraw the originally submitted bid and submit a new bid to OHCA by the response date and time. Bidders may withdraw and resubmit a bid at any time prior to the submission deadline. As part of the resubmission process, the bidder will acknowledge in writing that the resubmitted bid supersedes all previously submitted bids by including the following statement on the superseding bid cover page, "This bid supersedes the bid previously submitted". In the body of the submission transfer, whether by email or otherwise, the resubmitted bid should contain the solicitation number and solicitation response due date and time.

(b) **Bidder duties.** The bidder shall submit any bid:

(1) In strict conformance with the instructions provided to bidders along with a completed "Responding Bidder Information" form and any other forms required by the solicitation;

(2) Electronically;

(3) With a completed certification statement, as described in the solicitation, that uses the bidder's legal name and has been executed by an authorized person with full knowledge and acceptance of all certificate provisions;

(4) According to the "Technical Proposal Requirements" of the solicitation;

(5) With relevant information for a designated contact to receive notice, approvals, and requests that are allowed or required by the terms of the solicitation;

(6) As firm, including a guarantee that unit prices are correct, for a minimum of one hundred eighty (180) days after the solicitation closing date; and

(7) In accordance with 74 O.S. § 85.40, requiring the bidder to include in the total bid price all travel expenses, including but not limited to transportation, lodging, and meals, to be incurred by a bidder in performance of the awarded contract.

(c) **Bidder's acknowledgements.** By submitting a bid, the bidder promises, acknowledges, and agrees that:

(1) The bidder will adhere to any additional terms OHCA deems necessary to the performance of the contract, including but not limited to terms related to the contractor's need to access, process, or store Medicaid beneficiary data;

(2) All costs incurred by a bidder in participating in the procurement process is the sole responsibility of the bidder, and the bidder will not be reimbursed for or awarded damages for such costs;

(3) If a bidder fails to notify the contracting officer of an

ambiguity, conflict, discrepancy, omission, or other error in the procurement process or in any of the documents provided by OHCA that is known to the bidder, or that reasonably should be known by the bidder, the bidder accepts the risk of submitting a bid and, if awarded the contract, will not be entitled to additional compensation, relief, or time by reason of the error or its later correction; and

(4) Bidder waives any error in the procurement process or documents which is known to the bidder or reasonably should have been known, and such error will not be the grounds of a bid protest.

(d) **Indemnification.** By submitting a bid, the bidder understands, accepts, acknowledges, and agrees to this paragraph in its entirety. OHCA will not indemnify a bidder, any subcontractor, or any other party to an awarded contract. Any contract between the selected bidder and OHCA will not contain any terms limiting the liability of the bidder or providing indemnification by OHCA in favor of the bidder or any third parties. The State of Oklahoma and its agencies do not hold an individual or a private entity harmless from liability or provide indemnity to a private entity or individual. Any attempt by the bidder to add indemnification or limitation of liability provisions in favor of the bidder or third parties to the definitive contract may render the bidder's bid nonresponsive and subject to rejection. Should OHCA accept a bid that attempts to add indemnification or limitation of liability provisions in favor of the bidder or third parties, such attempts are severable from the remainder of the bid and have no effect on any awarded contract. At no time and in no way will OHCA be deemed to have waived this paragraph through action or inaction.

(e) **Conflict of laws.** With regard to the procurement process to which a bid is submitted and any business relationship or contract resulting from such procurement process, by submitting a bid, the bidder understands, accepts, acknowledges, and agrees:

(1) That the undertaking and all matters arising out of or relating to the undertaking, including all protests, claims, causes of action, controversies, or matters in dispute between OHCA and the bidder—whether sounding in contract, tort, statute, regulation, or otherwise—shall be governed by, construed, interpreted, and enforced in accordance with the substantive and procedural laws of the State of Oklahoma, including its statutes of limitations, without giving effect to any choice of law or conflict of laws rules or provisions, whether of the State of Oklahoma or any other jurisdiction, that would cause the application of the laws of any jurisdiction other than the State of Oklahoma;

(2) To exclude application of the United Nations Convention on Contracts for the International Sale of Goods; and

(3) That a final judgment in any matter described in (e)(1) of this Section is conclusive and binding and may be enforced in any other jurisdiction.

317:10-1-25. Property of the state

Any bid, including all related and submitted documents and information, is part of the public record(s) and is subject to disclosure; unless otherwise specified in the Oklahoma Open Records Act, the Central Purchasing Act, or other applicable law. All material submitted by a bidder becomes the property of the State of Oklahoma upon submission and will be a matter of public record, subject to the procedures for treatment of proprietary information. OHCA has the right to use all concepts described in any bid, regardless of whether such bid is accepted. By any secured means, including electronic transmission via secure file transfer protocol, OHCA has the right to transmit all material submitted as part of or in connection with a bid, including proprietary information, to any professional services contractor then or afterward contracted with OHCA for provision of professional services related to the solicitation, award, or administration of the contract.

317:10-1-25.1. Proprietary or confidentiality claims

(a) Unless otherwise specified in the Oklahoma Open Records Act, Central Purchasing Act, or other applicable law, documents and information that a bidder submits as part of or in connection with a bid are public records and subject to disclosure after the contract has been awarded pursuant to OAC 260:115-3-9.

(1) No portion of a bid shall be considered confidential after award of the contract except, pursuant to 74 O.S. §85.10, information in the bid determined to be confidential by the State Purchasing Director or delegate.

(2) A properly submitted confidentiality claim of a potential awardee is reviewed and determined prior to award.

(3) A properly submitted confidentiality claim of a non-awarded bidder is reviewed and determined only when responding to an open records request concerning the bid.

(b) Among the parties to a solicitation, OHCA is the sole and final determiner of the proprietary or confidential nature of a bid in part or in whole.

(1) OHCA has no responsibility to independently review a bid, including any associated documentation or information, for a potential proprietary or confidentiality claim.

(2) OHCA will not consider a proprietary or confidentiality claim if a bid fails to comply with the requirements of this section, the solicitation, and applicable law, including OAC 260:115-3-9. Nonconforming bids will be subject to disclosure pursuant to State law.

(3) A bidder, who wishes to seek an exemption from disclosure

under the Oklahoma Open Records Act or other statutory or regulatory requirements, is responsible for asserting any right of confidentiality that may exist. The OHCA will not assert a right of confidentiality on behalf of a bidder.

(c) To claim any portion of a bid as proprietary or confidential, the bidder will:

(1) Specifically identify what information is considered by the bidder to be confidential;

(2) Enumerate the specific grounds, based on applicable laws, which support treatment of the information as exempt from disclosure;

(3) Explain why disclosure is not in the best interest of the public if the information is incorporated into an awarded contract;

(4) Submit all information considered confidential under separate cover as described below; and

(5) Include, for efficient evaluation, the content considered confidential in applicable sections of the bid.

(d) Any bidder with bid information the bidder considers confidential must submit an additional electronic copy of the bid with the claimed information redacted (marked out to be illegible). The additional copy must be clearly labeled "Redacted Copy." If the bidder provides a copy of its bid with proprietary and confidential information redacted and OHCA appropriately supplies the redacted bid to another party under the Oklahoma Open Records Act or other statutory or regulatory requirements, the bidder agrees to indemnify OHCA and to defend the bidder's interest in protecting the referenced redacted material.

(e) OHCA does not consider as confidential a bid marked in total as proprietary and/or confidential (versus specific documents or portions of documents within a bid). Likewise, unless specifically referenced otherwise in a solicitation, resumes, pricing, marketing materials, business references, additional terms proposed by a bidder, and subcontractor information are not confidential and are not exempt from disclosure under the Oklahoma Open Records Act. The foregoing list is not exhaustive but is intended to address information often marked confidential that is not exempt from disclosure.

(f) Subject to the provisions of subsections (a)-(e) above, bids will be open for public inspection following contract award.

317:10-1-26. Withdrawal from solicitation

(a) At any time prior to the submission deadline of any solicitation, a bidder may withdraw a bid and remove itself from consideration by providing written notification, in the form specified in OAC 260:115-3-13, to the OHCA sole point of contact as identified in the solicitation. OHCA does not permit a bidder to withdraw a bid after the response due date and time except as

authorized by the OHCA CEO after the bidder provides sufficient proof that the bidder included a significant error in the bid.
(b) Unless properly withdrawn, the submitted bid is deemed to be a binding offer on the part of the bidder.

317:10-1-27. Binding bids

OHCA considers all bids to be firm representations that the responding bidder has carefully investigated and will comply with all OHCA and State terms and conditions relating to the solicitation. A bidder whose bid is accepted for evaluation will be bound by the terms of the solicitation and the contents of the bid for the duration of the solicitation. The bidder will be bound by the terms in its solicitation response unless or until OHCA instructs the bidder to perform any function reflected in the solicitation response in a modified way to the extent it does not substantially alter the specifications or statement of work as defined in the solicitation. Bidders awarded a contract will be governed foremost by applicable law, then by the terms of the solicitation, including any associated model contract, then by any non-rule policy documents created by OHCA for the purposes of interpreting and implementing contract terms.

317:10-1-28. Contracting officer's actions

(a) The contracting officer may reject a bid for any valid reason, including but not limited to those listed at OAC 260:115-7-32(8) and the bidder's:

(1) Failure to submit required information;

(2) Failure to submit the bid by the response date and time unless OHCA has authorized acceptance of bids due to a significant error or incident that occurred which affected the receipt of a bid, per OAC 260:115-3-11;

(3) Failure to comply with bidder instructions or solicitation requirements;

(4) Failure to meet any mandatory specification of the solicitation; however, failure to meet a permissible specification of the solicitation will not be a valid reason to reject a bid;

(5) Failure to submit the bid by the strict deadline as described by date and time within the solicitation; and

(6) Attempted or actual inclusion or imposition of terms or conditions that would modify the requirements of the solicitation, require OHCA to indemnify the bidder or a third party, or limit the bidder's liability.

(b) The contracting officer may take any reasonable action with regard to a solicitation, including but not limited to:

(1) Waiving minor irregularities in any bid if determined to be in the best interest of the State. If granted, a waiver will in no way modify the requirements of the solicitation or the obligations of bidders awarded contracts;

(2) Awarding a contract based on a solicitation and the bid of any selected bidder;
(3) Awarding the contract to more than one (1) bidder;
(4) Rejecting any or all bids received, if deemed to be in the best interest of the State;
(5) Requesting clarification or correction of any bid;
(6) Amending any solicitation or any segment of any solicitation;
(7) Canceling any solicitation, if determined to be in the best interest of the State; or
(8) Discontinuing the solicitation process at any time prior to contract award.

(c) The contracting officer may question the grade and quality of any acquisition delivered to the agency.

(1) The contracting officer or delegate has sole discretion in determining whether the acquisition meets the grade and quality specified in the contract.
(2) If the acquisition fails to meet the contract-specified grade and/or quality, OHCA may take remedial action with the appropriate supplier. Refer to 74 O.S. § 85.6.

317:10-1-29. Deficiencies

In accordance with the OAC 260:115-7-32(10), OHCA has the right but is not required to waive minor deficiencies or informalities if OHCA determines the deficiencies or informalities do not prejudice another bidder. OHCA may also permit bidders to cure certain non-substantive deficiencies if there is sufficient time prior to the award of the contract.

317:10-1-30. Submission of questions

(a) A bidder may submit written questions by email only to the OHCA sole point of contact as designated in the solicitation and using the "Questions" form, in original format, included in the Bidder's Library.
(b) OHCA will provide written answers to all technical bid and price questions received on or before the dates specified in the solicitation for questions and answers. Answers will be made publicly available in the form of one or more solicitation amendments posted to the Bidder's Library. Only posted answers will be considered official and valid. A bidder will not rely upon, take any action upon, or make any decision based upon any verbal communication with any State employee.

317:10-1-31. Bidder's conference

OHCA may hold a bidder's conference at OHCA offices or virtually on the date and time specified in the solicitation. Additional information about the bidder's conference, if any, will be provided in advance of the session.

317:10-1-32. Bid evaluation

A responsive bid that is not otherwise rejected will proceed to bid evaluation, which will be conducted in accordance with the solicitation. Within any solicitation, the bid specifications for evaluation will be provided and will be based on the subject matter of the solicitation, the type of solicitation, and the needs to be met by the supplier(s) awarded a contract from the solicitation.

(1) The bid evaluation may consist of one (1) or more evaluative activities, including but not limited to:

(A) Best price review;

(B) Best value review;

(C) Certifications;

(D) Administrative review;

(E) Technical proposal evaluation;

(F) Oral presentation evaluation; and

(G) Any other activity that could reasonably be expected to result in determining the value, nature, character, or quality of the bid.

(2) Bids responding to request for quotation will be evaluated solely on a "best price" basis.

(3) Bids responding to request for proposal will be evaluated on a "best value" basis unless the request for proposal specifies otherwise.

(4) A bidder's past performance may be considered when evaluating a bid.

(5) No evaluator acting in their role as an evaluator will make any decision regarding procurement, including but not limited to which, if any, bidder(s) will or will not be awarded the contract, whether a bid will or will not be rejected, and whether a solicitation will be continued or canceled. Evaluators, individually or collectively, may provide bid evaluation information and recommendations to the contracting official. A record of evaluators' numeric scores of bids, made by evaluators individually or collectively, will be maintained as part of the acquisition file.

(6) The contracting official will make all decisions regarding the procurement, including but not limited to which, if any, bidder(s) will or will not be awarded the contract, whether a bid will or will not be rejected, and whether a solicitation will be continued or canceled.

317:10-1-33. Contract award

(a) **Time of award.** OHCA will not award a contract at the time of a bid opening but, if at all, only upon completion of the following:

(1) Bid evaluation;

(2) Documentation of evaluation on each bid;

(3) Determination of the lowest and best or best value bidder;

(4) Verification of Oklahoma and federal debarment status;

(5) Verification, pursuant to applicable provisions of law, that

the supplier is registered with the Secretary of State and maintains appropriate franchise tax payment status pursuant to 68 O.S. §§ 1203 and 1204; and

(6) Completion of any award-related administrative tasks.

(b) **Award by item.** If the procurement documents do not specify an all or none bid, more than one (1) bidder may be awarded a contract by item or groups of items.

(c) **No contract award.** OHCA may refrain from awarding a contract during any solicitation when:

(1) No bid meets the requirements of the solicitation;

(2) All bids exceed fair market value for the acquisition;

(3) The bid price exceeds available funds available to OHCA;

(4) OHCA no longer requires the acquisition in the form or manner specified; or

(5) Not awarding the contract is determined to be in the best interest of the state.

(d) **Evaluation tie.** Whenever it is determined that two (2) or more bids are equal, the contracting officer will determine the successful bid by a coin toss.

(e) **Notification of successful bidder.** OHCA will notify the successful bidder(s), if any, within a reasonable time after determination of the contract award.

E.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 25. SOONERCARE CHOICE
SUBCHAPTER 7. SOONERCARE
PART 3. ENROLLMENT CRITERIA
317:25-7-12 [AMENDED]
(REFERENCE APA WF # 21-14)

317:25-7-12. Enrollment/eligibility requirements

(a) Eligible SoonerCare members mandatorily enrolled in SoonerCare Choice include persons categorically related to AFDC~~, Pregnancy-related services and Aged, Blind or Disabled~~;pregnancy-related services; expansion adult; and aged, blind or disabled who are not dually-eligible for SoonerCare and Medicare.

(b) Children in foster care may voluntarily enroll into SoonerCare Choice.

F.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME
PART 1. DETERMINATION OF QUALIFYING CATEGORICAL RELATIONSHIPS
317:35-5-4 [AMENDED]
(REFERENCE APA WF # 21-27)

317:35-5-4. Determining categorical relationship to the disabled

An individual is related to disability if he/she is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death, or which has lasted (or can be expected to last) for a continuous period of not less than twelve (12) months.

(1) **Determination of categorical relationship to the disabled by Social Security Administration (SSA).** The procedures outlined in (A) through (G) of this paragraph are applicable when determining categorical relationship based on a SSA disability decision:

(A) **Already determined eligible for Social Security disability benefits.** If the applicant states he/she is already receiving Social Security benefits on the basis of disability, the information is verified by seeing the applicant's notice of award or the Social Security benefit check. If the applicant states an award letter approving Social Security disability benefits has been received but a check has not been received, this information is verified by seeing the award letter. Such award letter or check establishes categorical relationship. The details of the verification used are recorded in the case record.

(B) **Already determined eligible for Supplemental Security Income (SSI) on disability.** If the applicant, under age sixty-five (65), states he/she is already receiving SSI on the basis of his/her disability (or that a written notice of SSI eligibility on disability has been received but has not yet received a check) this information is verified by seeing the written notice or check. If neither are available, the county clears on the terminal system for the Supplemental Data Exchange (SDX) record. The SDX record shows, on the terminal, whether the individual has been approved or denied for SSI. If the individual has been approved for such benefits, the county uses this terminal clearance to establish disability for categorical relationship. The details of the verification used are recorded in the case record.

(C) **Pending SSI/SSA application or has never applied for SSI.** If the applicant says he/she has a pending SSI/SSA application, an SDX record may not appear on the terminal.

Therefore, it is requested that the applicant bring the notice regarding the action taken on his/her SSI/SSA application to the county office as soon as it is received. The other conditions of eligibility are established while awaiting the SSI/SSA decision. When the SSI/SSA notice is presented, the details of the verification are recorded in the case record and the indicated action is taken on the Title XIX application. If the applicant says he/she has never applied for SSI/SSA but appears potentially eligible from the standpoint of unearned income and has an alleged disability which would normally be expected to last for a period of twelve (12) months, he/she is referred to the SSA office to make SSI/SSA application immediately following the filing of the Title XIX application.

(D) **Already determined ineligible for SSI.** If the applicant says he/she has been determined ineligible for SSI, the written notice of ineligibility from SSA is requested to determine if the denial was based on failure to meet the disability definition. If the SSI notice shows ineligibility was due to not meeting the disability definition, and the applicant says the medical condition has not worsened since the SSI denial, the Title XIX application is denied for the same reason. If written notice is not available, the SDX record on the terminal system is used. This record shows whether the individual has been determined eligible or ineligible for SSI. If he/she has been determined ineligible, the payment status code for ineligibility is shown. The definition of this code is found on OKDHS Appendix Q in order to determine the reason for SSI ineligibility. If the reason for SSI ineligibility was based on failure to meet the disability definition, the Title XIX application is denied for the same reason and the details of the verification are recorded in the case record. If the reason for SSI ineligibility was based on some reason other than failure to meet the disability definition (and therefore, a determination of disability was not made), the Level of Care Evaluation Unit (LOCEU) must determine categorical relationship. In any instance in which an applicant who was denied SSI on "disability" states the medical condition has worsened since the SSI denial, he/she is referred to the SSA office to reapply for SSI immediately following the filing of the Title XIX application.

(E) **Already determined ineligible for Social Security disability benefits.** If the applicant says he/she has been determined ineligible for Social Security disability benefits, he/she is requested to provide written notice of ineligibility to determine if the denial was based on failure to meet the disability definition. If the SSA notice shows ineligibility was due to not meeting the disability

definition, and the applicant says the medical condition has not worsened since the denial, the Title XIX application is denied for the same reason. The details of the verification used are recorded in the case record. If the written notice is not available, third party query procedure (TPQY) is used to verify the denial and the reason for ineligibility. If the reason for ineligibility was based on failure to meet the disability definition, the Title XIX application is denied for the same reason and the details of the verification are recorded in the case record. If the reason for ineligibility was based on some reason other than failure to meet the disability definition (and a determination of disability was, thus, not made), the LOCEU must determine categorical relationship. In any instance in which an applicant who was denied Social Security benefits on disability states the medical condition has worsened since the denial, he/she is referred to the SSA office to reapply immediately following the filing of the Title XIX application.

(F) **Determined retroactively eligible for SSA/SSI due to appeal.** If an individual becomes retroactively eligible for SSA/SSI due to a decision on an appeal, categorical relationship is established as of the effective date of the retroactive disability decision. Payment will be made for medical services only if the claim is received ~~within twelve (12) months from the date of medical services~~timely, per Oklahoma Administrative Code (OAC) 317:30-3-11. After the submission of a timely claim, a claim may be resubmitted, per OAC 317:30-3-11.1. If the effective date of the retroactive disability decision does not cover the period of the medical service because the SSA/SSI application was made subsequent to the service, a medical social summary with pertinent medical information is sent to the LOCEU for a categorical relationship decision for the time period of the medical service.

(G) **SSA/SSI appeal with benefits continued.** A Title XIX recipient who has filed an appeal due to SSA's determination that he/she is no longer disabled may continue to receive SSA benefits. The recipient has the option to have Title XIX benefits continued until the appeal decision has been reached. After the decision has been reached, the appropriate case action is taken. If SSA's decision is upheld, an overpayment referral is submitted for any Title XIX benefits the recipient received beginning with the month that SSA/SSI determined the recipient did not meet disability requirements.

(H) **Applicant deceased.** Categorical relationship to the disabled is automatically established if an individual dies while receiving a medical service or dies as a result of an illness for which he/she was hospitalized if death occurs

within two (2) months after hospital release. The details of the verification used are recorded in the case record.

(2) **Determination of categorical relationship to the disabled by the LOCEU.**

(A) A disability decision from the LOCEU to determine categorical relationship to the disabled is required only when SSA makes a disability decision effective after medical services were received or when the SSA will not make a disability decision. The LOCEU is advised of the basis for the referral. SSA does not make disability decisions on individuals who:

(i) have been determined ineligible by SSA on some condition of eligibility other than disability,

(ii) have unearned income in excess of the SSI standard and, therefore, are not referred to SSA, or

(iii) do not have a disability which would normally be expected to last twelve (12) months but the applicant disagrees.

(B) A disability decision from the LOCEU is not required if the disability obviously will not last twelve (12) months and the individual agrees with the short term duration. The case record is documented to show the individual agrees with the short term duration.

(C) The local DHS office is responsible for submitting a medical social summary on DHS form ABCDM-80-D 08MA022E with pertinent medical information substantiating or explaining the individual's physical and mental condition. The medical social summary should include relevant social information such as the worker's personal observations, details of the individual's situation including date of onset of the disability, and the reason for the medical decision request. The worker indicates the beginning date for the categorical relationship to disability. Medical information submitted might include physical exam results, psychiatric, lab, and x-ray reports, hospital admission and discharge summaries, and/or doctors' notes and statements. Copies of medical and hospital bill and DHS Form 08MA005E are not normally considered pertinent medical information by themselves. Current (less than ninety (90) days old) medical information is required for the LOCEU to make a decision on the client's current disability status. If existing medical information cannot be obtained without cost to the client, the county administrator authorizes either payment for existing medical information or one general physical examination by a medical or osteopathic physician of the client's choice. The physician cannot be in an intern, residency or fellowship program of a medical facility, or in the full-time employment of Veterans Administration, Public Health Service or other Agency. Such examination is authorized by use of DHS form

08MA016E, Authorization for Examination and Billing. The DHS worker sends the 08MA016E and DHS form 08MA080E, Report of Physician's Examination, to the physician who will be completing the exam.

(3) **Responsibility of Medical Review Team in the LOCEU.** The responsibilities of the Medical Review Team in the LOCEU include:

(A) The decision as to whether the applicant is related to Aid to the Disabled.

(B) The effective date (month and year) of eligibility from the standpoint of disability. (This date may be retroactive for any medical service provided on or after the first day of the third month prior to the month in which the application was made.)

(C) A request for additional medical and/or social information when additional information is necessary for a decision.

(D) When the LOCEU has made a determination of categorical relationship to disability and SSA later renders a different decision, the Oklahoma Health Care Authority (OHCA) uses the effective date of the SSA approval or denial as their date of disability approval or denial. No overpayment will occur based solely on the SSA denial superseding the LOCEU approval.

(E) Public Law 97-248, the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982, provides coverage to certain disabled children living in the home if they would qualify for Medicaid as residents of nursing facilities, ICF/IIDs, or inpatient acute care hospital stays expected to last not less than sixty (60) days. In addition to disability, LOCEU determines the appropriate level of care and cost effectiveness.

(4) **Determination of categorical relationship to the disabled based on Tuberculosis (TB) infection.** Categorical relationship to disability is established for individuals with a diagnosis of TB. An individual is related to disability for TB related services if he/she has verification of an active TB infection established by a medical practitioner.

(5) **Determination of categorical relationship to the disabled for TEFRA.** Section 134 of TEFRA allows states, at their option, to make Medicaid benefits available to children, under nineteen (19) years of age, living at home who are disabled as defined by the SSA, even though these children would not ordinarily be eligible for SSI benefits because of the deeming of parental income or resources. Under TEFRA, a child living at home who requires the level of care provided in an acute care hospital (for a minimum of sixty (60) days), nursing facility or intermediate care facility for individuals with intellectual disabilities, is determined eligible using only his/her income

and resources as though he/she were institutionalized.

G.
TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 6. INPATIENT PSYCHIATRIC AND SUBSTANCE USE DISORDER SERVICES
317:30-5-95.22 [AMENDED]
317:30-5-95.29 [AMENDED]
317:30-5-95.30 [AMENDED]
317:30-5-95.33 [AMENDED]
317:30-5-95.34 [AMENDED]
317:30-5-95.37 [AMENDED]
317:30-5-95.38 [AMENDED]
(REFERENCE APA WF # 21-30)

317:30-5-95.22. Coverage for children
(a) In order for services to be covered, services in psychiatric units of general hospitals, psychiatric hospitals, and PRTF programs must meet the requirements in OAC 317:30-5-95.25 through 317:30-5-95.30. OHCA rules that apply to inpatient psychiatric coverage for individuals aged twenty-one (21) and under are found in Sections OAC 317:30-5-95.22 through 317:30-5-95.42.
(b) The following words and terms, when used in OAC 317:30-5-95.22 through 317:30-5-95.42, shall have the following meaning, unless the context clearly indicates otherwise:

(1) **"Acute"** means care delivered in a psychiatric unit of a general hospital or psychiatric hospital that provides assessment, medical management and monitoring, and short-term intensive treatment and stabilization to individuals experiencing acute episodes of behavioral health disorders.

(2) **"Acute II"** means care delivered in a psychiatric unit of a general hospital or psychiatric hospital; however, services at this level of care are designed to serve individuals under twenty-one (21) who need longer-term, more intensive treatment, and a more highly-structured environment than they can receive in family and other community-based alternatives to hospitalization. However, care delivered in this setting is less intense than the care provided in Acute.

(3) **"Border placement"** means placement in an inpatient psychiatric facility that is in one (1) of the states that borders Oklahoma (Arkansas, Colorado, Kansas, Missouri, New Mexico, and Texas).

(4) **"Border status"** means placement in a facility in a state that does not border Oklahoma, but which facility routinely provides inpatient psychiatric services to SoonerCare members.

(5) **"Chemical dependency/substance abuse services/detoxification"** means services offered to individuals with a substance-related disorder whose biomedical and emotional/behavioral problems are sufficiently severe to require inpatient care.

~~(6) **"Community-based extended"** means a PRTF with sixteen (16) beds or more but less than thirty (30) beds. The typical facility is not a locked facility.~~

~~(7) **"Community-based transitional (CBT)"** means a PRTF level of care designed for individuals under twenty-one (21) who require the continued structure and psychiatric intervention of twenty-four (24) hour care, but are ready to begin transitioning from more intense residential treatment into the community. It is the intent that members admitted to this level of care should be able to attend public school. Community-based transitional facilities are non-secure PRTFs with sixteen (16) beds or less.~~

~~(8)~~(6) **"Enhanced treatment unit or specialized treatment"** means an intensive residential treatment unit that provides a program of care to a population with special needs or issues requiring increased staffing requirements, co-morbidities, environmental accommodations, specialized treatment programs, and longer lengths of stay.

~~(9)~~(7) **"Evidence-based practice (EBP)"** means programs or practices that are supported by research methodology and have produced consistently positive patterns of results in accordance with the Substance Abuse and Mental Health Services Administration (SAMHSA).

~~(10)~~(8) **"Out-of-state placement"** means a placement for intensive or specialized services not available in Oklahoma requiring additional authorization procedures and approval by the OHCA Behavioral Health Unit.

~~(11)~~(9) **"Public facilities"** means Oklahoma government owned or operated facilities.

~~(12)~~(10) **"Trauma-informed"** means the recognition and responsiveness to the presence of the effects of past and current traumatic experiences in the lives of members.

317:30-5-95.29. Medical necessity criteria Acute II and PRTF admissions for children

~~(a)~~ Acute II and PRTF admissions for individuals under twenty-one (21) must meet the terms and conditions in (1), (2), (3), (4), (5) and one (1) of the terms and conditions of (6)(A) through (D) of this subsection.

(1) A primary diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) with the exception of V-codes, adjustment disorders, and substance-related disorders, accompanied by detailed symptoms supporting the diagnosis. Members eighteen (18) to twenty (20) years of age may have a diagnosis of any personality disorder. Adjustment or substance-related disorders may be a secondary diagnosis.

(2) Conditions are directly attributed to a mental disorder as the primary reason for professional attention (this does not include placement issues, criminal behavior, or status offenses).

(3) Patient has either received treatment in an acute setting or it has been determined by the OHCA, or its designated agent, that the current disabling symptoms could not or have not been manageable in a less-intensive treatment program.

(4) Member must be medically stable.

(5) Requires twenty-four (24) hour observation and treatment as evidenced by:

(A) Intensive behavioral management;

(B) Intensive treatment with the family/guardian and child in a structured milieu; and

(C) Intensive treatment in preparation for re-entry into community.

(6) Within the past fourteen (14) calendar days, the patient has demonstrated an escalating pattern of self-injurious or assaultive behaviors as evidenced by any of (A) through (D) below. Exceptions to the fourteen (14) day requirement may be made in instances when evidence of the behavior could not have reasonably been discovered within fourteen (14) days (e.g., sexual offenses).

(A) Suicidal ideation and/or threat.

(B) History of/or current self-injurious behavior.

(C) Serious threats or evidence of physical aggression.

(D) Current incapacitating psychosis or depression.

~~(b) CBT admissions for children must meet the terms and conditions in (1) through (6) of this subsection.~~

~~(1) A primary diagnosis from the DSM-V with the exception of V-codes, adjustment disorders, and substance-related disorders, accompanied by detailed symptoms supporting the diagnosis. Members eighteen (18) to twenty (20) years of age may have a diagnosis of any personality disorder.~~

~~(2) Conditions are directly attributed to a mental disorder as the primary reason for professional attention (this does not include placement issues, criminal behavioral, or status offenses).~~

~~(3) Patient has either received treatment in Acute, Acute II, PRTF or children's crisis unit setting (refer to OAC 317:30-5-241.4), or it has been determined by OHCA or its designated agent that the current disabling symptoms could not or have not been manageable in a less-intensive treatment program.~~

~~(A) Patient must have tried and failed a lower level of care or is stepping down from a higher level of care.~~

~~(B) Clinical documentation must support need for CBT, rather than facility-based crisis stabilization, therapeutic foster care, intensive treatment foster care, or intensive outpatient services.~~

~~(C) There is clear evidence to support a reasonable expectation that stepping down to a lower level of care would result in rapid and marked deterioration of functioning in at least two (2) of the five (5) critical areas, listed below,~~

~~placing the member at risk of need for acute stabilization/inpatient care.~~

~~(i) Personal safety;~~

~~(ii) Cognitive functioning;~~

~~(iii) Family relations;~~

~~(iv) Interpersonal relations; or~~

~~(v) Educational/vocational performance.~~

~~(4) Child must be medically stable.~~

~~(5) Within the past fourteen (14) calendar days, the patient must have demonstrated an escalating pattern of self-injurious or assaultive behavior as evidenced by any of (a)(5)(A) through (D) above. Exceptions to the fourteen (14) day requirement may be made in instances when evidence of the behavior could not have reasonably been discovered within fourteen (14) days (e.g., sexual offenses).~~

~~(6) Within the past fourteen (14) calendar days, the patient's behaviors have created significant functional impairment.~~

317:30-5-95.30. Medical necessity criteria for Acute II and PRTF continued stay for children

~~(a)~~ For continued stay in Acute II and PRTF programs, members must meet the terms and conditions contained in (1), (2), (3), (4), and either (5) or (6) of this subsection:

(1) A primary diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) with the exception of V codes, adjustment disorders, and substance abuse-related disorders, accompanied by detailed symptoms supporting the diagnosis. In lieu of a qualifying primary diagnosis, members eighteen (18) to twenty (20) years of age may have a secondary diagnosis of any personality disorder.

(2) Conditions are directly attributed to a psychiatric disorder as the primary reason for continued stay (this does not include placement issues, criminal behavior, or status offenses).

(3) There is documented continuing need for twenty-four (24) hour observation and treatment as evidenced by:

(A) Intensive behavioral management.

(B) Intensive treatment with the family/guardian and child in a structured milieu.

(C) Intensive treatment in preparation for re-entry into community.

(4) Documented efforts of working with child's family, legal guardian and/or custodian and other human service agencies toward a tentative discharge date.

(5) Patient is making measurable progress toward the treatment objectives specified in the treatment plan.

(A) Progress is measured in behavioral terms and reflected in the patient's treatment and discharge plans.

(B) Patient has made gains toward social responsibility and independence.

(C) There is active, ongoing psychiatric treatment and documented progress toward the treatment objective and discharge.

(D) There are documented efforts and evidence of active involvement with the family, guardian, child welfare worker, extended family, etc.

(6) Child's condition has remained unchanged or worsened.

(A) Documentation of regression is measured in behavioral terms and reflected in the patient's treatment and discharge plans.

(B) If condition is unchanged, there is evidence of re-evaluation of the treatment objectives and therapeutic interventions.

~~(b) For continued stay in a CBT, members must meet the terms and conditions found in (1) through (5) of this subsection.~~

~~(1) A primary diagnosis from the DSM-V with the exception of V codes, adjustment disorders, and substance use disorders, accompanied by detailed symptoms supporting the diagnosis. Members eighteen (18) to twenty (20) years of age may have a diagnosis of any personality disorder.~~

~~(2) Conditions are directly attributed to a psychiatric disorder as the primary reason for continued stay (this does not include placement issues, criminal behavior, or status offenses).~~

~~(3) There is documented continued need for twenty-four (24) hour observation and treatment as evidenced by:~~

~~(A) Patient making measurable progress toward the treatment objectives specified in the treatment plan.~~

~~(B) Clinical documentation clearly indicates continued significant functional impairment in two (2) of the following five (5) critical areas, as evidenced by specific clinically relevant behavior descriptors:~~

~~(i) Personal safety;~~

~~(ii) Cognitive functioning;~~

~~(iii) Family relations;~~

~~(iv) Interpersonal relations; or~~

~~(v) Educational/vocational performance.~~

~~(4) Clinical documentation includes behavioral descriptors indicating patient's response to treatment and supporting patient's ability to benefit from continued treatment at this level of care.~~

~~(5) Documented, clear evidence of consistent, active involvement by patient's primary caregiver(s) in the treatment process.~~

317:30-5-95.33. Individual plan of care for children

(a) An individual plan of care (IPC) is a written plan developed for each member within four (4) calendar days of admission to an Acute, Acute II, or a PRTF that directs the care and treatment of that member. The IPC must be recovery-focused, trauma-informed, and specific to culture, age, and gender and include:

(1) A primary diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) with the exception of V-codes, adjustment disorders, and substance abuse-related disorders, accompanied by a detailed description of the symptoms supporting the diagnosis. Members eighteen (18) to twenty (20) years of age may have a diagnosis of any personality disorder. Adjustment or substance-related disorders may be a secondary diagnosis;

(2) The current functional level of the individual;

(3) Treatment goals and measurable, time-limited objectives;

(4) Any orders for psychotropic medications, treatments, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures recommended for the health and safety of the member;

(5) Plans for continuing care, including review and modification to the IPC; and

(6) Plan for discharge, all of which is developed to improve the member's condition to the extent that the inpatient care is no longer necessary.

(b) The IPC:

(1) Must be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the individual member and reflects the need for inpatient psychiatric care;

(2) Must be developed by a team of professionals in consultation with the member, his or her parents or legal guardians [for members under the age of eighteen (18)], or others in whose care he or she will be released after discharge. This team must consist of professionals as specified below:

(A) For a member admitted to a psychiatric hospital or PRTF, by the "interdisciplinary team" as defined by OAC 317:30-5-95.35(b)(2), per 42 C.F.R. §§ 441.155 and 483.354; or

(B) For a member admitted to a psychiatric unit of a general hospital, by a team comprised of at least:

(i) An allopathic or osteopathic physician with a current license and a board certification/eligible in psychiatry, or a current resident in psychiatry practicing as described in OAC 317:30-5-2(a)(1)(U); and

(ii) A registered nurse (RN) with a minimum of two (2) years of experience in a mental health treatment setting; and

(iii) An LBHP.

(3) Must establish treatment goals that are general outcome statements and reflective of informed choices of the member served. Additionally, the treatment goals must be appropriate to the member's age, culture, strengths, needs, abilities, preferences, and limitations;

(4) Must establish measurable and time-limited treatment

objectives that reflect the expectations of the member served and parents/legal guardians (when applicable), as well as being age, developmentally, and culturally appropriate. When modifications are being made to accommodate age, developmental level, or a cultural issue, the documentation must be reflected on the IPC. The treatment objectives must be achievable and understandable to the member and the parents/legal guardians (when applicable). The treatment objectives also must be appropriate to the treatment setting and list the frequency of the service;
(5) Must prescribe an integrated program of therapies, activities, and experiences designed to meet the objectives;
(6) Must include specific discharge and aftercare plans that are appropriate to the member's needs and effective on the day of discharge. At the time of discharge, aftercare plans will include referral to medication management, outpatient behavioral health counseling, and case management, to include the specific appointment date(s), names, and addresses of service provider(s) and related community services to ensure continuity of care and reintegration for the member into his or her family, school, and community;
(7) Must be reviewed, at a minimum, every nine (9) calendar days for members admitted to Acute; every fourteen (14) calendar days for members admitted to Acute II or non-specialty PRTF; every twenty-one (21) calendar days for members admitted to an OHCA-approved longer-term treatment program or specialty Acute II or PRTF~~; and every thirty (30) calendar days for members admitted to a CBT PRTF~~. Review must be undertaken by the appropriate team specified in OAC 317:30-5-95.33(b)(2), above, to determine that services being provided are or were required on an inpatient basis, and to recommend changes in the IPC as indicated by the member's overall adjustment, progress, symptoms, behavior, and response to treatment;
(8) Development and review must satisfy the utilization control requirements for recertification [42 C.F.R. §§ 456.60(b), 456.160(b), and 456.360(b)], and establishment and periodic review of the IPC (42 C.F.R. §§ 456.80, 456.180, and 456.380); and,
(9) Each IPC and IPC review must be clearly identified as such and be signed and dated individually by the member, parents/legal guardians [for members under the age of eighteen (18)], and required team members.~~ All IPCs and IPC reviews must be signed by the member upon completion, except when a member is too physically ill or the member's acuity level precludes him or her from signing. If the member is too physically ill or the member's acuity level precludes him or her from signing the IPC and/or the IPC review at the time of completion, the member must sign the plan when his or her condition improves, but before discharge. The documentation should indicate the reason the~~

~~member was unable to sign and when the next review will occur to obtain the signature. IPCs and IPC reviews are not valid until completed and appropriately signed and dated. All requirements for the IPCs and IPC reviews must be met; otherwise, a partial per diem recoupment will be merited. If the member's parent/legal guardian is unable to sign the IPC or IPC review on the date it is completed, then within seventy-two (72) hours the provider must in good faith and with due diligence attempt to telephonically notify the parent/legal guardian of the document's completion and review it with them. Documentation of reasonable efforts to make contact with the member's parent/legal guardian must be included in the clinical file. In those instances where it is necessary to mail or fax an IPC or IPC review to a parent/legal guardian or Oklahoma Department of Human Services/Oklahoma Office of Juvenile Affairs (OKDHS/OJA) worker for review, the parent/legal guardian and/or OKDHS/OJA worker may fax back his or her signature. The provider must obtain the original signature for the clinical file within thirty (30) days. Stamped or photocopied signatures are not allowed for any parent/legal guardian or member of the treatment team.~~

(A) All IPCs and IPC reviews must be signed by the member upon completion, except when a member is too physically ill or the member's acuity level precludes him or her from signing.

(i) If the member is too physically ill or the member's acuity level precludes him or her from signing the IPC and/or the IPC review at the time of completion, the member must sign the plan when his or her condition improves, but before discharge.

(ii) The documentation should indicate the reason the member was unable to sign and when the next review will occur to obtain the signature.

(B) IPCs and IPC reviews are not valid until completed and appropriately signed and dated.

(i) All requirements for the IPCs and IPC reviews must be met; otherwise, a partial per diem recoupment will be merited.

(ii) If the member's parent/legal guardian is unable to sign the IPC or IPC review on the date it is completed, then within seventy-two (72) hours the provider must in good faith and with due diligence attempt to telephonically notify the parent/legal guardian of the document's completion and review it with them.

(iii) Documentation of reasonable efforts to make contact with the member's parent/legal guardian must be included in the clinical file.

(iv) In those instances where it is necessary to mail or

fax an IPC or IPC review to a parent/legal guardian or Oklahoma Department of Human Services/Oklahoma Office of Juvenile Affairs (OKDHS/OJA) worker for review, the parent/legal guardian and/or OKDHS/OJA worker may fax back his or her signature. The provider must obtain the original signature for the clinical file within thirty (30) days. Stamped or photocopied signatures are not allowed for any parent/legal guardian or member of the treatment team.

(10) Medically necessary Early and Periodic Screening, ~~Diagnosis~~Diagnostic and Treatment (EPSDT) services shall be provided to members, under the age of twenty-one (21), who are residing in an inpatient psychiatric facility, regardless of whether such services are listed on the IPC. Reimbursement for the provision of medically necessary EPSDT services to individuals under age twenty-one (21), while the member is residing in an inpatient psychiatric facility, will be provided in accordance with the Oklahoma Medicaid State Plan.

317:30-5-95.34. Active treatment for children

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

(1) **"Active treatment"** means implementation of a professionally developed and supervised individual plan of care (IPC) that involves the member and his or her family or guardian from the time of an admission, and through the treatment and discharge process.

(2) **"Discharge/transition planning"** means a patient-centered, interdisciplinary process that begins with an initial assessment of the member's needs at the time of admission and continues throughout the member's stay. Active collaboration with the member, family, and all involved outpatient practitioners and agencies should be ongoing throughout treatment so that effective connections remain intact. Needed services may consist of the wraparound process through Systems of Care, counseling, case management, and other supports in the member's community. The linkages with these supports should be made prior to discharge to allow for a smooth transition.

(3) **"Expressive group therapy"** means art, music, dance, movement, poetry, drama, psychodrama, structured therapeutic physical activities, and experiential (e.g., ropes course), recreational, or occupational therapies that encourage the member to express themselves emotionally and psychologically.

(4) **"Family therapy"** means interaction between an LBHP or licensure candidate, member, and family member(s) to facilitate emotional, psychological, or behavioral changes and promote successful communication and understanding.

(5) **"Group rehabilitative treatment"** means behavioral health

remedial services, as specified in the individual care plan, which are necessary for the treatment of the existing primary behavioral health disorders and/or any secondary alcohol and other drug (AOD) disorders in order to increase the skills necessary to perform activities of daily living (ADL).

(6) **"Individual rehabilitative treatment"** means a face-to-face, one-on-one interaction which is performed to assist a member who is experiencing significant functional impairment due to the existing primary behavioral health disorder and/or any secondary AOD disorder, in order to increase the skills necessary to perform ADL.

(7) **"Individual therapy"** means a method of treating existing primary behavioral health disorders and/or any secondary AOD disorders using face-to-face, one-on-one interaction between an LBHP or licensure candidate and a member to promote emotional or psychological change to alleviate disorders.

(8) **"Process group therapy"** means a method of treating existing primary behavioral health disorders and/or secondary AOD disorders using the interaction between an LBHP or licensure candidate, and two (2) or more members to promote positive emotional and/or behavioral change.

(b) Inpatient psychiatric programs must provide "active treatment". Families and/or guardians must be notified of the dates and times of treatment team meetings and be welcomed to attend. Family members must attend family therapy weekly for continued SoonerCare reimbursement. Reasons for exceptions to this requirement must be well-documented in the member's treatment plan. Family therapy attendance by family members is not a requirement for individuals in the age range of eighteen (18) up to twenty-one (21). Active treatment also includes ongoing assessment, diagnosis, intervention, evaluation of care and treatment, and planning for discharge and aftercare under the direction of a physician.

(c) For individuals ~~age~~ages eighteen (18) up to twenty-one (21), the active treatment program must be appropriate to the needs of the member and be directed toward restoring and maintaining optimal levels of physical and psychiatric-social functioning. The services and the IPC must be recovery-focused, trauma-informed, specific to culture, age, and gender, and provided face to face. Services, including type and frequency, will be specified in the IPC.

(d) A treatment week consists of seven (7) calendar days. In an Acute setting, the treatment week begins the day of admission. In Acute II and PRTF, the treatment week starts on Sunday and ends on Saturday. Active treatment service components are provided as per item (e) below if the services are provided within a seven (7) day treatment week. A chart outlining active treatment component requirements and timelines may also be found at www.okhca.org. If a member has a length of stay of less than seven (7) days, the treatment week is considered a partial treatment week. Active treatment requirements, when provided during a partial treatment

week, are delivered as per item (f) below. An hour of treatment must be sixty (60) minutes. When appropriate to meet the needs of the child, the sixty (60) minute timeframe may be split into sessions of no less than fifteen (15) minutes each, on the condition that the active treatment requirements are fully met by the end of the treatment week.

(e) For individuals under age eighteen (18), the components of active treatment consist of face-to-face integrated therapies that are provided on a regular basis and will remain consistent with the member's ongoing need for care. The services and IPC must be recovery-focused, trauma-informed, and specific to culture, age, and gender. Individuals receiving services in an Acute setting must receive seventeen (17) hours of documented active treatment services each week, with seven (7) of those hours dedicated to core services as described in (1) below. Individuals in Acute II and PRTFs must receive fourteen (14) hours of documented active treatment services each week, with four and a half (4.5) of those hours dedicated to core services as described in (1) below. ~~Individuals in CBT PRTFs must receive ten (10) hours of documented active treatment services each week, with four and a half (4.5) of those hours dedicated to core services as described in (1) below.~~ Upon fulfilling the core service hours requirement, the member may receive either the elective services listed in (2) below or additional core services to complete the total required hours of active treatment. The following components meet the minimum standards required for active treatment, although an individual child's needs for treatment may exceed this minimum standard:

(1) **Core services.**

(A) **Individual treatment provided by the physician.** Individual treatment provided by the physician is required three (3) times per week for Acute and one (1) time a week in Acute II and PRTFs. Individual treatment provided by the physician will never exceed ten (10) calendar days between sessions in Acute II and PRTFs, and never exceed seven (7) calendar days in a specialty Acute II and specialty PRTF~~, and never exceed thirty (30) calendar days in CBTs~~. Individual treatment provided by the physician may consist of therapy or medication management intervention for Acute, Acute II, and PRTF programs.

(B) **Individual therapy.** LBHPs or licensure candidates performing this service must use and document an approach to treatment such as cognitive behavioral treatment, narrative therapy, solution-focused brief therapy, or another widely accepted theoretical framework for treatment. Ongoing assessment of the member's status and response to treatment, as well as psycho-educational intervention, are appropriate components of individual therapy. Individual therapy must be provided in a confidential setting. The therapy must be goal-directed, utilizing techniques appropriate to the member's

plan of care and the member's developmental and cognitive abilities. Individual therapy must be provided two (2) hours per week in Acute and one (1) hour per week in Acute II and PRTFs by an LBHP or licensure candidate. One (1) hour of family therapy may be substituted for one (1) hour of individual therapy at the treatment team's discretion.

(C) **Family therapy.** The focus of family therapy must be directly related to the goals and objectives on the individual member's plan of care. Family therapy must be provided one (1) hour per week in Acute, Acute II, and PRTFs. One (1) hour of individual therapy addressing relevant family issues may be substituted for a family session in an instance in which the family is unable to attend a scheduled session by an LBHP or licensure candidate.

(D) **Process group therapy.** The focus of process group therapy must be directly related to goals and objectives on the individual member's plan of care. The individual member's behavior and the focus of the group must be included in each member's medical record. This service does not include social skills development or daily living skills activities and must take place in an appropriate confidential setting, limited to the therapist, appropriate hospital staff, and group members. Group therapy must be provided three (3) hours per week in Acute and two (2) hours per week in Acute II and PRTFs by an LBHP or licensure candidate. In lieu of one (1) hour of process group therapy, one (1) hour of expressive group therapy provided by an LBHP, licensure candidate, or licensed therapeutic recreation specialist may be substituted.

(E) **Transition/discharge planning.** Transition/discharge planning must be provided one (1) hour per week in Acute and thirty (30) minutes per week in Acute II and PRTFs. Transition/discharge planning can be provided by any level of inpatient staff.

(2) **Elective services.**

(A) **Expressive group therapy.** Through active expression, ~~inner-strengths~~inner strengths are discovered that can help the member deal with past experiences and cope with present life situations in more beneficial ways. The focus of the group must be directly related to goals and objectives on the individual member's plan of care. Documentation must include how the member is processing emotions/feelings. Expressive therapy must be a planned therapeutic activity, facilitated by staff with a relevant bachelor's degree and/or staff with relevant training, experience, or certification to facilitate the therapy.

(B) **Group rehabilitative treatment.** Examples of educational and supportive services, which may be covered under the definition of group rehabilitative treatment services, are basic living skills, social skills (re)development,

interdependent living, self-care, lifestyle changes, and recovery principles. Each service provided under group rehabilitative treatment services must have goals and objectives directly related to the IPC.

(C) **Individual rehabilitative treatment.** Services are provided to reduce psychiatric and behavioral impairment and to restore functioning consistent with the requirements of independent living and enhanced self-sufficiency. This service includes educational and supportive services regarding independent living, self-care, social skills (re)development, lifestyle changes, and recovery principles and practices. Each individual rehabilitative treatment service provided must have goals and objectives directly related to the IPC and the member's diagnosis.

(D) **Recreation therapy.** Services are provided to reduce psychiatric and behavioral impairment and to restore, remediate, and rehabilitate an individual's level of functioning and independence in life activities. Services are provided to promote health and wellness, as well as reduce or eliminate barriers caused by illness or disabling conditions that limit or restrict a member from participating in life activities. Recreational therapy can be provided in an individual or group setting. If the only activities prescribed for the individual are primarily diversional in nature, (i.e., to provide some social or recreational outlet for the individual), it will not be regarded as active treatment. If provided, recreational therapy must be a planned therapeutic activity, facilitated by a licensed therapeutic recreation specialist.

(E) **Occupational therapy.** Services are provided to address developmental and/or functional needs related to the performance of self-help skills, adaptive behavioral, and/or sensory, motor, and postural development. Services include therapeutic goal-directed activities and/or exercises used to improve mobility and ADL functions when such functions have been impaired due to illness or injury. Services must be provided by an occupational therapist appropriately licensed in the state in which he or she practices.

(F) **Wellness resource skills development.** Services include providing direction and coordinating support activities that promote physical health. The focus of these activities should include areas such as nutrition, exercise, support to avert and manage physical health concerns like heart disease, diabetes, and cholesterol, and guidance on the effects that medications have on physical health. Services can include ~~individual/ group~~individual/group support, exercise groups, and individual physical wellness plan development, implementation, and assistance.

(3) **Modifications to active treatment.** When a member is too

physically ill, or his or her acuity level precludes him or her from active behavioral health treatment, documentation must demonstrate that alternative clinically-appropriate services were provided.

(f) Active treatment components, furnished during a partial treatment week, are provided as per item (1) through (4) below. A chart outlining active treatment component requirements and timelines may also be found at www.okhca.org. Assessments/evaluations may serve as the initial individual or family session if completed by an LBHP or licensure candidate. Start and stop time must be documented. Active treatment begins the day of admission. Days noted are calendar days.

(1) **Individual treatment provided by the physician.**

(A) In Acute, by day two (2), one (1) visit is required. By day four (4), two (2) visits are required. By day seven (7), three (3) visits are required.

(B) In Acute II and PRTFs, one (1) visit during admission week is required. In PRTFs, ~~not including CBTs,~~ one (1) visit during the admission week is required, then once a week thereafter. ~~In CBT, one (1) visit is required within seven (7) days of admission, then once a month thereafter.~~ Individual treatment provided by the physician will never exceed ten (10) days between sessions in Acute II and PRTFs, never exceed seven (7) days in specialty Acute II and specialty PRTFs ~~and never exceed thirty (30) days in CBTs~~. The completion of a psychiatric evaluation or a combined psychiatric evaluation and a history and physical (H&P) evaluation may count as the first visit by the physician if the evaluation was personally rendered by the psychiatrist. If the member is admitted on the last day of the admission week, then the member must be seen by a physician within sixty (60) hours of admission time.

(2) **Individual therapy.**

(A) In Acute, by day three (3), thirty (30) minutes of treatment are required. By day five (5), one (1) hour of treatment is required. Beginning on day seven (7), two (2) hours of treatment are required each week. This does not include admission assessments/evaluations or psychosocial evaluations unless personally (face to face) rendered by the LBHP or licensure candidate.

(B) In Acute II and PRTFs, by day six (6), thirty (30) minutes of treatment must be documented. Beginning on day seven (7), one (1) hour of treatment is required each week. The treatment week is defined as Sunday through Saturday. Individual therapy may not exceed a total of ten (10) days between sessions. This does not include admission assessment/evaluation or psychosocial evaluations unless personally (face to face) rendered by the LBHP or licensure candidate.

(3) **Family therapy.**

(A) In Acute, by day six (6), thirty (30) minutes of treatment must be documented. Beginning on day seven (7), one (1) hour of treatment is required each week. This does not include admission assessments/evaluation or psychosocial evaluations unless personally (face to face) rendered by the LBHP or licensure candidate and the assessments/evaluation or psychosocial evaluation has not been used to substitute the initial individual therapy requirement.

(B) In Acute II and PRTFs, by day six (6), thirty (30) minutes of treatment must be documented. Beginning on day seven (7), one (1) hour of treatment is required each week. This does not include admissions assessment/evaluation or psychosocial evaluation unless personally (face to face) rendered by the LBHP or licensure candidate and the assessment/evaluation or psychosocial evaluation has not been used to substitute the initial individual therapy requirement. Family therapy provided by the LBHP or licensure candidate should not exceed ten (10) days in between sessions.

(4) **Process group therapy.**

(A) In Acute, by day three (3), one (1) hour of treatment is required. By day five (5), two (2) hours of treatment are required. Beginning on day seven (7), three (3) hours of treatment are required each week.

(B) In Acute II and PRTFs, by day five (5), one (1) hour of treatment is required. Beginning on day seven (7), two (2) hours of treatment are required each week.

(g) When an individual is determined to be too ill to participate in treatment, as determined by medical/nursing staff [registered nurse (RN)/licensed practical nurse (LPN)], documentation must be in the record clearly indicating the reason, limitations, and timeframe for those services to be excused without penalty.

317:30-5-95.37. Medical, psychiatric and social evaluations for inpatient services for children

The member's medical record must contain complete medical, psychiatric, and social evaluations.

(1) These evaluations are considered critical documents to the integrity of care and treatment and must be completed as follows:

(A) History and physical evaluation must be completed within twenty-four (24) hours of admission by a licensed independent practitioner (M.D., D.O., A.P.N., or P.A.) in Acute, Acute II, and PRTFs~~, excluding CBTs, and within seven (7) calendar days of admission in a CBT~~.

(B) Psychiatric evaluation must be completed within sixty (60) hours of admission by an allopathic or osteopathic physician with a current license and a board

certification/eligible in psychiatry in Acute, Acute II, and PRTFs~~, excluding CBTs, and within seven (7) calendar days of admission in a CBT~~.

(C) Psychosocial evaluation must be completed within seventy-two (72) hours of an Acute admission, and within seven (7) calendar days of admission to Acute II and PRTFs~~, including CBTs,~~ by a licensed independent practitioner (M.D., D.O., A.P.N., or P.A.), LBHP, or licensure candidate.

(2) Each of the evaluations must be clearly identified as such and must be signed and dated by the evaluators.

(3) Each of the evaluations must be completed when the member changes levels of care if the existing evaluation is more than thirty (30) calendar days from admission. For continued stays at the same level of care, evaluations remain current for twelve (12) months from the date of admission and must be updated annually within seven (7) calendar days of that anniversary date.

(4) Existing evaluations of thirty (30) days or less may be used when a member changes provider or level of care. The evaluation(s) must be reviewed, updated as necessary, and signed and dated by the appropriate level of professional as defined by the type of evaluation.

317:30-5-95.38. Nursing services for children

Each facility must have a qualified director of psychiatric nursing. In addition to the director of nursing, there must be adequate numbers of registered nurses (RNs), licensed practical nurses (LPNs), and mental health workers to provide nursing care necessary under the active treatment program and to maintain progress notes on each member. ~~In a CBT, an RN must be on site at least one (1) hour each day and be available twenty-four (24) hours a day when not on site. An RN must document member progress at least weekly, except in a CBT where the requirement will be twice a month.~~ The progress note must contain recommendations for revisions in the individual plan of care (IPC), as needed, as well as an assessment of the member's progress as it relates to the IPC goals and objectives.

H.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 3. GENERAL PROVIDER POLICIES
PART 4. EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) PROGRAM/CHILD-HEALTH SERVICES
317:30-3-65.12 [AMENDED]
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 30. APPLIED BEHAVIOR ANALYSIS (ABA) SERVICES [NEW]
317:30-5-310 [NEW]
317:30-5-311 [NEW]
317:30-5-312 [NEW]
317:30-5-313 [NEW]
317:30-5-314 [NEW]
317:30-5-315 [NEW]
317:30-5-316 [NEW]
(REFERENCE APA WF # 21-31)

317:30-3-65.12. Applied behavior analysis (ABA) services

~~(a) **Purpose and general provisions.** The purpose of this Section is to establish guidelines for the provision of ABA services under the EPSDT benefit.~~

~~(1) ABA focuses on the analysis, design, implementation, and evaluation of instructional and other environmental modifications to produce meaningful changes in human behavior. ABA services include the use of direct observation, measurement, and functional analysis of the relations between the environment and behavior. Common ABA-based techniques include, but are not limited to; discrete trial training (DTT); naturalistic developmental behavioral intervention (NDBI); and verbal behavioral intervention.~~

~~(2) ABA may be provided in a variety of settings, including home, community, or a clinical setting. It involves development of an individualized treatment plan that includes transition and aftercare planning, and family/caregiver involvement.~~

~~(3) At an initial assessment, target symptoms are identified. A treatment plan is developed to identify core deficits and aberrant behaviors, and includes designated interventions intended to address these deficits and behaviors and that are functional, meaningful and connected to the member's daily activities routines.~~

~~(4) ABA services require prior authorization [refer to Oklahoma Administrative Code (OAC) 317:30-3-31 and 317:30-3-65.12(e)].~~

~~(b) **Functional behavior assessment (FBA) and treatment plan components**~~

~~(1) The FBA serves as a critical component of the treatment plan and is conducted by a board certified behavior analyst (BCBA) to identify the specific behavioral needs of the member. The FBA consists of:~~

(A) Description of the problematic behavior (topography, onset/offset, cycle, intensity, severity);
(B) History of the problematic behavior (long-term and recent);
(C) Antecedent analysis (setting, people, time of day, events);
(D) Consequence analysis; and
(E) Impression and analysis of the function of the problematic behavior.

(2) The treatment plan is developed by a BCBA or a licensed psychologist from the FBA. The treatment plan shall:
(A) Be person-centered and individualized;
(B) Delineate the baseline levels of target behaviors;
(C) Specify long and short term objectives that are defined in observable, measureable behavioral terms;
(D) Specify criteria that will be used to determine achievement of objectives;
(E) Include assessment and treatment protocols for addressing each of the target behaviors;
(F) Clearly identify the schedule of services planned and the individuals responsible for delivering the services, including frequent review of data on target behaviors and adjustments in the treatment plan and/or protocols by the BCBA or licensed psychologist as needed;
(G) Include training and supervision to enable board certified assistant behavior analysts (BCaBAs) and registered behavior technicians (RBTs) to implement assessment and treatment protocols;
(H) Include training and support to enable parents and other caregivers to participate in treatment planning and successfully reinforce the established treatment plan;
(I) Include care coordination involving the parents or caregiver(s), school, state disability programs, and others as applicable; and
(J) Ensure that services are consistent with applicable professional standards and guidelines relating to the practice of applied behavior analysis as well as state Medicaid laws and regulations.

(c) **Eligible providers.** Eligible ABA provider types include:
(1) Board certified behavior analyst® (BCBA®) - A master's or doctoral level independent practitioner who is certified by the national-accrediting Behavior Analyst Certification Board, Inc.® (BACB®) and licensed by the Oklahoma Department of Human Services' (OKDHS) Developmental Disabilities Services Division (DDS) to provide behavior analysis services. A BCBA may supervise the work of board certified assistant behavior analysts and registered behavior technicians implementing behavior analytic interventions;
(2) Board certified assistant behavior analyst® (BCaBA®) - A

~~bachelor's level practitioner who is certified by the national-accrediting BACB and certified by OKDHS DDS to provide behavior analysis services under the supervision of a BCBA;~~

~~(3) Registered behavior technician™ (RBT®) - A high school level or higher paraprofessional who is certified by the national-accrediting BACB and practices under the close and ongoing supervision of a BCBA. The RBT works under the license number of a BCBA and is primarily responsible for the direct implementation of BCBA designed and prescribed behavior-analytic services;~~

~~(4) Licensed psychologist - An individual who is licensed and in good standing with the Oklahoma State Board of Examiners of Psychologists and has professional experience in the use of ABA therapy may render behavior analysis services. Refer to OAC 317:30-5-275; and~~

~~(5) Human services professional - A practitioner who is licensed by the State of Oklahoma pursuant to (A) - (H), and certified by the national-accrediting BACB, and who is working within the scope of his or her practice, to include:~~

~~(A) A licensed physical therapist;~~

~~(B) A licensed occupational therapist;~~

~~(C) A licensed clinical social worker or social worker candidate under the supervision of a licensed clinical social worker;~~

~~(D) A licensed speech-language pathologist or licensed audiologist;~~

~~(E) A licensed professional counselor or professional counselor candidate under the supervision of a licensed professional counselor;~~

~~(F) A licensed marital and family therapist or marital and family therapist candidate under the supervision of a licensed marital and family therapist; or~~

~~(G) A licensed behavioral practitioner or behavioral practitioner candidate under the supervision of a licensed behavioral practitioner.~~

~~(d) **Provider criteria.** To direct, supervise, and/or render ABA services, the following conditions shall be met.~~

~~(1) A BCBA shall:~~

~~(A) Be currently licensed by OKDHS DDS as a BCBA;~~

~~(B) Have no sanctions or disciplinary actions by OKDHS DDS or the BACB;~~

~~(C) Have no current overpayment(s) due to SoonerCare, and no Medicare or Medicaid sanctions or exclusions from participation in federally funded programs; and~~

~~(D) Be fully contracted with SoonerCare as a provider.~~

~~(2) A BCaBA shall:~~

~~(A) Be currently certified by OKDHS DDS as a BCaBA;~~

~~(B) Work under the supervision of a SoonerCare-contracted~~

BCBA provider;

(C) Have no current overpayment(s) due to SoonerCare, and no Medicare or Medicaid sanctions or exclusions from participation in federally funded programs; and

(D) Be fully contracted with SoonerCare as a provider.

(3) An RBT shall:

(A) Be currently certified by the national-accrediting BACB as an RBT;

(B) Work under the supervision of a SoonerCare-contracted BCBA provider;

(C) Have no current overpayment(s) due to SoonerCare, and no Medicare or Medicaid sanctions or exclusions from participation in federally funded programs; and

(D) Be fully contracted with SoonerCare as a provider.

(4) A human services professional shall:

(A) Be currently licensed or certified by the State of Oklahoma, in accordance with Section 1928 of Title 59 of the Oklahoma Statutes;

(B) Be currently certified by the national-accrediting BACB;

(C) Have no sanctions or disciplinary actions by the applicable state licensing board or the BACB;

(D) If working under supervision within the scope of his or her practice, have a documented relationship with a fully-licensed human service professional working in a supervisory capacity;

(E) Have no current overpayment(s) due to SoonerCare, and no Medicare or Medicaid sanctions or exclusions from participation in federally funded programs; and

(F) Be fully contracted with SoonerCare as a provider.

(e) **Medical necessity criteria for members under twenty-one (21) years of age.** ABA services are considered medically necessary when all of the following conditions are met:

(1) The member is under twenty-one (21) years of age with a definitive diagnosis of an Autism Spectrum Disorder (ASD) from the following providers:

(A) Pediatric neurologist or neurologist;

(B) Developmental pediatrician;

(C) Licensed psychologist;

(D) Psychiatrist or neuropsychiatrist; or

(E) Other licensed physician experienced in the diagnosis and treatment of ASD.

(2) A comprehensive diagnostic evaluation completed by one (1) of the above identified professionals must:

(A) Be completed within the last two (2) years;

(B) Include a complete pertinent medical and social history, including pre-and perinatal, medical, developmental, family, and social elements; and

(C) Be based on criteria outlined in the Diagnostic and

Statistical Manual of Mental Disorders (DSM-V) or the most current version of the DSM for ASD and/or may also include scores from the use of formal diagnostic tests such as the Autism Diagnostic Interview-Revised (ADI-R), Autism Diagnostic Observation Schedule-2 (ADOS-2), Childhood Autism Rating Scale (CARS) or other tools with acceptable psychometric properties. Screening scales are not sufficient to make a diagnosis and will not be accepted as the only formal scale.

(3) There must be a reasonable expectation that the member will benefit from ABA. The member must exhibit:

(A) The ability/capacity to learn and develop generalized skills to assist with his or her independence; and

(B) The ability to develop generalized skills to assist in addressing maladaptive behaviors associated with ASD.

(4) The member is medically stable and does not require twenty-four (24) hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for individuals with intellectual disabilities (ICF/IID).

(5) The member exhibits atypical or disruptive behavior within the most recent thirty (30) calendar days that significantly interferes with daily functioning and activities. Such atypical or disruptive behavior may include, but is not limited to:

(A) Impulsive aggression toward others;

(B) Self-injury behaviors;

(C) Intentional property destruction; or

(D) Severe disruption in daily functioning (e.g. the individual's inability to maintain in school, child care settings, social settings, etc.) due to changes in routine activities that have not been helped by other treatments such as occupational, speech therapy, additional psychotherapy and/or school/ daycare interventions.

(6) The focus of treatment is not custodial in nature (which is defined as care provided when the member "has reached maximum level of physical or mental function and such person is not likely to make further significant improvement" or "any type of care where the primary purpose of the type of care provided is to attend to the member's daily living activities which do not entail or require the continuing attention of trained medical or paramedical personnel.") Interventions are intended to strengthen the individual's/parent's/legal guardian's capacity for self care and self sufficiency to decrease interventions in the home by those other than the parent(s)/legal guardian(s).

(7) It has been determined that there is no less intensive or more appropriate level of service which can be safely and effectively provided.

(f) **Prior authorization.** Eligible providers must submit an initial prior authorization request to the Oklahoma Health Care Authority

~~(OHCA) or its designated agent. Prior authorization requests shall be granted up to six (6) months of ABA treatment services at one (1) time unless a longer duration of treatment is clinically indicated. The number of hours authorized may differ from the hours requested on the prior authorization request based on the review by an OHCA reviewer and/or physician. If the member's condition necessitates a change in the treatment plan, the provider must request a new prior authorization. The prior authorization request must meet the following SoonerCare criteria for ABA services.~~

~~(1) The criteria includes a comprehensive behavioral and FBA outlining the maladaptive behaviors consistent with the diagnosis of ASD and its associated comorbidities. In addition to completing the initial request form, providers will be required to submit documentation that will consist of the following:~~

~~(A) Information about relevant medical status, prior assessment results, response to prior treatment, and other relevant information gathered from review of records and past assessments.~~

~~(B) Information gathered from interview of family and/or caregivers, rating scales, and social validity measures to assess perceptions of the client's skill deficits and behavioral excesses, and the extent to which these deficits impede the daily life of the member and the family.~~

~~(C) Direct assessment and observation, including any data related to the identified problem behavior. The analysis of such data serves as the primary basis for identifying pretreatment levels of functioning, developing and adapting treatment protocols, and evaluating response to treatment and progress towards goals.~~

~~(D) Functional assessment of problem behavior that includes antecedent factors, skill deficits, and consequences contributing to the problem behavior. The treatment plan should address all three (3) areas, including antecedent interventions, teaching replacement skills, and modification of consequences.~~

~~(2) The prior authorization for ABA treatment will be time limited for up to thirty (30) hours per week unless other hours are deemed medically necessary and authorized through a prior authorization request and must:~~

~~(A) Be a one-on-one encounter (face to face between the member and ABA provider) except in the case of family adaptive treatment guidance;~~

~~(B) Be child-centered and based upon individualized goals that are strengths-specific, family focused, and community based;~~

~~(C) Be culturally competent and the least intrusive as possible;~~

(D) Clearly define in measurable and objective terms the intervention plan so it can address specific target behaviors. The intervention plan should be clearly linked to the function of the maladaptive behavior and include antecedent interventions, replacement skills to be taught, and modification of consequences. Additional goals may be identified that are related to the core deficits of ASD and are prioritized based on current research and social significance for the individual.

(E) Record the frequency, rate, symptom intensity/duration, or other objective measures of baseline levels;

(F) Set quantifiable criteria for progress;

(G) Establish and record behavioral intervention techniques that are appropriate to target behaviors. The detailed treatment plan utilizes reinforcement and other behavioral principles and excludes the use of methods or techniques that lack consensus about their effectiveness based on evidence in peer-reviewed publications;

(H) Specify strategies for generalization of learned skills beyond the clinical settings such as in the home or other community settings;

(I) Document planning for transition through the continuum of interventions, services, and settings, as well as discharge criteria. Treatment (behavioral training) will be individualized and documentation will support the identified atypical or disruptive behavior.

(J) Include parent(s)/legal guardian(s) in behavioral training techniques so that they can practice additional hours of intervention on their own. The treatment plan is expected to achieve the parent(s)/legal guardian(s) ability to successfully reinforce the established plan of care and support generalization of skills in the home and community settings. Frequency of parental involvement will be determined by the treatment provider and listed on the treatment plan;

(K) Document parent(s)/legal guardian(s) participation in the training of behavioral techniques in the member's medical record. Parent(s)/legal guardian(s)' participation is critical to the generalization of treatment goals to the member's environment; and

(L) Ensure that recommended ABA services do not duplicate or replicate services received in a member's primary academic education setting, or provided within an Individualized Education Plan (IEP), Individualized Service Plan (ISP), or any other individual plan of care. Documentation may be requested by the OHCA to support coordination of services with other providers and to prevent overlap and duplication of services including those in school settings.

(g) **ABA extension requests.** Extension requests for ABA services

must be submitted to the OHCA or its designated agent. Extension requests must contain the appropriate documentation validating the need for continued treatment and establish the following:

(1) Eligibility criteria in OAC 317:30-3-65.12(d) 1-6;

(2) The frequency of the target behavior has diminished since last review, or if not, there has been modification of the treatment or additional assessments have been conducted;

(3) A functional analysis shall be completed by the provider when no measurable progress has occurred, or it may be requested by the OHCA. The functional analysis should record the member's serious maladaptive target behavioral symptom(s) and precipitants, and document the modifications of the current treatment plan to address progress, as well as make a determination of the function a particular maladaptive behavior serves for the member in the environmental context;

(4) Appropriate consultations from other staff or experts have occurred (to optimize psychiatric medications and medical treatments to include but not limited to psychiatric consults, pediatric evaluation for other conditions, etc.) and interventions have been changed, including the number of hours per week of service or setting (higher level of care);

(5) The OHCA may suggest appropriate consultation from other staff or experts during the process of prior authorization;

(6) Parent(s)/legal guardian(s) have received re-training on these changed approaches; and

(7) The treatment plan documents a gradual tapering of higher intensities of intervention and transitioning to supports from other sources (i.e., schools) as progress allows.

(h) **Reimburement methodology.** SoonerCare shall provide reimbursement for ABA services in accordance with the Medicaid State Plan.

(1) Payment shall only be made to SoonerCare-contracted groups or qualified individual providers who are currently licensed and in good standing. Payment is not made to under supervision ABA practitioners/paraprofessionals, including but not limited to, BCaBAs and RBTs.

(2) Reimbursement for ABA services is only made on a fee-for-services basis. The maximum allowable fee for a unit of service has been determined by OHCA to be a reasonable fee, consistent with efficiency, economy, and quality of care. Payment for covered services is the lower of the provider's actual billed charges, consistent with the provider's usual and customary charge to the general public for the service, or the maximum allowable per unit of service.

(3) Reimbursement shall only be made for services that have been prior-authorized by OHCA or its designee; and performed on an individualized basis and not in a group setting except for family adaptive behavior treatment guidance by a qualified ABA

~~provider [OAC 317:30-3-65.12(b)].~~

~~(4) Reimbursement for ABA services shall not be made to or for services rendered by a parent, legal guardian, or other legally responsible person.~~

ABA services are provided under the EPSDT benefit. Refer to OAC 317:30-5-310 through 317:30-5-316 for coverage, provider and program requirements, and reimbursement methodology.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 30. APPLIED BEHAVIOR ANALYSIS (ABA) SERVICES

317:30-5-310. Purpose

The purpose of this Section is to establish guidelines for the provision of ABA services under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit.

(1) ABA focuses on the analysis, design, implementation, and evaluation of instructional and other environmental modifications to produce meaningful changes in human behavior. ABA services include the use of direct observation, measurement, and functional analysis of the relations between the environment and behavior. Common ABA-based techniques include but are not limited to; discrete trial training (DTT); naturalistic developmental behavioral intervention (NDBI); and verbal behavioral intervention.

(2) ABA may be provided in a variety of settings, including home, community, or clinical. It involves development of an individualized treatment plan that includes transition and aftercare planning, and family/caregiver involvement.

(3) At an initial assessment, target symptoms are identified. A treatment plan is developed to identify core deficits and aberrant behaviors, and includes designated interventions intended to address these deficits and behaviors and that are functional, meaningful, and connected to the member's daily activities routines.

(4) ABA services require prior authorization [refer to Oklahoma Administrative Code (OAC) 317:30-3-31 and 317:30-5-314].

317:30-5-311. Eligible providers and requirements

(a) Eligible ABA provider types include:

(1) Board certified behavior analyst® (BCBA®) – A master's or doctoral level independent practitioner who is certified by the national-accrediting Behavior Analyst Certification Board, Inc.® (BACB®) and licensed by the Oklahoma Human Services' (OKDHS) Developmental Disabilities Services Division (DDS) to provide behavior analysis services. A BCBA may supervise the work of board-certified assistant behavior analysts and registered behavior technicians implementing behavior analytic interventions;

(2) Board-certified assistant behavior analyst® (BCaBA®) – A

bachelor's level practitioner who is certified by the national-accrediting BACB and certified by OKDHS DDS to provide behavior analysis services under the supervision of a BCBA;

(3) Registered behavior technician™ (RBT®) – A high school level or higher paraprofessional who is certified by the national-accrediting BACB and practices under the close and ongoing supervision of a BCBA. The RBT works under the license number of a BCBA and is primarily responsible for the direct implementation of BCBA designed and prescribed behavior-analytic services;

(4) Licensed psychologist – An individual who is licensed and in good standing with the Oklahoma State Board of Examiners of Psychologists and has professional experience in the use of ABA therapy may render behavior analysis services. Refer to OAC 317:30-5-275; and

(5) Human services professional - A practitioner who is licensed by the State of Oklahoma pursuant to (A) - (G), and certified by the national-accrediting BACB, and who is working within the scope of his or her practice, to include:

(A) A licensed physical therapist;

(B) A licensed occupational therapist;

(C) A licensed clinical social worker or social worker candidate under the supervision of a licensed clinical social worker;

(D) A licensed speech-language pathologist or licensed audiologist;

(E) A licensed professional counselor or professional counselor candidate under the supervision of a licensed professional counselor;

(F) A licensed marital and family therapist or marital and family therapist candidate under the supervision of a licensed marital and family therapist; or

(G) A licensed behavioral practitioner or behavioral practitioner candidate under the supervision of a licensed behavioral practitioner.

(b) **Provider criteria.** To direct, supervise, and/or render ABA services, the following conditions shall be met.

(1) A BCBA shall:

(A) Be currently licensed by OKDHS DDS as a BCBA;

(B) Have no sanctions or disciplinary actions by OKDHS DDS or the BACB;

(C) Have no current overpayment(s) due to SoonerCare, and no Medicare or Medicaid sanctions or exclusions from participation in federally funded programs; and

(D) Be fully contracted with SoonerCare as a provider.

(2) A BCaBA shall:

(A) Be currently certified by OKDHS DDS as a BCaBA;

(B) Work under the supervision of a SoonerCare-contracted

BCBA provider;

(C) Have no current overpayment(s) due to SoonerCare, and no Medicare or Medicaid sanctions or exclusions from participation in federally funded programs; and

(D) Be fully contracted with SoonerCare as a provider.

(3) An RBT shall:

(A) Be currently certified by the national-accrediting BACB as an RBT;

(B) Work under the supervision of a SoonerCare-contracted BCBA provider;

(C) Have no current overpayment(s) due to SoonerCare, and no Medicare or Medicaid sanctions or exclusions from participation in federally funded programs; and

(D) Be fully contracted with SoonerCare as a provider.

(4) A human services professional shall:

(A) Be currently licensed or certified by the State of Oklahoma, in accordance with Section 1928 of Title 59 of the Oklahoma Statutes;

(B) Be currently certified by the national-accrediting BACB;

(C) Have no sanctions or disciplinary actions by the applicable state licensing board or the BACB;

(D) If working under supervision within the scope of his or her practice, have a documented relationship with a fully-licensed human service professional working in a supervisory capacity;

(E) Have no current overpayment(s) due to SoonerCare, and no Medicare or Medicaid sanctions or exclusions from participation in federally funded programs; and

(F) Be fully contracted with SoonerCare as a provider.

317:30-5-312. Treatment plan components and documentation requirements

(a) **Functional behavior assessment (FBA).** The FBA serves as a critical component of the treatment plan and is conducted by a board-certified behavior analyst (BCBA) to identify the specific behavioral needs of the member. The FBA consists of:

(1) Description of the problematic behavior (topography, onset/offset, cycle, intensity, severity);

(2) History of the problematic behavior (long-term and recent);

(3) Antecedent analysis (setting, people, time of day, events);

(4) Consequence analysis; and

(5) Impression and analysis of the function of the problematic behavior.

(b) **Treatment plan.** The treatment plan is developed by a BCBA or a licensed psychologist from the FBA. The treatment plan shall:

(1) Be person-centered and individualized;

(2) Delineate the baseline levels of target behaviors;

(3) Specify long-term and short-term objectives that are defined

in observable, measurable behavioral terms;
(4) Specify criteria that will be used to determine achievement of objectives;
(5) Include assessment and treatment protocols for addressing each of the target behaviors such as include antecedent and consequence interventions, and teaching of replacement skills specific to the function of the identified maladaptive behaviors;
(6) Clearly identify the schedule of services planned and the individuals responsible for delivering the services, including frequent review of data on target behaviors and adjustments in the treatment plan and/or protocols by the BCBA or licensed psychologist as needed;
(7) Include training and supervision to enable board certified assistant behavior analysts (BCaBAs) and registered behavior technicians (RBTs) to implement assessment and treatment protocols;
(8) Include training and support to enable parents and other caregivers to participate in treatment planning and successfully reinforce the established treatment plan in the home and community settings;
(9) Include care coordination involving the parents or caregiver(s), school, state disability programs, and others as applicable; and
(10) Ensure that services are consistent with applicable professional standards and guidelines relating to the practice of applied behavior analysis as well as state Medicaid laws and regulations.

(c) **Documentation requirements.** All ABA services must be documented in the member's record. All assessment and treatment services must include the following:
(1) Date;
(2) Start and stop time for each session/unit billed and physical location where service was provided;
(3) Signature of the provider;
(4) Credentials of provider;
(5) Specific problem(s), goals and/or objectives addressed;
(6) Methods used to address problem(s), goals and objectives;
(7) Progress made toward goals and objectives;
(8) Patient response to the session or intervention; and
(9) Any new problem(s), goals and/or objectives identified during the session.
(10) Treatment plans are not valid until all signatures are present [signatures are required from the member, if fourteen (14) or over (unless the member who by reason of a physical or mental incapacity cannot give consent as defined by state law)], the parent/guardian [if younger than eighteen (18) or otherwise applicable] and the supervising BCBA or licensed psychologist. The signatures may be included in a signature page applicable to

both the assessment and treatment plan if the signature page clearly indicates that the signatories consent and approve of both.

317:30-5-313. Medical necessity criteria for members under twenty-one (21) years of age.

ABA services are considered medically necessary when all the following conditions are met:

(1) The member is under twenty-one (21) years of age with a definitive diagnosis of an Autism Spectrum Disorder (ASD) from the following providers:

(A) Pediatric neurologist or neurologist;

(B) Developmental pediatrician;

(C) Licensed psychologist;

(D) Psychiatrist or neuropsychiatrist; or

(E) Other licensed physician experienced in the diagnosis and treatment of ASD.

(2) A comprehensive diagnostic evaluation or thorough clinical assessment completed by one (1) of the above identified professionals must:

(A) Be completed within the most recent treatment plan; however, the OHCA may request an updated psychological evaluation to be completed prior to the next extension period;

(B) Include a complete pertinent medical and social history, including pre-and perinatal, medical, developmental, family, and social elements; and

(C) Be based on criteria outlined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) or the most current version of the DSM for ASD and/or may also include scores from the use of formal diagnostic tests such as the Autism Diagnostic Interview-Revised (ADI-R), Autism Diagnostic Observation Schedule-2 (ADOS-2), Childhood Autism Rating Scale (CARS) or other tools with acceptable psychometric properties. Screening scales are not sufficient to make a diagnosis and will not be accepted as the only formal scale.

(3) There must be a reasonable expectation that the member will benefit from ABA. The member must exhibit:

(A) The ability/capacity to learn and develop generalized skills to assist with his or her independence; and

(B) The ability to develop generalized skills to assist in addressing maladaptive behaviors associated with ASD.

(4) The member is medically stable and does not require twenty-four (24) hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for individuals with intellectual disabilities (ICF/IID).

(5) The member exhibits atypical or disruptive behavior within

the most recent thirty (30) calendar days that significantly interferes with daily functioning and activities. Such atypical or disruptive behavior may include, but is not limited to:

(A) Impulsive aggression toward others;

(B) Self-injury behaviors;

(C) Intentional property destruction; or

(D) Severe disruption in daily functioning (e.g., the individual's inability to maintain in school, child care settings, social settings, etc.) due to changes in routine activities that have not been helped by other treatments such as occupational therapy, speech therapy, additional psychotherapy and/or school/ daycare interventions.

(6) The focus of treatment is not custodial in nature (which is defined as care provided when the member "has reached maximum level of physical or mental function and such person is not likely to make further significant improvement" or "any type of care where the primary purpose of the type of care provided is to attend to the member's daily living activities which do not entail or require the continuing attention of trained medical or paramedical personnel.") Interventions are intended to strengthen the individual's/parent's/legal guardian's capacity for self care and self sufficiency to decrease interventions in the home by those other than the parent(s)/legal guardian(s).

(7) It has been determined that there is no less intensive or more appropriate level of service which can be safely and effectively provided.

317:30-5-314. Prior authorization

Eligible providers must submit an initial prior authorization request to the Oklahoma Health Care Authority (OHCA) or its designated agent. Prior authorization requests shall be granted up to six (6) months of ABA treatment services at one (1) time unless a longer duration of treatment is clinically indicated. The number of hours authorized may differ from the hours requested on the prior authorization request based on the review by an OHCA reviewer and/or physician. If the member's condition necessitates a change in the treatment plan, the provider must request a new prior authorization. The prior authorization request must meet the following SoonerCare criteria for ABA services.

(1) The criteria include a comprehensive behavioral and FBA outlining the maladaptive behaviors consistent with the diagnosis of ASD and its associated comorbidities. In addition to completing the initial request form, providers will be required to submit documentation that will consist of the following:

(A) Information about relevant medical status, prior assessment results, response to prior treatment, and other relevant information gathered from review of records and past assessments.

(B) Information gathered from interview of family and/or caregivers, rating scales, and social validity measures to assess perceptions of the client's skill deficits and behavioral excesses, and the extent to which these deficits impede the daily life of the member and the family.

(C) Direct assessment and observation, including any data related to the identified problem behavior. The analysis of such data serves as the primary basis for identifying pretreatment levels of functioning, developing, and adapting treatment protocols, and evaluating response to treatment and progress towards goals.

(D) Functional assessment of problem behavior that includes antecedent factors, skill deficits, and consequences contributing to the problem behavior. The treatment plan should address all three (3) areas, including antecedent interventions, teaching replacement skills, and modification of consequences.

(2) The prior authorization for ABA treatment will be time limited for up to thirty (30) hours per week unless other hours are deemed medically necessary and authorized through a prior authorization request and must:

(A) Be a one-on-one encounter (face to face between the member and ABA provider) except in the case of family adaptive treatment guidance;

(B) Be child-centered and based upon individualized goals that are strengths-specific, family focused, and community based;

(C) Be culturally competent and the least intrusive as possible;

(D) Clearly define in measurable and objective terms the intervention plan so it can address specific target behaviors. The intervention plan should be clearly linked to the function of the maladaptive behavior and include antecedent interventions, replacement skills to be taught, and modification of consequences. Additional goals may be identified that are related to the core deficits of ASD and are prioritized based on current research and social significance for the individual.

(E) Record the frequency, rate, symptom intensity/duration, or other objective measures of baseline levels;

(F) Set quantifiable criteria for progress;

(G) Establish and record behavioral intervention techniques that are appropriate to target behaviors. The detailed treatment plan utilizes reinforcement and other behavioral principles and excludes the use of methods or techniques that lack consensus about their effectiveness based on evidence in peer-reviewed publications;

(H) Specify strategies for generalization of learned skills beyond the clinical settings such as in the home or other

community settings;
(I) Document planning for transition through the continuum of interventions, services, and settings, as well as discharge criteria. Treatment (behavioral training) will be individualized, and documentation will support the identified atypical or disruptive behavior.
(J) Include parent(s)/legal guardian(s) in behavioral training techniques so that they can practice additional hours of intervention on their own. The treatment plan is expected to achieve the parent(s)/legal guardian(s) ability to successfully reinforce the established plan of care and support generalization of skills in the home and community settings. Frequency of parental involvement will be determined by the treatment provider and listed on the treatment plan;
(K) Document parent(s)/legal guardian(s) participation in the training of behavioral techniques in the member's medical record. Parent(s)/legal guardian(s)' participation is critical to the generalization of treatment goals to the member's environment; and
(L) Ensure that recommended ABA services do not duplicate, or replicate services received in a member's primary academic education setting or provided within an Individualized Education Plan (IEP), Individualized Service Plan (ISP), or any other individual plan of care. Documentation may be requested by the OHCA to support coordination of services with other providers and to prevent overlap and duplication of services including those in school settings.

317:30-5-315. ABA extension requests

Extension requests for ABA services must be submitted to the OHCA or its designated agent. Extension requests must contain the appropriate documentation validating the need for continued treatment and establish the following:

(1) Eligibility criteria in OAC 317:30-5-313;
(2) The frequency of the target behavior has diminished since last review, or if not, there has been modification of the treatment or additional assessments have been conducted;
(3) A functional analysis shall be completed by the provider when no measurable progress has occurred, or it may be requested by the OHCA. The functional analysis should record the member's serious maladaptive target behavioral symptom(s) and precipitants, and document the modifications of the current treatment plan to address progress, as well as make a determination of the function a particular maladaptive behavior serves for the member in the environmental context;
(4) Appropriate consultations from other staff or experts have occurred (to optimize psychiatric medications and medical treatments to include but not limited to psychiatric consults, pediatric evaluation for other conditions, etc.) and

interventions have been changed, including the number of hours per week of service or setting (higher level of care);
(5) The OHCA may suggest appropriate consultation from other staff or experts during the process of prior authorization;
(6) Parent(s)/legal guardian(s) have received re-training on these changed approaches; and
(7) The treatment plan documents a gradual tapering of higher intensities of intervention and transitioning to supports from other sources (i.e., schools) as progress allows.

317:30-5-316. Reimbursement methodology

SoonerCare shall provide reimbursement for ABA services in accordance with the Medicaid State Plan.

(1) Payment shall only be made to SoonerCare-contracted groups or qualified individual providers who are currently licensed and in good standing. Payment is not made to under supervision ABA practitioners/paraprofessionals, including but not limited to, BCaBAs and RBTs.
(2) Reimbursement for ABA services is only made on a fee-for-services basis. The maximum allowable fee for a unit of service has been determined by OHCA to be a reasonable fee, consistent with efficiency, economy, and quality of care. Payment for covered services is the lower of the provider's actual billed charges, consistent with the provider's usual and customary charge to the general public for the service, or the maximum allowable per unit of service.
(3) Reimbursement shall only be made for services that have been prior authorized by OHCA or its designee; and performed on an individualized basis and not in a group setting except for family adaptive behavior treatment guidance by a qualified ABA provider (OAC 317:30-5-311).
(4) Providers may only concurrently bill current Procedural Terminology (CPT) codes when they outline in the prior authorization the following criteria:
(A) The BCBA or licensed psychologist meet with the member and/or parent/guardian and are directing the RBT through one (1) or more of the following:
(i) Selection of treatment targets;
(ii) Collaboration with family members and other stakeholders;
(iii) Training RBTs;
(iv) Creating materials, gathering materials; and/or
(v) Reviewing data.
(B) The BCBA or licensed psychologist used behavior training in session. Behavioral skills training consists of instructions, modeling, rehearsal, and feedback between provider and member.
(5) Reimbursement for ABA services shall not be made to or for

services rendered by a parent, legal guardian, or other legally responsible person.

I.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 5. PHARMACIES
317:30-5-87 [AMENDED]
(REFERENCE APA WF # 21-33)

317:30-5-87. 340B Drug Discount Program

~~(a) The purpose of this Section is to provide special provisions for providers participating in the 340B Drug Discount program. The 340B Drug Discount program special provisions apply to a provider that has asserted it is a "covered entity" or a contract pharmacy for a covered entity under the provisions of 42 U.S.C. § 256b of the United States Code (otherwise known as the 340B Drug Discount Program).~~

~~(b) Covered Entities.~~

~~(1) The covered entity must notify OHCA in writing within 30 days of any changes in 340B participation, as well as any changes in name, address, NPI number, etc.~~

~~(2) The covered entity must maintain their status on the HRSA Medicaid exclusion file and report any changes to OHCA within 30 days.~~

~~(3) The covered entity must execute a contract addendum with OHCA in addition to their provider contract.~~

~~(4) To prevent a duplicate discount, quarterly adjustments will be made to all pharmacy or medical claims for drugs submitted by the covered entity. OHCA will adjust each claim by subtracting the 340B Ceiling Price from the amount reimbursed and multiplying the difference by the quantity submitted. All drugs shall be adjusted by the 340B Ceiling Price whether purchased through the 340B program or otherwise when billed using the registered SoonerCare NPI number on the HRSA Medicaid Exclusion File. OHCA will use the 340B Ceiling Price applicable to the quarter in which the claim is paid.~~

~~(c) Contract pharmacies for covered entities may be permitted to bill drug products purchased under the 340B Drug Discount Program to the Oklahoma Medicaid Program when certain conditions are met and an agreement is in place between OHCA, the contract pharmacy and the covered entity. These pharmacies will be subject to the recovery process stated above.~~

(a) The 340B Drug Discount Program is a drug-pricing program established under section 256b of Title 42 of the United States Code (U.S.C) under which a manufacturer of covered outpatient drugs agrees that it will not charge a 340B covered entity more than the 340B price for a 340B covered outpatient drug.

(b) Covered entities participating in the 340B Drug Discount Program will adhere to the following provisions outlined in this Section and as defined in 42 U.S.C. §256b. Covered entities must:

(1) Notify the OHCA Pharmacy Department in writing within thirty (30) days of any changes in 340B Program participation, as well as any changes in name, address, National Provider Identification (NPI) number, etc.

(2) Maintain their status on the Health Resources & Services Administration (HRSA) Medicaid Exclusion File (MEF) and report any changes to the OHCA within thirty (30) days.

(3) Execute a contract addendum with the OHCA in addition to their provider contract.

(c) To prevent a duplicate discount, quarterly adjustments will be made to all pharmacy or medical claims for drugs submitted by covered entities when billed using the registered SoonerCare NPI number on the MEF.

(1) All pharmacy claims submitted by covered entities shall be adjusted by the 340B ceiling price whether purchased through the 340B Program or otherwise.

(2) Medical claims submitted by covered entities with procedure code modifiers indicating the use of the 340B purchased drugs shall be adjusted by the 340B ceiling price. OHCA will adjust each claim by subtracting the 340B ceiling price from the amount reimbursed and multiplying the difference by the quantity submitted. OHCA will use the 340B ceiling price applicable to the quarter in which the claim is paid. Medical claims submitted by covered entities with a procedure code modifier indicating the use of non 340B purchased drugs will not be adjusted by the 340B ceiling price and will be submitted for federal rebates as required by CMS. Covered entities are required to use an appropriate procedure code modifier on all physician administered drug lines when submitting medical claims.

(d) Contract pharmacies for covered entities may be permitted to bill drug products purchased under the 340B Drug Discount Program to the Oklahoma Medicaid Program when certain conditions are met and an agreement is in place between the OHCA, the contract pharmacy, and the covered entity. These pharmacies will be subject to the recovery process stated in this Section.

J.
TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 21. OUTPATIENT BEHAVIORAL HEALTH AGENCY SERVICES
317:30-5-240.1 [AMENDED]
PART 24. CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS
317:30-5-266 [AMENDED]
317:30-5-267 [AMENDED]
(REFERENCE APA WF # 21-34)

317:30-5-240.1. Definitions

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

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

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

(B) American Osteopathic Association (AOA);

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

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

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

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

(G) ~~other~~Other OHCA approved accreditation.

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

"AOD" means ~~Alcohol~~alcohol and ~~Other Drug~~other drug.

"AODTP" means ~~Alcohol and Other Drug Treatment Professional~~alcohol and other drug treatment professional.

"ASAM" means the American Society of Addiction Medicine.

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

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

"BHAs" means ~~Behavioral Health Aides~~behavioral health aides.

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

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

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

"Client Assessment Record (CAR)" means the ~~use of~~ standardized tool recognized by OHCA and ODMHSAS to evaluate the functioning of

the member as per the OHCA prior authorization manual on the OHCA'S website at www.oklahoma.gov/ohca.

"CM" means case management.

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

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

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

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

"FBCS" means ~~Facility Based Crisis Stabilization~~facility-based crisis stabilization.

"FSPs" means ~~Family Support Providers~~family support providers.

"ICF/IID" means ~~Intermediate Care Facility for Individuals with Intellectual Disabilities~~intermediate care facility for individuals with intellectual disabilities.

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

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

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

Abuse (SA) treatment.

"LBHP" means a licensed behavioral health professional.

"MST" means the EBP Multi-Systemic Therapy.

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

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

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

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

"OHCA" means the Oklahoma Health Care Authority.

"OJA" means the Office of Juvenile Affairs.

"O.S." means Oklahoma Statutes.

"RBMS" means ~~Residential Behavioral Management Services~~residential behavioral management services within a group home or therapeutic foster home.

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

"PRSS" means ~~Peer Recovery Support Specialist~~peer recovery support specialist.

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

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

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

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

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

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

(ii) Experience difficulties that substantially interfere with or limit a child or adolescent from achieving or

maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills. There is functional impairment in at least two (2) of the following capacities (compared with expected developmental level):

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

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

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

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

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

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

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

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

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

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

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

capacities (compared with expected developmental level):

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

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

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

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

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

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

PART 24. CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS

317:30-5-266. Covered services

CCBHCs provide a comprehensive array of services that create access, stabilize people in crisis, and provide the needed treatment and recovery support services for those with the most serious and complex mental health and substance use disorders. CCBHCs integrate additional services to ensure an approach to health care that emphasizes recovery, wellness, trauma-informed care, and physical-behavioral health integration. Initial screening, assessment, and diagnosis must be completed in order to receive a covered service. Services must be medically necessary and recommended by an LBHP or licensure candidate (see OAC 317:30-5-263). Services are covered when provided in accordance with a person-centered and family-centered service plan. Coverage includes the following services:

(1) **Crisis assessment and intervention services.**

(A) **Service requirements.** This service is an immediately available service designed to meet the psychological, physiological, and environmental needs of individuals who are experiencing mental health and/or substance use disorder crises. Services include the following:

(i) Twenty-four (24) hours mobile crisis teams [see OAC 317:30-5-241.4(a) for service definition]. Reimbursement

is triggered by the LBHP/licensure candidate crisis assessment;

(ii) Emergency crisis intervention service [see OAC 317:30-5-241.4(a) for service definition]; ~~and~~

(iii) Facility-based crisis stabilization [see OAC 317:30-5-241.4(b) for service definition], provided directly by the CCBHC or by a State-sanctioned alternative~~.~~; and

(iv) Urgent recovery clinic (URC) services provided in accordance with OAC 450:23-3-20 through 450:23-3-24.

(B) **Qualified professionals.** Twenty-four (24) hours mobile crisis intervention is provided by either a team consisting of an LBHP/licensure candidate and a CM II or CADC, or just an LBHP/licensure candidate. Emergency crisis intervention is provided by an LBHP/licensure candidate. Facility-based crisis stabilization is provided by a team, directed by a physician, and consisting of an LBHP/licensure candidate, licensed nurses, CM II or CADC, and PRSS staff. URC services are provided by an LBHP/licensure candidate with supervision from a physician or APRN with prescribing authority.

(2) **Behavioral health integrated (BHI) services.**

(A) **Service requirements.** This service includes activities provided that have the purpose of coordinating and managing the care and services furnished to each member, assuring a fixed point of responsibility for providing treatment, rehabilitation, and support services. This service includes, but is not limited to:

(i) Care coordination for primary health care, specialty health care, and transitional care from emergency departments, hospitals, and PRTFs;

(ii) Ensuring integration and compatibility of mental health and physical health activities;

(iii) Providing on-going service coordination and linking members to resources;

(iv) Tracking completion of mental and physical health goals in member's comprehensive care plan;

(v) Coordinating with all team members to ensure all objectives of the comprehensive care plan are progressing;

(vi) Appointment scheduling;

(vii) Conducting referrals and follow-up monitoring;

(viii) Participating in hospital discharge processes; and

(ix) Communicating with other providers and members/family.

(B) **Qualified professionals.** This service is performed by an LBHP/licensure candidate, nurse, CM II or CADC, and/or PRSS staff.

(3) **Person-centered and family-centered treatment planning.**

(A) **Service requirements.** This service is a process in which the information obtained in the initial screenings and assessments are used to develop a treatment plan that has

individualized goals, objectives, activities, and services that will enable the member to improve. For children assessed as SED with significant behavioral needs, treatment planning is a wraparound process consistent with System of Care values. A wraparound planning process supports children and youth in returning to or remaining in the community.

(B) **Qualified professionals.** This service is conducted by LBHPs/licensure candidates, nurses, CM II or CADC, and/or PRSS staff. Treatment planning must include the member and involved practitioners.

(4) **Psychotherapy (individual / group / family).**

(A) **Service requirements.** See OAC 317:30-5-241.2 for service definitions and requirements. Fee-for-service billing limitations do not apply.

(B) **Qualified professionals.** This service is conducted by an LBHP/licensure candidate.

(5) **Medication training and support.**

(A) **Service requirements.** This service includes:

(i) A review and educational session focused on the member's response to medication and compliance with the medication regimen and/or medication administration;

(ii) Prescription administration and ordering of medication by appropriate medical staff;

(iii) Assisting the member in accessing medications;

(iv) Monitoring medication response and side effects; and

(v) Assisting members with developing the ability to take medications with greater independence.

(B) **Qualified professionals.** This service is performed by an RN, APRN, or a physician assistant (PA) as a direct service under the supervision of a physician.

(6) **Psychosocial rehabilitation services (PSR).**

(A) **Service requirements.**

(i) Adult. PSR services are face-to-face behavioral health rehabilitation (BHR) services which are necessary to improve the member's ability to function in the community. They are performed to improve the skills and abilities of members to live independently in the community, improve self-care and social skills, and promote lifestyle change and recovery practices. Rehabilitation services may be provided individually or in group sessions through the format of curriculum-based education and skills training. This service is generally performed with only the member and the qualified provider, but may include a member and the member's family/support system when providing educational services from a curriculum that focuses on the member's diagnosis, symptom management, and recovery. A member who, at the time of service, is not able to cognitively benefit from the treatment due to active hallucinations, substance abuse, or other impairments, is

not suitable for this service. Family involvement is allowed for support of the member and education regarding his/her recovery but does not constitute family therapy, which requires a licensed provider. Eligibility requirements and billing limits found in OAC 317:30-5-241.3 do not apply.

(ii) Children. PSR services are an array of services that are provided in the child's home, in the location where behavioral challenges are most likely to occur such as school, or in community settings for all children, youth, and young adults ages zero (0) to twenty (20). PSR services must be provided in a context that is child-centered, family-focused, strength-based, culturally competent, and responsive to each child's psychosocial, developmental, and treatment care needs. PSR service array includes:

(I) Intensive in-home services;

(II) Therapeutic behavioral services;

(III) Intensive family intervention; and

(IV) Intensive outpatient substance abuse rehabilitation.

(B) **Qualified professionals.** This service is solely restorative in nature and may be performed by a behavioral health CM II, CADC, LBHP, or licensure candidate, following development of a service plan and treatment curriculum approved by an LBHP or licensure candidate. ~~The behavioral health CM II and CADC~~For children, services are typically provided by a team that can offer a combination of therapy from a LBHP or licensure candidate and skills training and support from a paraprofessional [CM II, behavioral health aide (BHA)]. The behavioral health CM II, CADC, and BHA must have immediate access to an LBHP who can provide clinical oversight and collaborate with the qualified PSR provider in the provision of services.

(7) **Psychoeducation and counseling.**

(A) **Service requirements.** This service is designed to restore, rehabilitate, and support the individual's overall health and wellness. Services are intended for members to provide purposeful and ongoing psychoeducation and counseling that are specified in the individual's person-centered, individualized plan of care. For children and their families, treatment services are an array of therapeutic strategies and services designed to ameliorate or reduce the risk of social, emotional, and behavioral disorders and disruptions in the relationship between an infant and parent/caregiver. Such disorders and disruptions may be due to infant/toddler and/or parent/caregiver vulnerabilities and/or negative environmental factors that are significantly impacting the infant and/or parent/caregiver-infant relationship. Treatment

services are grounded in attachment theory and are relationship focused. Components include:

(i) Delivery of manualized wellness management interventions via group and individual work such as WRAP or IMR/WMR; and

(ii) Emotional support, education, resources during periods of crisis, and problem-solving skills.

(B) **Qualified professionals.** For children, zero (0) to five (5) years old, this service is provided by an LBHP or licensure candidate. For all other ages, this service is provided by a licensed nurse, licensed nutritionist, or CM II or CADC within the scope of their licensure, certification, and/or training.

(8) **Peer recovery support services.**

(A) **Service requirements.** See OAC 317:30-5-241.5(d) for service requirements.

(B) **Qualified professionals.** PRSS must be certified through ODMHSAS pursuant to OAC 450:53.

(9) **Family support and training.**

(A) **Service requirements.** See OAC 317:30-5-241.5(c) for service requirements.

(B) **Qualified professionals.** Family support providers must be trained/credentialed through ODMHSAS.

(10) **Screening, assessment, and service planning.**

(A) **Service requirements.** See OAC 317:30-5-241.1 for service requirements. Service billing limitations found in OAC 317:30-5-241.1 do not apply.

(B) **Qualified professionals.** Screenings can be performed by any qualified team member as listed in OAC 317:30-5-265(b). Assessment and service planning can only be performed by an LBHP or licensure candidate.

(11) **Occupational therapy.**

(A) **Service requirements.** This service includes the therapeutic use of everyday life activities (occupations) with an individual or groups for the purpose of participation in roles and situations in home, school, workplace, community, and other settings for the purpose of promoting health and wellness. Occupational therapy services are provided to those who have developed an illness, injury, disease, disorder, condition, impairment, disability, activity limitation, or participation restrictions. Occupational therapy addresses the physical, cognitive, psychosocial, sensory, and other aspects of performance in a variety of contexts to support engagement in everyday life activities that affect health, well-being, and quality of life.

(B) **Qualified professionals.** This service is solely restorative in nature and provided by a qualified occupational therapist who is contracted with the OHCA or an

occupational therapist assistant who is working under the supervision of a licensed occupational therapist (see OAC 317:30-5-295).

(C) **Coverage limitations.** In order to be eligible for SoonerCare reimbursement, occupational therapy services must be prior authorized and/or prescribed by a physician or other licensed practitioner of the healing arts, in accordance with State and federal law, including, but not limited to, OAC 317:30-5-296, OAC 317:30-5-1020, and 42 C.F.R. § 440.110.

(12) Behavioral health targeted case management.

(A) Service requirements. See OAC 317:30-5-241.6 for service requirements.

(B) Qualified professionals. This service is provided by a CM II certified in accordance with OAC 450:50.

(C) Coverage limitations. Services are provided to individuals of all ages who meet medical necessity criteria.

(13) Outpatient substance abuse prevention counseling.

(A) Service requirements. This service provides counseling to enable individuals to successfully resist social and other pressures to engage in destructive activities.

(B) Qualified professionals. This service must be recommended by a physician or licensed practitioner and provided by LBHP/licensure candidate.

(C) Coverage limitations. Services are provided to individuals under age twenty-one (21) who meet medical necessity criteria.

317:30-5-267. Reimbursement

(a) In order to be eligible for payment, CCBHCs must have an approved provider agreement on file with the OHCA. Through this agreement, the CCBHC assures that OHCA's requirements are met and assures compliance with all applicable federal and state Medicaid law, including, but not limited to, OHCA administrative rules, ODMHSAS administrative rules, the Code of Federal Regulations, and the Oklahoma State Medicaid Plan. These agreements are renewed annually with each provider.

(b) Reimbursement is made using a provider-specific prospective payment system (PPS) rate developed based on provider-specific cost report data. The PPS rate varies by category and level of service intensity and is paid when a CCBH program delivers at least one (1) CCBHC covered service, and when a valid individual procedure code is reported for the calendar month. ~~Care coordination services do not trigger a PPS payment when billed alone in a calendar month.~~ For reimbursement purposes, members are categorized as follows, and are assigned to special populations by the State:

(1) Standard population;

(2) Special population 1. This population includes individuals eighteen (18) years of age and over with SMI and complex needs

including those with co-occurring substance use disorder (SUD). Individuals between eighteen (18) and twenty-one (21) years of age can be served in either special population 1 or 2 depending on the member's individualized needs; and

(3) Special population 2. This population includes children and youth [ages six (6) through twenty-one (21)] with SED and complex needs, including those with co-occurring mental health and SUD.

~~(c) Payments for services provided to non-established clients will be separately billable. Non-established CCBH clients are those who receive crisis services directly from the CCBHC without receiving a preliminary screening and risk assessment by the CCBHC and those referred to the CCBHC directly from other outpatient behavioral health agencies for pharmacologic management.~~

~~(d) Additional reimbursement may be made to the CCBHC once in the same calendar month as the PPS payment for care coordination provided by CCBHC staff to members who are involved in a drug court or other specialty court program. Physician services provided to these members by the CCBHC are reimbursable using the SoonerCare fee schedule.~~

~~(e) Reimbursement rates will be reviewed bi-annually and updated as necessary by the Medicare Economic Index (MEI).~~

(c) Preliminary screening, risk assessment, and care coordination services are required activities to establish CCBHC members but do not trigger a PPS payment. An additional, qualifying service must be provided in the calendar month for the CCBHC to receive the PPS payment.

(d) Payments for services provided to non-established CCBHC members will be separately billable. Non-established CCBHC members are those who receive crisis services directly from the CCBHC without receiving a preliminary screening and risk assessment by the CCBHC and who are not established at another CCBHC, and those referred to the CCBHC directly from other outpatient behavioral health agencies for pharmacologic management.

(e) Additional reimbursement may be made to the CCBHC once in the same calendar month as the PPS payment for care coordination provided by CCBHC staff to members who are involved in a drug court or other specialty court program. Physician services provided to these members by the CCBHC are reimbursable using the SoonerCare fee schedule.

(f) Initial provider-specific rates are rebased after one (1) year based on actual cost and visit data. All other provider-specific rates are rebased once every two (2) years. Provider-specific rates are updated between rebasing periods based on the Medicare Economic Index (MEI).

(g) Providers may receive a provider-specific rate adjustment for changes in scope expected to change payment rates by two point five percent (2.5%) or more, once per year, subject to State approval in accordance with the Oklahoma Medicaid State Plan.