

## **AGENDA**

March 12, 2020  
1:00 PM – 3:30 PM

Charles Ed McFall Board Room

- I. Welcome, Roll Call, and Public Comment Instructions: **Chairman, Jason Rhynes**
- II. Action Item: Approval of Minutes of the January 9<sup>th</sup>, 2020: **Medical Advisory Committee Meeting**
- III. MAC Member Comments/Discussion
- IV. Financial Report: **Aaron Morris, Chief Financial Officer**
- V. SoonerCare Operations Update: **Melinda Thomason, Senior Director for Stakeholder Engagement**
- VI. Legislative Update: **Christina Foss, Legislative Liaison**
- VII. Proposed Rule Changes: Presentation, Discussion, and Vote: **Sandra Puebla, Director of Federal & State Authorities**
  - A. **19-10 American Indian/Alaska Native (AI/AN) Cost Sharing Exemptions**
  - B. **19-15 Rural Health Clinic (RHC)**
  - C. **19-24 Urine Drug Screening and Laboratory Services Policy**
  - D. **19-25 Polymerase Chain Reaction (PCR) Testing for Infectious Diseases**
  - E. **19-26 Countable Income and Resources for the (ABD) Eligibility Groups and Eligibility as a (QMB) Plus Member**
  - F. **19-27 Ground Emergency Medical Transportation (GEMT) Supplemental Payment Program**
  - G. **19-29 Reasonable Limits for Necessary Medical and Remedial Care Not covered under the Oklahoma Medicaid State Plan**
  - H. **19-32 Inpatient Psychiatric Services and Service Quality Review (SQR) Revisions**
  - I. **19-34 ADvantage Waiver**
  - J. **19-35 Developmental Disabilities Services (DDS)**
  - K. **19-37 Mobile and Portable Dental Treatment Facilities**
  - L. **19-41A Patient-Centered Medical Home (PCMH), Health Access Networks (HAN), and Health Management Program (HMP) Updates**
  - M. **19-41B Insure Oklahoma Individual Plan (IP) and Insure Oklahoma Employer Sponsored Insurance (ESI)**
  - N. **19-42 Adult Inpatient Rehabilitation Days**
  - O. **19-43A Coverage Definitions for Children and Adults**

- P. 19-43B Coverage Definitions for Children and Adults**
- Q. 19-44 Organ Transplant**
- R. 19-45 Private Duty Nursing (PDN) Revisions**
- S. 19-46 School-Based/Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Revisions**
- T. 19-47 Medically Necessary Extractions Revisions**
- U. 20-01 High-Investment Drugs Carve-Out**
- V. 20-03 Treatment of Lottery or Gambling Winnings for Income Eligibility**

VIII. Public Comments on Proposed Rules (2 minute limit)

IX. New Business: Chairman, Jason Rhynes

X. Future Meeting:

May 14, 2020

July 9, 2020

September 10, 2020

November 12, 2020

XI. Adjourn

Oklahoma Health Care Authority  
MEDICAL ADVISORY COMMITTEE  
MINUTES of the January 9, 2020 Meeting  
4345 N. Lincoln Blvd., Oklahoma City, OK 73105

**I. Welcome, Roll Call, and Public Comment Instructions:**

Chairman, Dr. Jason Rhynes called the meeting to order at 1:00 PM.

***Delegates present were:*** Dr. Erin Balzer, Dr. Joe Catalano, Dr. Steven Crawford, Ms. Wanda Felty, Dr. Arlen Foulks, Ms. Terrie Fritz, Dr. Lori Holmquist-Day, Mr. Mark Jones, Dr. Daniel Post, Ms. Kristi Balckburn, Ms. Tina Johnson, Dr. Jason Rhynes, Dr. Dwight Sublett, Mr. Rick Snyder, Mr. William Whited, Dr. Paul Wright, and Dr. Whitney Yeates.

***Alternates present were:*** Ms. Lindsay Hanna and Ms. Lois Baer providing a quorum.

***Delegates absent without an alternate were:*** Ms. Debra Billingsly, Mr. Victor Clay, Mr. Brett Coble, Ms. Allison Garrison, Mr. Steve Goforth, Ms. Annette Mays, Mr. James Patterson, Ms. Toni Pratt-Reid, Ms. Carrie Slatton-Hodges, Dr. Raymond Smith, and Mr. Jeff Tallent.

**II. Approval of the November 7th, 2019 Minutes**

Medical Advisory Committee

**The motion to approve the minutes was by Dr. Daniel Post and seconded by Dr. Dwight Sublett with an abstention from Ms. Kristi Blackburn and passed unanimously.**

**III. Public Comments (2 minute limit):**

There were no public comments made at this meeting.

**IV. MAC Member Comments/Discussion:**

There were no MAC Member comments.

**V. Financial Report:**

Tasha Black, Senior Director of Financial Services

Ms. Black presented the financial report ending in September 2019. OHCA is 1.3% under budget in revenues and 1.8% under budget in expenditures with the result that our budget variance is a positive 4,732,196 dollars. The budget variance is primarily attributed to the following: Medicaid Program Variance is a positive 5.1 million state dollars, and administration is a positive 0.5 million state dollars. Drug Rebate is 2.4 million state dollars under budget. Taxes and Fees, which also included tobacco tax is 1.2 million state dollars over budget, and Medical refunds is 0.3 million state dollars over budget. For more detailed information, see item 5 in the MAC agenda.

**VI. SoonerCare Operations Update:**

Melinda Thomason, Senior Director for Stakeholder Engagement

Ms. Thomason presented the SoonerCare Operations update to the committee. Information is based on data for November 2019. Patient Centered Medical Home enrollment is at 527,191 which is up by 2,669. Sooner Care Traditional has a current enrollment of 232,760 which is 2,239 less than the previous month. SoonerPlan is up by 9, giving a total number of 27,723. Insure Oklahoma has a total enrollment of 18,382, of which 13,061 are in the Employee Sponsored Plan, and 5,321 are in the individual plan. In total, SoonerCare enrollment is at 806,056. Total in-state providers is up 355, giving a total of 44,437.

Ms. Thomason also gave the presentation “All things SoonerCare”. Ms. Thomason gave some background on the Oklahoma Health Care Authority (OHCA), Oklahoma’s current Medicaid program, Partial benefit programs, Agency program areas, Behavioral Health programs, and a few of OHCA external partners and shared programs. For more detailed information, see item 6 in the MAC agenda.

**VII. Proposed Rule Changes: Presentation, Discussion, and Vote:**

Sandra Puebla, Director of Federal & State Authorities

A face-to-face tribal consultation regarding the following proposed changes was held on Tuesday, November 5, 2019 in the Charles Ed McFall Boardroom of the Oklahoma Health Care Authority (OHCA).

The following work folders will be posted on the OHCA public website for a comment period through January 15, 2020.

**19-21 Claim Inquiry Policy** — The proposed policy revisions are necessary due to a new streamlined electronic process developed by OHCA for providers. The revisions will outline how providers can request a review of submitted claims and how to submit supporting documentation for their request through the OHCA provider portal. The electronic review process will replace the previous manual process of submitting paper forms and documentation to a post office box.

**Budget Impact: Budget neutral**

**The rule change motion to approve was by Mr. Joe Catalano and seconded by Dr. Steven Crawford and passed unanimously.**

**19-22 Expedited Appeals** — The proposed revisions will add language to specify that requests for expedited appeal hearings should be sent to the Administrative Law Judge (ALJ) with a copy sent to the OHCA. Additionally, the appeal hearing request shall specify the services denied and the specific reason(s) why a regular 30-day appeal will seriously jeopardize the life or health of the member requesting an expedited appeal hearing.

**Budget Impact: Budget neutral**

**The rule change motion to approve was by Dr. Dwight Sublett and seconded by Dr. Steven Crawford and passed unanimously.**

**19-23 Free-Standing Birthing Centers** — The policy for free-standing birthing centers is being revoked as this type of provider no longer exists in Oklahoma.

**Budget Impact: Budget neutral**

**The rule change motion to approve was by Dr. Paul Wight and seconded by Dr. Dwight Sublett and passed unanimously.**

**19-30 The Oklahoma Office of Juvenile Affairs (OJA) Targeted Case Management (TCM) Services** — The proposed rule changes, requested by OJA, will increase the maximum eligible age for individuals who are involved in or at serious risk of involvement with the juvenile justice system and who are eligible for TCM services from eighteen (18) to under twenty-one (21). Additionally, the proposed revisions will align and reorganize TCM policy with the current evidence-based practices used by OJA.

**Budget Impact: The estimated budget impact for State Fiscal Year (SFY) 2021 will be an increase in the total amount of \$1,703,215; with \$578,752 in state share. The estimated budget impact for SFY 2022 will be an increase in the total amount of \$2,270,953; with \$771,670 in state share. The state share will be paid by OJA.**

**The rule change motion to approve was by Dr. Arlen Foulks and seconded by Dr. Steven Crawford and passed unanimously.**

**19-31 Nursing Licensure Revisions** — The proposed revisions will comply with Oklahoma House Bill (HB) 2351, which allows Oklahoma to enter into the enhanced Nurse Licensure Compact (eNLC). The eNLC is an agreement between states that allows a nurse's licensure to be portable to other member-states of the Compact. These revisions amend references that narrowly tie a nurse's license to the Oklahoma Board of Nursing and align SoonerCare rules with the eNLC.

**Budget Impact: Budget neutral**

**The rule change motion to approve was by Dr. Joe Catalano and seconded by Ms. Terrie Fritz and passed unanimously.**

**19-33 Indian Health Services, Tribal Programs, and Urban Indian Clinics (I/T/Us) Obstetrical (OB) Care** — The proposed revisions will clarify how I/T/U OB providers should bill for OB care. I/T/Us have the option of either billing for OB encounters or a bundled rate for total OB care. The clarification will require I/T/Us to be specific when choosing a billing method as they are only allowed to choose one of the billing methods.

**Budget Impact: Budget neutral**

**The rule change motion to approve was by Dr. Paul Wright and seconded by Dr. Steven Crawford and passed unanimously.**

**19-36 Programs of All-Inclusive Care for the Elderly (PACE)** — The proposed revisions will bring the OHCA into compliance with Senate Bill (SB) 888 and federal regulations by adding language to clarify PACE participant enrollment and voluntary disenrollment process and criteria. Revisions will also add language to allow PACE providers to either be a non-profit

or for-profit entity to align with the Social Security Act sections 1894(a)(3)(B) and 1934(a)(3)(B).

**Budget Impact: Budget neutral**

**The rule change motion to approve was by Dr. Paul Wright and seconded by Dr. Joe Catalano and passed unanimously.**

**19-38 Title XXI Parity Compliance** — The proposed revisions will amend policy to remove the two visit limitation for pregnant women covered under the Title XXI State Plan. All visits shall require medical review to deem whether the medical visit affects fetal effect. The revisions are needed to comply with Parity federal regulations which instruct the State to provide equivalent services to all children covered under the Plan.

**Budget Impact: The estimated budget impact for SFY 2021 will be an increase in the total amount of \$337,260; with \$107,957 in state share.**

**The rule change motion to approve was by Dr. Steven Crawford and seconded by Dr. Joe Catalano and passed unanimously.**

**19-39A&B Nursing Home Supplemental Payment Program Revocation** — The proposed revisions will remove rule sections that were created for the nursing home supplemental payment program, a program that was never implemented; the Centers for Medicare and Medicaid Services (CMS) did not ultimately approve the proposal.

**Budget Impact: Budget neutral**

**The rule change motion to approve was by Mr. William Whited and seconded by Dr. Steven Crawford and passed unanimously.**

**19-40 Defunding Statutory Rape Cover-Up Act** — The proposed new rule is needed to comply with House Bill (HB) 2591 which creates the Defunding Statutory Rape Cover-Up Act. The new law requires the OHCA to deny an application for a new or renewed provider agreement, or terminate an existing agreement, if a provider is investigated and found by a court to have failed to report statutory rape. The new rule outlines how an individual can report a complaint or a provider and the actions OHCA can take if the complaint has been found valid.

**Budget Impact: Budget neutral**

**The rule change motion to approve was by Dr. Dwight Sublett and seconded by Dr. Daniel Post and passed unanimously.**

**VIII. New Business: Chairman, Jason Rhynes, O.D.**

No new business was identified.

**IX. Future Meetings**

March 12, 2020

May 14, 2020

July 9, 2020

September 10, 2020

November 12, 2020

Oklahoma Health Care Authority  
MEDICAL ADVISORY COMMITTEE  
MINUTES of the January 9, 2020 Meeting  
4345 N. Lincoln Blvd., Oklahoma City, OK 73105

**X. Adjournment**

Chairman Rhynes asked for a motion to adjourn. Motion was provided by Dr. Steven Crawford and seconded by Ms. Terri Fritz. There was no dissent and the meeting adjourned at 1:46.

DRAFT



## FINANCIAL REPORT

For the Five Month Period Ended November 30, 2019  
Submitted to the CEO & Board

- Revenues for OHCA through November, accounting for receivables, were **\$1,885,737,852** or **1.6% under** budget.
- Expenditures for OHCA, accounting for encumbrances, were **\$1,854,342,807** or **2.4% under** budget.
- The state dollar budget variance through November is a positive **\$14,521,128**.
- The budget variance is primarily attributable to the following (in millions):

<b>Expenditures:</b>	
Medicaid Program Variance	14.4
Administration	0.4
<b>Revenues:</b>	
Drug Rebate	(1.9)
Medical Refunds	1.2
Taxes and Fees	0.4
<b>Total FY 20 Variance</b>	<b>\$ 14.5</b>

### ATTACHMENTS

Summary of Revenue and Expenditures: OHCA	1
Medicaid Program Expenditures by Source of Funds	2
Other State Agencies Medicaid Payments	3
Fund 205: Supplemental Hospital Offset Payment Program Fund	4
Fund 230: Quality of Care Fund Summary	5
Fund 245: Health Employee and Economy Act Revolving Fund	6
Fund 250: Belle Maxine Hilliard Breast and Cervical Cancer Treatment Revolving Fund	7

**OKLAHOMA HEALTH CARE AUTHORITY**  
**Summary of Revenues & Expenditures: OHCA**  
**SFY 2020, For the Five Month Period Ending November 30, 2019**

REVENUES	FY20 Budget YTD	FY20 Actual YTD	Variance	% Over/ (Under)
State Appropriations	\$ 445,783,637	\$ 445,783,637	\$ -	0.0%
Federal Funds	1,134,378,390	1,105,975,449	(28,402,940)	(2.5)%
Tobacco Tax Collections	18,379,793	20,249,694	1,869,901	10.2%
Quality of Care Collections	35,008,237	33,397,816	(1,610,420)	(4.6)%
Prior Year Carryover	20,110,285	20,110,285	-	0.0%
Federal Deferral - Interest	145,192	145,192	-	0.0%
Rate Preservation Fund	12,233,645	12,233,645	-	0.0%
Drug Rebates	125,301,309	119,917,570	(5,383,739)	(4.3)%
Medical Refunds	15,326,509	18,546,117	3,219,608	21.0%
Supplemental Hospital Offset Payment Program	100,767,416	100,767,416	-	0.0%
GME Federal Disallowance Repayment - OU/OSU	6,380,222	6,380,222	-	0.0%
Other Revenues	2,107,180	2,230,808	123,628	5.9%
<b>TOTAL REVENUES</b>	<b>\$ 1,915,921,815</b>	<b>\$ 1,885,737,852</b>	<b>\$ (30,183,963)</b>	<b>(1.6)%</b>

EXPENDITURES	FY20 Budget YTD	FY20 Actual YTD	Variance	% (Over)/ Under
<b>ADMINISTRATION - OPERATING</b>	<b>\$ 24,722,143</b>	<b>\$ 22,271,338</b>	<b>\$ 2,450,805</b>	<b>9.9%</b>
<b>ADMINISTRATION - CONTRACTS</b>	<b>\$ 54,714,676</b>	<b>\$ 52,704,589</b>	<b>\$ 2,010,087</b>	<b>3.7%</b>
<b>MEDICAID PROGRAMS</b>				
<u>Managed Care:</u>				
SoonerCare Choice	18,296,998	17,691,255	605,744	3.3%
<u>Acute Fee for Service Payments:</u>				
Hospital Services	411,310,123	411,430,960	(120,837)	(0.0)%
Behavioral Health	7,719,073	7,982,453	(263,381)	(3.4)%
Physicians	168,427,492	163,094,580	5,332,912	3.2%
Dentists	58,541,574	59,224,217	(682,643)	(1.2)%
Other Practitioners	28,027,718	23,792,622	4,235,096	15.1%
Home Health Care	11,331,541	11,712,986	(381,446)	(3.4)%
Lab & Radiology	11,551,831	10,183,209	1,368,622	11.8%
Medical Supplies	23,756,501	22,765,880	990,621	4.2%
Ambulatory/Clinics	115,816,882	110,049,209	5,767,673	5.0%
Prescription Drugs	279,765,096	274,084,299	5,680,797	2.0%
OHCA Therapeutic Foster Care	8,280	-	8,280	100.0%
<u>Other Payments:</u>				
Nursing Facilities	262,183,767	245,140,775	17,042,991	6.5%
Intermediate Care Facilities for Individuals with Intellectual Disabilities Private	27,573,783	27,675,567	(101,784)	(0.4)%
Medicare Buy-In	73,530,557	74,775,266	(1,244,709)	(1.7)%
Transportation	31,427,418	30,687,437	739,980	2.4%
Money Follows the Person-OHCA	134,420	81,102	53,318	39.7%
Electronic Health Records-Incentive Payments	100,403	100,403	-	0.0%
Part D Phase-In Contribution	43,361,144	43,474,927	(113,783)	(0.3)%
Supplemental Hospital Offset Payment Program	242,022,105	242,022,105	-	0.0%
Telligen	4,634,991	3,397,626	1,237,365	26.7%
<b>Total OHCA Medical Programs</b>	<b>1,819,521,697</b>	<b>1,779,366,880</b>	<b>40,154,818</b>	<b>2.2%</b>
OHCA Non-Title XIX Medical Payments	89,382	-	89,382	0.0%
<b>TOTAL OHCA</b>	<b>\$ 1,899,047,898</b>	<b>\$ 1,854,342,807</b>	<b>\$ 44,705,091</b>	<b>2.4%</b>
<b>REVENUES OVER/(UNDER) EXPENDITURES</b>	<b>\$ 16,873,917</b>	<b>\$ 31,395,045</b>	<b>\$ 14,521,128</b>	

**OKLAHOMA HEALTH CARE AUTHORITY**  
**Total Medicaid Program Expenditures**  
**by Source of State Funds**  
**SFY 2020, For the Five Month Period Ending November 30, 2019**

Category of Service	Total	Health Care Authority	Quality of Care Fund	HEEIA	SHOPP Fund	BCC Revolving Fund	Other State Agencies
SoonerCare Choice	\$ 17,731,782	\$ 17,687,319	\$ -	\$ 40,527	\$ -	\$ 3,936	\$ -
Inpatient Acute Care	517,622,199	258,455,834	202,786	1,367,494	181,748,867	401,932	75,445,286
Outpatient Acute Care	204,009,810	150,207,377	17,335	2,621,008	49,018,395	2,145,696	-
Behavioral Health - Inpatient	34,549,119	4,663,687	-	194,059	10,439,416	-	19,251,957
Behavioral Health - Psychiatrist	4,134,193	3,316,785	-	-	815,427	1,981	-
Behavioral Health - Outpatient	7,820,051	-	-	-	-	-	7,820,051
Behavioral Health-Health Home	10,075,759	-	-	-	-	-	10,075,759
Behavioral Health Facility- Rehab	104,398,057	-	-	-	-	54,573	104,398,057
Behavioral Health - Case Management	1,167,138	-	-	-	-	-	1,167,138
Behavioral Health - PRTF	5,250,654	-	-	-	-	-	5,250,654
Behavioral Health - CCBHC	32,819,070	-	-	-	-	-	32,819,070
Residential Behavioral Management	3,732,019	-	-	-	-	-	3,732,019
Targeted Case Management	18,671,768	-	-	-	-	-	18,671,768
Therapeutic Foster Care	-	-	-	-	-	-	-
Physicians	194,721,087	161,687,717	24,209	2,851,154	-	1,382,655	28,775,353
Dentists	59,234,921	59,218,564	-	10,704	-	5,653	-
Mid Level Practitioners	1,072,399	1,065,026	-	6,250	-	1,123	-
Other Practitioners	22,977,005	22,501,491	185,985	250,532	-	38,996	-
Home Health Care	11,715,538	11,712,241	-	2,552	-	746	-
Lab & Radiology	10,469,404	10,105,221	-	286,195	-	77,988	-
Medical Supplies	22,856,412	21,622,528	1,129,805	90,531	-	13,547	-
Clinic Services	110,563,891	107,064,452	-	827,385	-	106,407	2,565,647
Ambulatory Surgery Centers	2,959,214	2,872,515	-	80,863	-	5,835	-
Personal Care Services	4,490,477	-	-	-	-	-	4,490,477
Nursing Facilities	245,140,927	147,901,597	97,239,179	151	-	-	-
Transportation	30,656,458	29,405,925	1,140,433	46,997	-	63,103	-
IME/DME/GME	81,487,483	-	-	-	-	-	81,487,483
ICF/IID Private	27,675,567	22,673,561	5,002,006	-	-	-	-
ICF/IID Public	12,333,478	-	-	-	-	-	12,333,478
CMS Payments	118,250,194	118,063,612	186,581	-	-	-	-
Prescription Drugs	281,376,743	272,913,274	-	7,292,445	-	1,171,024	-
Miscellaneous Medical Payments	77,976	74,246	-	-	-	3,730	-
Home and Community Based Waiver	91,959,138	-	-	-	-	-	91,959,138
Homeward Bound Waiver	33,167,854	-	-	-	-	-	33,167,854
Money Follows the Person	81,102	81,102	-	-	-	-	-
In-Home Support Waiver	11,033,051	-	-	-	-	-	11,033,051
ADvantage Waiver	68,555,411	-	-	-	-	-	68,555,411
Family Planning/Family Planning Waiver	1,585,110	-	-	-	-	-	1,585,110
Premium Assistance*	22,972,366	-	-	22,972,365.98	-	-	-
Telligen	3,397,626	3,397,626	-	-	-	-	-
Electronic Health Records Incentive Payments	100,403	100,403	-	-	-	-	-
<b>Total Medicaid Expenditures</b>	<b>\$ 2,432,892,852</b>	<b>\$ 1,426,792,103</b>	<b>\$ 105,128,319</b>	<b>\$ 38,941,211</b>	<b>\$ 242,022,105</b>	<b>\$ 5,478,926</b>	<b>\$ 614,584,762</b>

\* Includes \$22,767,835.94 paid out of Fund 245

**OKLAHOMA HEALTH CARE AUTHORITY**  
**Summary of Revenues & Expenditures:**  
**Other State Agencies**  
**SFY 2020, For the Five Month Period Ending November 30, 2019**

REVENUE	FY20 Actual YTD
Revenues from Other State Agencies	\$ 231,908,039
Federal Funds	400,704,765
<b>TOTAL REVENUES</b>	<b>\$ 632,612,805</b>
EXPENDITURES	Actual YTD
<b>Department of Human Services</b>	
Home and Community Based Waiver	91,959,138
Money Follows the Person	-
Homeward Bound Waiver	33,167,854
In-Home Support Waivers	11,033,051
ADvantage Waiver	68,555,411
Intermediate Care Facilities for Individuals with Intellectual Disabilities Public	12,333,478
Personal Care	4,490,477
Residential Behavioral Management	1,751,000
Targeted Case Management	15,544,033
<b>Total Department of Human Services</b>	<b>238,834,443</b>
<b>State Employees Physician Payment</b>	
Physician Payments	28,775,353
<b>Total State Employees Physician Payment</b>	<b>28,775,353</b>
<b>Education Payments</b>	
Graduate Medical Education	31,622,608
Indirect Medical Education	35,874,676
Direct Medical Education	13,990,199
<b>Total Education Payments</b>	<b>81,487,483</b>
<b>Office of Juvenile Affairs</b>	
Targeted Case Management	982,762
Residential Behavioral Management	1,981,019
<b>Total Office of Juvenile Affairs</b>	<b>2,963,781</b>
<b>Department of Mental Health</b>	
Case Management	1,167,138
Inpatient Psychiatric Free-standing	19,251,957
Outpatient	7,820,051
Health Homes	10,075,759
Psychiatric Residential Treatment Facility	5,250,654
Certified Community Behavioral Health Clinics	32,819,070
Rehabilitation Centers	104,398,057
<b>Total Department of Mental Health</b>	<b>180,782,685</b>
<b>State Department of Health</b>	
Children's First	216,571
Sooner Start	974,650
Early Intervention	1,512,603
Early and Periodic Screening, Diagnosis, and Treatment Clinic	768,175
Family Planning	153,228
Family Planning Waiver	1,426,445
Maternity Clinic	-
<b>Total Department of Health</b>	<b>5,051,671</b>
<b>County Health Departments</b>	
EPSDT Clinic	289,768
Family Planning Waiver	5,437
<b>Total County Health Departments</b>	<b>295,206</b>
<b>State Department of Education</b>	<b>68,918</b>
<b>Public Schools</b>	<b>346,880</b>
<b>Medicare DRG Limit</b>	<b>72,267,584</b>
<b>Native American Tribal Agreements</b>	<b>533,054</b>
<b>Department of Corrections</b>	<b>943,141</b>
<b>JD McCarty</b>	<b>2,234,561</b>
<b>Total OSA Medicaid Programs</b>	<b>\$ 614,584,762</b>
<b>OSA Non-Medicaid Programs</b>	<b>\$ 44,057,359</b>
<b>Accounts Receivable from OSA</b>	<b>\$ 26,029,316</b>

**OKLAHOMA HEALTH CARE AUTHORITY**  
**SUMMARY OF REVENUES & EXPENDITURES:**  
Fund 205: Supplemental Hospital Offset Payment Program Fund  
SFY 2020, For the Five Month Period Ending November 30, 2019

REVENUES	FY 20 Revenue
SHOPP Assessment Fee	100,671,965
Federal Draws	\$ 155,632,951
Interest	95,451
Penalties	-
State Appropriations	(15,100,000)
<b>TOTAL REVENUES</b>	<b>\$ 241,300,366</b>

EXPENDITURES	Quarter	Quarter	Quarter	Quarter	FY 20 Expenditures
	7/1/19 - 9/30/19	10/1/19 - 12/31/19	1/1/20 - 3/31/20	4/1/20 - 6/30/20	
<b>Program Costs:</b>					
Hospital - Inpatient Care	85,252,282	96,496,585			\$ 181,748,867
Hospital -Outpatient Care	23,774,225	25,244,169			49,018,395
Psychiatric Facilities-Inpatient	4,602,238	5,837,178			10,439,416
Rehabilitation Facilities-Inpatient	383,416	432,011			815,427
<b>Total OHCA Program Costs</b>	<b>114,012,161</b>	<b>128,009,944</b>	-	-	<b>\$ 242,022,105</b>

<b>Total Expenditures</b>	<b>\$ 242,022,105</b>
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<b>CASH BALANCE</b>	<b>\$ (721,738)</b>
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\*\*\* Expenditures and Federal Revenue processed through Fund 340

**OKLAHOMA HEALTH CARE AUTHORITY**  
**SUMMARY OF REVENUES & EXPENDITURES:**  
**Fund 230: Nursing Facility Quality of Care Fund**  
**SFY 2020, For the Five Month Period Ending November 30, 2019**

REVENUES	Total Revenue	State Share
Quality of Care Assessment	\$ 33,372,858	\$ 33,372,858
Interest Earned	24,959	24,959
<b>TOTAL REVENUES</b>	<b>\$ 33,397,816</b>	<b>\$ 33,397,816</b>

EXPENDITURES	FY 20 Total \$ YTD	FY 20 State \$ YTD	Total State \$ Cost
<b>Program Costs</b>			
Nursing Facility Rate Adjustment	\$ 95,686,595	\$ 34,535,882	
Eyeglasses and Dentures	117,704	42,525	
Personal Allowance Increase	1,434,880	518,874	
Coverage for Durable Medical Equipment and Supplies	1,129,805	408,583	
Coverage of Qualified Medicare Beneficiary	430,315	155,619	
Part D Phase-In	186,581	186,581	
ICF/IID Rate Adjustment	2,233,600	807,423	
Acute Services ICF/IID	2,768,406	1,000,755	
Non-emergency Transportation - Soonerride	1,140,433	412,358	
<b>Total Program Costs</b>	<b>\$ 105,128,319</b>	<b>\$ 38,068,600</b>	<b>\$ 38,068,600</b>
<b>Administration</b>			
OHCA Administration Costs	\$ 232,185	\$ 116,093	
DHS-Ombudsmen	88,861	88,861	
OSDH-Nursing Facility Inspectors	76,195	76,195	
Mike Fine, CPA	-	-	
<b>Total Administration Costs</b>	<b>\$ 397,241</b>	<b>\$ 281,149</b>	<b>\$ 281,149</b>
<b>Total Quality of Care Fee Costs</b>	<b>\$ 105,525,560</b>	<b>\$ 38,349,749</b>	
<b>TOTAL STATE SHARE OF COSTS</b>			<b>\$ 38,349,749</b>

Note: Expenditure amounts are for informational purposes only. Actual payments are made from Fund 340. Revenues deposited into the fund are transferred to Fund 340 to support the costs, not to exceed the calculated state share amount.

**OKLAHOMA HEALTH CARE AUTHORITY**  
**SUMMARY OF REVENUES & EXPENDITURES:**  
**Fund 245: Health Employee and Economy Improvement Act Revolving Fund**  
**SFY 2020, For the Five Month Period Ending November 30, 2019**

REVENUES	FY 19 Carryover	FY 20 Revenue	Total Revenue
Prior Year Balance	\$ 8,433,128	\$ -	\$ -
State Appropriations	-	-	-
Federal Draws - Prior Year	256,769		
Total Prior Year Revenue			8,689,897
Tobacco Tax Collections	-	16,654,721	16,654,721
Interest Income	-	111,206	111,206
Federal Draws	-	14,971,544	14,971,544
<b>TOTAL REVENUES</b>	<b>\$ 8,689,897</b>	<b>\$ 31,737,471</b>	<b>\$ 40,427,368</b>

EXPENDITURES	FY 19 Expenditures	FY 20 Expenditures	Total State \$ YTD
<b>Program Costs:</b>			
Employer Sponsored Insurance		\$ 22,767,836	\$ 22,767,836
College Students/ESI Dental		204,530	73,901
<b>Individual Plan</b>			
SoonerCare Choice		\$ 39,621	\$ 14,327
Inpatient Hospital		1,356,283	485,882
Outpatient Hospital		2,592,825	935,028
BH - Inpatient Services-DRG		188,590	68,121
BH -Psychiatrist		-	-
Physicians		2,812,748	1,015,192
Dentists		10,654	3,822
Mid Level Practitioner		5,703	2,041
Other Practitioners		246,995	88,965
Home Health		2,552	919
Lab and Radiology		280,412	100,731
Medical Supplies		89,792	32,365
Clinic Services		806,656	291,954
Ambulatory Surgery Center		80,310	28,901
Skilled Nursing		151	51
Prescription Drugs		7,212,982	2,591,436
Transportation		46,627	16,859
Premiums Collected		-	(216,891)
<b>Total Individual Plan</b>		<b>\$ 15,772,902</b>	<b>\$ 5,459,702</b>
<b>College Students-Service Costs</b>		<b>\$ 195,943</b>	<b>\$ 71,163</b>
<b>Total OHCA Program Costs</b>		<b>\$ 38,941,211</b>	<b>\$ 28,372,602</b>
<b>Administrative Costs</b>			
Salaries	\$ 43,006	\$ 900,739	\$ 943,745
Operating Costs	1,501	4,609	6,110
Health Dept-Postponing	-	-	-
Contract - HP	81,669	335,249	416,918
<b>Total Administrative Costs</b>	<b>\$ 126,176</b>	<b>\$ 1,240,596</b>	<b>\$ 1,366,772</b>
<b>Total Expenditures</b>			<b>\$ 29,739,374</b>
<b>NET CASH BALANCE</b>	<b>\$ 8,563,721</b>	<b>\$ 2,124,273.24</b>	<b>\$ 10,687,994</b>

**OKLAHOMA HEALTH CARE AUTHORITY  
SUMMARY OF REVENUES & EXPENDITURES:**

**Fund 250: Belle Maxine Hilliard Breast and Cervical Cancer Treatment Revolving Fund  
SFY 2020, For the Five Month Period Ending November 30, 2019**

<b>REVENUES</b>	<b>FY 20 Revenue</b>	<b>State Share</b>
Tobacco Tax Collections	\$ 332,380	\$ 332,380
<b>TOTAL REVENUES</b>	<b>\$ 332,380</b>	<b>\$ 332,380</b>

<b>EXPENDITURES</b>	<b>FY 20 Total \$ YTD</b>	<b>FY 20 State \$ YTD</b>	<b>Total State \$ Cost</b>
<b>Program Costs</b>			
SoonerCare Choice	\$ 3,936	\$ 998	
Inpatient Hospital	401,932	103,723	
Outpatient Hospital	2,145,696	543,803	
Inpatient Services-DRG	-	-	
Psychiatrist	1,981	522	
TFC-OHCA	-	-	
Nursing Facility	-	-	
Physicians	1,382,655	350,603	
Dentists	5,653	1,397	
Mid-level Practitioner	1,123	296	
Other Practitioners	38,996	9,826	
Home Health	746	183	
Lab & Radiology	77,988	19,817	
Medical Supplies	13,547	3,368	
Clinic Services	106,407	26,923	
Ambulatory Surgery Center	5,835	1,507	
Prescription Drugs	1,171,024	294,934	
Transportation	63,103	16,058	
Miscellaneous Medical	3,730	928	
<b>Total OHCA Program Costs</b>	<b>\$ 5,424,353</b>	<b>\$ 1,374,884</b>	
<b>OSA DMHSAS Rehab</b>	<b>54,573</b>	<b>13,801</b>	
<b>Total Medicaid Program Costs</b>	<b>\$ 5,478,926</b>	<b>\$ 1,388,685</b>	
<b>TOTAL STATE SHARE OF COSTS</b>			<b>\$ 1,388,685</b>

Note: Expenditure amounts are for informational purposes only. Actual payments are made from Fund 340. Revenues deposited into the fund are transferred to Fund 340 to support the costs, not to exceed the calculated state share amount.

# OHCA Monthly Metrics March 2020 (January 2020 Data)

## SOONERCARE ENROLLMENT/EXPENDITURES

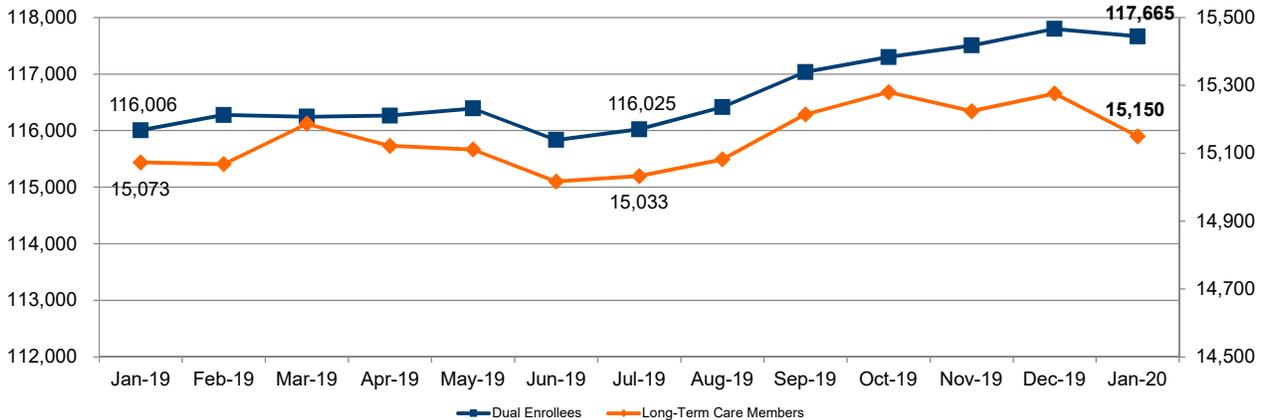
Delivery System		Enrollment January 2020	Children January 2020	Adults January 2020	Enrollment Change	Total Expenditures January 2020	PMPM January 2020
<b>SoonerCare Choice Patient-Centered Medical Home</b>		<b>524,604</b>	<b>437,714</b>	<b>86,890</b>	<b>3,944</b>	<b>\$176,509,164</b>	
Lower Cost	<i>(Children/Parents; Other)</i>	482,225	424,445	57,780	3,311	\$123,988,164	\$257
Higher Cost	<i>(Aged, Blind or Disabled; TEFRRA; BCC)</i>	42,379	13,269	29,110	633	\$52,521,000	\$1,239
<b>SoonerCare Traditional</b>		<b>230,709</b>	<b>81,357</b>	<b>149,352</b>	<b>-3,854</b>	<b>\$222,691,814</b>	
Lower Cost	<i>(Children/Parents; Other; Q1; SLMB)</i>	114,118	76,749	37,369	-3,555	\$46,411,340	\$407
Higher Cost	<i>(Aged, Blind or Disabled; LTC; TEFRRA; BCC &amp; HCBS Waiver)</i>	116,591	4,608	111,983	-299	\$176,280,474	\$1,512
<b>Insure Oklahoma</b>		<b>18,257</b>	<b>520</b>	<b>17,737</b>	<b>425</b>	<b>\$6,831,665</b>	
Employer-Sponsored Insurance		13,058	322	12,736	307	\$4,173,037	\$320
Individual Plan		5,199	198	5,001	118	\$2,658,628	\$511
<b>SoonerPlan</b>		<b>26,457</b>	<b>1,968</b>	<b>24,489</b>	<b>-236</b>	<b>\$193,471</b>	<b>\$7</b>
<b>TOTAL</b>		<b>800,027</b>	<b>521,559</b>	<b>278,468</b>	<b>279</b>	<b>\$406,226,114</b>	

Enrollment totals include all members enrolled during the report month. Members may not have expenditure data. Children are members aged 0 - 20 or for Insure Oklahoma enrolled as Students or Dependents. Dual Eligibles (Medicare & Medicaid) are in the Traditional delivery system in both the Low Cost (Q1 & SLMB) and High Cost (ABD) groups. OTHER includes DDSD, PKU, Q1, Refugee, SLMB, STBS and TB.

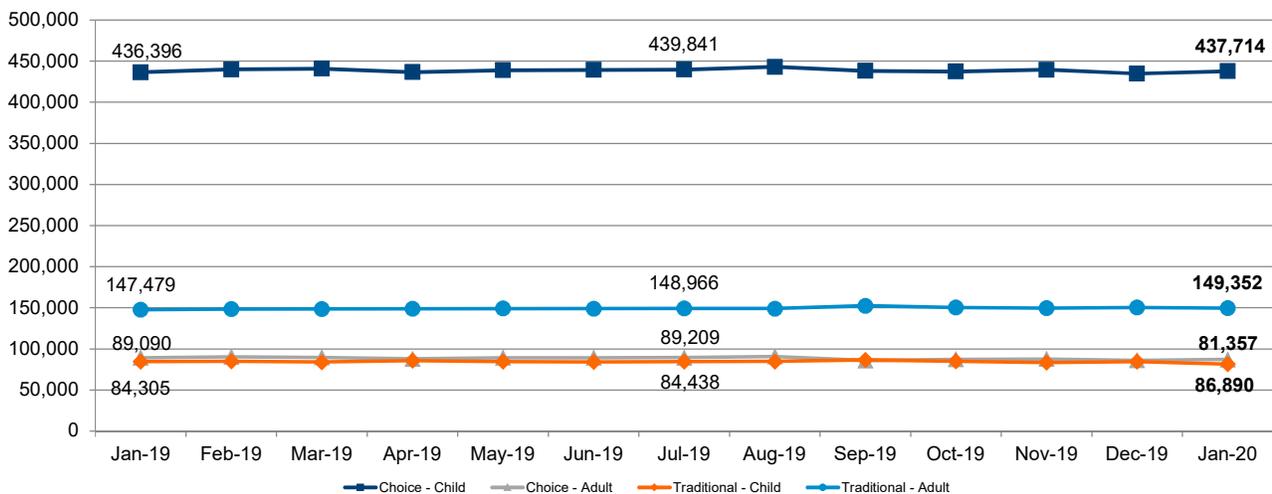
Total In-State Providers: 45,200 (+445) (In-State Providers counted multiple times due to multiple locations, programs, types, and specialties)								
Physician	Pharmacy	Dentist	Hospital	MH/BH	Optometrist	Extended Care	Total PCPs*	PCMH
10,511	907	1,245	159	12,236	688	431	7,836	2,735

\*PCPs consist of all providers contracted as a Certified Registered Nurse Practitioner, Family Practitioner, General Pediatrician, General Practitioner, Internist, General Internist, and Physician Assistant.

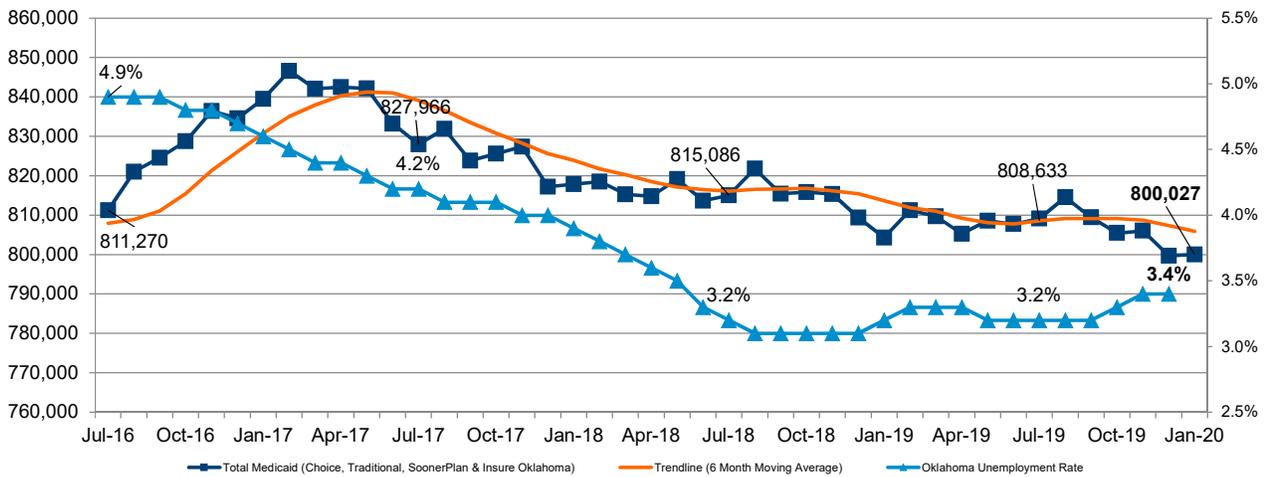
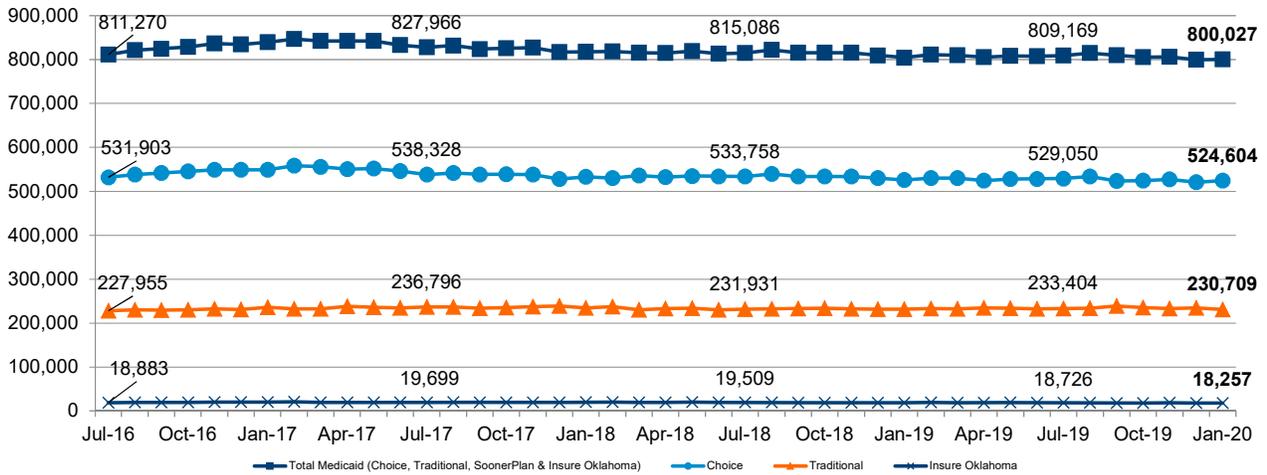
## DUAL ENROLLEES & LONG-TERM CARE MEMBERS



## CHILDREN & ADULTS ENROLLMENT

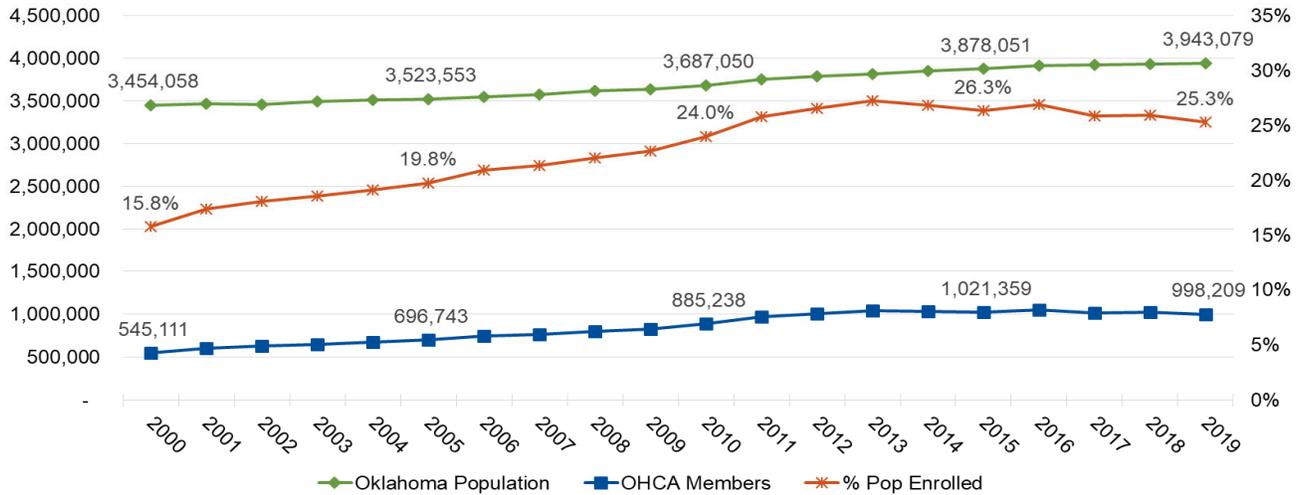


## ENROLLMENT BY MONTH



Oklahoma Unemployment Rate is from the Bureau of Labor Statistics 'Local Area Unemployment Statistics' (<https://www.bls.gov/lau/>) and is seasonally adjusted. In June 2017 there were changes to the passive renewal system criteria that reduced the number of passively renewed members by 2/3rds.

## ENROLLMENT BY STATE FISCAL YEAR



OHCA members includes Insure Oklahoma.  
Population is from the Census.

## BEHAVIORAL HEALTH SERVICES BY STATE FISCAL YEAR

Type of Service	Members Served SFY2017	Members Served SFY2018	Members Served SFY2019
Inpatient (Acute - General)	3,805	3,575	3,333
Inpatient (Acute - Freestanding)	2,579	2,550	3,180
Psychiatric Residential Treatment Facility (PRTF)	3,848	3,469	3,524
Outpatient	119,335	121,703	118,678
Psychologist	20,099	17,879	18,599
Psychiatrist	25,528	23,971	23,629
Residential Behavior Mgmt Services (Group)	868	964	903
Residential Behavior Mgmt Services (TFC)	860	591	389
SM/SED Case Management	43,647	32,937	25,135
Other OP Behavioral Hlth Services	1,568	1,567	1,837
Psychotropic Drugs	132,228	119,761	116,943
<b>Total Members Served (Unduplicated)</b>	<b>157,765</b>	<b>156,102</b>	<b>153,027</b>
<b>Total OHCA Enrollment</b>	<b>1,014,983</b>	<b>1,020,726</b>	<b>998,209</b>
<b>Percent Served</b>	<b>15.5%</b>	<b>15.3%</b>	<b>15.3%</b>

For each SFY, members served is 65% children (0-20). Member Served figures are the unduplicated counts of members that received a service. If a member received services from multiple service type providers, they would be counted once for each type of service; the total count is the unduplicated count overall. Psychotropic Drugs includes all uses of the drugs included within the behavioral health categories.

## **March MAC Proposed Rule Amendment Summaries**

Face-to-face tribal consultations regarding the following proposed changes were held on Tuesday, May 7, 2019, Tuesday, July 2, 2019, Tuesday, September 3, 2019, Tuesday, November 5, 2019, and Tuesday, January 7, 2020 in the Charles Ed McFall Boardroom of the Oklahoma Health Care Authority (OHCA).

The following work folders were posted on the OHCA public website for a 30-day comment period.

**19-10 American Indian/Alaska Native (AI/AN) cost sharing exemptions** — The proposed rule changes will align policy with Oklahoma's Medicaid State Plan language and 42 Code of Federal Regulations (C.F.R.) § 447.56(a)(x). Section 5006 of the American Recovery and Reinvestment Act (ARRA) precludes states from imposing Medicaid premiums or any other Medicaid cost sharing on Indian applicants and participants served by Indian health providers.

**Budget Impact: Budget neutral**

**19-15 Rural Health Clinic (RHC)** — The proposed rule changes will update policy to come into compliance with the Benefits Improvement and Protection Act of 2000. Policy changes will reflect a revised payment methodology for RHCs increasing access to care in rural areas. Further revisions will update policy to reflect current business practices.

**Budget Impact: The estimated budget impact for SFY 2020 will be an increase in the total amount of \$17,657,446; with \$6,160,683 in state share.**

**19-24 Urine Drug Screening and Laboratory Services Policy** — The proposed rule changes will update urine drug screening policy by removing the word “urine”, in order to clarify that this policy applies to multiple specimens and not just urine specimens. Additionally, the proposed revisions will update laboratory services policy to clarify that laboratory testing for routine diagnostic or screening purposes are compensable when they are recommended by the clinical guidelines of nationally recognized professional medical academies or societies, and those sources meet medical necessity criteria, as outlined in OHCA rules.

**Budget Impact: Budget neutral**

**19-25 Polymerase Chain Reaction (PCR) Testing for Infectious Diseases** — The proposed rule changes will establish guidelines to assure medical necessity and consistency in the prior authorization (PA) process for PCR testing. The guidelines include criteria to meet medical necessity and required documentation for approval of the PA.

**Budget Impact: Agency staff has determined that the proposed rule changes will result in a budget savings by decreasing reimbursement of medically unnecessary PCR tests. The total spending for calendar year 2018, on PCR infectious disease testing CPT codes which will now be subject to prior authorization was \$6,282,503. With an estimated denial rate of 50% for lack of medical necessity, total estimated budget savings will be \$3,141,252 annually, of which \$1,067,397 is state dollars.**

**19-26 Countable Income and Resources for the Aged, Blind and Disabled (ABD) Eligibility Groups and Eligibility as a Qualified Medicare Beneficiary (QMB) Plus Member** — The proposed rule changes will update policy regarding the determination of countable income for ABD individuals. The rule changes will incorporate federal Supplemental Security Income (SSI) standards, including earned and unearned income which is to be excluded, and clarifies guidance on how income is deemed from certain individuals to another, for example, ineligible

spouses to the applicant. Additional rule changes will update policy so that the value of a life estate may be established by a written estimate instead of a written appraisal. Additional rule changes will update QMB Plus policy so that the intent of the rule regarding income and resource standards for individuals and couples is clearly stated. Finally, the QMB Plus policy will be aligned with other Medicare savings programs.

**Budget Impact: Budget neutral**

**19-27 Ground Emergency Medical Transportation (GEMT) Supplemental Payment Program** — The proposed rule changes will establish rules consistent with the Oklahoma's Medicaid State Plan which outlines the GEMT Supplemental Payment Program. The GEMT is a voluntary program which provides supplemental payments to eligible providers for specific allowable and uncompensated costs incurred for providing ground ambulance services to SoonerCare recipients and certified on an annual cost report. Payments are made in the form of an interim payment and a later reconciliation payment (i.e. settle-up payment).

**Budget Impact: There is no estimated federal budget impact for federal fiscal year (FFY) 2019. The estimated federal budget impact for FFY 2020 is \$17,258,031. It is estimated that the revisions will be budget neutral for the State as participating GEMT providers will bear the cost of providing the state share for the program, as well as, any administrative costs.**

**19-29 Reasonable Limits for Necessary Medical and Remedial Care Not covered under the Oklahoma Medicaid State Plan** — The proposed rule changes will revise the formula for calculating the vendor payment for SoonerCare members receiving services in a nursing facility (NF) or an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). The vendor payment is the monthly amount the member must contribute toward the cost of their care in a long-term care facility. The revisions will establish limitations and/or reasonable requirements before a medical expense can be deducted from the individual's post-eligibility income when determining the vendor payment. Currently, there are no limitations or established criteria by which expenses are quantified or determined to be allowed for deduction. Similar reasonable limits have been implemented by numerous State Medicaid agencies, including that of Arkansas, Colorado, Massachusetts, and Texas.

**Budget Impact: The OHCA anticipates, but cannot reliably estimate, a budget impact for the proposed changes, because the amount of expenses for medical or remedial care that are not subject to third party payment (hereinafter, 'Expenses') will: 1) vary from person to person; and 2) be unknown until the person or his or her representative reports them to the OHCA. Currently, there are no limitations or established criteria by which Expenses are quantified or determined to be allowable for deduction. Accordingly, implementing reasonable limits on these types of Expenses should minimize total potential losses to the agency, over the long term.**

**19-32 Inpatient Psychiatric Services and Service Quality Review (SQR) Revisions** — The proposed rule changes will amend inpatient psychiatric services policy for members under twenty-one (21) to reflect current practice, update obsolete references, and reorganize sections for consistent application of policy. The proposed rule changes will also address SQR findings of deficiency regarding inpatient psychiatric facilities' compliance with federal regulations and OHCA administrative rules. Additionally, the proposed rule changes will create a general specialty add-on payment for children and adolescents with specialized treatment needs who are being served in a psychiatric residential treatment facility (PRTF), Acute II unit of a psychiatric hospital and general hospital with an Acute II psychiatric.

**Budget Impact: The proposed rule changes that amend inpatient psychiatric services policy for members under twenty-one would be budget neutral. The proposed rule**

changes that address SQR findings of deficiency would potentially result in savings; however, the agency is unable to provide a measurable savings amount. The proposed rule changes that create a general specialty add-on payment would potentially result in an annual total cost of \$5,747,126; \$2,000,000 state share for SFY2021. The state share will be paid by the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS).

**19-34 ADvantage Waiver** — The proposed rule changes, to the ADvantage Waiver policy, will add new language addressing the State Plan Personal Care eligibility provider exception criteria. Additionally revisions will update existing policy that will clarify the criteria an applicant must meet to receive ADvantage services and the type of living arrangements that are not eligible for ADvantage members.

**Budget Impact: Budget neutral**

**19-35 Developmental Disabilities Services (DDS)** — The proposed rule changes to the DDS policy will allow for self-directed services to be an option under the Community waiver. Additional revisions will add language to note the daily hourly limits on services provided by the self-directed habilitation training specialist. Other revisions will establish guidelines for the DDS Home and Community-Based Services waiver's Electronic Visit Verification (EVV) billing procedures.

**Budget Impact: Budget neutral**

**19-37 Mobile and Portable Dental Treatment Facilities** — The proposed rule changes will add coverage and reimbursement for preventive dental services received through mobile and portable dental treatment facilities. Additionally, revisions will add provider participation requirements pursuant to the Oklahoma State Dentistry Act and the OHCA contracting requirements, while also defining coverage and limitations for preventive dental services, billing requirements, basic consent form requirements, and follow-up care requirements.

**Budget Impact: The estimated budget impact for SFY 2021 will be an increase in the total amount of \$115,753; with \$37,921 in state share.**

**19-41A Patient-Centered Medical Homes (PCMH), Health Access Networks (HAN) and Health Management Program (HMP) Updates** — The proposed rule changes will update the policy for Patient-Centered Medical Homes (PCMH) and Health Access Networks (HAN). Additionally, a new section of policy will be added to address the Health Management Program (HMP) which will provide an overview of the program and outline provider participation guidelines. Finally, policy changes will include general policy cleanup and align policy with current business practices.

**Budget Impact: Budget neutral**

**19-41B Insure Oklahoma Individual Plan (IP) and Insure Oklahoma Employer Sponsored Insurance (ESI)** — The proposed rule changes will add language to the Insure Oklahoma IP and ESI policy on how a newborn child can be deemed eligible on their date of birth for SoonerCare benefits when the child is born to a member of the Insure Oklahoma IP or ESI. Additionally, the proposed policy changes will define eligibility criteria for the newborn to receive SoonerCare benefits.

**Budget Impact: Budget neutral**

**19-42 Adult Inpatient Rehabilitation Days** — The proposed rule changes will increase the number of covered inpatient rehabilitation hospital days for adult SoonerCare members from twenty-four (24) days per state fiscal year to ninety (90) days per state fiscal year. These

changes are necessary to meet the health care needs of SoonerCare members by increasing access to stabilization services in an inpatient rehabilitation setting.

**Budget Impact: The estimated budget impact for SFY 2021 will be an increase in the total amount of \$584,266 total; with \$187,023 in state share. The estimated budget impact for SFY 2022 will be an increase in the total amount of \$779,021; with \$187,023 in state share.**

**19-43A and B Coverage Definitions for Children and Adults** — The proposed rule changes will add definitions to clarify what the OHCA views as a child and an adult, unless otherwise specified by federal and/or state law. Additional revisions will involve limited rewriting aimed at clarifying text, fixing any grammatical errors, and aligning rules with current business practices.

**Budget Impact: Budget neutral**

**19-44 Organ Transplant** — The proposed rule changes will update organ transplant requirements and guidelines to reflect current practice.

**Budget Impact: Budget neutral**

**19-45 Private Duty Nursing (PDN) Revisions** — The proposed rule changes will update and strengthen PDN policy by defining the place of services where/that PDN is allowed. Additional revisions will include adding language to allow for medically necessary PDN services outside of the home if certain requirements are met. Further revisions will clarify which PDN services will and will not be authorized. Finally, the proposed revisions will involve limited rewriting aimed at clarifying text, fixing any grammatical errors, and aligning rules with current business practices.

**Budget Impact: Budget neutral**

**19-46 School-based/Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Revisions** — The proposed rule changes will cleanup the school-based policy to separate and differentiate between services provided in a school setting under EPSDT benefit versus those school-based services that are pursuant to an Individual Education Plan (IEP).

**Budget Impact: Budget neutral**

**19-47 Medically Necessary Extractions Revisions** — In an effort to improve dental access and coverage for adults, the proposed rule changes will amend the rule that limits dental services for adults to "emergency" extractions only by changing it to "medically necessary" extractions. Additionally, the proposed rule revisions will add definitions for medically necessary oral healthcare and medically necessary extractions. Finally, the proposed revisions will involve limited rewriting aimed at clarifying text, fixing any grammatical errors, and aligning rules with current business practices.

**Budget Impact: The estimated budget impact for SFY 2020 will be an increase in the total amount of \$1,734,313; with \$605,102 in state share.**

**20-01 High-Investment Drugs Carve-Out** — The proposed rule changes will allow certain high-investment drugs to be reimbursed outside of the inpatient and outpatient hospital payment methodologies. Additionally, the proposed rule changes will require inpatient and outpatient hospitals to seek prior authorization of high-investment drugs and follow applicable requirements and conditions of payment. Lastly, revisions will align policy with current practice and correct grammatical errors.

**Budget Impact: The proposed rule changes will be budget neutral as high-investment drugs are included in the pharmacy budget.**

**20-03 Treatment of Lottery or Gambling Winnings for Income Eligibility** — The proposed rule changes are in response to the Advancing Chronic Care, Extenders and Social Services

Act, referred to as the ACCESS Act and included in Public Law No. 115-123 § 53103, which changed the way qualified lottery winnings or qualified gambling winnings of \$80,000 and above are treated when determining MAGI-based income eligibility. Previous federal regulations and OHCA rules required that all lump sum income, including lottery and gambling winnings, be counted as income only in the month received. Winnings will still be counted as income against the SoonerCare household in the month received; however, winnings of \$80,000 and above that are paid out in a single payout option, will be counted in multiple months and in equal monthly installments against the individual household member receiving the winnings. Lottery winnings that are paid out in installments over a period of time would be treated as recurring income. The formula for counting winnings of \$80,000 and above is set forth in the new OHCA policy at OAC 317:35-6-55(b) and (c).

**Budget Impact: Agency staff has determined that the impact of the proposed rule changes on the budget is unknown as the number of SoonerCare members who will have lottery or gambling winnings is unknown; however, savings could potentially be realized if a member lost eligibility for multiple months due to receipt of lottery or gambling winnings above \$80,000 paid out in a single payout.**

**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY  
CHAPTER 45. INSURE OKLAHOMA**

**SUBCHAPTER 9. INSURE OKLAHOMA ESI EMPLOYEE ELIGIBILITY**

**317:45-9-4. Employee cost sharing**

Employees are responsible for up to ~~15 percent~~fifteen percent (15%) of their benefit plan premium. The employees are also responsible for up to ~~15 percent~~fifteen percent (15%) of their dependent's benefit plan premium if the dependent is included in the program. The combined portion of the employee's cost sharing for benefit plan premiums cannot exceed three percent of his/her annual gross household income computed monthly. ~~Native American children providing documentation of ethnicity are exempt from cost-sharing requirements, including premium payments and out-of-pocket expenses~~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.

**SUBCHAPTER 11. INSURE OKLAHOMA IP**

**PART 5. INSURE OKLAHOMA IP MEMBER ELIGIBILITY**

**317:45-11-24. Member cost sharing**

(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 ~~100 percent~~one-hundred percent (100%) of the Federal Poverty Level.

(3) ~~Native Americans providing documentation of ethnicity are exempt from premium payments~~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.

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

**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**

**PART 35. RURAL HEALTH CLINICS**

**317:30-5-359.1. Cost reports**

(a) Provider-based ~~RHCs~~Rural Health Clinics (RHC) are required to report each RHC on a separate clinic line cost center on the Medicare Cost Report (HCFA 2552). A copy of the HCFA 2552, including the Medicaid Supplemental Worksheet S-2, is submitted to the ~~OHCA~~Oklahoma Health Care Authority (OHCA) as part of the year-end cost report process of the parent hospital. ~~(Refer to OAC 317:30-5-48).~~

(b) Independent RHCs are required to submit to the OHCA a completed copy of the Medicare Cost Report for the annual cost reporting period (HCFA 222-92) within the due date for filing the cost report to the fiscal intermediary. Preventive services, i.e., prenatal, EPSDT and family planning visits, should not be counted in total visits in the Medicare cost report. The associated cost for the ~~rural health clinic~~RHC services covered by Medicaid only should be reported as a non-reimbursable cost on the clinic's Medicare cost report.

~~(c) If the clinic does not submit an adequate annual report on time, the OHCA may reduce or suspend payments to preclude excess payment to the clinic.~~

**317:30-5-359.2. Reimbursement**

(a) **Provider-based clinics.** ~~Interim payments for provider-based clinics will be made for RHC "core" services based on an all-inclusive visit fee established by reference to payments to other Rural Health Clinics in the same or adjacent areas or by cost reporting methods. The interim rate for core services will be reviewed and revised as appropriate, based on cost data from an initial cost report. Costs will be determined from the parent hospital's cost-to-charge ratios per the HCFA-2552 Medicare (or Medicaid, when filed) Worksheet C, Part 1, Computation of Ratio of Costs to Charges. Lower of cost or charge provision will be calculated using the lesser of costs or two times charges (as determined by averaged cost to charge ratios based on FY 95 cost reports). After the initial year and the per visit rate are established, the rate will be updated annually by the increase in the MEI.~~Payments for provider-based clinics will be made for RHC "core" services based on an all-inclusive visit fee established by one of the following:

- (1) An interim rate established by calculating a statewide average rate for RHCs in the state; and

(2) The statewide average rate will be updated annually by the increase in the Medicare Economic Index (MEI); or

(3) An Alternative Payment Methodology (APM) established by the RHC periodic rate notification from the Medicare Fiscal Intermediary. In order to receive this rate, the RHC must submit a copy of the periodic rate notification letter for its most recent full cost reporting year received from the fiscal intermediary to the state. The APM rate cannot be lower than mentioned above in (a) (1) or (a) (2).

~~(b) **Independent clinics.** Interim payments for independent clinics will be made for RHC "core" services based on the all-inclusive rate established by reference to payments to other Rural Health Clinics in the same or adjacent areas or by cost reporting methods. The interim rate for core services will be reviewed and revised as appropriate, based on cost data from an initial 12 month cost report and payments may be subject to adjustment at the end of the reporting period. After the initial year and the per visit rate are established, the rate will be updated annually by the increase in the MEI. For clinics that offer "other ambulatory" services and preventive services, payment will be made on a reasonable charge basis in accordance with Medicaid fee schedule guidelines. Payments for independent clinics will be made for RHC "core" services based on an all-inclusive visit fee established by one of the following:~~

(1) An interim rate established by calculating a statewide average rate for RHCs in the state; and

(2) The statewide average rate will be updated annually by the increase in the MEI; or

(3) An APM established by the RHCs periodic rate notification from the Medicare Fiscal Intermediary. In order to receive this rate, the RHC must submit a copy of the periodic rate notification letter for its most recent full cost reporting year received from the fiscal intermediary to the state. The APM rate cannot be lower than mentioned above in (b) (1) or (b) (2).

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**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**

**PART 1. PHYSICIANS**

**317:30-5-20. Laboratory services**

This Section covers the guidelines for payment of laboratory services by a provider in his/her office, a certified laboratory and for a pathologist's interpretation of laboratory procedures.

(1) **Compensable services.** Providers may be reimbursed for compensable clinical diagnostic laboratory services only when they personally perform or supervise the performance of the test. If a provider refers specimen to a certified laboratory or a hospital laboratory serving outpatients, the certified laboratory or the hospital must bill for performing the test.

(A) Reimbursement for lab services is made in accordance with the Clinical Laboratory Improvement Amendment of 1988 (CLIA). These regulations provide that payment may be made only for services furnished by a laboratory that meets CLIA conditions, including those furnished in physicians' offices. Eligible providers must be certified under the CLIA program and have obtained a CLIA ID number from Centers for Medicare and Medicaid Services and have a current contract on file with the Oklahoma Health Care Authority (OHCA). Providers performing laboratory services must have the appropriate CLIA certification specific to the level of testing performed.

(B) Only medically necessary laboratory services are compensable.

(i) Testing must be medically indicated as evidenced by patient-specific indications in the medical record.

(ii) Testing is only compensable if the results will affect patient care and are performed to diagnose conditions and illnesses with specific symptoms.

(iii) Testing is only compensable if the services are performed in furtherance of the diagnosis and/or treatment of conditions that are covered under SoonerCare.

(C) Laboratory testing must be ordered by the physician or non-physician provider, and must be individualized to the patient and the patient's medical history or assessment indicators as evidenced in the medical documentation.

(D) Laboratory testing for routine diagnostic or screening tests following clinical guidelines such as those found in the American Academy of Pediatrics (AAP) Bright Futures'

periodicity schedule, the United States Preventive Services Task Force (USPSTF) A and B recommendations, the American Academy of Family Practitioners (AAFP), or other nationally recognized medical professional academy or society standards of care, is compensable. Additionally, such sources as named in this subdivision should meet medical necessity criteria as outlined in Oklahoma Administrative Code (OAC) 317:30-3-1(f).

**(2) Non-compensable laboratory services.**

(A) Laboratory testing for routine diagnostic or screening tests not supported by the clinical guidelines of a nationally recognized medical professional academy or society standard of care, and/or testing that is performed without apparent relationship to treatment or diagnosis of a specific illness, symptom, complaint or injury is not covered.

(B) Non-specific, blanket panel or standing orders for laboratory testing, custom panels particular to the ordering provider, or lab panels which have no impact on the patient's plan of care are not covered.

(C) Split billing, or dividing the billed services for the same patient for the same date of service by the same ~~rendering~~ rendering laboratory into two or more claims is not allowed.

(D) Separate payment is not made for blood specimens obtained by venipuncture or urine specimens collected by a laboratory. These services are considered part of the laboratory analysis.

(E) Claims for inpatient full service laboratory procedures are not covered since this is considered a part of the hospital rate.

(F) Billing multiple units of nucleic acid detection for individual infectious organisms when testing for more than one infectious organism in a specimen is not permissible. Instead, OHCA considers it appropriate to bill a single unit of a procedure code indicated for multiple organism testing.

(G) Billing multiple Current Procedural Terminology (CPT) codes or units for molecular pathology tests that examine multiple genes or incorporate multiple types of genetic analysis in a single run or report is not permissible. Instead, OHCA considers it appropriate to bill a single CPT code for such test. If an appropriate code does not exist, then one unit for an unlisted molecular pathology procedure may be billed.

**(3) Covered services by a pathologist.**

(A) A pathologist may be paid for the interpretation of inpatient surgical pathology specimen when the appropriate

CPT procedure code and modifier is used.

(B) Full service or interpretation of surgical pathology for outpatient surgery performed in an outpatient hospital or ambulatory surgery center setting.

(4) **Non-compensable services by a pathologist.** The following are non-compensable pathologist services:

(A) Experimental or investigational procedures.

(B) Interpretation of clinical laboratory procedures.

### **317:30-5-20.1. ~~Urine drug~~Drug screening and testing**

(a) **Purpose.** ~~Urine~~Drug Testing (~~UDT~~) is performed for undisclosed drug use and/or abuse, and to verify compliance with treatment. Testing for drugs of abuse to monitor treatment compliance should be included in the treatment plan for pain management when chronic opioid therapy is involved.

(1) Qualitative (presumptive) drug testing may be used to determine the presence or absence of a drug or drug metabolite in the ~~urine~~ sample and is expressed as a positive or negative result. Qualitative testing can be performed by a CLIA waived or moderate complexity test, or by a high complexity testing method.

(2) Quantitative (definitive) drug testing is specific to the drug or metabolite being tested and is expressed as a numeric result or numeric level which verifies concentration.

(3) Specimen validity testing is used to determine if a ~~urine~~ specimen has been diluted, adulterated or substituted. Specimen validity tests include, but are not limited to, creatinine, oxidants, specific gravity, urine pH, nitrates and alkaloids.

(b) **Eligible providers.** Providers performing ~~urine~~drug testing should have CLIA certification specific to the level of testing performed as described in 317:30-5-20(1)(A).

(c) **Compensable services.** ~~Urine drug~~Drug testing must be ordered by the physician or non-physician provider and must be individualized to the patient and the patient's medical history or assessment indicators as evidenced in the medical documentation.

(1) Compensable testing must be medically indicated as evidenced by patient specific indications in the medical record.

(A) Testing is only compensable if the results will affect patient care.

(B) Drugs or drug classes being tested should reflect only those likely to be present.

(2) The frequency of ~~urine~~drug screening and/or testing is determined by the patient's history, patient's physical assessment, behavioral assessment, risk assessment, treatment plan and medication history.

(3) Quantitative (definitive) ~~urine~~-drug testing may be indicated for the following:

(A) To identify a specific substance or metabolite that is inadequately detected or undetectable by a qualitative (presumptive) test; or

(B) To definitively identify specific drugs in a large family of drugs; or

(C) To identify drugs when a definitive concentration of a drug is needed to guide management; or

(D) To identify a negative, or confirm a positive, qualitative (presumptive) result that is inconsistent with a patient's self-report, presentation, medical history or current prescribed medication plan; or

(E) To identify a non-prescribed medication or illicit use for ongoing safe prescribing of controlled substances.

(d) **Non-compensable services.** The following tests are not medically necessary and therefore not covered by the OHCA:

(1) Specimen validity testing is considered a quality control measure and is not separately compensable;

(2) Drug testing for patient sample sources of saliva, oral fluids, or hair;

(3) Testing of two different specimen types (urine and blood) from the same patient on the same date of service;

(4) Drug testing for medico-legal purposes (court ordered drug screening) or for employment purposes;

(5) Non-specific, blanket panel or standing orders for ~~urine~~ drug testing, custom panels specific for the ordering provider, routine testing of therapeutic drug levels or drug panels which have no impact to the member's plan of care;

(6) Scheduled and routine ~~urine~~-drug testing (i.e. testing should be random);

(7) Reflex testing for any drug is not medically indicated without specific documented indications;

(8) Confirmatory testing exceeding three specific drug classes at an interval of greater than every ~~30~~thirty (30) days will require specific documentation in the medical record to justify the medical necessity of testing; and

(9) Quantitative (definitive) testing of multiple drug levels that are not specific to the patient's medical history and presentation are not allowed. Justification for testing for each individual drug or drug class level must be medically indicated as reflected in the medical record documentation.

(e) **Documentation requirements.** The medical record must contain documents to support the medical necessity of drug screening and/or testing. Medical records must be furnished on request and may include, but are not limited to, the following:

(1) A current treatment plan;

- (2) Patient history and physical;
- (3) Review of previous medical records if treated by a different physician for pain management;
- (4) Review of all radiographs and/or laboratory studies pertinent to the patient's condition;
- (5) Opioid agreement and informed consent of ~~UDT~~drug testing, as applicable;
- (6) List of prescribed medications;
- (7) Risk assessment, as identified by use of a validated risk assessment tool/questionnaire, with appropriate risk stratification noted and utilized;
- (8) Office/provider monitoring protocols, such as random pill counts; and
- (9) Review of prescription drug monitoring data or pharmacy profile as warranted.

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SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 1. PHYSICIANS

**317:30-5-20.2. Molecular Diagnostic Testing Utilizing Polymerase Chain Reaction for Infectious Diseases**

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

**(1) "Polymerase Chain Reaction (PCR)"** means a biochemical laboratory technique used to make thousands or even millions of copies of a segment of DNA. It is commonly used to amplify a small amount of specifically targeted DNA from among a mixture of DNA samples. It is also known as Nucleic Acid Amplification Test (NAAT).

**(2) "Direct Probe Technique"** means detection methods where nucleic acids are detected without initial amplification processing.

**(3) "Amplified Probe Technique"** means technique without quantification, a detection method in which the sensitivity of the assay is improved over direct probe techniques.

**(4) "Probe with Quantification Technique"** means methods used to report absolute or relative amounts of nucleic acid sequences in the original sample.

**(c) Medical necessity.**

**(1)** PCR testing for infectious diseases, following clinical guidelines such as those set forth by the Infectious Disease Society of America's (IDSA) or other nationally recognized medical professional academy or society standards of care, may be compensable.

**(2)** For the full PCR guideline which includes medically necessity and prior authorization criteria, and a list of codes that require authorization, please refer to [www.okhca.org](http://www.okhca.org).

**(d) Documentation.**

**(1)** The medical record must contain documentation that the testing is expected to influence treatment of the condition towards which the testing is directed.

**(2)** The laboratory or billing provider must have on file the physician requisition which sets forth the diagnosis or condition that warrants the test(s).

**(3)** Examples of documentation requirements for the ordering provider include, but are not limited to, history and physical exam findings that support the decision making, problems/diagnoses, relevant data (e.g., lab testing results).

(4) Documentation requirements for the performing laboratory include, but are not limited to, lab accreditation, test requisition, test records, preliminary and final report, and quality control record.

(5) Documentation requirements for lab developed tests/protocols include diagnostic test/assay, lab manufacturer, names of comparable assays/services (if relevant), descriptions of assay, analytical validity evidence, clinical validity evidence, and clinical utility.

(6) Billing providers are required to code specificity; however, if an unlisted or not otherwise specified Current Procedural Terminology (CPT) code is used, the documentation must clearly identify the unique procedure performed. When multiple procedure codes are submitted (unique, unlisted, and/or not otherwise specified), the documentation supporting each code should be easily identifiable. If on review the billed code cannot be linked to the documentation, this service may be denied.

(7) When the documentation does not meet the criteria for the service rendered/requested or the documentation does not establish the medical necessity for the service, the service may be denied as not reasonable and necessary.

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

**SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME**

**PART 5. COUNTABLE INCOME AND RESOURCES**

**317:35-5-41.1. Home/real property**

(a) Home property is excluded from resources regardless of value unless the individual is applying for long-term care services [See Oklahoma Administrative Code (OAC) 317:35-5-41.8(a) (relating to eligibility for long-term care services)]. For purposes of the home property resource exclusion, a home is defined as any shelter in which the individual has an ownership interest and which is used by the individual as his/her principal place of residence. The home may be either real or personal property, fixed or mobile.

(1) Home property includes all property which is adjacent to the home. Land is considered adjacent even if separated by a boundary line, street, alley, highway, or waterway.

(2) Property has a value regardless of whether there is an actual offer to purchase. Verification of home/real property value is established by collateral contacts with specialized individuals knowledgeable in the type and location of property being considered. Mineral rights and wind rights associated with the home property are not valued separate from the surface.

(3) The home may be retained without affecting eligibility during periods when it is necessary to be absent for illness or other necessity. When it is determined that the member does not have a feasible plan for and cannot be expected to return to his/her home, the market value of the property is considered in relation to the resource. The member is responsible for taking all steps necessary to convert the resource for use in meeting current needs. If the member is making an effort to make the resource available, a reasonable period of time is given [not to exceed ninety (90) days] to convert the resource. He/she is advised in writing that the ninety-day (90-day) period begins with the determination that the property be considered in relation to the resource. The ninety-day (90-day) period is given only if efforts are in progress to make the resource available. Any extension beyond the initial ninety-day (90-day) period is justified only after interviewing the member, determining that a good faith effort to sell is still being made and failure to sell is due to circumstances beyond the control of the member. A written notification is also provided to the member at any time an extension is allowed. Detailed documentation in the case record is required.

(4) If the member fails or is unwilling to take steps necessary to convert the resource for use in meeting current needs, continuing eligibility cannot be established and the member is advised as to the effective date of closure and of the right to receive assistance when the resources are within the maximum allowable resources provided other conditions of eligibility continue to be met.

(5) When a member sells his/her home with the intention of purchasing another home or when an insurance payment for damage to the home is received, a reasonable period of time is given to reinvest the money in another home. A reasonable period of time is considered to not exceed a ninety-day (90-day) period. Extensions beyond the ninety (90) days may be justified only after interviewing the member; and determining that a good faith effort is still being made; and that completion of the transaction is beyond his/her control. This must be documented in the case record.

(6) At the point a member decides not to reinvest the proceeds from the sale of his/her home in another home, the member's plan for use of the proceeds is evaluated in relation to rules on resources disposed of while receiving assistance.

(7) A home traded for another home of equal value does not affect the member's eligibility status. If the home is traded for a home of lesser value, the difference may be invested in improvement of the new home.

(8) Absences from home for up to ninety (90) days for trips or visits or six (6) months for medical care (other than nursing facilities) do not affect receipt of assistance or the home exclusion as long as the individual intends to return home. Such absences, if they extend beyond those limits, may indicate the home no longer serves as the principal place of residence.

(9) Mineral rights, associated with the home property, are considered along with the surface rights and are excluded as a resource.

(b) Real property other than home property shall be treated as follows:

(1) Mineral rights which are not associated with the home property are considered as a resource. Since evaluation and ~~scalability~~salability of mineral rights fluctuate, the establishment of the value of mineral rights are established based on the opinion of collateral sources. Actual offers of purchase are used when established as a legitimate offer through a collateral source. Mineral rights not associated with home property which are income producing are considered in the same way as income producing property. Refer to OAC 317:35-5-41.12(c)(3) for treatment of mineral rights as non-trade or non-business property.

(2) The market value of real estate other than home property owned by the member or legal dependent and encumbrances against such property are ascertained in determining the equity (including the cost to the member of a merchantable title to be determined when the resource approaches the maximum). The market value of real estate other than the home owned by the applicant is established on the basis of oral or written information which the applicant has on hand and counsel with persons who have specialized knowledge about this kind of resource. Refer to OAC 317:35-5-41.12(c) for exclusion of real estate that produces income.

(3) For any individual (and spouse, if any) who is of Indian descent from a federally recognized Indian tribe, any interest in land which is held in trust by the United States for an individual Indian or tribe, or which is held by an individual Indian or tribe and which can only be sold, transferred, or otherwise disposed of with the approval of other individuals, his or her tribe, or an agency of the federal government, shall be excluded from resource determinations, in accordance with 20 Code of Federal Regulations (C.F.R.) ' 416.1234.

(4) A life estate conveys upon an individual or individuals for his/her lifetime, certain rights in property. Its duration is measured by the lifetime of the tenant or of another person; or by the occurrence of some specific event, such as remarriage of the tenant. The owner of a life estate has the right of possession, the right to use the property, the right to obtain profits from the property and the right to sell his/her life estate interest. However, the contract establishing the life estate may restrain one or more rights of the individual. The individual does not have title to all interest in the property and does not have the right to sell the property other than the interest owned during his/her lifetime. He/she may not usually pass it on to heirs in the form of an inheritance.

(A) When a life estate in property is not used as the member's home, it is necessary to establish the value. A computer procedure is available to compute the value of a life estate by input of the current market value of the property and the age of the life estate owner.

(B) The value of a life estate on mortgaged property is based on equity rather than market value and the age of the individual.

(C) In the event the member does not accept as valid the value of the life estate as established through this method, the member must secure a written appraisal estimate by two (2) persons who are familiar with current values. If there is substantial unexplained divergence between these appraisals, the worker and the member will jointly arrange

for the market value to be established by an appraisal made by a third (3<sup>rd</sup>) person who is familiar with current market values and who is acceptable to both the member and the worker.

(5) Real and/or personal property which produces income is excluded if it meets the following conditions established in OAC 317:35-5-41.12.

**317:35-5-42. Determination of countable income for individuals categorically related to aged, blind and disabled**

(a) **General.** The term income is defined as ~~that a~~ gross gain or gross recurrent benefit ~~which is derived~~ that derives from labor, business, property, retirement and other benefits, ~~and many other forms which can be counted on as currently~~ or sources that are available for use on a regular basis. ~~When an individual's income is reduced due to recoupment of an overpayment or garnishment, the gross amount before the recoupment or garnishment is counted as income. Verification of the member's countable income or resources held in bank accounts or at other financial institutions can be established through an Asset Verification System (AVS).~~

(1) If it appears the applicant or SoonerCare member is eligible for any type of income (excluding Supplemental Security Income (SSI)) or resources, ~~he/she~~ Oklahoma Department of Human Services (OKDHS) staff must be notified notify the individual in writing by the Agency of his/her potential eligibility, per Section 416.210 of Title 20 of the Code of Federal Regulations (20 C.F.R. § 416.210). ~~The notice must contain the information that failure to file for and take all appropriate steps to obtain such benefit within thirty (30) days from the date of the notice will result in a determination of ineligibility.~~

(A) Potential income may include, but is not limited to:

- (i) Retirement, Survivors, Disability Insurance (RSDI) benefits;
- (ii) Benefits from the United States (U.S.) Department of Veterans Affairs (VA);
- (iii) Workers' compensation payments;
- (iv) Unemployment insurance benefits (UIB);
- (v) Annuities;
- (vi) Pensions or other retirement benefits; or
- (vii) Disability benefits.

(B) The notice must contain the information that failure to file for and take all appropriate steps to obtain the potential income within thirty (30) calendar days from the date of the notice will result in an ineligibility determination of ineligibility.

(C) When the individual has a good cause reason for not filing for the potential income within the thirty (30) calendar day period or taking other necessary steps to obtain the income, he or she is not determined ineligible.

~~(2) If a husband and wife are living spouses live in their own home, the couple's total income and/or resource is resources are divided equally between the two cases. If they both enter a nursing facility, their income and resources are considered separately.~~

(3) When an eligible individual or child resides with an ineligible spouse or parent(s), a portion of the ineligible spouse's or parent's income is deemed as available income to the eligible individual, per Oklahoma Administrative Code (OAC) 317:35-5-42(k).

~~(3)(4) If only one spouse in a couple is eligible and the couple ceases to livestops living together, only the income and resources of that the ineligible spouse that are actually contributedcontributes to the eligible spouse are considered in determining the eligible spouse's eligibility, beginning with the month after the month which they ceased to livestop living together are considered.~~

~~(4) In calculating monthly income, cents are included in the computation until the monthly amount of each individual's source of income has been established. When the monthly amount of each income source has been established, cents are rounded to the nearest dollar (1 - 49 cents is rounded down, and 50 - 99 cents is rounded up). For example, an individual's weekly earnings of \$99.90 are multiplied by 4.3 and the cents rounded to the nearest dollar (\$99.90 x 4.3 = \$429.57 rounds to \$430). See rounding procedures in OAC 340:65-3-4 when using BENDEX to verify Retirement, Survivors, and Disability Insurance (RSDI) benefits. Refer to OAC 317:35-9-68 to determine how to consider a community spouse's income eligibility for SoonerCare (Medicaid) when his or her spouse:~~

- (A) Is institutionalized in a nursing facility or an intermediate care facility for the intellectually disabled;
- (B) Is sixty-five (65) years or older and lives in a mental health hospital; or
- (C) Receives ADvantage or Home and Community Based Waiver services.

~~(5) In certain circumstances, the amount of income determined to be available to an individual may be greater than the amount of income the individual actually receives for his or her own use. This includes, but is not limited to:~~

- (A) Court-ordered income deductions for child and/or spousal support even when the support is paid directly to the child's guardian or spouse by the individual's employer or benefit payer;
- (B) Deductions due to a repayment of an overpayment, loan, or other debt, unless the amount being withheld to reduce a previous overpayment was included when determining the amount of unearned income for a previous month in the determination of medical assistance eligibility; or

(C) Garnishments or liens placed against earned or unearned income of the individual, regardless of the purpose for the garnishment or lien.

(6) The individual's statement regarding the source and amount of available income must be verified at application, renewal, and when changes occur by:

(A) Award letters, warrants, or other documents provided by the individual;

(B) Automated data exchange with other agencies such as Beneficiary and Earnings Data Exchange System (BENDEX); Supplemental Security Income (SSI)/State Data Exchange System (SDX), or UIB;

(C) The Asset Verification System (AVS) when income is held in bank accounts or other financial institutions;

(D) Public records; or

(E) Collateral contacts such as employers, agencies, businesses, or community action groups.

(7) The individual is responsible for reporting and verifying income changes within ten (10) calendar days of the change occurring.

~~(b) **Income disregards.** In determining need, the following are not considered as income:~~

~~(1) The value of Supplemental Nutrition Assistance Program (food stamps) received;~~

~~(2) Any payment received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970;~~

~~(3) Educational grants (excluding work study), scholarships, etc., that are contingent upon the student regularly attending school. The student's classification (graduate or undergraduate) is not a factor;~~

~~(4) Loans (regardless of use) if a bona fide debt or obligation to pay can be established. Criteria to establish a loan as bona fide includes:~~

~~(A) An acknowledgment of obligation to repay or evidence that the loan was from an individual or financial institution in the loan business. If the loan agreement is not written, an OKDHS Form 08AD103E, Loan Verification, should be completed by the borrower attesting that the loan is bona fide and signed by the lender verifying the date and amount of loan. When copies of written agreements or OKDHS Form 08AD103E are not available, detailed case documentation must include information that the loan is bona fide and how the debt amount and date of receipt was verified.~~

~~(B) If the loan was from a person(s) not in the loan business, the borrower's acknowledgment of obligation to repay (with or without interest) and the lender's verification of the loan are required to indicate that the loan is bona fide.~~

- ~~(C) Proceeds of a loan secured by an exempt asset are not an asset;~~
- ~~(5) One-third of child support payments received on behalf of the disabled minor child;~~
  - ~~(6) Indian payments (including judgment funds or funds held in trust) distributed by the Secretary of the Interior (Bureau of Indian Affairs) or distributed by the tribe subject to approval by the Secretary of the Interior. Also, any interest or investment income accrued on such funds while held in trust or any purchases made with judgment funds, trust funds, interest or investment income accrued on such funds. Any income from mineral leases, from tribal business investments, etc. However, any interest or income derived from the principal or produced by purchases made with funds after distribution is considered as any other income;~~
  - ~~(7) Special allowance for school expenses made available upon petition (in writing) for funds held in trust for the student;~~
  - ~~(8) Title III benefits from State and Community Programs on Aging;~~
  - ~~(9) Payment for supportive services or reimbursement of out-of-pocket expenses made to individual volunteers serving as foster grandparents, senior health aides, or senior companions, and to persons serving in the Service Corps of Retired Executives (SCORE) and Active Corps of Executives (ACE);~~
  - ~~(10) Payments to volunteers under the Domestic Volunteer Services Act of 1973 (VISTA), unless the gross amount of VISTA payments equals or exceeds the state or federal minimum wage, whichever is greater;~~
  - ~~(11) The value of supplemental food assistance received under the Child Nutrition Act or the special food service program for children under the National School Lunch Act;~~
  - ~~(12) Any portion of payments made under the Alaska Native Claims Settlement Act to an Alaska Native which are exempt from taxation under the Settlement Act;~~
  - ~~(13) Reimbursements from an employer for out-of-pocket expenditures and allowances for travel or training to the extent the funds are used for expenses directly related to such travel or training and uniform allowance if the uniform is uniquely identified with company names or logo;~~
  - ~~(14) Assistance or services from the Vocational Rehabilitation program such as transportation expenses to a rehabilitation center, extra clothing, lunches, grooming needed for a training program and any other such complementary payments;~~
  - ~~(15) Experimental Housing Allowance Program (EHAP) payments made under Annual Contributions Contracts entered into prior to January 1, 1975, under Section 23 of the U.S. Housing Act of 1937, as amended;~~
  - ~~(16) Payments made by a public or private non-profit child care agency for a child placed in foster care or subsidized adoption;~~

- ~~(17) Governmental rental or housing subsidies by governmental agencies, e.g., HUD (received in kind or in cash) for rent, mortgage payments, or utilities;~~
- ~~(18) Low Income Home Energy Assistance Program (LIHEAP) payments for energy assistance and payments for emergency situations under Emergency Assistance to Needy Families with Children;~~
- ~~(19) Payments made from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In Re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.);~~
- ~~(20) Payments made from the Radiation Exposure Compensation Trust Fund as compensation for injuries or deaths resulting from the exposure to radiation from nuclear testing and uranium mining;~~
- ~~(21) Federal major disaster and emergency assistance provided under the Disaster Relief Act of 1974, and comparable disaster assistance provided by States, local governments, and disaster assistance organizations;~~
- ~~(22) Income of a sponsor to the sponsored eligible alien;~~
- ~~(23) Income that is set aside under an approved Plan for Achieving Self-Support for Blind or Disabled People (PASS). The Social Security Administration (SSA) approves the plan, the amount of income excluded and the period of time approved. A plan can be approved for an initial period of eighteen (18) months. The plan may be extended for an additional eighteen (18) months if needed, and an additional twelve (12) months (total forty-eight (48) months) when the objective involves a lengthy educational or training program;~~
- ~~(24) Payments made to individuals because of their status as victims of Nazi persecution (PL 103-286);~~
- ~~(25) Payments received under the Civil Liberties Act of 1988. These payments are to be made to individuals of Japanese ancestry who were detained in internment camps during World War II;~~
- ~~(26) Payments received as a result of participation in a class action lawsuit entitled "Factor VIII or IX Concentrate Blood Products Litigation". These payments are made to hemophilia patients who are infected with HIV. However, if the payments are placed in an interest-bearing account, or some other investment medium that produces income, the income generated by the account may be countable as income to the individual;~~
- ~~(27) Payments made to certain Vietnam veterans' children with spina bifida (PL 104-204);~~
- ~~(28) Payments made to certain Korea service veterans' children with spina bifida (PL 108-183);~~

- ~~(29) Payments made to the children of women Vietnam veterans who suffer from certain birth defects (PL 106-419);~~
- ~~(30) Additional payments of regular unemployment compensation in the amount of \$25 per week ending June 30, 2010, and any amount of emergency unemployment compensation paid through May 31, 2010, as authorized under the American Recovery and Reinvestment Tax Act of 2009;~~
- ~~(31) Wages paid by the Census Bureau for temporary employment related to Census activities;~~
- ~~(32) Income tax refunds;~~
- ~~(33) Home energy assistance;~~
- ~~(34) Food or shelter based on need provided by nonprofit agencies;~~
- ~~(35) Money someone else spends to pay your expenses for items other than food or shelter (e.g., someone pays for your telephone or medical bills);~~
- ~~(36) Earned income for working students younger than twenty-two (22) years of age when they regularly attend a school, college, university or a course of vocational or technical training. Refer to Appendix C-1, Schedule VIII.E; Maximum Income, Resource and Payment Standards for the maximum monthly and yearly exclusion amounts;~~
- ~~(37) The cost of impairment-related work expenses for items or services that a disabled person needs in order to work; and~~
- ~~(38) The first \$2,000 of compensation received per calendar year for participating in certain clinical trials.~~

(b) **Sources of income considered.** The individual is responsible for reporting information regarding all sources of available income. All monies or payments that are available for current living expenses, unless specifically disregarded per (c) of this Section are considered in determining monthly gross income. Some of the more common income sources to be considered in determining eligibility are included in (1) through (8) of this subsection:

(1) **Annuities, pensions, retirement, disability, and other payments.** In accordance with 20 C.F.R. 416.1123, benefits and payments are considered for the month they are received, unless they include retroactive payments. Retroactive payments are considered as lump sum payments per (b) (5) of this Section.

(A) Payments include, but are not limited to:

- (i) RSDI and SSI benefits;
- (ii) Veteran's benefits;
- (iii) Railroad retirement annuities;
- (iv) Pensions, retirement, or disability benefits from government or private sources;
- (v) Workers' compensation; and
- (vi) UIB.

(B) Determination of RSDI benefits to be considered;

disregarding cost-of-living adjustments (COLAs) for former State Supplemental Payment recipients, who are reapplying for medical benefits under the Pickle Amendment, are computed, per OKDHS Appendix C-2-A, COLA Increase Computation Formulas.

(C) The U.S. Department of Veterans Affairs allows their recipients to request reimbursement for medical expenses not covered by SoonerCare. When a recipient is eligible for a readjustment payment, it is paid in a lump sum for the entire past year. When received, this reimbursement is disregarded as income or a resource for the month received. Any amount retained in the month following receipt is considered as a resource.

(D) Government financial assistance in the form of VA Aid and Attendance or Champus payments are considered as:

- (i) A third party resource whether paid to the individual or the facility when the individual resides in a nursing facility. These payments do not affect income eligibility or the vendor payment of the member; or
- (ii) Excluded income when paid for an attendant in the individual's home.

(E) SSI benefits may be continued for up to three (3) months for a recipient who enters a public medical or psychiatric institution, a SoonerCare approved hospital, extended care facility, intermediate care facility for individuals with an intellectual disability, or nursing facility. To be eligible for the continuation of benefits, the SSI recipient must have a physician's certification that the institutionalization is not expected to exceed three (3) months and there must be a need to maintain and provide expenses for the home. These continued payments are intended for the use of the recipient and do not affect the vendor payment.

(F) A veteran or his or her surviving spouse who receives a VA pension may have the pension reduced to ninety dollars (\$90) per month if the veteran does not have dependents, is SoonerCare (Medicaid) eligible, and resides in a nursing facility that is approved under SoonerCare, per Section 8003 of Public Law (P.L.) 101-508. The VA pension for a veteran or his or her surviving spouse who meets these conditions is reduced the month following the month of admission to a SoonerCare (Medicaid) approved nursing facility.

- (i) The reduced VA pension is not used to compute the vendor payment or spenddown. The nursing facility resident is entitled to receive the ninety-dollars (\$90) reduced VA pension and the regular nursing facility maintenance standard, per OKDHS Appendix C-1, Maximum

Income, Resource, and Payment Standards, Schedule VIII.B.2, Maximum Income, Resource, and Payment Standards.

(ii) The vendor payment or spenddown is computed using other income minus the monthly nursing facility maintenance standard and any applicable medical deductions.

(2) **Child support and alimony payments.** Child support and alimony payments are counted as unearned income whether in cash or in-kind. Per (f)(11) of this Section, one-third of child support payments received on behalf of the disabled minor child is excluded.

(3) **Dividends, interest, and certain royalties.** Dividends, interest, and certain royalties are counted as unearned income. Dividends and interest are returns on capital investments, such as stocks, bonds, or savings accounts. Royalties are compensation paid to the owner for the use of property or natural resources. Royalties are considered earned income when received as part of the individual's trade or business or in conjunction with a work publication.

(4) **Income from capital resources and rental property.** Income from capital resources may be received from the use of real or personal property, such as land, housing, machinery, leasing of minerals, a life estate, homestead rights, or interest.

(A) Rental income may be treated as self-employment income when the individual participates in the management of the trade or business or invests his/her own labor in producing the income. When the individual does not participate in the management of the trade or business or does not invest his/her own labor in producing the income, it is considered as unearned income.

(i) The individual's federal income tax return or business records verify when the rental income is considered as self-employment income. When the individual's federal tax return or business records do not verify the rental income is from self-employment, the income is considered unearned income.

(ii) Expenses necessary for the production or collection of the rental income are deducted when paid, not when they are incurred. Examples of deductible expenses include interest on debt, state and local taxes on real or personal property and on motor fuel, general sales taxes, and expenses on managing or maintaining the property. Depreciation or depletion of property is not considered a deductible expense.

(iii) When rental property is handled by a leasing agent who collects the rent and deducts a management fee, only

the rent actually received by the individual is considered as income.

(B) If the individual receives royalty income monthly but in irregular amounts or less often than monthly, the income is averaged over the previous six (6) month period to determine the countable monthly income.

(i) At any time a dramatic increase or decrease in royalty income occurs, the previous two (2) months of royalty income is averaged to compute the countable monthly income.

(ii) When the difference between the gross and net royalty income is due to a production or severance tax, the net income is used to determine income eligibility as this tax is considered the cost of producing the income.

(5) **Lump sum payments.** Any income received in a lump sum, with the exception of an SSI or RSDI lump sum, covering a period of more than one (1) month, whether received on a recurring or nonrecurring basis, is considered as income in the month it is received. Any amount retained on the first day of the month following receipt of the lump sum is considered as a resource.

(A) A lump sum payment may be considered as earned or unearned income, depending on the source of the lump sum payment. Lump sum payments may include, but are not limited to:

- (i) Wages or wage bonuses;
- (ii) Retroactive RSDI, VA, or workers' compensation payments;
- (iii) Bonus lease payments;
- (iv) Annual rentals from land or minerals;
- (v) Life insurance death benefits;
- (vi) Lottery or gambling winnings;
- (vii) Personal injury awards or settlements; or
- (viii) Inheritances.

(B) RSDI and SSI retroactive payments do not count as income in the month of receipt. Any unspent portion retained on the first day of the month following receipt of the lump sum is excluded from resources for nine (9) calendar months, per 20 C.F.R. § 416.1233. However, unspent money from a retroactive payment must be identifiable from other resources for this exclusion to apply. The money may be commingled with other funds, but if this is done in such a fashion that the retroactive amount can no longer be separately identified, that amount is counted toward the resource limit.

(C) Lump sum payments used to establish dedicated bank accounts by representative payees in order to receive and maintain retroactive SSI benefits for children with

disabilities or blindness who are under eighteen (18) years of age are excluded as income or a resource. The interest income generated from dedicated bank accounts is also excluded.

(D) A life insurance death benefit received by the individual for another person is considered as income in the month received except for amounts paid for the person's last illness and burial expenses. Money retained in the month following receipt of the benefit is counted as a resource to the extent that it is available.

(E) Changing a resource from one form to another, such as converting personal property to cash, is not considered a lump sum payment, all other things being equal.

(6) **Non-negotiable notes and mortgages.** Installment payments received on a note or mortgage are considered as monthly unearned income.

(7) **Income from the Workforce Innovation and Opportunity Act (WIOA).** Unearned income received by an adult, such as a need-based payment, cash assistance, compensation in lieu of wages, or allowances from a program funded by WIOA is considered as any other unearned income.

(8) **In-kind support and maintenance.** In-kind support and maintenance is food or shelter given to the individual or that the individual receives because someone else pays for it. Shelter includes room, rent, mortgage payments, real property taxes, heating fuel, gas, electricity, water, sewerage, and garbage collection services. The value of this support may be counted as income using the one-third reduction rule, per 20 C.F.R. §§ 416.1131 through 416.1133 or the presumed value rule, per 20 C.F.R. §§ 416.1140 through 416.1145.

(A) **One-third reduction rule.** The one-third reduction rule applies when the individual or the individual and his/her spouse lives in the household of a person who provides him/her with both food and shelter for at least a full calendar month. Per 20 C.F.R. § 416.1131, instead of determining the actual value of in-kind support and maintenance, one-third of the SSI federal benefit rate, per OKDHS Appendix C-1, Schedule VIII.C is counted as income.

(i) The one-third reduction rule applies in full or not at all. When the individual lives in another person's household and the one-third reduction rule applies, no income exclusions are applied to the reduction amount.

(ii) When the one-third reduction rule applies and the individual receives other support and maintenance, the other support and maintenance is not counted.

(iii) The one-third reduction rule does not apply when the individual or the individual and his/her spouse:

(I) Lives in another person's household but does not receive both food and shelter from that person;

(II) Lives in his/her own household; or

(III) Lives in a non-medical institution such as a public or private non-profit educational or vocational institution, or a private non-profit retirement home.

(B) **Another person's household.** The individual is considered to be living in another person's household if the person is not considered to be living in his/her own home per (C) of this subsection, the person who supplies the support and maintenance lives in the same household, and is not:

(i) The individual's spouse;

(ii) A minor child; or

(iii) An ineligible person whose income may be deemed to the individual per OAC 317:35-5-42(k).

(C) **Living in own household.** The individual or the individual and his/her spouse are considered to be living their own household when:

(i) The individual, the individual and his/her spouse, or a person whose income is deemed to the individual, live in a home in which one of them has an ownership interest or life estate in the home;

(ii) The individual, the individual and his/her spouse, or a person whose income is deemed to the individual is liable for any part of the rent charges;

(iii) The individual pays at least a pro rata share of the household and operating expenses;

(iv) The individual lives in a non-institutional care setting. The individual is considered to be living in a non-institutional care situation when:

(I) He/she is placed by a public or private agency under a specific program such as foster or family care;

(II) The placing agency is responsible for the individual's care;

(III) He/she lives in a private household that is licensed or approved by the placing agency to provide care; and

(IV) The individual, a public agency, or someone else pays for his/her care; or

(v) All members of the household receive public maintenance payments such as:

(I) Supplemental Security Income (SSI);

(II) State Supplemental Payment (SSP);

(III) Temporary Assistance for Needy Families (TANF);

(IV) Refugee cash assistance;

(V) Assistance provided under the Disaster Relief and

Emergency Assistance Act;

(VI) Bureau of Indian Affairs (BIA) general assistance programs;

(VII) State or local government assistance programs based on need; or

(VIII) VA payments based on need.

(D) **Presumed value rule.** The presumed value rule applies when the individual receives in-kind support and maintenance and the one-third reduction rule does not apply. The maximum presumed value is one-third of the SSI FBR, per OKDHS Appendix C-1, Schedule VIII.C plus the \$20 general income exclusion.

(i) The presumed value rule allows the individual to show that the amount of in-kind support and maintenance is not equal to the maximum presumed value. When the individual does not question the maximum presumed value, one-third of the SSI FBR, per OKDHS Appendix C-1, Schedule VIII.C plus the \$20 general income exclusion is counted as unearned income.

(I) When the individual disputes the amount counted for in-kind support and maintenance, he/she may verify that the current market value of the food or shelter he/she receives or the actual amount someone else pays for the individual's food and shelter is lower than the maximum presumed value.

(II) When the individual verifies that the food or shelter received is lower the maximum presumed value, the lower amount is used as the presumed value and counted as unearned income.

(III) When the individual verifies the actual value of the food or shelter he she receives and it is higher than the maximum presumed value amount, the actual amount is counted as unearned income.

(ii) In-kind support and maintenance received by an individual is excluded if:

(I) It is identified as excluded per (e) or (f) of this Section,

(II) It is received from another member of a public assistance household; or

(iii) The individual receives SSI and the SSA does not reduce the individual's SSI benefit because of in-kind support and maintenance.

(iv) When the individual or the individual and his or her spouse live in a household in which all members receive a public maintenance payment per (b) (8) (C) (v) of this subsection, in-kind support and maintenance is not counted unless the individual receives food and shelter

from someone outside of the household.

(9) **Earned income.** Earned income may include:

(A) **Wages.** Wages include the gross income earned for work performed as an employee before deductions, such as taxes, bonds, pensions, union dues, credit union payments, or cafeteria plans are subtracted.

(i) Wages paid in cash may include salaries, commissions, tips, piece-rate payments, longevity payments, bonuses, severance pay, and any other special payments received due to employment.

(ii) Wages paid to uniformed service members include basic pay, some types of special pay, and some allowances. Allowances paid for on-base housing or privatized military housing are considered unearned income in the form of in-kind support and maintenance. Allowances paid for private housing are considered wages.

(iii) Wages paid in-kind may include the value of food, clothing, shelter, or other items provided in lieu of or in conjunction with wages. The cash value of in-kind benefits must be verified by the employer. Medical insurance secured through the employer, whether purchased or as a benefit, is not considered a countable in-kind benefit. Exception: In-kind pay received by a domestic or agricultural worker is considered unearned income.

(iv) Work study received by an individual who is attending school is considered as earned income with appropriate earned income exclusions, per (g) of this Section applied.

(v) Payments received for services performed in a sheltered workshop or work activities center are counted as earned income. Payments for each calendar quarter are averaged to determine monthly income.

(vi) Income received as wages from a program funded by WIOA is counted as any other earned income.

(vii) Earnings received from the Senior Community Service Employment Program under Title V of the Older Americans Act of 1965 as amended and employment positions allocated at the discretion of Governor of Oklahoma are counted as earned income.

(B) **Self-employment income.** Self-employment income is the gross income earned from a trade or business. Self-employment income also includes in-kind benefits for a work activity or service for which the self-employed person ordinarily receives payment in his/her business enterprise, such as an exchange of business or labor, the individual's share of profit or loss in any partnership to which he/she belongs, and money received for the sale of whole blood or

plasma. Income eligibility is based on the individual's net self-employment income after subtracting business expenses. Refer to (i)(4) of this Section for self-employment income determination procedures.

(c) **What is not income.** Items that are not considered income per 20 C.F.R. § 416.1103 because the individual cannot use them as food or shelter or to obtain food or shelter include, but are not limited to:

(1) Medical care and services, including medical insurance premiums paid directly by anyone on the individual's behalf:

(2) Social services, as follows:

(A) Assistance provided in cash or in-kind under any federal, state, or local government program to provide social services such as vocational rehabilitation or VA aid and attendance services;

(B) In-kind assistance provided under a non-governmental program for social services. This does not include food or shelter;

(C) Cash provided by a non-governmental social services program, except for cash to cover food or shelter, when the cash:

(i) Is a repayment for program-approved services for which the individual already paid; or

(ii) Is a payment restricted to the future purchase of a program-approved service.

(3) Receipts from the sale, exchange, or replacement of a resource, including cash or an in-kind item provided to replace or repair a resource that was lost, damaged, or stolen;

(4) Any amount refunded on income taxes already paid by the individual;

(5) Payments made to the individual under a credit life or credit disability insurance policy;

(6) Money the individual borrows or receives as repayment of a loan. When the individual borrow money, regardless of use, it is not considered income if a bona fide debt or obligation to pay can be established. Interest the individual receives on money he/she loans someone else is considered income. Criteria to establish a loan as bona fide includes:

(A) An acknowledgment of the obligation to repay or evidence that the loan was from an individual or financial institution in the loan business. If the loan agreement is not written, OKDHS Form 08AD103E, Loan Verification, should be completed by the borrower attesting that the loan is bona fide and signed by the lender verifying the date and amount of loan. When copies of written agreements or OKDHS Form 08AD103E are not available, documentation must show that the loan is bona fide and how the debt amount and date of receipt was

verified.

(B) The borrower's acknowledgment of obligation to repay, with or without interest, and the lender's verification of the loan are required to indicate that the loan is bona fide when the loan is from a person(s) not in the loan business.

(7) Bills paid for the individual by someone else directly to the provider unless it is considered payment for food or shelter;

(8) Replacement of income that is lost, destroyed, or stolen, such as receiving a replacement paycheck because the original payment was stolen;

(9) Weatherization assistance; or

(10) Receipt of certain non-cash items that would be excluded as a non-liquid resource.

(d) **Income exclusions.** Certain types and amounts of income are excluded in determining the individual's eligibility for SoonerCare. When applying exclusions:

(1) Unearned income exclusions are applied before applying earned income exclusions;

(2) Income excluded by other federal laws per (e) of this Section are excluded first and then unearned income excluded by the Social Security Act per (f) of this Section;

(3) Earned income exclusions are then applied in the order listed per (h) of this Section;

(4) Income must never reduce income below zero;

(5) Unused portions of a monthly exclusion must not be carried over for use in a subsequent month;

(6) Other than the \$20 general income exclusion, unused unearned income exclusions are not applied to earned income; and

(7) Unused earned income exclusions are never applied to unearned income.

(e) **Income excluded by other federal laws.** Unearned income excluded by federal laws other than the Social Security Act, per the Appendix to Subpart K of Part 416, includes:

(1) Federal food and nutrition programs, including:

(A) The value of Supplemental Nutrition Assistance Program food benefits;

(B) U.S. Department of Agriculture food commodities distributed by a private or governmental program;

(C) The value of supplemental food assistance received under the Child Nutrition Act or the special food service program for children under the National School Lunch Act;

(D) Women, infants, and children program (WIC); and

(E) Nutrition programs for older Americans;

(2) Housing and utility programs including:

(A) Energy assistance provided through the Low Income Home Energy Program that includes the Energy Crisis Assistance

Program;

(B) Housing assistance provided under the:

(i) U.S. Housing Act of 1937;

(ii) National Housing Act;

(iii) Governmental rental or housing subsidies received in-kind or in cash by governmental agencies, such as the Department of Housing and Urban Development (HUD) for rent, mortgage payments, or utilities;

(iv) Title V of the Housing Act of 1949; or

(v) Any payment received under Section 216 of P. L, 91-646, the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970;

(3) Student financial assistance that includes:

(A) Grants or loans to undergraduate students made or insured under programs administered by the Secretary of Education under Section 507 of the Higher Education Amendments of 1968 (P. L. 90-575);

(B) Wages, allowances, or reimbursements for transportation and attendant care costs, unless excepted on a case-by-case basis, when received by an eligible individual with disabilities employed in a project under Title VI of the Rehabilitation Act of 1973 as added by 29 U.S.C. § 795(b) (c); and

(C) Student financial assistance received for attendance costs from a program funded in whole or in part under Title IV of the Higher Education Act of 1965, as amended, or under BIA student assistance programs when it is made available for tuition and fees normally assessed to a student carrying the same academic workload, as determined by the institution. This includes costs for rental or purchase of any equipment, materials, or supplies required of all students in the same course of study and an allowance for books, supplies, transportation, and miscellaneous personal expenses for a student attending the institution on at least a half-time basis, as determined by the institution, under Section 14(27) of P. L. 100-50, the Higher Education Technical Amendments Act of 1987 (20 U.S.C. § 1087uu);

(4) Native American payments excluded without regard to a specific tribe or group includes:

(A) Indian judgment funds that are held in trust by the Secretary of the Interior or distributed per capita pursuant to a plan prepared by the Secretary of the Interior and not disapproved by a joint resolution of the Congress under P. L. 93-134 as amended by Section 4 of P. L. 97-458 (25 U.S.C. § 1408). Indian judgment funds include interest and investment income accrued while such funds are so held in trust. This exclusion extends to initial purchases made with

Indian judgment funds but does not apply to sales or conversions of initial purchases or to subsequent purchases. This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household;

(B) All funds held in trust by the Secretary of the Interior for an Indian tribe and distributed per capita to a member of that tribe under P.L. 98-64 (25 U.S.C. § 117b). Funds held by Alaska Native Regional and Village Corporations (ANRVC) are not held in trust by the Secretary of the Interior and therefore ANRVC dividend distributions are not excluded from countable income under this exclusion. This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household;

(C) Cash distributions and dividends received by an individual Alaska Native or descendant under the Alaska Native Claims Settlement Act Amendments of 1987, P.L. 100-241, (43 U.S.C. § 1626(c)) to the extent that it does not, in the aggregate, exceed two-thousand dollars (\$2,000) per individual each year. This exclusion does not apply in deeming income from sponsors to aliens;

(D) Up to two-thousand dollars (\$2,000) per year received by Indians that is derived from individual interests in trust or restricted lands under P.L. 103-66, (25 U.S.C. § 1408), as amended;

(5) Payments made to members of specific Indian tribes and groups. Refer to 20 C.F.R § 416 Subpart K Appendix, Section IV.B for the complete list. Payments to tribes in Oklahoma on this list include:

(A) Judgement funds distributed per capita to, or held in trust for, members of the Sac and Fox Indian Nation, and the availability of such funds under Section 6 of P. L. 94-189. This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household;

(B) Any judgement funds distributed per capita or made available for programs for members of the Delaware Tribe of Indians and the Absentee Delaware Tribe of Western Oklahoma under Section 8 of P. L. 96-318;

(C) Any distribution of judgement funds to members of the Wyandotte Nation of Oklahoma under Section 6 of P. L. 97-371;

(D) Distributions of judgement funds to members of the Shawnee Tribe of Indians (Absentee Shawnee Tribe of Oklahoma, the Eastern Shawnee Tribe of Oklahoma, and the Cherokee Band of Shawnee descendants) under Section 7 of P. L. 97-372;

(E) Judgement funds distributed per capita or made available for programs for members of the Miami Tribe of Oklahoma and

the Miami Indians of Indiana under Section 7 of P. L. 97-376;

(F) Judgement funds distributed per capita or made available for any tribal program for members of the Wyandotte Nation of Oklahoma and the Absentee Wyandottes under Section 106 of P. L. 98-602; and

(F) Judgement funds distributed per capita, or held in trust, or made available for programs, for members of the Seminole Nation of Oklahoma, the Seminole Tribe of Florida, the Miccosukee Tribe of Indians of Florida, and the independent Seminole Indians of Florida under Section 8 of P. L. 101-277. This exclusion applies to income of sponsors of aliens only when the alien lives in the sponsor's household;

(6) Receipts from lands held in trust and:

(A) Distributed to members of certain Indian tribes under Section 6 of P.L. 94-114, (25 U.S.C. § 459e);

(B) Awarded to the Pueblo of Santa Ana and distributed to members of that tribe under Section 6 of P.L. 95-498; and

(C) Awarded to the Pueblo of Zia in New Mexico and distributed to members of that tribe under Section 6 of P.L. 95-499;

(7) Compensation provided to volunteers by the Corporation for National and Community Service (CNCS), unless determined by the CNCS to constitute the federal or state minimum wage. Programs included under CNCS include:

(A) AmeriCorps programs;

(B) The Retired Senior Volunteer Program;

(C) The Foster Grandparent Program; and

(D) The Senior Companion Program;

(8) Benefits from State and Community Programs on Aging, per Title III of the Older Americans Act of 1965, as amended by P.L. 114-144, Older Americans Act Reauthorization Act of 2016. Income received from the Senior Community Service Employment Program under Title V of the Older Americans Act as well as employment positions allocated at the discretion of Governor of Oklahoma is counted as earned income;

(9) Payments made as restitution under the Civil Liberties Act of 1988 to certain individuals of Japanese ancestry who were detained in internment camps during World War II;

(10) Payments made on or after January 1, 1989, from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In Re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.) under P. L. 101-201 and Section 10405 of P.L. 101-239;

(11) Payments made under Section 6 of the Radiation Exposure Compensation Act, P.L. 101-426 for injuries or deaths resulting from the exposure to radiation from nuclear testing and uranium

mining;

(12) The value of any child care provided or arranged under the Child Care and Development Block Grant Act, as amended by Section 8(b) of P.L. 102-586.

(13) Payments made to individuals because of their status as victims of Nazi persecution per P.L. 103-286;

(14) Matching funds and any interest earned on these funds that are deposited into individual development accounts (IDAs), as a demonstration project or TANF-funded, per 42 U.S.C. § 604;

(15) Payments made to individuals who were captured and interned by the Democratic Republic of Vietnam as a result of participation in certain military operations, per P.L. 105-78;

(16) Payments made to certain Vietnam or Korea veterans' children with spina bifida, per P.L. 104-204 (38 U.S.C. § 1805(a)) or PL 108-183;

(17) Payments made to the children of women Vietnam veterans who suffer from certain birth defects, per P.L. 106-419 (38 U.S.C. § 1833(c));

(18) Payments of the refundable child tax credit made under Section 24 of the Internal Revenue Code of 1986;

(19) Assistance provided for flood mitigation activities, per Section 1 of P.L. 109-64 (42 U.S.C. § 4031);

(20) Payments made to individuals under the Energy Employees Occupational Illness Compensation Program Act of 2000, per Section 1 of P.L. 106-398 (42 U.S.C. § 7385e); and

(21) The Oklahoma Achieving a Better Life Experience (ABLE) Program, in accordance with OAC 317:35-5-41.9(c)(1) and 26 U.S.C. § 529A. Money deposited into or withdrawn from a qualified ABLE Program account or a qualified ABLE Program account set up in any other state, is excluded as income or a resource when the individual:

(A) Provides documents to verify the account meets exemption criteria;

(B) Verifies money deposited in the account does not exceed the annual federal gift tax exclusion amount per 26 U.S.C. § 2503(b). Any money deposited in the account in the calendar year that is in excess of the annual federal gift tax exclusion amount is considered as countable income in the amount deposited; and

(C) Verifies withdrawals from the account were used to pay qualified disability expenses (QDE). Money withdrawn for reasons other than to pay QDE is considered as income for the month of withdrawal.

(22) Any other income exempted by new or revised federal statutes that are in effect before the Subpart K Appendix is updated.

**(f) Unearned income excluded by the Social Security Act. Unearned**

income excluded by the Social Security Act, per 20 C.F.R. § 416.1124 includes:

- (1) Any public agency's refund of taxes on real property or food;
- (2) Need-based assistance that is wholly funded by a State or one of its political subdivisions. For purposes of this rule, an Indian tribe is considered a political subdivision of a State. Assistance is based on need when it is provided under a program that uses the individual's income as an eligibility factor. State need-based assistance programs include the SSP program, but not federal/state programs such as TANF;
- (3) Any portion of a grant, scholarship, fellowship, or gift used or set aside for paying tuition, fees, or other necessary educational expenses. This does not include any portion set aside or actually used for food or shelter;
- (4) Food raised by the individual and/or his or her spouse, if it is consumed by the individual or the individual's household;
- (5) Assistance received under the Disaster Relief and Emergency Assistance Act and assistance provided under any federal statute because of a presidentially-declared disaster;
- (6) The first sixty dollars (\$60) of unearned income received in a calendar quarter that is received infrequently or irregularly. Income is considered:
  - (A) To be infrequent when the individual receives it only once during a calendar quarter from a single source and did not receive that type of income in the month preceding or following the month the income was received; and
  - (B) Irregular when the individual cannot reasonably expect to receive it;
- (7) Alaska longevity bonus payments;
- (8) Payments for providing foster care to an ineligible child placed in the individual's home by a public or private nonprofit child placement or child care agency;
- (9) Any interest earned on excluded burial funds and any appreciation in the value of an excluded burial arrangement that are left to accumulate and become a part of the separate burial fund;
- (10) Certain support and maintenance assistance as described in 20 C.F.R. §416.1157 that is certified in writing by the appropriate state agency to be both based on need and:
  - (A) Provided in-kind by a private nonprofit agency; or
  - (B) Provided in cash or in-kind by a:
    - (i) Supplier of home heating oil or gas;
    - (ii) Rate-of-return entity providing home energy; or
    - (iii) A municipal utility providing home energy;
- (11) One-third of child support payments received on behalf of the minor child with disabilities;

(12) The first twenty dollars (\$20) of any unearned income received in a month other than income in the form of in-kind support and maintenance received in the household of another per (b) (8) of this Section and need-based income. Need-based income is a benefit that uses financial need as a factor to determine eligibility. The twenty dollars (\$20) exclusion does not apply to a needs-based benefit that is totally or partially funded by the federal government or by a nongovernmental agency. However, assistance which is based on need and funded wholly by a State or one of its political subdivisions, such as SSP, is excluded totally from income. When the individual has less than twenty dollars (\$20) of unearned income in a month, the rest of the twenty dollars (\$20) exclusion may be deducted from the individual's countable earned income;

(13) Any unearned income received and used to fulfill an approved plan to achieve self-support (PASS) for an individual with disabilities or blindness. The Social Security Administration (SSA) approves the plan, the amount of income excluded, and the period of time approved;

(14) Federal housing assistance provided under:

(A) The U.S. Housing Act of 1937;

(B) The National Housing Act;

(C) Section 101 of the Housing and Urban Development Act of 1965;

(D) Title V of the Housing Act of 1949; or

(E) Section 202(h) of the Housing Act of 1959;

(15) Any interest accrued on and left to accumulate as part of the value of an excluded burial space purchase agreement. This exclusion from income applies to interest accrued on or after April 1, 1990;

(16) The value of any commercial transportation ticket among the fifty states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands, that is received as a gift and is not converted to cash;

(17) Payments received by an individual from a fund established by a state to aid crime victims;

(18) Relocation assistance provided by a state or local government that is comparable to assistance provided under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 that is subject to the treatment required by Section 216 of that Act;

(19) Special pay received from one of the uniformed services, per 37 U.S.C. § 310;

(20) Interest or other earnings on a dedicated account established for an eligible individual under eighteen (18) years of age when past due benefit payments must or may be paid

into such an account, per 20 C.F. R. § 416.1247;

(21) Gifts to children under eighteen (18) years of age with life-threatening conditions from an organization described in Section 501(c) (3) of the Internal Revenue Code of 1986, provided that:

(A) In-kind gifts not converted to cash; or

(B) Cash gifts do not exceed two-thousand dollars (\$2,000) within a calendar year;

(22) Interest and dividend income from a countable resource or from a resource excluded under a federal statute other than Section 1613(a) of the Social Security Act;

(23) AmeriCorps State and National and Americorps National Civilian Community Corps cash or in-kind payments made to participants or on their behalf, such as food, shelter, and clothing allowances;

(24) Any annuity paid by a state to an individual, or his or her spouse, based on the State's determination that the individual is a veteran and is blind, disabled, or aged; and

(25) The first two-thousand dollars (\$2,000) per calendar year received as compensation for participation in clinical trials that meet the criteria, per Section 1612(b) (26) of the Social Security Act.

(g) **Earned income exclusions.** Per 20 C.F.R. § 416.1112, earned income exclusions are applied after the unearned income exclusions, and in the order listed per (1) through (11) of this subsection. Earned income exclusions must not exceed the amount earned and include:

(1) Earned income tax credit and child tax credit payments;

(2) The first \$30 of infrequent or irregular earned income received in a calendar quarter;

(3) The student earned income exclusion (SEIE) up to the SEIE monthly limit, per OKDHS Appendix C-1, Schedule VIII.E is applied to the earned income of a student who:

(i) Is blind or disabled;

(ii) Is under twenty-two (22) years of age; and

(iii) Attends a college, university, or a course of vocational or technical training designed to prepare students for gainful employment;

(4) Any portion of the twenty (\$20) month general income exclusion that was not excluded from unearned income in the same month;

(5) The first five-hundred dollars (\$500) of the monthly earnings of an individual who is blind, per Section 15 of Title 7 of the Oklahoma Statutes;

(6) Sixty-five dollars (\$65) of earned income in a month. This exclusion is applied once per couple;

(7) The earned income individuals with disabilities who are not

blind used to pay impairment-related work expenses, per 20 C.F.R. § 404.1576, including, but not limited to:

- (A) Attendant care services;
- (B) Assistance with personal functions;
- (C) Payments for medical devices;
- (D) Payments for prosthetic devices;
- (E) Payments for work-related equipment;
- (F) Payments for drugs and medical services used to control the impairment; and
- (G) Payments for transportation costs;

(8) One-half of any remaining earned income in a month;  
(9) Actual work expenses paid by individuals who are blind and under age sixty-five (65) or who receive SSI as a blind person the month before reaching the age of sixty-five (65), such as transportation expenses to and from work and job performance or improvement expenses;

(10) Earned income received and used to fulfill an approved plan to achieve self-support (PASS) for individuals who are blind or disabled and under sixty-five (65) years of age or who are blind and disabled and received SSI as a blind or disabled person for the month before reaching sixty-five (65) years of age. The SSA approves the plan, the amount of income excluded, and the period of time approved; and

(11) Payments made to participants in AmeriCorps State and National and AmeriCorps National Civilian Community Corps (NCCC). These payments may be made in cash or in-kind and may be made directly to the AmeriCorps participant or on the AmeriCorps participant's behalf. These payments include, but are not limited to: living allowance payments, stipends, educational awards, and payments in lieu of educational awards.

**(h) Unused exclusions. Unused:**

- (A) Earned or unearned exclusions are never reduced below zero;
- (B) Portions of a monthly exclusion cannot be carried over for use in a subsequent month;
- (C) Earned income exclusions are never applied to unearned income;
- (D) Unearned income exclusions are not applied to earned income except for any remaining portion of the \$20 general income exclusion.

~~(e)(i) **Determination of income**Monthly income determination. The member is responsible for reporting information regarding all sources of available income. This information is verified and used by the worker in determining eligibility. The total gross amount of earned and unearned income available to the eligible individual and eligible or ineligible spouse is determined before subtracting applicable unearned and earned income exclusions per (d) through (g) of this section. In calculating monthly income, cents are~~

included in the computation until the monthly amount of each income source is established. Once the monthly amount of each income source is established, cents are rounded to the nearest dollar (one (1) to forty-nine (49) cents is rounded down, and fifty (50) to ninety-nine (99) cents is rounded up).

~~(1) Gross income is listed for purposes of determining eligibility. It may be derived from many sources, and some items may be automatically disregarded by the computer when so provided by state or federal law.~~

~~(2) If a member is determined to be categorically needy and is also an SSI recipient, any change in countable income (see OAC 317:35-5-42(d)(3) to determine countable income) will not affect receipt of SoonerCare and amount of State Supplemental Payment (SSP) as long as the amount does not cause SSI ineligibility. Income which will be considered by SSI in the retrospective cycle is documented in the case with computer update at the time that SSI makes the change (in order not to penalize the member twice). If the SSI change is not timely, the worker updates the computer using the appropriate date as if it had been timely. If the receipt of the income causes SSI ineligibility, the income is considered immediately with proper action taken to reduce or close the SoonerCare benefit and SSP case. Any SSI overpayment caused by SSA not making timely changes will result in recovery by SSI in the future. When the worker becomes aware of income changes which will affect SSI eligibility or payment amount, the information is to be shared with the SSA office.~~

~~(3) Some of the more common income sources to be considered in determining eligibility are as follows:~~

~~(A) **Retirement and disability benefits.** These include but are not limited to OASDI, VA, Railroad Retirement, SSI, and unemployment benefits. Federal and State benefits are considered for the month they are intended when determining eligibility.~~

~~(i) Verifying and documenting the receipt of the benefit and the current benefit amount are achieved by:~~

~~(I) seeing the member's award letter or warrant;~~

~~(II) obtaining a signed statement from the individual who cashed the warrant; or~~

~~(III) by using BENDEX and SDX.~~

~~(ii) Determination of OASDI benefits to be considered (disregarding COLA's) for former State Supplemental recipients who are reapplying for medical benefits under the Pickle Amendment must be computed according to OKDHS Form 08AX011E.~~

~~(iii) The Veterans Administration allows their recipients the opportunity to request a reimbursement for medical~~

~~expenses not covered by SoonerCare. If a recipient is eligible for the readjustment payment, it is paid in a lump sum for the entire past year. This reimbursement is disregarded as income and a resource in the month it is received; however, any amount retained in the month following receipt is considered a resource.~~

~~(iv) Government financial assistance in the form of VA Aid and Attendance or Champus payments is considered as follows:~~

~~(I) **Nursing facility care.** VA Aid and Attendance or Champus payment whether paid directly to the member or to the facility, are considered as third party resources and do not affect the income eligibility or the vendor payment of the member.~~

~~(II) **Own home care.** The actual amount of VA Aid and Attendance payment paid for an attendant in the home is disregarded as income. In all instances, the amount of VA Aid and Attendance is shown on the computer form.~~

~~(v) Veterans or their surviving spouse who receive a VA pension may have their pension reduced to \$90 by the VA if the veteran does not have dependents, is SoonerCare eligible, and is residing in a nursing facility that is approved under SoonerCare. Section 8003 of Public Law 101-508 allows these veterans' pensions to be reduced to \$90 per month. None of the \$90 may be used in computing any vendor payment or spenddown. In these instances, the nursing home resident is entitled to the \$90 reduced VA pension as well as the regular nursing facility maintenance standard. Any vendor payment or spenddown will be computed by using other income minus the monthly nursing facility maintenance standard minus any applicable medical deduction(s). Veterans or their surviving spouse who meet these conditions will have their VA benefits reduced the month following the month of admission to a SoonerCare approved nursing facility.~~

~~(B) **SSI benefits.** SSI benefits may be continued up to three months for a recipient who enters a public medical or psychiatric institution, a SoonerCare approved hospital, extended care facility, intermediate care facility for individuals with an intellectual disability or nursing facility. To be eligible for the continuation of benefits, the SSI recipient must have a physician's certification that the institutionalization is not expected to exceed three (3) months and there must be a need to maintain and provide expenses for the home. These continued payments are intended for the use of the recipient and do not affect the vendor payment.~~

~~(C) Lump sum payments.~~

~~(i) Any income received in a lump sum (with the exception of SSI and Retirement, Survivors, and Disability Insurance (RSDI) lump sum) covering a period of more than one (1) month, whether received on a recurring or nonrecurring basis, is considered as income in the month it is received. Any amount from any lump sum source, excluding RSDI and SSI (with the exception of dedicated bank accounts for disabled/blind children under age eighteen (18)), retained on the first day of the next month is considered as a resource. Such lump sum payments may include, but are not limited to, accumulation of wages, VA benefits, Workers' Compensation, bonus lease payments and annual rentals from land and/or minerals.~~

~~(ii) OASDI and SSI retroactive payments do not count as income in the month of receipt. Any unspent portion of retroactive SSI and RSDI benefits is excluded from resources for nine (9) calendar months following the month of receipt. However, unspent money from a retroactive payment must be identifiable from other resources for this exclusion to apply. The money may be commingled with other funds, but if this is done in such a fashion that the retroactive amount can no longer be separately identified, that amount will count toward the resource limit. Refer to 20 Code of Federal Regulations (CFR) ' 416.1233.~~

~~(iii) Lump sum payments used to establish dedicated bank accounts by representative payees in order to receive and maintain retroactive SSI benefits for disabled/blind children under age eighteen (18) are excluded as income. The interest income generated from dedicated bank accounts is also excluded. The dedicated bank account consisting of the retroactive SSI lump sum payment and accumulated interest is excluded as a resource in both the month received and any subsequent months.~~

~~(iv) A life insurance death benefit received by an individual while living is considered as income in the month received and as a resource in the following months to the extent it is available.~~

~~(v) Changing a resource from one form to another, such as converting personal property to cash, is not considered a lump sum payment.~~

~~(D) Income from capital resources and rental property.~~

~~Income from capital resources can be derived from rental of a house, rental from land (cash or crop rent), leasing of minerals, life estate, homestead rights or interest.~~

~~(i) If royalty income is received monthly but in irregular~~

amounts, an average based on the previous six (6) months' royalty income is computed and used to determine income eligibility. When the difference between the gross and net income represents a production or severance tax (e.g., most oil royalties are reduced by this tax), the OHCA only uses the net figure when determining income eligibility. The production or severance tax is the cost of producing the income, and, therefore, is deducted from the gross income. Exception: At any time that the county becomes aware of and can establish a trend showing a dramatic increase or decrease in royalty income, the previous two (2) months' royalty income is averaged to compute countable monthly income.

(ii) Rental income may be treated as earned income when the individual participates in the management of a trade or business or invests his/her own labor in producing the income. The individual's federal income tax return will verify whether or not the income is from self-employment. Otherwise, income received from rental property is treated as unearned income.

(iii) When rental property is handled by a leasing agent who collects the rent and deducts a management fee, only the rent actually received by the member is considered as income.

(E) **Earned income/self-employment.** The term "earned income" includes income in cash earned by an individual through the receipt of wages, salary, commission, or profit from activities in which he/she is engaged as a self-employed individual or as an employee. See subparagraph (G) of this paragraph for earnings received in fluctuating amounts. "Earned Income" is also defined to include in-kind benefits received by an employee from an employer in lieu of wages or in conjunction with wages. Such benefits received in-kind are considered as earned income only when the employee/employer relationship has been established. The cash value of the in-kind benefits must be verified by the employer. Income from self-employment also includes in-kind benefits for a work activity or service for which the self-employed person ordinarily receives payment in his/her business enterprise. An exchange of labor or services, e.g., barter, is considered as an in-kind benefit. Medical insurance secured through the employer, whether purchased or as a benefit, is not considered in-kind but is recorded on the case computer input document for coordination with SoonerCare benefits.

(i) Work study received by an individual who is attending school is considered as earned income with appropriate

~~earned income disregards applied.~~

~~(ii) Money from the sale of whole blood or blood plasma is considered as self-employment income subject to necessary business expenses and appropriate earned income disregards.~~

(1) **Averaging income.** When the individual indicates that he/she receives income monthly, but on an irregular basis, the most recent two (2) months of income are averaged to determine income eligibility.

(A) Income that is received less often than monthly or in amounts that vary significantly over the course of a year may be averaged over a longer period of time. For instance, royalty income must be averaged over a six (6) month period.

(B) Less than two (2) months of income may be used when the income started less than two (2) months ago or previous income amounts are not representative of future income. For instance, the individual may have started a new job less than two (2) months ago or may have received a one-time bonus or overtime pay that is not expected to recur.

(2) **Converting income to a monthly amount.** Income received more often than monthly is converted to monthly amounts as indicated in (A) through (E) of this subsection:

(A) **Daily.** Income received on a daily basis is converted to a weekly amount. When there is consistency in days worked each week and regular pay dates, the income is multiplied by 4.3. When there is no consistency, refer to (3) of this subsection for irregular income processing.

(B) **Weekly.** Income received weekly is multiplied by 4.3.

(C) **Twice a month.** Income received twice a month is multiplied by two (2).

(D) **Biweekly.** Income received every two (2) weeks is multiplied by 2.15.

(E) **Irregular income.** Income received monthly but at irregular intervals is not converted by 4.3, 2, or 2.15 when there is no consistency in the work offered or when pay is received. Instead, the income received over the last two (2) months is added together and divided by two (2) to arrive at a monthly average.

(3) **Infrequent or irregular income.** Infrequent or irregular income is considered countable income in the month it is received unless excluded per (C) of this paragraph.

(A) Income is considered to be infrequent if the individual receives it only once during a calendar quarter from a single source and the individual did not receive that type of income in the month preceding or following the month the income was received.

(B) Income is considered to be irregular if the individual

cannot reasonably expect to receive it.

(C) When the individual receives infrequent or irregular income, exclude the first:

(i) \$30 per calendar quarter of earned income; and

(ii) \$60 per calendar quarter of unearned income.

~~(iii) Self-employment income is determined as follows:~~

(4) **Self-employment income determination.** Self-employment income is determined per (A) through (E) of this paragraph:

~~(I) Generally, the federal or state income tax form for the most recent year is used for calculating the self-employment income to project income on a monthly basis for the certification period. The gross income amount, as well as the allowable deductions, are the same as can be claimed under the Internal Revenue code for tax purposes.~~

~~(II) Self-employment income which represents a household's annual support is prorated over a 12-month period, even if the income is received in a short period of time. For example, self-employment income received by crop farmers is averaged over a 12-month period if the income represents the farmer's annual support.~~

~~(III) If the household's self-employment enterprise has been in existence for less than a year, the income from that self-employment enterprise is averaged over the period of time the business has been in operation to establish the monthly income amount.~~

~~(IV) If a tax return is not available because one has not been filed due to recent establishment of the self-employment enterprise, a profit and loss statement must be seen to establish the monthly income amount.~~

~~(V) The purchase price and/or payment(s) on the principal of loans for capital assets, equipment, machinery, and other durable goods is not considered as a cost of producing self-employed income. Also not considered are net losses from previous periods, depreciation of capital assets, equipment, machinery, and other durable goods; and federal, state and local income taxes, FICA, money set aside for retirement purposes, and other work related personal expenses, such as meals and necessary transportation (these expenses are accounted for by the work related expense deduction given in OAC 340:10-3-33(1)).~~

~~(iv) Countable self-employment income is determined by deducting allowable business expenses to determine the adjusted gross income. The earned income deductions are then applied to establish countable earned income.~~

(A) When filed, the federal income tax form for the most recent year is used to calculate the individual's self-employment income and business expenses for the certification period. The net earnings shown on the income tax form after business expenses are subtracted is divided by twelve (12) months to determine the individual's monthly countable self-employment income.

(B) When the individual did not file a federal tax form for the most recent year, the individual's business records showing monthly income and expenses are used to determine the individual's self-employment income. When the business was in operation for the entire year, the individual's net income after subtracting business expenses is divided by twelve (12) months to determine the individual's monthly countable self-employment income.

(C) Self-employment income that represents a household's annual support is prorated over a twelve-month (12-month) period, even if the income is received in a short period of time. For example, self-employment income received by crop farmers is averaged over a twelve-month (12-month) period if the income represents the farmer's annual support.

(D) If the household's business has operated for less than a year, the income from that business is averaged over the period of time the business has operated to establish the monthly income amount.

(E) After the net countable self-employment income is determined, the earned income exclusions per (g) of this section are then applied to establish countable earned income.

~~(F) **Infrequent or irregular income.**~~

~~(i) Income is considered to be infrequent if the individual receives it only once during a calendar quarter from a single source and the individual did not receive that type of income in the month preceding or following the month the income was received.~~

~~(ii) Income is considered to be irregular if the individual cannot reasonably expect to receive it.~~

~~(iii) OHCA excludes the following amount of infrequent or irregular income:~~

~~(I) the first \$30 per calendar quarter of earned income; and~~

~~(II) the first \$60 per calendar quarter of unearned income.~~

~~(iv) Infrequent or irregular income, whether earned or unearned, that exceeds these amounts is considered countable income in the month it is received.~~

~~(G) **Monthly income received in fluctuating amounts.** Income~~

~~which is received monthly but in irregular amounts is averaged using two (2) months' income, if possible, to determine income eligibility. Less than two (2) months' income may be used when circumstances (e.g., new employment, unpaid sick leave, etc.) would indicate that previous income amounts would not be appropriate to use in determining future income amounts. Income received more often than monthly is converted to monthly amounts as follows:~~

~~(i) **Daily.** Income received on a daily basis is converted to a weekly amount then multiplied by 4.3.~~

~~(ii) **Weekly.** Income received weekly is multiplied by 4.3.~~

~~(iii) **Twice a month.** Income received twice a month is multiplied by two (2).~~

~~(iv) **Biweekly.** Income received every two (2) weeks is multiplied by 2.15.~~

~~(H) **Non-negotiable notes and mortgages.** Installment payments received on a note, mortgage, etc., are considered as monthly income.~~

~~(I) **Income from the Job Training and Partnership Act (JTPA).** Unearned income received by an adult, such as a needs based payment, cash assistance, compensation in lieu of wages, allowances, etc., from a program funded by JTPA is considered as any other unearned income. JTPA earned income received as wages is considered as any other earned income.~~

~~(J) **Other income.** Any other monies or payments which are available for current living expenses must be considered.~~

(5) **SSI recipients.** If a member is determined to be categorically needy and is also an SSI recipient, any change in countable income does not affect SoonerCare receipt and the State Supplemental Payment (SSP) payment amount as long as the changed income amount does not cause SSI ineligibility.

(A) Income considered by SSI in the retrospective cycle is not counted until SSI makes the change so the income is not counted twice. If the SSI change is not made timely by SSA, the income is counted as if it had been timely.

(B) If the receipt of the income causes SSI ineligibility, the income is considered immediately with proper action taken to reduce or close the SoonerCare and SSP benefit. Any SSI overpayment caused by SSA not making timely changes will result in recovery by SSI in the future. When the OKDHS worker becomes aware of income changes that affect the individual's SSI eligibility or payment amount, he/she shares the information with the SSA office.

~~(d)~~(j) **Computation of income.** After determining the individual's and his/her spouse's monthly income.

(1) **EarnedGeneral income or unearned incomeexclusion.** The general income exclusion of ~~\$20~~twenty dollars (\$20) per month

~~is allowed for~~subtracted from earned or unearned income, unless the unearned income is SSP, on the combined unearned income of the eligible individual and eligible or ineligible spouse, unless the only unearned income is SSP. See paragraph (5) of this subsection if there are ineligible minor children. After the \$20 exclusion, deduct \$65 and one-half of the remaining combined earned income. The total gross amount of unearned income of the eligible individual and eligible or ineligible spouse is considered. If any portion of the general income exclusion is not subtracted from unearned income, it is subtracted from earned income.

(2) **Earned income deduction.** When the individual has earned income, after deducting the twenty dollars (\$20) exclusion, the sixty-five (\$65) and one-half of the remaining combined earned income is then deducted.

~~(2) **Countable income.** The countable income is the sum of the earned income and the total gross unearned income after exclusions.~~

(3) **Deeming computation for disabled or blind minor child(ren) procedures.** An automated calculation is available for computing the income amount to be deemed from parent(s) and the spouse of the parent to eligible disabled or blind minor child(ren) by use of transaction CID. The ineligible minor child in the computation regarding allocation for ineligible child(ren) is defined as: a dependent child under age eighteen (18). Refer to OAC 340:35-5-42(k) for deeming computation procedures from an ineligible spouse, ineligible parent, sponsor of an alien or an essential person to the eligible individual or child.

~~(A) An intellectually disabled child living in the home who is ineligible for SSP due to the deeming process may be approved for SoonerCare under the Home and Community Based Services Waiver (HCBS) Program as outlined in OAC 317:35-9-5.~~

~~(B) For TEFRA, the income of child's parent(s) is not deemed to him/her.~~

~~(4) **Premature infants.** Premature infants (i.e., thirty seven (37) weeks or less) whose birth weight is less than twelve hundred (1200) grams (approximately two (2) pounds ten (10) ounces) will be considered disabled by SSA even if no other medical impairment(s) exist. In this event, the parents' income is not deemed to the child until the month following the month in which the child leaves the hospital and begins living with his/her parents.~~

~~(5) **Procedures for deducting ineligible minor child allocation.** When an eligible individual has an ineligible spouse and ineligible minor children (not receiving TANF), the computation~~

~~is as follows:~~

~~(A) Each ineligible child's allocation (OKDHS Form 08AX001E, Schedule VII. C.) minus each child's gross countable income is deducted from the ineligible spouse's income. Deeming of income is not done from child to parent.~~

~~(B) The deduction in subparagraph (A) of this paragraph is prior to deduction of the general income exclusion and work expense.~~

~~(C) After computations in subparagraphs (A) and (B) of this paragraph, the remaining amount is the ineligible spouse's countable income considered available to the eligible spouse.~~

~~(6) **Special exclusions for blind individuals.** Any blind individual who is employed may deduct the general income exclusion and the work exclusion from the gross amount of earned income. After the application of these exclusions, one-half of the remaining income is excluded. The actual work expense is then deducted from the remaining half to arrive at the amount of countable income. If this blind individual has a spouse who is also eligible due to blindness and both are working, the amount of ordinary and necessary expenses attributable to the earning of income for each of the blind individuals may be deducted. Expenses are deductible as paid but may not exceed the amount of earned income. To be deductible, an expense need not relate directly to the blindness of the individual, it need only be an ordinary and necessary work expense of the blind individual. Such expenses fall into three (3) broad categories:~~

~~(A) transportation to and from work;~~

~~(B) job performance; and~~

~~(C) job improvement.~~

**(k) General income deeming procedures. The term deeming is used** to identify the process for considering another individual's income to be available to the applicant or SoonerCare member, described in this Section as the eligible individual or child. Per Section 416.1160 of Title 20 of the Code of Federal Regulations (20 C.F.R. § 416.1160), there are four categories of individuals whose income may be deemed when determining eligibility: an ineligible spouse, ineligible parent, the sponsor of an alien, or an essential individual. The first step in deeming is determining how much income the applicable individual(s) has. When deeming rules apply, it does not matter if the other individual's income is actually available to the eligible individual or child.

**(1) Ineligible spouse.** An ineligible spouse is a spouse who lives in the same household with the eligible individual and is not eligible for Supplemental Security Income (SSI). For spouse-to-spouse deeming to apply, the eligible individual must be eligible based on his or her own income.

(2) **Ineligible parent.** An ineligible parent is a natural or adoptive parent or stepparent who lives with an eligible child under eighteen (18) years of age and is not eligible for SSI. A stepparent's income is not deemed if the eligible child's natural or adoptive parent dies or permanently leaves the home, per 20 C.F.R. § 416.1165.

(3) **Sponsor of an alien.** A sponsor is an individual, not an organization or an employer, who signs an affidavit agreeing to support the alien as a condition for the alien's admission for permanent residence in the United States (U.S.). A portion of the sponsor's income is deemed to the alien for three (3) years even when the sponsor and alien do not live together unless (A) if this paragraph applies.

(A) Deeming rules regarding sponsored aliens do not apply when the alien:

(i) Is a refugee admitted to the United States (U.S.), per Section 203(a) (7), 207(c) (1) or Section 212(d) (5) the Immigration and Nationality Act;

(ii) Was granted asylum by the Attorney General of the U. S.; or

(iii) Becomes blind or disabled, per 20 C.F.R §416.901 after admission to the U. S. When this occurs, the sponsor's income is no longer deemed beginning with the month in which you're the disability or blindness begins.

(B) If the sponsor is the alien's ineligible spouse or ineligible parent(s), the spouse-to-spouse or parent-to-child deeming calculations apply.

(C) If a sponsored alien has a sponsor and an ineligible spouse or ineligible parent(s) who is not his/her sponsor, both sponsor-to-alien and spouse-to-spouse or parent-to-child deeming calculations apply.

(4) **Household definition.** A household for deeming purposes may include the eligible individual or child, an eligible or ineligible spouse, and any children of the couple or of either member of the couple. A household for an eligible child includes the eligible child's parent(s), and any other children of the parent(s).

(A) A child is considered a member of the household from birth for deeming purposes unless the parent(s) completed paperwork to give the child up for adoption or the child was placed in the temporary custody of a public children's services agency. Exception: A premature infant born at thirty-seven (37) weeks or less whose birth weight is less than two (2) pounds ten (10) ounces is considered disabled by the Social Security Administration even if no other medical impairment exists. When this occurs, the parent(s)' income is not deemed to the child until the month after the

month the child leaves the hospital and begins living with his/her parent(s).

(B) An eligible individual or an ineligible spouse or ineligible parent who is temporarily absent from the home per (5) of this subsection, is considered to be a member of the household for deeming purposes per 20 C.F.R. § 416.1167.

(5) **Temporary absence for deeming purposes.** During a temporary absence, per 20 C.F.R. § 416.1167, the absent individual is considered a household member for deeming purposes when an:

(A) Eligible individual or child, ineligible spouse, ineligible parent, or an ineligible child leaves the household but intends to and does return in the same month or the next month;

(B) Eligible individual or child enters a medical treatment facility for up to two (2) or three (3) full months;

(C) Eligible child is away at school but comes home on some weekends or lengthy holidays and is subject to his/her parent's control; or

(D) Ineligible spouse or parent is absent from the household due solely to a duty assignment as a member of the Armed Forces on active duty.

(1) **Income exclusions for an ineligible spouse or ineligible parent.** Income excluded for an ineligible spouse or parent per 20 C.F.R. § 416.1161 include:

(1) Income excluded by federal laws other than the Social Security Act, per the Appendix to Subpart K of Part 416 and Oklahoma Administrative Code (OAC) 317:35-5-42(e);

(2) Any public income-maintenance payments the ineligible spouse or parent receives and any income that was counted or excluded in figuring the amount of that payment. Per 20 C.F.R. § 416.1142, these payments include SSI, State Supplemental Payment (SSP), TANF, refugee cash assistance, disaster relief and emergency assistance, general assistance provided by the Bureau of Indian Affairs, and U.S. Department of Veteran Affairs, State or local government assistance programs based on need;

(3) Any of the ineligible spouse's or parent's income that is used by a public income-maintenance program to determine that program's benefits to someone else;

(4) Income used to comply with the terms of court-ordered support, or support payments enforced under Title IV-D of the Social Security Act;

(5) Income the ineligible spouse or ineligible parent was paid under a federal, state, or local government program to provide the eligible spouse or child with chore, attendant, or homemaker services, such as payments under Title XX of the Social Security Act;

- (6) Any portion of a grant, scholarship, fellowship, or gift used or set aside to pay tuition, fees or other necessary educational expenses;
- (7) Money received for providing foster care to an ineligible child;
- (8) The value of Supplemental Nutrition Assistance Program food benefits and the value of Department of Agriculture donated foods;
- (9) Food raised by the spouse or parent and consumed by members of the household in which you live;
- (10) Tax refunds on income, real property, or food purchased by the family;
- (11) Income used to fulfill an approved plan for achieving self-support, per 20 C.F.R. §§ 416.1180 through 416.1182 and OAC 317:35-5-42(f) (13) and (g) (10);
- (12) The value of in-kind support and maintenance as described in OAC 317:35-5-42(b) (8);
- (13) Alaska longevity bonus payments;
- (14) Disaster assistance, per 20 C.F.R. §§ 416.1150 and 416.1151;
- (15) Income received infrequently or irregularly, per 20 C.F.R. §§ 416.1112(c) (1) and 416.1124(c) (6) and OAC 317:35-5-42(f) (6) and (g) (2);
- (16) Work expenses if the ineligible spouse or parent is blind such as transportation expenses to and from work and job performance or improvement expenses;
- (17) Certain support and maintenance assistance, per 20 C.F.R. § 416.1157(c) and OAC 317:35-5-42(e) (10);
- (18) Housing assistance, per 20 C.F.R. §416.1124(c) (14);
- (19) The value of a commercial transportation ticket, per 20 C.F.R. § 416.1124(c) (16). However, if such a ticket is converted to cash, the cash is income in the month your spouse or parent receives the cash;
- (20) Refunds of Federal income taxes and advances made by an employer relating to an earned income tax credit, per 20 C.F.R. § 416.1112(c);
- (21) Payments from a fund established by a State to aid victims of crime, per 20 C.F.R. § 416.1124(c) (17));
- (22) Relocation assistance, per 20 C.F.R. §416.1124(c) (18);
- (23) Special pay received from one of the uniformed services pursuant to Section 310 of Title 37 of the United States Code;
- (24) Impairment-related work expenses, per 20 C.F.R. 404.1576 and OAC 317:35-5-42(g) (7), incurred and paid by an ineligible spouse or parent, if the ineligible spouse or parent receives disability benefits under Title II of the Social Security Act;
- (25) Interest earned on excluded burial funds and appreciation in the value of excluded burial arrangements which are left to

accumulate and become part of separate burial funds, and interest accrued on and left to accumulate as part of the value of agreements representing the purchase of excluded burial spaces per 20 C.F.R. § 416.1124(c) (9) and (15));

(26) Interest and dividend income from a countable resource or from a resource excluded under a Federal statute other than Section 1613(a) of the Social Security Act;

(27) Earned income of a student, per 20 C.F.R. § 416.1112(c) (3) and OAC 317:35-5-42(g) (3); and

(28) Any additional increment in pay, other than any increase in basic pay, received while serving as a member of the uniformed services, if the ineligible spouse or parent:

(A) Received the pay as a result of deployment to or service in a combat zone; and

(B) Was not receiving the additional pay immediately prior to deployment to or service in a combat zone.

**(m) Deeming from an ineligible spouse.** When the eligible individual lives with an ineligible spouse who has income, the deeming steps in (1) through (5) of this paragraph are used to calculate the amount of income to deem to the eligible individual.

(1) The ineligible's spouse's total gross unearned and earned income is determined and appropriate exclusions per (1) of this Section are applied.

(2) An ineligible child allocation is then subtracted for each ineligible child in the home, per OKDHS Appendix C-1, Maximum Income, Resource, and Payment Standards, Schedule VIII.C.

(A) The ineligible child allocation is subtracted from the ineligible spouse's unearned income before subtracting any remaining allocation from his/her earned income.

(B) An ineligible child allocation is not allowed for a child who receives a public income-maintenance payments, per 20 C.F.R. § 416.1142 and as listed per (1) (2) of this Section.

(C) When the ineligible child has countable income, the child's income is subtracted from the ineligible child allocation before subtracting the remaining allocation from the ineligible spouse's income.

(3) When the ineligible spouse sponsors an alien(s), the allocation for the alien(s) that is deemed from the ineligible spouse's income is subtracted from the ineligible spouse's unearned income before subtracting any remaining allocation from his/her earned income.

(A) The allocation for each sponsored alien is the difference between the SSI federal benefit rate (FBR) for an eligible couple minus the FBR for an eligible individual, per OKDHS Appendix C-1, Schedule VIII.C.

(B) Each alien's allocation is reduced by the amount of the alien's own income, per (m) of this Section.

(4) When, after subtracting the ineligible child allocation and, if appropriate, the sponsored alien allocation, the ineligible spouse's income is less than or equal to the difference between the SSI FBR for an eligible couple and the SSI FBR for an eligible individual, per OKDHS Appendix C-1, Schedule VIII.C, no income is deemed from the ineligible spouse.

(A) In this instance, only the eligible individual's own countable income minus exclusions per (l) of this Section is considered.

(B) When the eligible individual's countable income is less than or equal to the SSI FBR for an individual, per OKDHS Appendix C-1, Schedule VIII.C, he/she is financially eligible for SoonerCare (Medicaid).

(5) When, after subtracting the appropriate allocations, the ineligible spouse's income is greater than the difference between the SSI FBR for an eligible couple and the SSI FBR for an eligible individual, per OKDHS Appendix C-1, Schedule VIII.C, the spouses are treated as an eligible couple by:

(A) Combining the remainder of the ineligible spouse's unearned income with the eligible individual's unearned income and the remainder of the ineligible spouse's earned income with the eligible individual's earned income;

(B) Applying appropriate income exclusions, per OAC 317:35-5-42(e), (f), and (g) from the eligible spouse's income, including the \$20 general exclusion from the couple's unearned income and \$65 plus one-half of the remaining earned income from the couple's earned income; and

(C) Subtracting the couple's countable income from the SSI FBR for an eligible couple, per OKDHS Appendix C-1, Schedule VIII.C. When the income is less than or equal to the SSI FBR for an eligible couple, the eligible individual is financially eligible for SoonerCare (Medicaid).

(n) **Deeming from ineligible parent(s).** When a child with disabilities or blindness lives with ineligible parent(s), the deeming steps in (1) through (6) of this paragraph are used to calculate the amount of income to deem to the eligible child, up through the month in which the child reaches age eighteen (18).

(1) The gross unearned and earned income of each ineligible parent living in the home is determined and appropriate exclusions are applied, per (l) of this Section.

(2) An ineligible child allocation is subtracted for each ineligible child in the home, per OKDHS Appendix C-1, Schedule VIII.C. Exception: An ineligible child allocation is not allowed for a child who receives public income-maintenance payments, per 20 C.F.R. § 416.1142 and as listed per (1)(2) of this Section.

(A) The ineligible child allocation is first subtracted from

the ineligible parent(s)' combined unearned income before subtracting any remaining allocation from their earned income.

(B) When the ineligible child has countable income, the child's income is subtracted from the ineligible child allocation before applying the allocation.

(3) When the ineligible parent sponsors an alien(s), the allocation for the alien(s) that is deemed from the ineligible parent's income per (p) of this Section is subtracted from the ineligible parent(s)' income.

(4) An allocation is then subtracted for the ineligible parent(s) unless the parent receives public income-maintained payments. The allocation is calculated by:

(A) Subtracting the twenty dollars (\$20) general exclusion from the combined unearned income of the ineligible parent(s). If there is less than twenty dollars (\$20) of unearned income, subtract the twenty dollars (\$20) remaining exclusion from their combined earned income;

(B) Subtracting sixty-five dollars (\$65) and one-half of the remainder of their earned income; and

(C) Totaling the ineligible parent(s)' remaining earned and unearned income and, depending on the number of parents in the home, subtracting the SSI FBR for an individual or a couple, per OKDHS Appendix C-1, Schedule VIII.C.

(5) The parent(s)' remaining income is then deemed to the eligible child. When there is more than one eligible child in the home, the parent(s)' remaining income is divided by the number of eligible children in the home.

(6) The deemed income is added to the eligible child's own countable unearned income. When the eligible child's deemed and own unearned and earned income, minus appropriate exclusions, per OAC 317:35-5-42(e), (f), and (g), is less than or equal to the SSI FBR for an individual, per OKDHS Appendix C-1, Schedule VIII.C, the child is financially eligible for SoonerCare (Medicaid).

(A) When a child with intellectual disabilities is ineligible for SoonerCare due to the deeming process, he/she may be approved for SoonerCare under the Home and Community Based Services Waiver (HCBS) Program, per OAC 317:35-9-5.

(B) When a child is eligible for Tax Equity & Fiscal Responsibility Act (TEFRA), the income of child's parent(s) is not deemed to him/her.

(C) The parent(s)' income is not deemed to a premature infant born at thirty seven (37) weeks or less whose birth weight is less than twelve hundred (1200) grams or approximately two (2) pounds ten (10) ounces until the child leaves the hospital and begins living with his/her parent(s).

(o) Deeming when the household includes an ineligible spouse, an eligible spouse, and an eligible and ineligible child. When the household includes an ineligible spouse, an eligible spouse, one or more eligible children, and one or more ineligible children, the ineligible spouse's income is first deemed to the eligible spouse and the remainder to the eligible child(ren) using the deeming steps in (1) through (6) of this subsection.

(1) The gross unearned and earned income of the ineligible spouse is determined and appropriate exclusions are applied, per (1) of this Section.

(2) An ineligible child allocation is subtracted for each ineligible child in the home, per OKDHS Appendix C-1, Schedule VIII.C. Exception: An ineligible child allocation is not allowed for a child who receives public income-maintenance payments, per 20 C.F.R. § 416.1142 and as listed per (1)(2) of this Section.

(3) If the ineligible spouse's remaining income is less than or equal to the current SSI FBR for a couple minus the current SSI FBR for an individual, no income is deemed to the eligible spouse or eligible child(ren).

(A) Compare the eligible spouse's and each eligible child's own countable income, after applying appropriate exclusions, per OAC 317:35-5-42(e), (f), and (g) to the current SSI FBR for an individual, per OKDHS Appendix C-1, Schedule VIII.C.

(B) When the eligible spouse's and/or each eligible child's own income is less than or equal to the current SSI FBR for an individual, they are financially eligible for SoonerCare.

(4) If the ineligible spouse's remaining income after subtracting the ineligible child allocation(s) is greater than the current SSI FBR for a couple minus the current SSI FBR for an individual:

(A) Combine the ineligible spouse's post-allocation unearned and earned income and the eligible spouse's unearned and earned income, after applying the appropriate exclusions, per OAC 317:35-5-42(e), (f), and (g);

(B) Subtract the twenty dollars (\$20) general exclusion from the couple's combined unearned income. If there is less than twenty dollars (\$20) of unearned income, then subtract the remainder of the exclusion from the couple's combined earned income; and

(C) Subtract sixty-five dollars (\$65) plus one-half of the remainder from the couple's combined earned income.

(5) If the couple's countable income is less than or equal to the current SSI FBR for a couple, per OKDHS Appendix C-1, Schedule VIII.C, the eligible spouse is financially eligible for SoonerCare and no income is deemed to the eligible child(ren). If the couple's countable income is greater than

the current SSI FBR for a couple, the eligible spouse is not financially eligible for SoonerCare.

(6) When the eligible spouse is not financially eligible for SoonerCare, the amount of the couple's income in excess of the SSI FBR for a couple is divided by the number of eligible children in the household. The resulting amount is deemed to each eligible child.

(A) Any income deemed to an eligible child is added to the eligible child's own unearned income.

(B) The eligible child's unearned and earned income are combined after applying appropriate exclusions, per OAC 317:35-5-42 (e), (f), and (g).

(C) If each eligible child's resulting countable income is less than or equal to the current SSI FBR for an individual, per OKDHS Appendix C-1, Schedule VIII.C, the eligible child is financially eligible for SoonerCare.

(p) **Deeming from a sponsor to an alien.** Sponsor-to-alien deeming applies regardless of whether the sponsor and the sponsored alien live in the same household or whether the sponsor actually provides any support to the sponsored alien unless (a) (3) (A) applies.

(1) The income of the sponsor and the sponsor's spouse, if applicable, is first determined and applicable exclusions applied, per OAC 317:35-5-42 (e).

(2) The appropriate allocation for the sponsor, the sponsor's spouse, and any children of the sponsor is then subtracted. An ineligible dependent's income is not subtracted from the sponsor's child(ren)'s allocation.

(A) The allocation amount for the sponsor is the current SSI FBR for an individual, per OKDHS Appendix C-1, Schedule VIII.C.

(B) The allocation for each sponsor's spouse and child(ren) of each sponsor is one-half of the current SSI FBR for an individual, per OKDHS Appendix C-1, Schedule VIII.C.

(3) The remaining income amount is deemed to the sponsored alien as unearned income. If the sponsor sponsors multiple aliens, the deemed amount is applied in full to each sponsored alien.

(4) The sponsored alien's unearned and earned income is combined and applicable exclusions applied, per OAC 317:35-5-42 (e), (f), and (g). When the alien's countable income and deemed income is less than or equal to the current SSI FBR for an individual, per OKDHS Appendix C-1, Schedule VIII.C, the alien is financially eligible for SoonerCare.

## **SUBCHAPTER 7. MEDICAL SERVICES**

### **PART 5. DETERMINATION OF ELIGIBILITY FOR MEDICAL SERVICES**

**317:35-7-40. Eligibility as Qualified Medicare Beneficiary Plus**

An individual determined to be categorically related to aged, blind or disabled is eligible for Medical Services as a Qualified Medicare Beneficiary Plus (QMBP) if he/she meets the conditions of eligibility shown in paragraphs (1)-(3) of this subsection. For persons age 65 and older in mental health hospitals, refer to Oklahoma Administrative Code 317:35-9-7.

~~(1) The individual's/couple's income and resources do not exceed the standards as shown on DHS Appendix C-1, Schedule VI, of which the income standard is based on 100 percent of the Federal Poverty Level.~~  
The individual's income and resources do not exceed the standard as shown on OKDHS Appendix C-1, Schedule VI, of which the income standard is based on 100 percent (100%) of the Federal Poverty Level. For an individual whose spouse is not eligible for Medicare, total countable income of the eligible individual must be equal to or less than the QMBP standards for an individual, and the income of both must be equal to or less than the QMBP standards for a couple. For a couple who are both eligible for Medicare, total countable income must be equal to or less than the QMBP standards for a couple.

(2) Countable income and resources are determined using the same rules followed in determining eligibility for individuals categorically related to Aged, Blind or Disabled, except that a \$20 general income disregard is applied to either earned or unearned income, but not both. For couples, only one \$20 general income disregard is given.

(3) The individual meets all other eligibility conditions for SoonerCare.

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

**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**

**PART 33. TRANSPORTATION BY AMBULANCE**

**317:30-5-344. Ground Emergency Medical Transportation (GEMT) Supplemental Payment Program**

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

(1) **"Advanced life support"** means emergency medical care and services which are provided by a licensed ground ambulance services provider in accordance with Oklahoma Administrative Code (OAC) 310:641, to include, but not limited to, advanced airway management, intravenous therapy, administration of drugs and other medicinal preparations, and other invasive medical procedures and specified techniques that are limited to the Intermediate, Advanced EMT, and Paramedic scope of practice in accordance with OAC 310:641, Subchapter 5.

(2) **"Allowable costs"** means an expenditure that complies with the regulatory principles as listed in Title 2 of the Code of Federal Regulations (C.F.R.), Section 200.

(3) **"Basic life support"** means emergency medical care and services which are provided by a licensed ground ambulance service in accordance with OAC 310:641 to include, but not limited to, cardiopulmonary resuscitation procedures (CPR), hemorrhage control, stabilization of actual or possible skeletal injuries, spinal immobilization, extrication, transportation, and other non-invasive medical care.

(4) **"Contracts with a local government"** means contracts pursuant to a county plan for ambulance and emergency medical services with a:

(A) City, county, or an Indian tribe as defined in Section 4 of the Indian Self-Determination and Education Assistance Act; or

(B) Local service district, including, but not limited to, a rural fire protection district, or all administrative subdivisions of such city, county, or local service district.

(5) **"Eligible GEMT provider"** means a GEMT provider that meets all eligibility requirements in OAC 317:30-5-344 and the Oklahoma Medicaid State Plan (State Plan).

(6) **"Federal financial participation (FFP)"** means the portion

of medical assistance expenditures for emergency medical services that are paid or reimbursed by the Centers for Medicare and Medicaid Services (CMS) in accordance with the State Plan.

(7) "GEMT services" means the act of transporting an individual by ground from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient, as well as the advanced, limited-advanced, and basic life support services provided to an individual by eligible GEMT providers before or during the act of transportation.

(8) "Governmental unit" means the entire state, local, or federally-recognized Indian tribal government, including any component thereof.

(9) "Publically owned or operated" means a unit of government that is a state, a city, a county, a special purpose district, or other governmental unit in a state that has taxing authority, has direct access to tax revenues, or is an Indian tribe as defined in Section 4 of the Indian Self-Determination and Education Assistance Act.

(b) **Purpose.** In accordance with 63 Oklahoma Statutes (O.S.) § 3242, the GEMT Supplemental Payment Program is a voluntary program which makes supplemental payments above the Medicaid fee schedule reimbursement rate to eligible GEMT providers for specific allowable, certified, and uncompensated costs incurred for providing GEMT Services to SoonerCare members.

(b) **Provider eligibility.** To be eligible for supplemental payments, a GEMT provider must meet all of the following requirements:

(1) Be enrolled as an Oklahoma SoonerCare provider for the time period claimed on its annual cost report;

(2) Provide ground ambulance transportation services to SoonerCare members;

(3) Be classified as a governmental unit provider in accordance with 2 C.F.R. 200;

(4) Comply with all applicable state and federal law;

(5) Be an organization that:

(A) Is publicly owned or operated; or

(B) Is under contract with a local government unit. A copy of any such contract must be submitted to the Oklahoma Health Care Authority (OHCA) simultaneous with the submission of the GEMT provider's annual cost report; and

(6) Timely submit all relevant information requested by the OHCA, in the format as prescribed by the OHCA, including, but not limited to, a certification that conforms with 42 C.F.R. § 433.51 that certifies that the claimed expenditures for GEMT Services are eligible for FFP.

**(d) Allowable costs.**

(1) Supplemental payments provided by this program are available only for the specific allowable costs per medical transport of a SoonerCare member that are in excess of the reimbursement paid by Medicaid and all other insurers and/or third-party resources.

(2) Total reimbursement from SoonerCare, including the supplemental payment, when combined with all other sources of reimbursement, must not exceed one-hundred percent (100%) of actual costs of providing services to SoonerCare members.

**(e) Payments and recoupment.**

(1) The OHCA will make annual supplemental payments after the conclusion of each state fiscal year (SFY) and in accordance with the methodology outlined in the State Plan. The payments will be made in the form of an interim payment and a later reconciliation payment (i.e., settle-up payment). The payments are not an increase to current fee-for-service (FFS) reimbursement rates.

(2) The interim supplemental payment will be equal to seventy-five percent (75%) of the total allowable costs as indicated on the annual approved cost report.

(3) The reconciliation payment will be computed by the OHCA based on the difference between the interim supplemental payment and total allowable costs from the approved cost report.

(4) Any excess payments determined in the reconciliation process are recouped and the federal share is returned to CMS.

(5) Cost reconciliation and cost settlement processes will be completed within twelve (12) months of the end of the cost reporting period.

**(f) Reporting requirements.**

(1) Eligible GEMT providers will:

(A) Submit a CMS-approved cost report annually, no later than ninety (90) days after the close of the SFY, on a form approved by the OHCA, unless a provider has made a written request for an extension and such request is granted by the OHCA;

(i) After the ninety (90) day deadline, an extension of no more than fifteen (15) calendar days can be granted;

and

(ii) Extensions of time shall be requested by a letter addressed to the Finance Division. Any such request must be received by October 1, and must explain the good faith reason for the extension. OHCA shall provide a written notice of any denial of a request for an extension, which shall become effective on the date it is mailed.

(B) Provide supporting documentation simultaneous with the cost report, as required by the OHCA;

(C) Keep, maintain, and have readily retrievable, such records as specified by the OHCA to fully disclose reimbursement amounts to which the eligible governmental entity is entitled, and any other records required by CMS; and

(D) Comply with the allowable cost requirements provided in 42 C.F.R. Part 413, 2 C.F.R. Part 200, and federal Medicaid non-institutional reimbursement policy.

(2) Penalties for false statements or misrepresentations made by or on behalf of the provider are established by 42 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 or representation of a material fact for use in determining rights to such benefit or payment...shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be under the program, be guilty of a felony and upon conviction thereof fined not more than \$100,000 or imprisoned for not more than 10 years or both, or (ii) in the case of such a statement, representation, concealment, failure, conversion, or provision of counsel or assistance by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than \$20,000 or imprisoned for not more than one (1) year, or both."

(g) **Agency responsibilities.** The OHCA will:

(1) Submit claims to CMS based on total computable certified expenditures for GEMT services provided, that are allowable and in compliance with federal laws and regulations and Medicaid non-institutional reimbursement policy;

(2) Submit on an annual basis, any necessary materials to the federal government to provide assurances that claims will include only those expenditures that are allowable under federal law; and

(3) Complete the audit and final reconciliation process of the interim cost settlement payments for the services provided within twelve (12) months of the postmark date of the cost report and conduct on-site audits as necessary.

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

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

PART 7. DETERMINATION OF FINANCIAL ELIGIBILITY

**317:35-9-68. Determining financial eligibility for care in an ICF/MR Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (public and private), for HCBW/MR HCBW/IID services, and for persons age 65 sixty-five (65) or older in mental health hospitals**

(a) **Determining financial eligibility for care in an ICF/MR ICF/IID.** Financial eligibility and spenddown for individuals in an ICF/MR ICF/IID is determined according to whether or not a spouse remains in the home.

(1) **Individual without a spouse.** For an individual without a spouse, the following rules are used to determine financial eligibility for ICF/MR ICF/IID care.

(A) **Income eligibility.** To determine the income of the individual without a spouse, the rules in (i) - (iii) of this subparagraph apply.

(i) If payment of income is made to the individual and another person(s), the income is considered in proportion to the individual's interest.

(ii) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.

(iii) After determination of income, the gross income of the individual cannot exceed the categorically needy standard in OKDHS Oklahoma Department of Human Services (OKDHS) Form 08AX001E (Appendix C-1), Schedule VIII. B. 1., to be eligible for ICF/MR ICF/IID services. If the individual's gross income exceeds this standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [OAC 317:35-5-41.6(a)(6)(B)].

(B) **Resource eligibility.** In order for an individual without a spouse to be eligible for ICF/MR ICF/IID services, his/her countable resources cannot exceed the maximum resource standard listed in OKDHS Form 08AX001E (Appendix C-1), Schedule VIII. D.

(C) **Vendor payment.** When eligibility for ICF/MR ICF/IID services has been determined, the vendor payment is computed. For an individual eligible for long-term care in an ICF/MR ICF/IID, the individual's share of the vendor

payment is not prorated over the month. As SoonerCare is the payer of last resort, the full amount of the member's share of the vendor payment must first be applied to the facility's charges before SoonerCare reimbursement begins. See (b) of this Section for calculation of the vendor payment after financial eligibility has been determined.

(D) **First month.** For the first month of care, the following procedures apply when determining the vendor payment:

(i) When an individual enters the facility on the first day of the month, all countable income is considered with the facility maintenance standard allowed.

(ii) When an individual enters the facility after the first day of the month, all countable income is considered with the own home standard allowed in computation of the vendor payment. Only the remaining income actually available is used to compute the vendor payment.

(E) **Equity in capital resources.** If the equity in capital resources is in excess of the standards, certification is delayed up to ~~30~~thirty (30) days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources, along with excess income to be considered against the vendor payment, are in excess of one month's vendor payment, the application is denied.

(2) **Individual with a spouse who is institutionalized in a NF or ~~ICF/MR~~ICF/IID, or who receives ADvantage or ~~HCBW/MR~~HCBW/IID services, or is ~~65~~sixty-five (65) or over and in a mental health hospital.** For an individual with a spouse who is institutionalized in a NF or ~~ICF/MR~~ICF/IID, or who receives ADvantage or ~~HCBW/MR~~HCBW/IID services, or is ~~65~~sixty-five (65) or over and in a mental health hospital, resources are determined for each individual as the amount owned by each individual plus one-half of the jointly owned resources of the couple. Once this separation of assets is made, a resource of either spouse is not considered available to the other during institutionalization.

(A) **Income eligibility.** To determine income for an individual whose spouse is institutionalized in a NF or ~~ICF/MR~~ICF/IID, or who receives ADvantage or ~~HCBW/MR~~HCBW/IID services, or is ~~65~~sixty-five (65) or over and in a mental health hospital, income determination is made individually. The income of either spouse is not considered as available to the other during institutionalization for determination of financial eligibility. See (b) of this Section for post-

eligibility calculation of the vendor payment and the community spouse income allowance, if applicable. The rules in (i) - (v) of this subparagraph apply in this situation.

(i) If payment of income is made solely to one or the other, the income is considered available only to that individual.

(ii) If payment of income is made to both, one-half is considered for each individual.

(iii) If payment of income is made to either one or both and another person(s), the income is considered in proportion to either spouse's interest (if payment is to that spouse) or one-half of the joint interest if no interest is specified.

(iv) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.

(v) After determination of income, the gross income of the individual cannot exceed the categorically needy standard in OKDHS Form 08AX001E (Appendix C-1), Schedule VIII. B. 1., to be eligible for ~~ICF/MR~~ICF/IID care. If the individual's gross income exceeds this standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [OAC 317:35-5-41.6(a)(6)(B)].

(B) **Resource eligibility.** In order for an individual with a spouse who is institutionalized in a NF or ~~ICF/MR~~ICF/IID, receives Advantage or ~~HCBW/MR~~HCBW/IID services, or is ~~65~~sixty-five (65) or older and in a mental health hospital to be eligible for ~~ICF/MR~~ICF/IID services, his/her countable resources cannot exceed the maximum resource standard for an individual listed in OKDHS Form 08AX001E (Appendix C-1), Schedule VIII. D.

(C) **Vendor payment.** When eligibility for ~~ICF/MR~~ICF/IID services has been determined, the vendor payment is computed. For an individual eligible for long-term care in an ~~ICF/MR~~ICF/IID, the individual's share of the vendor payment is not prorated over the month. As SoonerCare is the payer of last resort, the full amount of the member's share of the vendor payment must first be applied to the facility's charges before SoonerCare reimbursement begins. See (b) of this Section for calculation of the vendor payment after financial eligibility has been determined.

(D) **First month.** For the first month of care, the following procedures apply when determining the vendor payment:

(i) When an individual enters the facility on the first day of the month, all countable income is considered with the facility maintenance standard allowed.

(ii) When an individual enters the facility after the

first day of the month, all countable income is considered with the own home standard allowed in computation of the vendor payment. Only the remaining income actually available is used to compute the vendor payment.

(E) **Equity in capital resources.** If the equity in capital resources is in excess of the standards, certification is delayed up to ~~30~~thirty (30) days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources, along with excess income to be considered against the vendor payment, are in excess of one month's vendor payment, the application is denied.

(3) **Individual with a spouse remaining in the home who does not receive ADvantage or HCBW/MRHCBW/IID services.** When an individual and spouse are separated due to the individual entering an ~~ICF/MR~~ICF/IID, income and resources are determined separately. However, the income and resources of the community spouse must be included on the application form. At redetermination of eligibility, the community spouse's income must be included in the review process. During any month that the individual is in the ~~ICF/MR~~ICF/IID, income of the community spouse is not considered available to that individual. The following rules are used to determine the income and resources of each:

(A) **Income eligibility.** To determine the income of both spouses, the rules in this subparagraph apply:

(i) If payment of income is made solely to one or the other, the income is considered available only to that individual.

(ii) If payment of income is made to both, one-half is considered for each individual.

(iii) If payment of income is made to either one or both and another person(s), the income is considered in proportion to either the spouse's interest (if payment is to that spouse) or one-half of the joint interest if no interest is specified.

(iv) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.

(v) If the individual's gross income exceeds the categorically needy standard as shown on OKDHS Form 08AX001E (Appendix C-1), Schedule VIII. B. 1., refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [OAC 317:35-5-41.6(a)(6)(B)].

(B) **Resource eligibility.** To determine resource eligibility, it is necessary to determine the amount of resources for both spouses for the month of the individual's entry into the nursing facility. Of the resources available to the couple (both individual and joint ownership) an amount will be protected for the community spouse which will not be considered available to the spouse in the ~~ICF/MR~~ICF/IID. OKDHS Form 08MA011E, Assessment of Assets, is used for the assessment prior to application for SoonerCare. The amount determined as the spousal share is used for all subsequent applications for SoonerCare, regardless of changes in the couple's resources. The protected spousal share cannot be changed for any reason. When application for SoonerCare is made at the same time the individual enters the ~~ICF/MR~~ICF/IID, OKDHS Form 08MA012E, Title XIX Worksheet, is used in lieu of OKDHS Form 08MA011E.

(i) The first step in the assessment process is to establish the total amount of resources for the couple during the first month of the entry of the spouse into the ~~ICF/MR~~ICF/IID.

(ii) The community spouse's share is equal to one-half of the total resources of the couple not to exceed the maximum amount of resource value that can be protected for the community spouse, as shown on OKDHS Appendix C-1, Section XI.

(iii) The minimum resource standard for the community spouse is found on OKDHS Appendix C-1, Schedule XI. When the community spouse's share is less than the minimum standard, an amount may be deemed from the other spouse's share to ensure the minimum resource standard for the community spouse. If the community spouse's share equals or exceeds the minimum resource standard, deeming cannot be done.

(iv) If deeming is necessary to meet the minimum resource standard for the community spouse, the amount that is deemed must be legally transferred to the community spouse within one (1) year of the effective date of certification for SoonerCare. At the first redetermination of eligibility, the worker must document that the resources have been transferred. After the first year of SoonerCare eligibility, resources of the community spouse will not be available to the other spouse and resources cannot be deemed to the community spouse.

(v) After the month in which the institutionalized spouse and community spouse have met the resource standards and the institutionalized spouse is determined eligible for benefits, no resources of the community spouse,

regardless of value, will be considered available to the institutionalized spouse. If the resources of the community spouse grow to exceed the original deemed amount, the State cannot require the community spouse to apply any of these excess resources toward the cost of the care of the institutionalized spouse.

(vi) When determining eligibility for SoonerCare, the community spouse's share of resources is protected and the remainder considered available to the spouse in the ~~ICF/MR~~ICF/IID.

(vii) The resources determined for the individual in the ~~ICF/MR~~ICF/IID cannot exceed the maximum resource standard for an individual as shown in OKDHS Form 08AX001E (Appendix C-1), Schedule VIII. D.

(viii) Once the dollar value of the community spouse's share of resources is established for the month of the other spouse's entry into an ~~ICF/MR~~ICF/IID, that amount is used when determining resource eligibility for a subsequent SoonerCare application for ~~ICF/MR~~ICF/IID.

(ix) Once a determination of eligibility for SoonerCare is made, either spouse is entitled to a fair hearing. Any such hearing regarding the determination of the community spouse's resource allowance is held within ~~30~~thirty (30) days of the date of the request for the hearing. Either spouse is entitled to a fair hearing if dissatisfied with a determination of:

- (I) ~~the~~The community spouse's monthly income allowance;
- (II) ~~the~~The amount of monthly income otherwise available to the community spouse;
- (III) ~~determination~~Determination of the spousal share of resource;
- (IV) ~~the~~The attribution of resources (amount deemed);
- or
- (V) ~~the~~The determination of the community spouse's resource allowance.

(x) The rules on determination of income and resources are applicable only when an individual has entered an ~~ICF/MR~~ICF/IID and is likely to remain under care for ~~30~~thirty (30) consecutive days. The ~~30-day~~thirty-day requirement is considered to have been met even if it is interrupted by a hospital stay or the individual is deceased before the ~~30-day~~thirty-day period ends.

(xi) The rules on resources included in this Section apply only to those cases in which an individual begins a continuous period of care in an ~~ICF/MR~~ICF/IID on or after September 30, 1989.

(xii) If the individual was admitted prior to September 30, 1989, there is not a protected amount for the community spouse. Resources are separated according to spousal ownership with one-half of jointly owned resources counted for each. In this instance, each spouse's resources are considered separately and the resources of the community spouse does not affect the eligibility of the spouse in the ~~ICF/MR~~ICF/IID.

(C) **Vendor payment.** After the institutionalized spouse has been determined eligible for long-term care, the vendor payment is computed. For an individual eligible for long-term care in an ~~ICF/MR~~ICF/IID, the individual's share of the vendor payment is not prorated over the month. As SoonerCare is the payer of last resort, the full amount of the member's share of the vendor payment must first be applied to the facility's charges before SoonerCare reimbursement begins. See (b) of this Section for calculation of the vendor payment after financial eligibility has been determined.

(D) **Excess resources.** If the equity in capital resources is in excess of the standards but less than the amount of one month's vendor payment, certification is delayed up to ~~30~~thirty (30) days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources, along with excess income to be considered against the vendor payment, are in excess of the vendor payment, the application is denied.

(b) **Determination of the vendor payment for ~~ICF/MR~~ICF/IID.** Calculation of the vendor payment after financial eligibility for care in an ~~ICF/MR~~ICF/IID has been established is determined according to whether or not a spouse remains in the home. For the purpose of calculating the community spouse income allowance, spouses receiving ADvantage or ~~HCBW/MR~~HCBW/IID services are considered community spouses. The formula for determining the vendor payment for individuals without a spouse or other dependents is in accordance with Oklahoma Administrative Code (OAC) 317:35-19-21(b).

~~(1) The formula for determining the vendor payment for individuals without a spouse or other dependents is:~~

~~(A) Countable income;~~

~~(B) Minus the institutional or own home standard; and~~

~~(C) Minus the verified countable medical expenses (only the actual monthly payments being made for medical insurance premiums including Medicare premiums).~~

~~(2) The own home standard is the categorically needy standard~~

~~found on OKDHS Form 08AX001E (Appendix C-1), Schedule VI.~~

~~(3) The computation for the community spouse's share of resources for individuals with a spouse remaining in the home is the total countable resources divided by two. This amount cannot exceed the maximum resource standard. If it is less than the minimum resource standard, resources are deemed from the institutionalized spouse to the community spouse, up to the minimum standard.~~

~~(4) The formula for determining the vendor payment for an individual with a spouse remaining in the home, regardless of whether the spouse receives ADvantage or HCBW/MR services, is:~~

~~(A) Determine the institutionalized spouse's monthly income as described in (b) (1) of this Section.~~

~~(B) Determine how much of the institutionalized spouse's income can be deemed to the community spouse:~~

~~(i) Subtract the community spouse's gross income from the maximum monthly income standard on OKDHS Form 08AX001E (Appendix C-1), Schedule XI.~~

~~(ii) The resulting amount is the maximum amount that can be deemed from the institutionalized spouse to the community spouse.~~

~~(C) The amount actually deemed from the institutionalized spouse to the community spouse is subtracted from the institutionalized spouse's monthly income as described in (b) (1) of this Section. Any amount remaining is the vendor payment if there are no minor dependent children, parents, or siblings residing with the community spouse.~~

~~(D) If there are minor dependent children, parents, or siblings residing with the community spouse, the formula for determining their allowance is:~~

~~(i) Divide the maximum monthly income standard from OKDHS Form 08AX001E (Appendix C-1), Schedule XI by 3;~~

~~(ii) Subtract the gross income of each dependent child, parent, or sibling residing with the community spouse from the amount in (i);~~

~~(iii) If there is more than one dependent, add the amounts from (ii) together;~~

~~(iv) This amount is deemed to the dependents residing with the community spouse.~~

~~(E) The amount actually deemed to the dependents residing with the community spouse is subtracted from the amount determined in (b) (4) (C) of this Section. Any amount of the institutionalized spouse's income remaining is the vendor payment.~~

(c) **Determining financial eligibility for HCBW/MR**~~HCBW/IIID~~. For individuals determined eligible for ~~HCBW/MR~~HCBW/IIID services, there is no vendor payment. Financial eligibility for



(ii) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.

(iii) After determination of income, the gross income of the individual cannot exceed the categorically needy standard in ~~OKDHS~~Oklahoma Department of Human Services (DHS) Form 08AX001E (Appendix C-1), Schedule VIII. B. 1., to be eligible for NF services. If the individual's gross income exceeds this standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [~~OAC~~Oklahoma Administrative Code (OAC) 317:35-5-41.6(a)(6)(B)].

(B) **Resource eligibility.** In order for an individual without a spouse to be eligible for NF services, his/her countable resources cannot exceed the maximum resource standard listed in ~~OKDHS~~DHS Form 08AX001E (Appendix C-1), Schedule VIII. D.

(C) **Vendor payment.** When eligibility for NF care has been determined, the vendor payment is computed. For an individual eligible for long-term care in a NF, the individual's share of the vendor payment is not prorated over the month. As SoonerCare is the payer of last resort, the full amount of the member's share of the vendor payment must first be applied to the facility's charges before SoonerCare reimbursement begins. See (b) of this Section for calculation of the vendor payment after financial eligibility has been determined.

(D) **First month.** For the first month of care, the following procedures apply when determining the vendor payment:

(i) When an individual enters the facility on the first day of the month, all countable income is considered with the facility maintenance standard allowed.

(ii) When an individual enters the facility after the first day of the month, all countable income is considered with the own home standard allowed in computation of the vendor payment. Only the remaining income actually available is used to compute the vendor payment.

(E) **Equity in capital resources.** If the equity in capital resources is in excess of the standards, certification is delayed up to ~~30~~thirty (30) days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources, along with excess income to be considered against the vendor payment, are in excess of ~~one~~one month's vendor payment, the application is denied.

(2) **Individual with a spouse who is institutionalized in a NF or ICF/MR, or who receives ADvantage or HCBW/MR services, or is 65 or over and in a mental health hospital.** For an individual with a spouse who is institutionalized in a NF or ICF/MR, or who receives ADvantage or HCBW/MR services, or is ~~65~~sixty-five (65) or over and in a mental health hospital, resources are determined for each individual as the amount owned by each individual plus one-half of the jointly owned resources of the couple. Once this separation of assets is made, a resource of either spouse is not considered available to the other during institutionalization.

(A) **Income eligibility.** To determine income for an individual whose spouse is institutionalized in a NF or ICF/MR, or who receives ADvantage or HCBW/MR services, or is 65 or over and in a mental health hospital, income determination is made individually. The income of either spouse is not considered as available to the other during institutionalization for determination of financial eligibility. See (b) of this Section for post-eligibility calculation of the vendor payment and the community spouse income allowance, if applicable. The rules in (i) - (v) of this subparagraph apply in this situation.

(i) If payment of income is made solely to ~~oneone~~ or the other, the income is considered available only to that individual.

(ii) If payment of income is made to both, one-half is considered for each individual.

(iii) If payment of income is made to either one or both and another person(s), the income is considered in proportion to either spouse's interest (if payment is to that spouse) or one-half of the joint interest if no interest is specified.

(iv) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.

(v) After determination of income, the gross income of the individual cannot exceed the categorically needy standard in ~~OKDHS~~DHS Form 08AX001E (Appendix C-1), Schedule VIII. B. 1., to be eligible for Nursing Facility services. If the individual's gross income exceeds this standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [OAC 317:35-5-41.6(a)(6)(B)].

(B) **Resource eligibility.** In order for an individual with a spouse who is institutionalized in a NF or ICF/MR, receives ADvantage or HCBW/MR services, or is 65 or older and in a mental health hospital to be eligible for NF services,

his/her countable resources cannot exceed the maximum resource standard for an individual listed in ~~OKDHS~~DHS Form 08AX001E (Appendix C-1), Schedule VIII. D.

(C) **Vendor payment.** When eligibility for NF services has been determined, the spenddown calculation is used to compute the vendor payment. For an individual eligible for long-term care in a NF, the individual's share of the vendor payment is not prorated over the month. As SoonerCare is the payer of last resort, the full amount of the member's share of the vendor payment must first be applied to the facility's charges before SoonerCare reimbursement begins. See (b) of this Section for calculation of the vendor payment after financial eligibility has been determined.

(D) **First month.** For the first month of care, the following procedures apply when determining the vendor payment:

(i) When an individual enters the facility on the first day of the month, all countable income is considered with the facility maintenance standard allowed.

(ii) When an individual enters the facility after the first day of the month, all countable income is considered with the own home standard allowed in computation of the vendor payment. Only the remaining income actually available is used to compute the vendor payment.

(E) **Equity in capital resources.** If the equity in capital resources is in excess of the standards, certification is delayed up to ~~30~~thirty (30) days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources, along with excess income to be considered against the vendor payment, are in excess of ~~one~~one (1) month's vendor payment, the application is denied.

(3) **Individual with a spouse remaining in the home who does not receive ADvantage or HCBW/MR services.** When an individual and spouse are separated due to the individual entering an NF, income and resources are determined separately. However, the income and resources of the community spouse must be included on the application form. At redetermination of eligibility, the community spouse's income must be included in the review process. During any month that the individual is in the NF, income of the community spouse is not considered available to that individual. The following rules are used to determine the income and resources of each:

(A) **Income eligibility.** To determine the income of both spouses, the following rules in this subparagraph apply:

(i) If payment of income is made solely to one or the other, the income is considered available only to that individual.

(ii) If payment of income is made to both, one-half is considered for each individual.

(iii) If payment of income is made to either one or both and another person(s), the income is considered in proportion to either the spouse's interest (if payment is to that spouse) or one-half of the joint interest if no interest is specified.

(iv) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.

(v) If the individual's gross income exceeds the categorically needy standard as shown on ~~OKDHS~~DHS Form 08AX001E (Appendix C-1), Schedule VIII. B. 1., refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [OAC 317:35-5-41.6(a)(6)(B)].

(B) **Resource eligibility.** To determine resource eligibility, it is necessary to determine the amount of resources for both spouses for the month of the individual's entry into the nursing facility. Of the resources available to the couple (both individual and joint ownership) an amount will be protected for the community spouse which will not be considered available to the spouse in the NF. ~~OKDHS~~DHS Form 08MA011E, Assessment of Assets, is used for the assessment prior to application for SoonerCare. The amount determined as the spousal share is used for all subsequent applications for SoonerCare, regardless of changes in the couple's resources. The protected spousal share cannot be changed for any reason. When application for SoonerCare is made at the same time the individual enters the NF, ~~OKDHS~~DHS Form 08MA012E, Title XIX Worksheet, is used in lieu of ~~OKDHS~~DHS Form 08MA011E.

(i) The first step in the assessment process is to establish the total amount of resources for the couple during the first month of the entry of the spouse into the NF.

(ii) The community spouse's share is equal to one-half of the total resources of the couple not to exceed the maximum amount of resource value that can be protected for the community spouse, as shown on ~~OKDHS~~DHS Form 08AX001E (Appendix C-1), Schedule XI.

(iii) The minimum resource standard for the community spouse, as established by the ~~OHCA~~Oklahoma Health Care Authority (OHCA), is found on ~~OKDHS~~DHS Form 08AX001E (Appendix C-1), Schedule XI. When the community spouse's

share is less than the minimum standard, an amount may be deemed from the other spouse's share to ensure the minimum resource standard for the community spouse. If the community spouse's share equals or exceeds the minimum resource standard, deeming cannot be done.

(iv) If deeming is necessary to meet the minimum resource standard for the community spouse, the amount that is deemed must be legally transferred to the community spouse within ~~one~~ (1) year of the effective date of certification for SoonerCare. At the first redetermination of eligibility, the worker must document that the resources have been transferred. After the first year of SoonerCare eligibility, resources of the community spouse will not be available to the other spouse and resources cannot be deemed to the community spouse.

(v) After the month in which the institutionalized spouse and community spouse have met the resource standards and the institutionalized spouse is determined eligible for benefits, no resources of the community spouse, regardless of value, will be considered available to the institutionalized spouse. If the resources of the community spouse grow to exceed the original deemed amount, the State cannot require the community spouse to apply any of these excess resources toward the cost of the care of the institutionalized spouse.

(vi) When determining eligibility for SoonerCare, the community spouse's share of resources is protected and the remainder considered available to the spouse in the NF.

(vii) The resources determined above for the individual in the NF cannot exceed the maximum resource standard for an individual as shown in ~~OKDHS~~ DHS Form 08AX001E (Appendix C-1), Schedule VIII. D.

(viii) Once the dollar value of the community spouse's share of resources is established for the month of the other spouse's entry into NF, that amount is used when determining resource eligibility for a subsequent SoonerCare application for NF.

(ix) Once a determination of eligibility for SoonerCare is made, either spouse is entitled to a fair hearing. Any such hearing regarding the determination of the community spouse's resource allowance is held within ~~30~~ thirty (30) days of the date of the request for the hearing. Either spouse is entitled to a fair hearing if dissatisfied with a determination of:

- (I) the community spouse's monthly income allowance;
- (II) the amount of monthly income otherwise available

to the community spouse;

(III) determination of the spousal share of resource;  
 (IV) the attribution of resources (amount deemed); or  
 (V) the determination of the community spouse's resource allowance.

(x) The rules on determination of income and resources are applicable only when an individual has entered an NF and is likely to remain under care for ~~30~~thirty (30) consecutive days. The ~~30-day~~thirty (30) day requirement is considered to have been met even if it is interrupted by a hospital stay or the individual is deceased before the ~~30-day~~thirty (30) day period ends.

(xi) The rules on resources included in this Section apply only to those cases in which an individual begins a continuous period of care in an NF on or after September 30, 1989.

(xii) If the individual was admitted prior to September 30, 1989, there is not a protected amount for the community spouse. Resources are separated according to spousal ownership with one-half of jointly owned resources counted for each. In this instance, each spouse's resources are considered separately and the resources of the community spouse do not affect the eligibility of the spouse in the NF.

(C) **Vendor payment.** After the institutionalized spouse has been determined eligible for long-term care, the vendor payment is computed. For an individual eligible for long-term care in a NF, the individual's share of the vendor payment is not prorated over the month. As SoonerCare is the payer of last resort, the full amount of the member's share of the vendor payment must first be applied to the facility's charges before SoonerCare reimbursement begins. See (b) of this Section for calculation of the vendor payment after financial eligibility has been determined.

(D) **Excess resources.** If the equity in capital resources is in excess of the standards but less than the amount of ~~one~~one month's vendor payment, certification is delayed up to ~~30~~thirty (30) days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources, along with excess income to be considered against the vendor payment, are in excess of the vendor payment, the application is denied.

(b) Calculation of the vendor payment after financial eligibility for care in a NF has been determined is performed according to

whether or not a spouse remains in the home. For the purpose of calculating the community spouse income allowance, spouses receiving ADvantage or ~~HCBW/MR~~HCBW/IID services are considered community spouses.

(1) The formula for determining the vendor payment for individuals without a spouse or other dependents is:

- (A) Countable income;
- (B) Minus the institutional or own home standard; and
- (C) ~~Minus the verified countable medical expenses (only the actual monthly payments being made for medical insurance premiums including Medicare premiums);~~ and
- (D) Minus incurred expenses for necessary medical and remedial care not covered under Medicaid, as set forth in the Oklahoma State Medicaid Plan.

(i) In order to be allowed to be deducted, expenses must:

- (I) Have been incurred during the three (3) month period immediately preceding the month of application;
- (II) Have been prescribed by a medical professional;
- (III) Be certified as being medically necessary by a treating physician, physician assistant, or advanced practice registered nurse working within the scope of his or her licensure; and
- (IV) Be no more than the least of the fee recognized by Medicaid, Medicare, or the average cost allowed by a commercial health insurance plan in Oklahoma.

(ii) The following expenses are not allowed to be deducted:

- (I) Expenses incurred as the result of the imposition of a transfer penalty;
- (II) Expenses for which a third party (including Medicaid) is liable, even if provided by an out-of-state network provider;
- (III) Expenses resulting from the failure to obtain prior approval from applicable private insurance, Medicare, or Medicaid, due to the service being medically unnecessary;
- (IV) Expenses that had been the subject of a prior authorization denial by Medicaid, due to lack of medical necessity; and
- (V) Health insurance premiums paid by an individual who is not a financially responsible relative, for which repayment is not expected.

(2) The own home standard is the categorically needy standard found on ~~OKDHS~~DHS Form 08AX001E (Appendix C-1), Schedule VI.

(3) The computation for the community spouse's share of resources for individuals with a spouse remaining in the home

is the total countable resources divided by ~~two~~ two (2). This amount cannot exceed the maximum resource standard. If it is less than the minimum resource standard, resources are deemed from the institutionalized spouse to the community spouse, up to the minimum standard.

(4) The formula for determining the vendor payment for an individual with a spouse remaining in the home, regardless of whether the spouse receives ADvantage or HCBW/MR services, is:

(A) Determine the institutionalized spouse's monthly income as described in Paragraph (b)(1) of this Section.

(B) Determine how much of the institutionalized spouse's income can be deemed to the community spouse:

(i) Subtract the community spouse's gross income from the maximum monthly income standard on OKDHS Form 08AX001E (Appendix C-1), Schedule XI.

(ii) The resulting amount is the maximum amount that can be deemed from the institutionalized spouse to the community spouse.

(C) The amount actually deemed from the institutionalized spouse to the community spouse is subtracted from the institutionalized spouse's monthly income as described in Paragraph (b)(1) of this Section. Any amount remaining is the vendor payment if there are no minor dependent children, parents, or siblings residing with the community spouse.

(D) If there are minor dependent children, parents, or siblings residing with the community spouse, the formula for determining their allowance is:

(i) Divide the maximum monthly income standard from OKDHS Form 08AX001E (Appendix C-1), Schedule XI by 3;

(ii) Subtract the gross income of each dependent child, parent, or sibling residing with the community spouse from the amount in (i);

(iii) If there is more than ~~one~~ one dependent, add the amounts from (ii) together;

(iv) This amount is deemed to the dependents residing with the community spouse.

(E) The amount actually deemed to the dependents residing with the community spouse is subtracted from the amount determined in Subparagraph (b)(4)(C) of this Section. Any amount of the institutionalized spouse's income remaining is the vendor payment.

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

**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**

**PART 6. INPATIENT PSYCHIATRIC HOSPITALS**

**317:30-5-94. Definitions**

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

"Adult" means an individual twenty-one (21) and over, unless otherwise specified. Refer to Oklahoma Administrative Code (OAC) 317:30-1-4.

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

"Child" means an individual under the age of twenty (21) in an inpatient psychiatric setting as per 42 C.F.R. § 441.151(a)(3). If an individual is receiving services before he or she reaches twenty-one (21), then the individual can continue to receive services until the individual no longer requires the services or the date the individual turns twenty-two (22), whichever comes first. For services other than inpatient psychiatric services or otherwise specified by statute, regulation, and/or policy adopted by the Oklahoma Health Care Authority (OHCA), refer to OAC 317:30-1-4.

"C.M.S" means Centers for Medicare and Medicaid Services.

"General hospital" means a general medical surgical hospital, as defined by Section 1-701 (2) of Title 63 of the Oklahoma Statutes.

"Institution for Mental Diseases (IMD)" means 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, as defined by 42 C.F.R. § 435.1010.

"Licensed behavioral health professional (LBHP)" means any of the following practitioners:

(A) An allopathic or osteopathic physician with a current license and board certification in psychiatry or board eligible in the state in which services are provided, or a current resident in psychiatry practicing as described in OAC 317:30-5-2.

(B) A practitioner with a current license to practice in the state in which services are provided, within one (1) of the areas of practice listed in (i) through (vi).

(i) Psychology;

(ii) Social work (clinical specialty only);

(iii) Professional counselor;

(iv) Marriage and family therapist;

(v) Behavioral practitioner; or

(vi) Alcohol and drug counselor.

(C) An advanced practice registered nurse certified in a psychiatric mental health specialty, and licensed as a registered nurse (RN) with a current certification of recognition from the board of nursing in the state in which services are provided.

(D) A physician assistant who is licensed and in good standing in the state and has received specific training for and is experienced in performing mental health therapeutic, diagnostic, or counseling functions.

"Licensure candidate" means a practitioner actively and regularly receiving board approved supervision, and extended supervision by a fully licensed clinician if board's supervision requirement is met but the individual is not yet licensed, to become licensed by one (1) of the areas of practice listed in (B) (i) through (vi) above. The supervising LBHP responsible for the member's care must:

(1) Staff the member's case with the candidate;

(2) Be personally available, or ensure the availability of an LBHP to the candidate for consultation while they are providing services;

(3) Agree with the current plan for the member;

(4) Confirm that the service provided by the candidate was appropriate; and

(5) The member's medical record must show that the requirements for reimbursement were met and the LBHP responsible for the member's care has reviewed, countersigned, and dated the service plan and any updates thereto so that it is documented that the licensed professional is responsible for the member's care.

"OHCA" means Oklahoma Health Care Authority.

"OAC" means Oklahoma Administrative Code.

"O.S." means Oklahoma Statutes.

"Psychiatric hospital" means an institution which is primarily engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons, as defined by Section 1395x(f) of Title 42 of the United States Code.

"Psychiatric residential treatment facility (PRTF)" means a non-hospital facility contracted with the OHCA to provide inpatient psychiatric services to SoonerCare-eligible members under the age of twenty-one (21), as defined by 42 C.F.R. § 483.352.

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

### **317:30-5-95. General provisions and eligible providers**

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

~~(1) **"C.F.R."** means Code of Federal Regulations.~~

~~(2) **"CMS"** means Centers for Medicare and Medicaid Services.~~

~~(3) "General Hospital" means a general medical surgical hospital, as defined by 63 Oklahoma Statutes, Sec. 1-701(2).~~

~~(4) "Institution for Mental Diseases (IMD)" means 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, as defined by 42 C.F.R. § 435.1010.~~

~~(5) "OHCA" means Oklahoma Health Care Authority.~~

~~(6) "O.S." means Oklahoma Statutes.~~

~~(7) "Psychiatric Hospital" means an institution which is primarily engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons, as defined by 42 United States Code, Sec. 1395x(f).~~

~~(8) "Psychiatric Residential Treatment Facility (PRTF)" means a non-hospital facility contracted with the OHCA to provide inpatient psychiatric services to SoonerCare-eligible members under the age of twenty one (21), as defined by 42 C.F.R. § 483.352.~~

~~(9) "U.S.C." means United States Code.~~

~~(b) Eligible settings for inpatient psychiatric services. The following individuals may receive SoonerCare-reimbursable inpatient psychiatric services in the following eligible settings:~~

~~(1) Individuals twenty one (21) to sixty four (64) years of age may receive SoonerCare-reimbursable inpatient psychiatric and/or chemical dependency/substance use/detoxification services in a psychiatric unit of a general hospital, provided that such hospital is not an IMD.~~

~~(2) Individuals sixty five (65) years of age or older may receive SoonerCare-reimbursable inpatient psychiatric services in a psychiatric unit of a general hospital, or in a psychiatric hospital.~~

~~(3) Individuals under twenty one (21) years of age, in accordance with OAC 317:30-5-95.23, may receive SoonerCare-reimbursable inpatient psychiatric services in a psychiatric unit of a general hospital, a psychiatric hospital, or a PRTF.~~

~~(c) Psychiatric hospitals and psychiatric units of general hospitals. To be eligible for payment under this Part, inpatient psychiatric programs must be provided to eligible SoonerCare members in a hospital that:~~

~~(1) is a psychiatric hospital that:~~

~~(A) successfully underwent a State survey to determine whether the hospital meets the requirements for participation in Medicare as a psychiatric hospital per 42 C.F.R. § 482.60; or~~

~~(B) is accredited by a national organization whose psychiatric accrediting program has been approved by CMS; or~~

~~(2) is a general hospital with a psychiatric unit that:~~

~~(A) successfully underwent a State survey to determine whether the hospital meets the requirements for participation in Medicare as a hospital as specified in 42 C.F.R. Part 482; or~~

~~(B) is accredited by a national accrediting organization whose accrediting program has been approved by CMS; and~~

~~(3) meets all applicable federal regulations, including, but not limited to:~~

~~(A) Medicare Conditions of Participation for Hospitals (42 C.F.R. Part 482), including special provisions applying to psychiatric hospitals (42 C.F.R. §§ 482.60-.62);~~

~~(B) Medicaid for Individuals Age 65 or over in Institutions for Mental Diseases (42 C.F.R. Part 441, Subpart C);~~

~~(C) Inpatient Psychiatric Services for Individuals under Age 21 in Psychiatric Facilities or Programs (42 C.F.R. Part 441, Subpart D); and/or~~

~~(D) Utilization Control [42 C.F.R. Part 456, Subpart C (Utilization Control: Hospitals) or Subpart D (Utilization Control: Mental Hospitals)]; and~~

~~(4) is contracted with the OHCA; and~~

~~(5) if located within Oklahoma and serving members under eighteen (18) years of age, is appropriately licensed by the Oklahoma Department of Human Services (DHS) as a residential child care facility (10 O.S. §§ 401 to 402) that is providing services as a residential treatment facility in accordance with OAC 340:110-3-168.~~

~~(d) **PRTF.** Every PRTF must:~~

~~(1) be individually contracted with OHCA as a PRTF;~~

~~(2) meet all of the state and federal participation requirements for SoonerCare reimbursement, including, but not limited to, 42 C.F.R. § 483.354, as well as all requirements in 42 C.F.R. 483 Subpart G governing the use of restraint and seclusion;~~

~~(3) be appropriately licensed by DHS as a residential child care facility (10 O.S. §§ 401 to 402) that is providing services as a residential treatment facility in accordance with OAC 340:110-3-168; and~~

~~(4) be accredited by TJC, the Council on Accreditation of Rehabilitation Facilities (CARF), or the Council on Accreditation (COA).~~

~~(e) **Out-of-state PRTF.** Any out-of-state PRTF must be appropriately licensed and/or certified in the state in which it does business, and must provide an attestation to OHCA that the PRTF is in compliance with the condition of participation for restraint and seclusion, as is required by federal law. Any out-of-state PRTF must also be accredited in conformance with OAC 317:30-5-95(d)(4).~~

~~(f) **Required documents.** The required documents for enrollment for each participating provider can be downloaded from the OHCA's website.~~

~~(a) **Eligible settings for inpatient psychiatric services.** The~~

following individuals may receive SoonerCare-reimbursable inpatient psychiatric services in the following eligible settings:

(1) Individuals twenty-one (21) to sixty-four (64) years of age may receive SoonerCare-reimbursable inpatient psychiatric and/or chemical dependency/substance use/detoxification services in a psychiatric unit of a general hospital, provided that such hospital is not an IMD.

(2) Individuals sixty-five (65) years of age or older may receive SoonerCare-reimbursable inpatient psychiatric services in a psychiatric unit of a general hospital, or in a psychiatric hospital.

(3) Individuals under twenty-one (21) years of age, in accordance with OAC 317:30-5-95.23, may receive SoonerCare-reimbursable inpatient psychiatric services in a psychiatric unit of a general hospital, a psychiatric hospital, or a PRTF.

(b) **Psychiatric hospitals and psychiatric units of general hospitals.** To be eligible for payment under this Part, inpatient psychiatric programs must be provided to eligible SoonerCare members in a hospital that:

(1) Is a psychiatric hospital that:

(A) Successfully underwent a State survey to determine whether the hospital meets the requirements for participation in Medicare as a psychiatric hospital per 42 C.F.R. § 482.60; or

(B) Is accredited by a national organization whose psychiatric accrediting program has been approved by CMS; or

(2) Is a general hospital with a psychiatric unit that:

(A) Successfully underwent a State survey to determine whether the hospital meets the requirements for participation in Medicare as a hospital as specified in 42 C.F.R. Part 482; or

(B) Is accredited by a national accrediting organization whose accrediting program has been approved by CMS; and

(3) Meets all applicable federal regulations, including, but not limited to:

(A) Medicare Conditions of Participation for Hospitals (42 C.F.R. Part 482), including special provisions applying to psychiatric hospitals (42 C.F.R. § 482.60-.62);

(B) Medicaid for Individuals Age 65 or over in Institutions for Mental Diseases (42 C.F.R. Part 441, Subpart C);

(C) Inpatient Psychiatric Services for Individuals under Age 21 in Psychiatric Facilities or Programs (42 C.F.R. Part 441, Subpart D); and/or

(D) Utilization Control [42 C.F.R. Part 456, Subpart C (Utilization Control: Hospitals) or Subpart D (Utilization Control: Mental Hospitals)]; and

(4) Is contracted with the OHCA; and

(5) If located within Oklahoma and serving members under eighteen (18) years of age, is appropriately licensed by the

Oklahoma Department of Human Services (OKDHS) as a residential child care facility (10 O.S. §§ 401 to 402) that is providing services as a residential treatment facility in accordance with OAC 340:110-3-168.

(c) **PRTF.** Every PRTF must:

- (1) Be individually contracted with OHCA as a PRTF;
- (2) Meet all of the state and federal participation requirements for SoonerCare reimbursement, including, but not limited to, 42 C.F.R. § 483.354, as well as all requirements in 42 C.F.R. 483 Subpart G governing the use of restraint and seclusion;
- (3) Be appropriately licensed by OKDHS as a residential child care facility (10 O.S. § 401 to 402) that is providing services as a residential treatment facility in accordance with OAC 340:110-3-168;
- (4) Be appropriately certified by the State Survey Agency, the Oklahoma State Department of Health (OSDH) as meeting Medicare Conditions of Participation; and
- (5) Be accredited by TJC, the Council on Accreditation of Rehabilitation Facilities (CARF), or the Council on Accreditation (COA).

(d) **Out-of-state PRTF.** Any out-of-state PRTF must be appropriately licensed and/or certified in the state in which it does business, and must provide an attestation to OHCA that the PRTF is in compliance with the condition of participation for restraint and seclusion, as is required by federal law. Any out-of-state PRTF must also be accredited in conformance with OAC 317:30-5-95(c) (5).

(e) **Required documents.** The required documents for enrollment for each participating provider can be downloaded from the OHCA's website.

#### **317:30-5-95.4. Individual plan of care for adults aged twenty-one (21) to sixty-four (64)**

(a) Before admission to a psychiatric unit of a general hospital or immediately after admission, the attending physician or staff physician must establish a written plan of care for each member aged twenty-one (21) to sixty-four (64). The plan of care must include:

- (1) Diagnoses, symptoms, complaints, and complications indicating the need for admission;
- (2) A description of the functional level of the individual;
- (3) Objectives;
- (4) Any order for medication, treatments, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures recommended for the health and safety of the member;
- (5) Plans for continuing care, including review and modification to the plan of care; and
- (6) Plans for discharge.

(b) The attending or staff physician and other treatment team

personnel involved in the member's care must review each plan of care at least every seven (7) days.

(c) All plans of care and plan of care reviews must be clearly identified as such in the member's medical records. All must be signed and dated by the physician, RN, LBHP or licensure candidate, member, and other treatment team members that provide individual, family, and group therapy in the required review interval. Licensure candidate signatures must be co-signed. All plans of care and plan of care reviews must be signed by the member upon completion, except when a member is too physically ill or his or her acuity level precludes him or her from signing. If the member has designated an advocate, the advocate's signature is also required on all plans of care and plan of care reviews. If the member was too physically ill or his or her acuity level precluded him or her from signing the plan of care and/or the plan of care review at the time of completion, the member must sign the plan when his or her condition improves, but before discharge.

(d) The plan of care must document appropriate member participation in the development and implementation of the treatment plan.

**317:30-5-95.14. Individual plan of care for persons sixty-five (65) years of age or older receiving inpatient acute psychiatric services**

(a) Before admission to a psychiatric hospital or psychiatric unit of a general hospital or immediately after admission, the attending physician or staff physician must establish a written plan of care for each applicant or member. The plan of care must include:

- (1) Diagnoses, symptoms, complaints, and complications indicating the need for admission;
- (2) A description of the functional level of the individual;
- (3) Objectives;
- (4) Any order for medication, treatments, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures recommended for the health and safety of the member;
- (5) Plans for continuing care, including review and modification to the plan of care; and
- (6) Plans for discharge.

(b) The attending or staff physician and other treatment team personnel involved in the member's care must review each plan of care at least every seven (7) days.

(c) All plans of care and plan of care reviews must be clearly identified as such in the member's medical records. All must be signed and dated by the physician, RN, LBHP or licensure candidate, member, and other treatment team members that provide individual, family, and group therapy in the required review interval. Licensure candidate signatures must be co-signed. All plans of care

and plan of care reviews must be signed by the member upon completion, except when a member is too physically ill or his or her acuity level precludes him or her from signing. If the member has designated an advocate, the advocate's signature is also required on all plans of care and plan of care reviews. If the member was too physically ill or his or her acuity level precluded him or her from signing the plan of care and/or the plan of care review at the time of completion, the member must sign the plan when his or her condition improves, but before discharge.

(d) The plan of care must document appropriate member participation in the development and implementation of the treatment plan.

### **317:30-5-95.22. Coverage for children**

~~(a) In order for services to be covered, services in acute hospitals, free-standing hospitals, and Psychiatric Residential Treatment Facilities 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 children are found in Sections OAC 317:30-5-95.24 through 317:30-5-95.42.~~

~~(b) **Definitions.** The following words and terms, when used in Sections 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 care"** means care delivered in a psychiatric unit of a general hospital or free-standing 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) **"Border Placement"** means a placement in a facility that is in one of the states that borders Oklahoma (Arkansas, Colorado, Kansas, Missouri, New Mexico, and Texas). Border "status" may include other states that routinely provide PRTF services. Providers are subject to the same OHCA rules and program requirements as in-state providers, including claims submission procedures and are paid the same daily per diem as Oklahoma providers.~~

~~(3) **"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.~~

~~(4) **"Community Based Extended"** means a PRTF with 16 beds or more but less than 30 beds. The typical facility is not a locked facility.~~

~~(5) **"Community based transitional residential treatment"** means a level of care designed for children that require the continued structure, psychiatric intervention of 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 are non-secure PRTFs with 16 beds or less.~~

~~(6) "**Designated Agent**" means the entity contracted with the OHCA to provide certain services to meet federal and state statutory obligations of the OHCA.~~

~~(7) "**Enhanced Treatment Unit or Specialized Treatment Unit**" means an intensive residential treatment unit that provides a program of care to a population with a special need or issues requiring increased staffing requirements, co-morbidities, environmental accommodations, specialized treatment programs, and longer lengths of stay.~~

~~(8) "**Evidenced Based Practice (EBP)**" according to the Substance Abuse and Mental Health Services Administration (SAMHSA) means programs or practices that are supported by research methodology and have produced consistently positive patterns of results.~~

~~(9) "**Freestanding PRTFs**" are generally for profit secure facilities which range from 50 to over 100 beds and are generally staffed higher with RN personnel.~~

~~(10) "**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) "**Provider Based**" facilities are secure residential treatment facilities that are affiliated with private medical/surgical hospitals. The RN hours per day average 2.4 hours.~~

~~(12) "**Public facilities**" are Oklahoma government owned or operated facilities.~~

~~(13) "**Residential Treatment services**" means psychiatric services that are designed to serve children 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.~~

~~(14) "**Trauma Informed**" means the recognition and responsiveness to the presence of the effects of past and current traumatic experiences in the lives of members.~~

(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) "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) "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) "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) "Public facilities" means Oklahoma government owned or operated facilities.

(12) "Trauma-informed" means the recognition and responsiveness

to the presence of the effects of past and current traumatic experiences in the lives of members.

**317:30-5-95.24. Prior ~~Authorization~~authorization of inpatient psychiatric services for ~~children~~individuals under twenty-one (21)**

~~(a) All inpatient psychiatric services for members under twenty-one (21) years of age must be prior authorized by the Oklahoma Health Care Authority (OHCA) or its designated agent. All inpatient acute and residential psychiatric services will be prior authorized for an approved length of stay. Admission requirements for services must be provided in accordance with Code of Federal Regulations, Title 42 Public Health, Part 441 and 456. Additional information will be required for a SoonerCare compensable approval on enhanced treatment units or in special population programs.~~

~~(b) Staffing ratios shall always be present for each individual unit not by facility or program. Patients shall be grouped for accommodation by gender, age, and treatment needs. At a minimum, children, adolescent, and adult treatment programs shall be separate with distinct units for each population. A unit is determined by separate and distinct sleeping, living, and treatment areas often separated by walls and/or doors. A unit that does not allow clear line of sight due to the presence of walls or doors is considered a separate unit. Each individual unit shall have assigned staff to allow for appropriate and safe monitoring of patients and to provide active treatment.~~

~~(c) In an acute care setting, at least one Registered Nurse (RN) must be on duty per unit at all times, with additional RNs to meet program needs. RNs must adhere to Oklahoma Department of Health policy at Oklahoma Administrative Code (OAC) 310:667-15-3 and OAC 310:667-33-2(a)(3).~~

~~(d) Regular residential treatment programs require a staffing ratio of 1:6 during routine waking hours and 1:8 during time residents are asleep with twenty-four (24) hour nursing care supervised by an RN for management of behaviors and medical complications. At a minimum, the supervising RN must be available by phone and on-site within one (1) hour. If the supervising RN is off-site, then an RN or LPN must be on-site to adhere to a twenty-four (24) hour nursing care coverage ratio of 1:30 during routine waking hours and 1:40 during time residents are asleep.~~

~~(e) Specialty residential treatment at this level is a longer term treatment that requires a higher staff to member ratio because of the need for constant, intense, and immediate reinforcement of new behaviors to develop an understanding of the behaviors. The environment of specialized residential treatment centers requires special structure and configuration (e.g., sensory centers for autistic members) and specialized training for the staff in the area of the identified specialty. The physician will see the child at least one (1) time a week.~~

~~(f) A Psychiatric Residential Treatment Facility (PRTF) will not be considered a specialty treatment program for SoonerCare without~~

~~prior approval of the OHCA behavioral health unit.~~

~~(g) A treatment program that has been approved as a specialized treatment program must maintain medical records that document the degree and intensity of the psychiatric care delivered to the children.~~

~~(h) Criteria for classification as a specialized PRTF will require a staffing ratio of 1:3 at a minimum during routine waking hours and 1:6 during time residents are asleep with twenty-four (24) hour nursing care supervised by a RN for management of behaviors and medical complications. The PRTF will be a secure unit, due to the complexity of needs and safety considerations. Admissions will be restricted to children that meet the medical necessity criteria for Residential Treatment Center (RTC) and also meet at least two or more of the following:~~

~~(1) Have failed at other levels of care or have not been accepted at other levels of care;~~

~~(2) Behavioral, emotional, and cognitive problems requiring secure residential treatment that includes 1:1, 1:2, or 1:3 staffing due to the member being a danger to themselves and others, for impairments in socialization problems, communication problems, and restricted, repetitive and stereotyped behaviors. These symptoms are severe and intrusive enough that management and treatment in a less restrictive environment places the child and others in danger but, do not meet acute medical necessity criteria. These symptoms which are exhibited across multiple environments must include at least two or more of the following:~~

~~(A) Marked impairments in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction;~~

~~(B) Inability to regulate impulse control with frequent displays of aggression or other dangerous behavior toward self and/or others regularly;~~

~~(C) Failure to develop peer relationships appropriate to developmental level;~~

~~(D) Lack of spontaneously seeking to share enjoyment, interests, or achievements with other people;~~

~~(E) Lack of social or emotional reciprocity;~~

~~(F) Lack of attachment to caretakers;~~

~~(G) Require a higher level of assistance with activities of daily living requiring multiple verbal cues 50 percent of the time to complete tasks;~~

~~(H) Delay, or total lack of, the development of spoken language which is not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime;~~

~~(I) Marked impairment in individuals with adequate speech in the ability to initiate or sustain a conversation with others;~~

~~(J) Stereotyped and repetitive use of language or idiosyncratic language;~~

~~(K) Lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level;~~

~~(L) Encompassing preoccupation with one or more stereotyped and restricted pattern and interest that is abnormal in intensity of focus;~~

~~(M) Inflexible adherence to specific, nonfunctional routines or rituals;~~

~~(N) Stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting or complex whole body movements);~~

~~(O) Persistent occupation with parts of objects;~~

~~(3) Member is medically stable, but has co-morbid medical conditions which require specialized medical care during treatment;~~

~~(4) Full scale IQ below 40 (profound mental retardation intellectual disability).~~

~~(i) Non-authorized inpatient psychiatric services will not be SoonerCare compensable.~~

~~(j) The designated agent will prior authorize all services for an approved length of stay based on the medical necessity criteria described in OAC 317:30-5-95.25 through 317:30-5-95.31.~~

~~(k) For out-of-state placement policy, refer to OAC 317:30-3-89 through 317:30-3-92. A prime consideration for placements will be proximity to the family or guardian in order to involve the family or guardian in Active Treatment, including discharge and reintegration planning. Out of state facilities are responsible for insuring appropriate medical care as needed under SoonerCare provisions as part of the per-diem rate.~~

~~(l) Inpatient psychiatric services in all acute hospitals and psychiatric residential treatment facilities are limited to the approved length of stay. OHCA, or its designated agent, will approve lengths of stay using the current OHCA Behavioral Health medical necessity criteria as described in OAC 317:30-5-95.25 through OAC 317:30-5-95.31. The approved length of stay applies to both hospital and physician services. The Child and Adolescent Level of Care Utilization System (CALOCUS®) is a level of care assessment that will be used as a tool to determine the most appropriate level of care treatment for a member by LBHPs in the community.~~

(a) All inpatient psychiatric services for members under twenty-one (21) years of age must be prior authorized by the OHCA or its designated agent. All inpatient Acute, Acute II, and PRTF services will be prior authorized for an approved length of stay. Admission requirements for services must be provided in accordance with 42 C.F.R. Part 441 and 456. Additional information will be required for SoonerCare-compensable approval on enhanced treatment units or in special population programs.

(b) Unit staffing ratios shall always meet the requirements in OAC 317:30-5-95.24 (c), (d) and (h). The facility cannot use staff that is also on duty in other units of the facility in order to meet the

unit staffing ratios. Patients shall be grouped for accommodation by gender, age, and treatment needs. At a minimum, children, adolescent, and adult treatment programs shall be separate with distinct units for each population. A unit is determined by separate and distinct sleeping, living, and treatment areas often separated by walls and/or doors. A unit that does not allow clear line of sight due to the presence of walls or doors is considered a separate unit. Each individual unit shall have assigned staff to allow for appropriate and safe monitoring of patients and to provide active treatment.

(c) In Acute and Acute II settings, at least one (1) registered nurse (RN) must be on duty per unit at all times, with additional RNs to meet program needs. RNs must adhere to Oklahoma State Department of Health (OSDH) policy at OAC 310:667-15-3 and 310:667-33-2(a) (3).

(d) Acute, non-specialty Acute II, and non-specialty PRTF programs require a staffing ratio of one (1) staff: six (6) patients during routine waking hours and one (1) staff: eight (8) patients during time residents are asleep with twenty-four (24) hour nursing care supervised by an RN for management of behaviors and medical complications. For PRTF programs, at a minimum, a supervising RN must be available by phone and on-site within one (1) hour. If the supervising RN is off-site, then an RN or licensed practical nurse (LPN) must be on-site to adhere to a twenty-four (24) hour nursing care coverage ratio of one (1) staff: thirty (30) patients during routine waking hours and one (1) staff: forty (40) patients during time residents are asleep.

(e) Specialty treatment at Acute II or PRTF is a longer-term treatment that requires a higher staff-to-member ratio because of the need for constant, intense, and immediate reinforcement of new behaviors to develop an understanding of the behaviors. The environment of specialized residential treatment centers requires special structure and configuration (e.g., sensory centers for autistic members) and specialized training for the staff in the area of the identified specialty. The physician will see the child at least one (1) time a week.

(f) An Acute II or PRTF will not be considered a specialty treatment program for SoonerCare without prior approval of the OHCA behavioral health unit.

(g) A treatment program that has been approved as a specialized treatment program must maintain medical records that document the degree and intensity of the psychiatric care delivered to the members.

(h) Criteria for classification as a specialty Acute II or PRTF will require a staffing ratio of one (1) staff: three (3) patients at a minimum during routine waking hours and one (1) staff: six (6) patients during time residents are asleep with twenty-four (24) hour nursing care supervised by a RN for management of behaviors and medical complications. The specialty Acute II or PRTF will be a secure unit, due to the complexity of needs and safety

considerations. Admissions will be restricted to members who meet the medical necessity criteria for the respective level of care and also meet at least two (2) or more of the following:

(1) Have failed at other levels of care or have not been accepted by other non-specialty levels of care;

(2) Have behavioral, emotional, and cognitive problems requiring secure treatment that includes one (1) staff: one (1) patient, one (1) staff: two (2) patients, or one (1) staff: three (3) patients staffing due to the member being a danger to themselves and others, for impairments in socialization problems, communication problems, and restricted, repetitive, and stereotyped behaviors. These symptoms must be severe and intrusive enough that management and treatment in a less restrictive environment places the member and others in danger but, do not meet acute medical necessity criteria. These symptoms must be exhibited across multiple environments and must include at least two (2) or more of the following:

(A) Marked impairments in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction;

(B) Inability to regulate impulse control with frequent displays of aggression or other dangerous behavior toward self and/or others regularly;

(C) Failure to develop peer relationships appropriate to developmental level;

(D) Lack of spontaneously seeking to share enjoyment, interests, or achievements with other people;

(E) Lack of social or emotional reciprocity;

(F) Lack of attachment to caretakers;

(G) Require a higher level of assistance with activities of daily living requiring multiple verbal cues at least fifty (50) percent of the time to complete tasks;

(H) Delay, or total lack of, the development of spoken language which is not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime;

(I) Marked impairment in individuals with adequate speech in the ability to initiate or sustain a conversation with others;

(J) Stereotyped and repetitive use of language or idiosyncratic language;

(K) Lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level;

(L) Encompassing preoccupation with one (1) or more stereotyped and restricted pattern and interest that is abnormal in intensity of focus;

(M) Inflexible adherence to specific, nonfunctional routines or rituals;

(N) Stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting or complex whole body

movements); and/or

(O) Persistent occupation with parts of objects;

(3) Member is medically stable, but has co-morbid medical conditions which require specialized medical care during treatment; and/or

(4) Has full-scale IQ below forty (40) (profound intellectual disability).

(i) Non-authorized inpatient psychiatric services will not be SoonerCare compensable.

(j) The OHCA, or its designated agent, will prior authorize all services for an approved length of stay based on the medical necessity criteria described in OAC 317:30-5-95.25 through 317:30-5-95.30.

(k) For out-of-state placement policy, refer to OAC 317:30-3-89 through 317:30-3-92. A prime consideration for placements will be proximity to the family or guardian in order to involve the family or guardian in active treatment, including discharge and reintegration planning. Out-of-state facilities are responsible for insuring appropriate medical care, as needed under SoonerCare provisions, as part of the per-diem rate.

(l) Inpatient psychiatric services in all psychiatric units of general hospitals, psychiatric hospitals, and PRTFs are limited to the approved length of stay. OHCA, or its designated agent, will approve lengths of stay using the current OHCA Behavioral Health medical necessity criteria as described in OAC 317:30-5-95.25 through OAC 317:30-5-95.30. The approved length of stay applies to both facility and physician services.

**317:30-5-95.29. Medical necessity criteria for admission—~~psychiatric residential treatment~~ Acute II and PRTF admissions for children**

~~(a) Psychiatric Residential Treatment facility admissions for children must meet the terms and conditions in (1), (2), (3), (4), (6) and one of (5) (A) through (5) (D) of this subsection.~~

~~(1) A primary diagnosis from the most recent edition of "The Diagnostic and Statistical Manual of Mental Disorders" (DSM) with the exception of V-codes, adjustment disorders, and substance related disorders, accompanied by detailed symptoms supporting the diagnosis. Children 18-20 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 care setting or it has been determined by the OHCA designated agent that the current disabling symptoms could not or have not been manageable in a less intensive treatment program.~~

~~(4) Child must be medically stable.~~

~~(5) Within the past 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 14 day requirement may be made in instances when evidence of the behavior could not have reasonably been discovered within 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.~~

~~(6) Requires 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.~~

~~(b) Community Based Transitional Residential Treatment (CBT) facility admissions for children must meet the terms and conditions in (1) through (6) of this subsection.~~

~~(1) A primary diagnosis from the most recent edition of the DSM with the exception of V-codes, adjustment disorders, and substance related disorders, accompanied by detailed symptoms supporting the diagnosis. Children 18-20 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 an acute, RTC or children's crisis unit care setting 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, 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 2 of the 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.~~

~~(v) Educational/vocational performance.~~

~~(4) Child must be medically stable and not require 24 hour on-~~

~~site nursing or medical care.~~

~~(5) Within the past 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 14 day requirement may be made in instances when evidence of the behavior could not have reasonably been discovered within 14 days (e.g., sexual offenses).~~

~~(6) Within the past 14 calendar days, the patient's behaviors have created significant functional impairment.~~

(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 continued stay -- psychiatric residential treatment center for children Acute II and PRTF continued stay for children**

~~(a) For continued stay Psychiatric Residential Treatment Facilities for children, admissions must meet the terms and conditions contained in (1), (2), (5), (6), and either (3) or (4) of this subsection.~~

~~(1) A primary diagnosis from the most recent edition of "The~~

~~Diagnostic and Statistical Manual of Mental Disorders" (DSM) 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, children 18-20 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, status offenses).~~

~~(3) 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.~~

~~(4) Child's condition has remained unchanged or worsened.~~

~~(A) Documentation of regression is measured in behavioral terms.~~

~~(B) If condition is unchanged, there is evidence of re-evaluation of the treatment objectives and therapeutic interventions.~~

~~(5) There is documented continuing need for 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.~~

~~(6) Documented efforts of working with child's family, legal guardian and/or custodian and other human service agencies toward a tentative discharge date.~~

~~(b) For continued stay Community Based Transitional Residential Treatment (CBT), children must meet the terms and conditions found in (1) through (5) of this subsection.~~

~~(1) A primary diagnosis from the most recent DSM with the exception of V codes, adjustment disorders, and substance use disorders, accompanied by detailed symptoms supporting the diagnosis. Children 18-20 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, status offenses, etc.).~~

~~(3) There is documented continued need for 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 of the following five critical areas, as evidenced by specific clinically relevant behavior descriptors:~~

~~(i) Personal safety.~~

~~(ii) Cognitive functioning.~~

~~(iii) Family relations.~~

~~(iv) Interpersonal relations.~~

~~(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.~~

(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.

(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.

**317:30-5-95.31. Prior Authorization authorization and extension procedures for children**

~~(a) Prior authorization for inpatient psychiatric services for children must be requested from the Oklahoma Health Care Authority (OHCA) or its designated agent. The OHCA or its designated agent will evaluate and render a decision within twenty four (24) hours of receiving the request. A prior authorization will be issued by the OHCA or its designated agent, if the member meets medical necessity criteria. For the safety of SoonerCare members, additional approval from OHCA, or its designated agent is required for placement on specialty units or in special population programs or for members with special needs such as very low intellectual~~

functioning.

~~(b) Extension requests (psychiatric) must be made through OHCA, or its designated agent. All requests are made prior to the expiration of the approved extension. Requests for the continued stay of a child who has been in an acute psychiatric program for a period of fifteen (15) days and in a psychiatric residential treatment facility for three (3) months will require a review of all treatment documentation completed by the OHCA designated agent to determine the efficiency of treatment.~~

~~(c) Providers seeking prior authorization will follow OHCA's, or its designated agent's, prior authorization process guidelines for submitting behavioral health case management requests on behalf of the SoonerCare member.~~

~~(d) In the event a member disagrees with the decision by OHCA, or its designated agent, the member receives an evidentiary hearing under Oklahoma Administrative Code 317:2-1-2(b). The member's request for such an appeal must be received within thirty (30) calendar days of the initial decision.~~

(a) Prior authorization for inpatient psychiatric services for members must be requested from the OHCA or its designated agent. The OHCA or its designated agent will evaluate and render a decision within twenty-four (24) hours of receiving the request. A prior authorization will be issued by the OHCA or its designated agent, if the member meets medical necessity criteria. For the safety of SoonerCare members, additional approval from OHCA, or its designated agent, is required for placement on specialty units or in special population programs or for members with special needs such as very low intellectual functioning.

(b) Extension requests (psychiatric) must be made through OHCA or its designated agent. All requests are made prior to the expiration of the approved extension. Requests for the continued stay of a member who has been in an Acute psychiatric program for a period of fifteen (15) days and an Acute II or PRTF program for three (3) months will require a review of all treatment documentation completed by the OHCA, or its designated agent, to determine the efficiency of treatment.

(c) Providers seeking prior authorization will follow OHCA's, or its designated agent's, prior authorization process guidelines for submitting behavioral health case management requests on behalf of the SoonerCare member.

(d) In the event a member disagrees with the decision by OHCA, or its designated agent, the member may request an evidentiary hearing under OAC 317:2-1-2(b). The member's request for such an appeal must be received within thirty (30) calendar days of the date of the notice of the initial decision.

**317:30-5-95.33. Individual plan of care for members under the age of twenty-one (21) children**

~~(a) The following words and terms, when used in this Section, shall have the following meaning, unless the context clearly indicates~~

otherwise:

~~(1) "Licensed behavioral health professional (LBHP)" means licensed psychologists, licensed clinical social workers (LCSW), licensed marital and family therapists (LMFT), licensed professional counselors (LPC), licensed behavioral practitioners (LBP), licensed alcohol and drug counselors (LADC), and advanced practice registered nurses (APRN).~~

~~(2) "Licensure candidate" means practitioners actively and regularly receiving board approved supervision, and extended supervision by a fully licensed clinician if board's supervision requirement is met but the individual is not yet licensed, to become licensed by one of the following licensing boards:~~

~~(A) Psychology,~~

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

~~(C) Professional Counselor,~~

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

~~(E) Behavioral Practitioner, or~~

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

~~(3) "Individual plan of care (IPC)" means a written plan developed for each member within four (4) calendar days of admission to an acute psychiatric facility 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:~~

~~(A) A primary diagnosis from the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) 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;~~

~~(B) The current functional level of the individual;~~

~~(C) Treatment goals and measurable, time-limited objectives;~~

~~(D) 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;~~

~~(E) Plans for continuing care, including review and modification to the IPC; and~~

~~(F) 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 Oklahoma Administrative Code (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 after care plans that are appropriate to the member's needs and effective on the day of discharge. At the time of discharge, after care 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 five (5) to nine (9) calendar days for members admitted to an acute care setting; every fourteen (14) calendar days for members admitted to a regular PRTF; every twenty-one (21) calendar days for members~~

~~admitted to an OHCA approved longer term treatment program or specialty PRTF; and every thirty (30) calendar days for members admitted to a Community Based Transitional 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 (DHS/OJA) worker for review, the parent/legal guardian and/or DHS/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 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.~~

(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.

(10) Medically necessary Early and Periodic Screening, Diagnosis 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) **"Discharge/transition planning"** means a patient-centered, interdisciplinary process that begins with an initial assessment of the patient's potential needs at the time of admission and continues throughout the patient's stay. Active collaboration with the patient, 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 their community. The linkages with these supports should be made prior to discharge to allow for a smooth transition.

(2) **"Expressive group therapy"** means art, music, dance, movement, poetry, drama, psychodrama, structured therapeutic physical activities, experiential (e.g. ropes course), recreational, or occupational therapies that encourage the member to express themselves emotionally and psychologically.

(3) **"Family therapy"** means interaction between a licensed behavioral health providers (LBHP) or licensure candidate, member and family member(s) to facilitate emotional, psychological or behavioral changes and promote successful communication and understanding.

(4) **"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).

(5) **"Individual rehabilitative treatment"** means a face-to-face, one-on-one interaction which is performed to assist members who are 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.

(6) **"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.

(7) **"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 as defined in OAC 317:30-5-240.3, and two (2) or more members to promote positive emotional and/or behavioral change.

(b) Inpatient psychiatric programs must provide "active treatment." Active treatment involves the member and their family or guardian from the time of an admission throughout the treatment and discharge process. 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. For individuals in the age range of eighteen (18) up to twenty-one (21), it is understood that family members and guardians will not always be involved in the member's treatment. Active treatment also includes an ongoing program of assessment, diagnosis, intervention, evaluation of care and treatment, and planning for discharge and

~~aftercare under the direction of a physician. Evidence based practices such as trauma informed methodology should be utilized to minimize the use of restraint and seclusion.~~

~~(c) For individuals age 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 individual plan of care 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 individual plan of care.~~

~~(d) 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 individual plan of care must be recovery focused, trauma informed, and specific to culture, age, and gender. Individuals in acute care must receive seventeen (17) hours of documented active treatment services each week, with seven (7) of those hours being dedicated to core services as described in (1) below. Individuals in PRTFs must receive fourteen (14) hours of documented active treatment services each week, with four and a half (4.5) of those hours being dedicated to core services as described in (1) below. Individuals in Community Based Transitional (CBT) treatment must receive ten (10) hours of documented active treatment services each week, with four and a half (4.5) of those hours being dedicated to core services as described in (1) below. The remainder of the active treatment services may include any or all of the elective services listed in (2) below or additional hours of any of the core services. Sixty (60) minutes is the expectation to equal one (1) hour of treatment. 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. 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 care and one (1) time a week in PRTFs. Individual treatment provided by the physician will never exceed ten (10) calendar days between sessions in PRTFs, never exceed seven (7) calendar days in a 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 and residential 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 individual 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 care and one (1) hour per week in residential treatment by an LBHP or licensure candidate as described in OAC 317:30-5-240.3. 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 for acute care and residential. 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 as described in OAC 317:30-5-240.3.~~

~~(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 care and two (2) hours per week in residential treatment by an LBHP or licensure candidate as defined in OAC 317:30-5-240.3. 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 care and thirty (30) minutes per week in residential and CBT. Transition/discharge planning can be provided by any level of inpatient staff.~~

~~(2) **Elective services.**~~

~~(A) **Expressive group therapy.** Through active expression, inner-strengths are discovered that can help the member deal with past experiences and cope with present life situations in more beneficial ways. The focus of the group must be~~

~~directly related to goals and objectives on the individual member's plan of care. Documentation must include how the member is processing emotions/feelings. Expressive therapy must be a planned therapeutic activity, facilitated by staff with a relevant bachelor's degree and/or staff with relevant training, experience, or certification to facilitate the therapy.~~

~~(B) **Group rehabilitative treatment.** Examples of educational and supportive services, which may be covered under the definition of group rehabilitative treatment services, are basic living skills, social skills (re)development, interdependent living, self-care, lifestyle changes and recovery principles. Each service provided under group rehabilitative treatment services must have goals and objectives, directly related to the individual plan of care.~~

~~(C) **Individual rehabilitative treatment.** Services will be for the reduction of psychiatric and behavioral impairment and the restoration of 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 individualized plan of care and the member's diagnosis.~~

~~(D) **Recreation therapy.** Services will be provided to reduce psychiatric and behavioral impairment as well as to restore, remediate and rehabilitate an individual's level of functioning and independence in life activities. Services will also be provided in such a way as to promote health and wellness as well as reduce or eliminate the activity limitations and restrictions to participation in life situations caused by an illness or disabling condition. 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 will be 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-directing 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 they practice.~~

~~(F) **Wellness resource skills development.** Services include providing direction and coordinating support activities that promote good physical health. The focus of these activities should include areas such as nutrition, exercise, support with averting or managing physical health concerns like heart disease, diabetes, and cholesterol, and support regarding the effects of medications have on physical health. Services can include support groups, exercise groups, and individual physical wellness plan development, implementation assistance and support.~~

~~(3) **Modifications to active treatment.** When a member is too physically ill or their acuity level precludes them from active behavioral health treatment, documentation must demonstrate that alternative clinically appropriate services were provided.~~

~~(c) The expectation is that active treatment will occur regularly throughout the treatment week. A treatment week in acute is based on the number of days of acute service, beginning the day of admission (day 1). Required active treatment components will be based upon the length of stay as described below. A treatment week in a residential treatment center (RTC), PRTF and CBT is considered to be a calendar week (i.e. Sunday through Saturday). When a child is admitted to RTC, PRTF or CBT level of care on a day other than Sunday, or discharges on a day other than Saturday, the week will be considered a partial week and services will be required as described below. Active treatment components may include assessments/evaluations to 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 RTC, PRTF or CBT, one (1) visit during admission week is required. In RTCs, one (1) visit during the admission week is required, then once a week thereafter. In PRTFs, 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. Individual treatment provided by the physician will never exceed ten (10) days between sessions in PRTFs, never exceed seven (7) days in a specialty PRTF 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 residential treatment (including PRTF and CBT), 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 residential treatment (including PRTF and CBT), 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 residential treatment (including PRTF and CBT), 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.~~

~~(f) 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.~~

(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 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](http://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 in Acute 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, 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 are discovered that can help the member deal with past experiences and cope with present life situations in more beneficial ways. The focus of the group must be directly related to goals and objectives on the individual member's plan of care. Documentation must include how the member is processing emotions/feelings. Expressive therapy must be a planned therapeutic activity, facilitated by staff with a relevant bachelor's degree and/or staff with relevant training, experience, or certification to facilitate the therapy.

(B) **Group rehabilitative treatment.** Examples of educational and supportive services, which may be covered under the definition of group rehabilitative treatment services, are basic living skills, social skills (re)development, interdependent living, self-care, lifestyle changes, and recovery principles. Each service provided under group rehabilitative treatment services must have goals and objectives directly related to the IPC.

(C) **Individual rehabilitative treatment.** Services are provided to reduce psychiatric and behavioral impairment and to restore functioning consistent with the requirements of independent living and enhanced self-sufficiency. This service includes educational and supportive services regarding independent living, self-care, social skills (re)development, lifestyle changes, and recovery principles and practices. Each individual rehabilitative treatment service provided must have goals and objectives directly related to the IPC and the member's diagnosis.

(D) **Recreation therapy.** Services are provided to reduce psychiatric and behavioral impairment and to restore, remediate, and rehabilitate an individual's level of functioning and independence in life activities. Services are provided to promote health and wellness, as well as reduce or eliminate barriers caused by illness or disabling conditions

that limit or restrict a member from participating in life activities. Recreational therapy can be provided in an individual or group setting. If the only activities prescribed for the individual are primarily diversional in nature, (i.e., to provide some social or recreational outlet for the individual), it will not be regarded as active treatment. If provided, recreational therapy must be a planned therapeutic activity, facilitated by a licensed therapeutic recreation specialist.

(E) **Occupational therapy.** Services are provided to address developmental and/or functional needs related to the performance of self-help skills, adaptive behavioral, and/or sensory, motor, and postural development. Services include therapeutic goal-directed activities and/or exercises used to improve mobility and ADL functions when such functions have been impaired due to illness or injury. Services must be provided by an occupational therapist appropriately licensed in the state in which he or she practices.

(F) **Wellness resource skills development.** Services include providing direction and coordinating support activities that promote physical health. The focus of these activities should include areas such as nutrition, exercise, support to avert and manage physical health concerns like heart disease, diabetes, and cholesterol, and guidance on the effects that medications have on physical health. Services can include individual/ group support, exercise groups, and individual physical wellness plan development, implementation, and assistance.

(3) **Modifications to active treatment.** When a member is too physically ill, or his or her acuity level precludes him or her from active behavioral health treatment, documentation must demonstrate that alternative clinically-appropriate services were provided.

(f) Active treatment components, furnished during a partial treatment week, are provided as per item (1) through (4) below. A chart outlining active treatment component requirements and timelines may also be found at [www.okhca.org](http://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.

**317:30-5-95.35. Certificate of need requirements for members under the age of twenty-one (21) children in psychiatric hospital/hospitals and PRTFs**

~~(a) **General requirements.** This Section establishes the requirements for certification of the need for inpatient psychiatric services provided to members under twenty-one (21) years of age in psychiatric hospitals, in accordance with Section 1905(a) 16 and (h) of the Social Security Act, and in PRTFs, in accordance with 42 C.F.R. § 483.354. Pursuant to this federal law, a team, consisting of physicians and other qualified personnel, shall determine that inpatient services are necessary and can reasonably be expected to improve the member's condition. These requirements do not apply to an admission to a psychiatric unit of a general hospital.~~

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

~~(1) **"Independent team"** means a team that is not associated with the facility, such that no team member has an employment or consultant relationship with the admitting facility. The independent team shall include a licensed physician who has competence in diagnosis and treatment of mental illness, preferably child psychiatry, and who has knowledge of the member's clinical condition and situation. The independent team shall also include at least one other licensed behavioral health professional, as defined by OAC 317:30-5-240.3.~~

~~(2) **"Interdisciplinary team"** as defined by 42 C.F.R. § 441.156, means a team of physicians and other personnel who are employed by, or who provide services to, SoonerCare members in the facility or program. The interdisciplinary team must include, at a minimum, either a board-eligible or board-certified psychiatrist; or, a licensed physician and a psychologist licensed by the Oklahoma State Board of Examiners of Psychologists (OSBED) who has a doctoral degree in clinical psychology; or, a licensed physician with specialized training and experience in the diagnosis and treatment of mental diseases, and a psychologist licensed by the OSBED. The interdisciplinary team must also include one of the following:~~

- ~~(A) a licensed clinical social worker;~~
- ~~(B) a Registered Nurse with specialized training or one (1) year of experience in treating mentally ill individuals;~~
- ~~(C) and a psychologist licensed by the OSBED who has a doctoral degree in clinical psychology; or,~~
- ~~(D) an occupational therapist who is licensed by the state in which the individual is practicing, if applicable, and who has specialized training or one (1) year of experience in treating mentally ill individuals.~~

~~(c) **Certification of the need for services.** As described in 42 C.F.R. § 441.152, the certification shall be made by a team, either independent or interdisciplinary, as specified in (d), below, and shall certify that:~~

- ~~(1) Ambulatory care resources available in the community do not meet the treatment needs of the member;~~
- ~~(2) Proper treatment of the member's psychiatric condition requires services on an inpatient basis under the direction of a physician; and~~
- ~~(3) Services can reasonably be expected to improve the member's condition or prevent further regression so that inpatient services would no longer be needed.~~

~~(d) **Certification for admission.** The certification of the need for services, as stated in (c), above, shall be made by the appropriate team, in accordance with 42 C.F.R. § 441.153 and as specified as follows:~~

- ~~(1) Certification for the admission of an individual who is a member when admitted to a facility or program shall be made by an independent team, as described in (b)(1), above.~~
- ~~(2) Certification for an inpatient applying for SoonerCare while in the facility or program shall be made by an interdisciplinary team responsible for the plan of care and as described in (b)(2), above.~~
- ~~(3) Certification of an emergency admission of a member shall be made by the interdisciplinary team responsible for the plan of care within fourteen (14) days after admission, in accordance with 42 C.F.R. § 441.156.~~

~~(c) — Services provided by treatment team members not meeting the above credentialing requirements are not SoonerCare compensable and can not be billed to the SoonerCare member.~~

(a) **General requirements.** This Section establishes the requirements for certification of the need for inpatient psychiatric services provided to individuals under twenty-one (21) years of age in psychiatric hospitals, in accordance with Section 1905(a) 16 and (h) of the Social Security Act, and in PRTFs, in accordance with 42 C.F.R. § 483.354. Pursuant to this federal law, a team, consisting of physicians and other qualified personnel, shall determine that inpatient services are necessary and can reasonably be expected to improve the member's condition. These requirements do not apply to an admission to a psychiatric unit of a general hospital.

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

(1) **"Independent team"** means a team that is not associated with the facility, such that no team member has an employment or consultant relationship with the admitting facility. The independent team shall include a licensed physician who has competence in diagnosis and treatment of mental illness, preferably child psychiatry, and who has knowledge of the member's clinical condition and situation. The independent team shall also include at least one (1) other LBHP.

(2) **"Interdisciplinary team"** as defined by 42 C.F.R. § 441.156, means a team of physicians and other personnel who are employed by, or who provide services to, SoonerCare members in the facility or program. The interdisciplinary team must include, at a minimum, either a board-eligible or board-certified psychiatrist; or, a licensed physician and a psychologist licensed by the Oklahoma State Board of Examiners of Psychologists (OSBEP) who has a doctoral degree in clinical psychology; or, a licensed physician with specialized training and experience in the diagnosis and treatment of mental diseases, and a psychologist licensed by the OSBEP. The interdisciplinary team must also include one (1) of the following:

(A) A licensed clinical social worker;

(B) A registered nurse (RN) with specialized training or one (1) year of experience in treating mentally ill individuals;

(C) A psychologist licensed by the OSBEP who has a doctoral degree in clinical psychology; or

(D) An occupational therapist who is licensed by the state in which the individual is practicing, if applicable, and who has specialized training or one (1) year of experience in treating mentally ill individuals.

(c) **Certification of the need for services.** As described in 42 C.F.R. § 441.152, the certification shall be made by a team, either independent or interdisciplinary, as specified in (d), below, and shall certify that:

(1) Ambulatory care resources available in the community do not meet the treatment needs of the member;

(2) Proper treatment of the member's psychiatric condition requires services on an inpatient basis under the direction of a physician; and

(3) Services can reasonably be expected to improve the member's condition or prevent further regression so that inpatient services would no longer be needed.

(d) **Certification for admission.** The certification of the need for services, as stated in (c), above, shall be made by the appropriate team, in accordance with 42 C.F.R. § 441.153 and as specified as follows:

(1) Certification for the admission of an individual who is a member when admitted to a facility or program shall be made by an independent team, as described in (b) (1), above.

(2) Certification for an inpatient applying for SoonerCare while in the facility or program shall be made by an interdisciplinary team responsible for the plan of care and as described in (b) (2), above.

(3) Certification of an emergency admission of a member shall be made by the interdisciplinary team responsible for the plan of care within fourteen (14) days after admission, in accordance with 42 C.F.R. § 441.156.

### **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 24 hours of admission by a licensed independent practitioner (M.D., D.O., A.P.N., or P.A.) and within 7 days in a CBT.~~

~~(B) Psychiatric evaluation must be completed within 60 hours of admission by an allopathic or osteopathic physician with a current license and a board certification/eligible in psychiatry and within 7 calendar days in a CBT.~~

~~(C) Psychosocial evaluation must be completed within 72 hours of an acute admission, within seven calendar days of admission to a PRTF and within 7 calendar days in a CBT by a licensed independent practitioner (M.D., D.O., A.P.N., or P.A.), a licensed behavioral health professional (LBHP), or Licensure Candidate as defined in OAC 317:30-5-240.3.~~

~~(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 30 calendar days from admission. For continued stays at the same level of care, evaluations remain current for 12 months from the date of admission and must be updated annually within seven calendar days of that anniversary date.~~

~~(4) Existing evaluations of 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.~~

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, licensed practical nurses, and mental health workers to provide nursing care necessary under the active treatment program and to maintain progress notes on each member. In a Community Based Transitional RTC, an RN must be on site at least one hour each day and be available 24 hours a day when not on site. A registered nurse 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, as needed, as well as an assessment of the member's progress as it relates to the individual plan of care goals and objectives.~~

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.

### **317:30-5-95.40. Other required standards**

~~The provider is required to maintain all programs and services according to applicable Code of Federal Regulations (CFR) requirements, TJC/AOA standards for Behavioral Health care, State Department of Health's Hospital Standards for Psychiatric Care, and State of Oklahoma Department of Human Services Licensing Standards for Residential Treatment Facilities. Psychiatric Residential Treatment Facilities may substitute CARF accreditation in lieu of TJC or AOA accreditation.~~

The provider is required to maintain all programs and services according to applicable C.F.R. requirements, the Joint Commission' (TJC) and American Osteopathic Association' (AOA) standards for behavioral health care, Oklahoma State Department of Health's (OSDH) hospital standards for psychiatric care, and Oklahoma Department of Human Services' (OKDHS) licensing standards for residential treatment facilities. PRTFs may substitute the Commission on Accreditation of Rehabilitation Facilities (CARF) accreditation in lieu of TJC or AOA accreditation.

### **317:30-5-95.41. Documentation of records for ~~children's~~children receiving inpatient services**

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

- ~~(1) date;~~
- ~~(2) start and stop time for each session;~~
- ~~(3) dated signature of the therapist and/or staff that provided the service;~~
- ~~(4) credentials of the therapist;~~
- ~~(5) specific problem(s) addressed (problems must be identified on the plan of care);~~
- ~~(6) method(s) used to address problems;~~
- ~~(7) progress made towards goals;~~
- ~~(8) member's response to the session or intervention; and~~
- ~~(9) any new problem(s) identified during the session.~~

~~(b) Signatures of the member, parent/guardian for members under the age of 18, doctor, Licensed Behavioral Health Professional (LBHP), and RN are required on the individual plan of care and all plan of~~

~~care reviews. The individual plan of care and plan of care review are not valid until signed and separately dated by the member, parent/legal guardian for members under the age of 18, doctor, RN, LBHP, and all other requirements are met. All treatment team staff providing individual therapy, family therapy and process group therapy must sign the individual plan of care and all plan of care reviews. All plans of care and plan of care reviews must be signed by the member upon completion, except when a member is too physically ill, or the member's acuity level precludes him/her from signing. If the member is too physically ill or the member's acuity level precludes him/her from signing the plan of care and/or the plan of care review at the time of completion, the member must sign the plan when his/her condition improves but before discharge. Documentation should indicate the reason the member was unable to sign and when the next review will occur to obtain the signature.~~

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

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

(b) Signatures of the member, parent/guardian for members under the age of eighteen (18), physician, LBHP, and registered nurse (RN) are required on the individual plan of care (IPC) and all plan of care reviews. The IPC and plan of care review are not valid until signed and separately dated by the member, parent/legal guardian for members under the age of eighteen (18), physician, RN, LBHP, and all other requirements are met. All treatment team staff providing individual therapy, family therapy, and process group therapy must sign the IPC and all plan of care reviews. All plans of care and plan of care reviews must be signed by the member upon completion, except when a member is too physically ill, or the member's acuity level precludes him/her from signing. If the member is too physically ill or the member's acuity level precludes him/her from signing the plan of care and/or the plan of care review at the time of completion, the member must sign the plan when his/her condition improves but before discharge. Documentation should indicate the reason the member was unable to sign and when the next review will occur to obtain the signature.

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

**317:30-5-95.42. Service quality review (SQR) of psychiatric facilities ~~providing services to children~~**

~~(a) The Service Quality Review conducted by OHCA or its designated agent meets the utilization control requirements as set forth in 42 CFR 456.~~

~~(b) There will be an on-site Service Quality Review (SQR) of each in-state psychiatric facility that provides care to SoonerCare eligible children which will be performed by the OHCA or its designated agent. Out-of-state psychiatric facilities that provide care to SoonerCare eligible children will be reviewed according to the procedures outlined in the Medical Necessity Manual. OHCA or its designated agent may conduct ad hoc reviews. Ad hoc reviews may be conducted at the discretion of the agency.~~

~~(c) The Oklahoma Health Care Authority will designate the members of the Service Quality Review team. The SQR team will consist of one to three team members and will be comprised of Licensed Behavioral Health Professionals (LBHP) or Registered Nurses.~~

~~(d) The review will include observation and contact with members. The Service Quality Review will consist of members present or listed as facility residents at the beginning of the Service Quality Review visit as well as members on which claims have been filed with OHCA for acute or PRTF levels of care. The review includes validation of certain factors, all of which must be met for the services to be compensable.~~

~~(e) Following the on-site inspection, the SQR Team will report its findings to the facility. The facility will be provided with written notification if the findings of the review have resulted in any deficiencies. A copy of the final report will be sent to the facility's accrediting agency.~~

~~(f) Deficiencies found during the SQR may result in a partial per-diem recoupment or a full per-diem recoupment of the compensation~~

~~received. The following documents are considered to be critical to the integrity of care and treatment, must be completed within the time lines designated in OAC 317:30-5-95.37, and cannot be substituted with any other evaluation/assessments not specifically mentioned:~~

- ~~(1) History and physical evaluation;~~
- ~~(2) Psychiatric evaluation;~~
- ~~(3) Psychosocial evaluation; and~~
- ~~(4) Individual Plan of Care.~~

~~(g) For each day that the History and Physical evaluation, Psychiatric evaluation, Psychosocial evaluation and/or Individual Plan of Care are not contained within the member's records, those days will warrant a partial per-diem recoupment.~~

~~(h) If the review findings have resulted in a partial per-diem recoupment of \$50.00 per event, the days of service involved will be reported in the notification. If the review findings have resulted in full per-diem recoupment status, the non-compensable days of service will be reported in the notification. In the case of non-compensable days full per diem or partial per diem, the facility will be required to refund the amount.~~

~~(i) In the event that CMS recoups from OHCA an amount that exceeds the provider's liability for findings described in this Section, the provider will not be held harmless and will be required to reimburse OHCA the total federal amount identified by CMS and/or its designated audit contractor.~~

~~(j) Penalties of non-compensable days which are the result of the facility's failure to appropriately provide and document the services described herein, or adhere to applicable accreditation, certification, and/or state licensing standards, are not compensable or billable to the member or the member's family.~~

(a) The service quality review (SQR) conducted by the OHCA or its designated agent meets the utilization control requirements as set forth in 42 C.F.R. Part 456.

(b) There will be an SQR of each in-state psychiatric facility that provides services to SoonerCare members which will be performed by the OHCA or its designated agent. Out-of-state psychiatric facilities that provide services to SoonerCare members will be reviewed according to the procedures outlined in the Medical Necessity Manual. Ad hoc reviews may be conducted at the discretion of the agency.

(c) The OHCA will designate the members of the SQR team. The SQR team will consist of one (1) to three (3) team members and will be comprised of LBHPs or registered nurses (RNs).

(d) The SQR will include, but not be limited to, review of facility and clinical record documentation as well as observation and contact with members. The clinical record review will consist of those records of members present or listed as facility residents at the beginning of the visit as well as members on which claims have been filed with OHCA for acute or PRTF levels of care. The SQR

includes validation of compliance with policy, which must be met for the services to be compensable.

(e) Following the SQR, the SQR team will report its findings to the facility. The facility will be provided with written notification if the findings of the review have resulted in any deficiencies. A copy of the final report will be sent to the facility's accrediting agency, as well as the State Survey Agency and any licensing agencies.

(f) Deficiencies identified during the SQR may result in full or partial recoupment of paid claims. The determination of whether to assess full or partial recoupment shall be at the discretion of the OHCA based on the severity of the deficiencies.

(g) Any days during which the facility is determined to be out of compliance with Federal Conditions of Participation or in which a member does not meet medical necessity criteria will result in full recoupment. Full recoupment may also result from a facility's failure to provide requested documentation within the timeframes indicated on requests for such documents or if the SQR team is denied timely admittance to a facility and/or access to facility records during the on-site portion of the SQR.

(h) Items which may result in full or partial recoupment of paid claims shall include, but not be limited to:

(1) **Assessments and evaluations.** Assessments and evaluations must be completed, with dated signature(s), by qualified staff within the timeframes outlined in Oklahoma Administrative Code (OAC) 317:30-5-95.6 and 317:30-5-95.37.

(2) **Plan of care.** Plans of care must be completed, with all required dated signatures within the timeframes described in OAC 317:30-5-95.4 and 317:30-5-96.33.

(3) **Certification of need (CON).** CONs must be completed by the appropriate team and in the chart within the timeframes outlined in 42 C.F.R. §§ 441.152, 456.160, and 456.481.

(4) **Active treatment.** Treatment must be documented in the chart at the required frequency by appropriately qualified staff as described in OAC 317:30-5-95.5, 317:30-5-95.7, 317:30-5-95.8, 317:30-5-95.9, 317:30-5-95.10 and 317:30-5-95.34.

(5) **Documentation of services.** Services must be documented in accordance with OAC 317:30-5-95.5, 317:30-5-95.8, 317:30-5-95.10, 317:30-5-95.41 and 42 C.F.R. §§ 412.27(c) (4) and 482.61. Documentation with missing elements or documentation that does not clearly demonstrate the therapeutic appropriateness and benefit of the service may result in recoupment.

(6) **Staffing.** Staffing must meet the ratios described in OAC 317:30-5-95.24(b)-(d) & (h) and OAC 317:30-5-95.38 per unit/per shift; and credentialing requirements as outlined in OAC 317:30-5-95.8, 317:30-5-95.9, 317:30-5-95.35, 317:30-5-95.36, and 42 C.F.R. §§ 412.27(d), 441.153, 441.156, and 482.62.

(7) **Restraint/seclusion.** Orders for restraint and seclusion must be completely and thoroughly documented with all required

elements as described in OAC 317:30-5-95.39 and 42 C.F.R. § 482.13(e) & (f) and 42 C.F.R. Part 483. Documentation must support the appropriateness and necessity for the use of restraint/seclusion. For PRTFs, documentation must include evidence that staff and resident debriefings occurred as required by OAC 317:30-5-95.39 and 42 C.F.R. Part 483.

(i) If the review findings have resulted in a recoupment, the days and/or services involved will be reported in the notification.

(j) In the event that CMS recoups from OHCA an amount that exceeds the provider's liability for findings described in this Section, the provider will not be held harmless and will be required to reimburse OHCA the total federal amount identified by CMS and/or its designated audit contractor, limited to the amount of the original paid claim less any previously recouped amounts.

(k) Penalties of non-compensable days which are the result of the facility's failure to appropriately provide and document the services described herein, or adhere to applicable accreditation, certification, and/or state licensing standards, are not compensable or billable to the member or the member's family.

(l) Facilities that are determined to owe recoupment of paid claims will have the ability to request a reconsideration of the findings. Details and instructions on how to request a reconsideration will be part of the report documentation sent to the facility.

(m) Facilities that are determined by the SQR process to be out of compliance in significant areas will be required to submit a Corrective Action Plan (CAP) detailing steps being taken to bring performance in line with requirements. Facilities that are required to submit a CAP may be further assessed through a formal, targeted post-CAP review process.

### **317:30-5-96.2. Payments definitions**

The following words and terms, when used in Sections OAC 317:30-5-96.3 through 317:30-5-96.7, shall have the following meaning, unless the context clearly indicates otherwise:

**"Allowable costs"** means costs necessary for the efficient delivery of member care.

**"Ancillary Services"** means the services for which charges are customarily made in addition to routine services. Ancillary services include, but are not limited to, physical therapy, speech therapy, laboratory, radiology and prescription drugs.

**"Border Status"** means a placement in a state that does not border Oklahoma but agrees to the same terms and conditions of in-state or border facilities.

**"Developmentally disabled child"** means a child with deficits in adaptive behavior originating during the developmental period. This condition may exist concurrently with a significantly subaverage general intellectual functioning.

**"Eating Disorders Programs"** means acute or intensive residential behavioral, psychiatric and medical services provided in a discreet

~~unit to individuals experiencing an eating disorder.~~

~~"Professional services" means services of a physician, psychologist or dentist legally authorized to practice medicine and/or surgery by the state in which the function is performed.~~

~~"Psychiatric Residential Treatment Facility (PRTF)" means a non-hospital with an agreement to provide inpatient psychiatric services to individuals under the age of 21.~~

~~"Routine Services" means services that are considered routine in the freestanding PRTF setting. Routine services include, but are not limited to:~~

- ~~(A) room and board;~~
- ~~(B) treatment program components;~~
- ~~(C) psychiatric treatment;~~
- ~~(D) professional consultation;~~
- ~~(E) medical management;~~
- ~~(F) crisis intervention;~~
- ~~(G) transportation;~~
- ~~(H) rehabilitative services;~~
- ~~(I) case management;~~
- ~~(J) interpreter services (if applicable);~~
- ~~(K) routine health care for individuals in good physical health; and~~
- ~~(L) laboratory services for a substance abuse/detoxification program.~~

~~"Specialty treatment program/specialty unit" means acute or intensive residential behavioral, psychiatric and medical services that provide care to a population with a special need or issues such as developmentally disabled, intellectually disabled, autistic/Asperger's, eating disorders, sexual offenders, or reactive attachment disorders. These members require a higher level of care and staffing ratio than a standard PRTF and typically have multiple problems.~~

~~"Treatment Program Components" means therapies, activities of daily living and rehabilitative services furnished by physician/psychologist or other licensed mental health professionals.~~

~~"Usual and customary charges" refers to the uniform charges listed in a provider's established charge schedule which is in effect and applied consistently to most members and recognized for program reimbursement. To be considered "customary" for reimbursement, a provider's charges for like services must be imposed on most members regardless of the type of member treated or the party responsible for payment of such services.~~

~~The following words and terms, when used in OAC 317:30-5-96.3 through 317:30-5-96.7, shall have the following meaning, unless the context clearly indicates otherwise:~~

~~"Add-on payment" means an additional payment added to the per diem to recognize the increased cost of serving members with complex needs in a PRTF or Acute II.~~

"Allowable costs" means costs necessary for the efficient delivery of member care.

"Ancillary services" means the services for which charges are customarily made in addition to routine services. Ancillary services include, but are not limited to, physical therapy, speech therapy, laboratory, radiology, and prescription drugs.

"Border status" means a placement in a state that does not border Oklahoma. Reimbursement for out-of-state services is made in accordance with OAC 317:30-3-89 through 317:30-3-92 and the Oklahoma Medicaid State Plan.

"Developmentally disabled child" means a child with deficits in adaptive behavior originating during the developmental period. This condition may exist concurrently with a significantly subaverage general intellectual functioning.

"Eating disorder programs" means acute or intensive residential behavioral, psychiatric, and medical services provided in a discreet unit to individuals experiencing an eating disorder.

"Professional services" means services of a physician, psychologist, or dentist legally authorized to practice medicine and/or surgery by the state in which the function is performed.

"Routine services" means services that are considered routine in the Acute II and PRTF levels of care setting. Routine services include, but are not limited to:

- (A) Room and board;
- (B) Treatment program components;
- (C) Psychiatric treatment;
- (D) Professional consultation;
- (E) Medical management;
- (F) Crisis intervention;
- (G) Transportation;
- (H) Rehabilitative services;
- (I) Case management;
- (J) Interpreter services (if applicable);
- (K) Routine health care for individuals in good physical health; and
- (L) Laboratory services for a substance abuse/detoxification program.

"Specialty treatment program/specialty unit" means Acute or other intensive behavioral, psychiatric, and medical services that provide care to a population with special needs or issues such as developmentally disabled, intellectually disabled, autistic/Asperger's, eating disorders, sexual offenders, or reactive attachment disorders. These members require a higher level of care and staffing ratio than a standard PRTF and typically have multiple problems.

"Treatment program components" means therapies, activities of daily living, and rehabilitative services furnished by physician/psychologist or other licensed mental health professionals.

"Usual and customary charges" refers to the uniform charges listed in a provider's established charge schedule which is in effect and applied consistently to most members and recognized for program reimbursement. To be considered "customary" for reimbursement, a provider's charges for like services must be imposed on most members regardless of the type of member treated or the party responsible for payment of such services.

### **317:30-5-96.3. Methods of payment**

~~(a) **Reimbursement.** Covered inpatient psychiatric and/or substance abuse services will be reimbursed using one of the following methodologies:~~

- ~~(1) Diagnosis Related Group (DRG);~~
- ~~(2) cost based; or~~
- ~~(3) a predetermined per diem payment.~~

~~(b) **Acute Level of Care.**~~

~~(1) Psychiatric units within general medical surgical hospitals and Critical Access hospitals. Payment will be made utilizing a DRG methodology. [See OAC 317:30-5-41(b)]. Psychiatric professional (physicians and psychologists) services provided in conjunction with the inpatient stay are separately payable from the DRG paid to the hospital;~~

~~(2) Freestanding Psychiatric Hospitals. A predetermined statewide per diem payment will be made for all facility services provided during the inpatient stay. Psychiatric professional (physicians and psychologists) services provided in conjunction with the inpatient stay are separately payable from the per diem paid to the hospital. Rates vary for public and private providers.~~

~~(c) **Residential Level of Care**~~

~~(1) **Instate Services.**~~

~~(A) Psychiatric Hospitals or Inpatient Psychiatric Programs. A pre-determined all-inclusive per diem payment will be made for routine, ancillary and professional services. Public facilities will be reimbursed using either the statewide or facility specific interim rates and settled to total allowable costs as determined by analyses of the cost reports (Form CMS 2552) filed with the OHCA.~~

~~(B) Psychiatric Residential Treatment Facilities. A pre-determined per diem payment will be made to private PRTFs with 16 beds or less for routine services. All other services are separately billable. A predetermined all-inclusive per diem payment will be made for routine, ancillary and professional services to private facilities with more than 16 beds. Public facilities will be reimbursed using either the statewide or facility specific interim rates and settled to total allowable costs as determined by analyses of the cost reports (Form 2552) filed with the OHCA.~~

~~(2) **Out-of-state services.**~~

~~(A) Border and "border status" placements. Facilities are reimbursed in the same manner as in-state hospitals or PRTFs.~~  
~~(B) Out-of-state placements. In the event comparable services cannot be purchased from an Oklahoma facility and the current payment levels are insufficient to obtain access for the member, the OHCA may negotiate a predetermined, all-inclusive per diem rate for specialty programs/units. An incremental payment adjustment may be made for 1:1 staffing (if clinically appropriate and prior authorized). Payment may be up to, but no greater, than usual and customary charges. The 1:1 staffing adjustment is limited to 60 days annually.~~

~~(d) **Health Home Transitioning Services.** Health Home services for the provision of comprehensive transitional care to existing members are considered to be inpatient psychiatric services, when services exceed and do not duplicate ordinary inpatient discharge planning during the last 30 days of a covered acute or residential stay. Payment for Health Home transitioning services provided under arrangement with the inpatient provider will be directly reimbursed to the Health Home outside of the facility's per diem or DRG rate.~~

~~(a) **Reimbursement.**~~

~~(1) Covered inpatient psychiatric and/or substance use disorder services will be reimbursed using one (1) of the following methodologies:~~

~~(A) Diagnosis related group (DRG);~~

~~(B) Cost-based; or~~

~~(C) A predetermined per diem payment.~~

~~(2) For members twenty-one (21) to sixty-four (64) years of age, payment shall not be made to any inpatient psychiatric facility that qualifies as an IMD, except as provided by OAC 317:30-5-95.23 and 317:30-5-95.11.~~

~~(b) **Levels of care.**~~

~~(1) **Acute.**~~

~~(A) Payment will be made to psychiatric units within general medical surgical hospitals and critical access hospitals utilizing a DRG methodology. [See OAC 317:30-5-41]. Psychiatric professional (physicians and psychologists) services provided in conjunction with the inpatient stay are separately payable from the DRG paid to the hospital;~~

~~(B) Payment will be made to psychiatric hospitals utilizing a predetermined statewide per diem payment for all facility services provided during the inpatient stay. Psychiatric professional (physicians and psychologists) services provided in conjunction with the inpatient stay are separately payable from the per diem paid to the hospital. Rates vary for public and private providers.~~

~~(2) **Acute II.**~~

~~(A) Payment will be made to in-state psychiatric hospitals or inpatient psychiatric programs utilizing a predetermined all-inclusive per diem payment for routine, ancillary, and~~

professional services.

(B) Public facilities will be reimbursed using either the statewide or facility-specific interim rates and settled to total allowable costs as determined by analyses of the cost reports (Form CMS 2552) filed with the OHCA.

**(3) PRTFs.**

(A) A pre-determined per diem payment will be made to private PRTFs with sixteen (16) beds or less for routine services. All other services are separately billable.

(B) A predetermined all-inclusive per diem payment will be made for routine, ancillary, and professional services to private facilities with more than sixteen (16) beds.

(C) Public facilities will be reimbursed using either the statewide or facility-specific interim rates and settled to total allowable costs as determined by analyses of the cost reports (Form CMS 2552) filed with the OHCA.

**(c) Out-of-state services.**

(1) **Border and "border status" placements.** Facilities are reimbursed in the same manner as in-state hospitals or PRTFs. Refer to OAC 317:30-3-90 and 317:30-3-91.

(2) **Out-of-state placements.** In the event comparable services cannot be purchased from an Oklahoma facility and the current payment levels are insufficient to obtain access for the member, the OHCA may negotiate a predetermined, all-inclusive per diem rate for specialty programs/units. An incremental payment adjustment may be made for one (1): one (1) staffing (if clinically appropriate and prior authorized). Payment may be up to, but no greater, than usual and customary charges. The one (1): one (1) staffing adjustment is limited to sixty (60) days annually. Refer to OAC 317:30-3-90 and 317:30-3-91.

**(d) Add-on payments.**

(1) Additional payment shall only be made for services that have been prior authorized by OHCA or its designee and determined to be medically necessary. For medical necessity criteria applicable for the add-on payment(s), refer to the SoonerCare Medical Necessity Criteria Manual for Inpatient Behavioral Health Services found on the OHCA website.

(2) SoonerCare shall provide additional payment for the following services rendered in an Acute II and PRTF, as per the Oklahoma Medicaid State Plan.

(A) **Intensive treatment services (ITS) add-on.** Payment shall be made for members requiring intensive staffing supports.

(B) **Prospective complexity add-on.** Payment shall be made to recognize the increased cost of serving members with a mental health diagnosis complicated with non-verbal communication.

(C) **Specialty add-on.** Payment shall be made to recognize the increased cost of serving members with complex needs.

**(e) Services provided under arrangement.**

**(1) Health home transitioning services.**

(A) Services for the provision of comprehensive transitional care to existing members are considered to be inpatient psychiatric services, when services exceed and do not duplicate ordinary inpatient discharge planning during the last thirty (30) days of a covered acute or residential stay.

(B) Payment for health home transitioning services provided under arrangement with the inpatient provider will be directly reimbursed to the health home outside of the facility's per diem or DRG rate.

**(2) Case management transitioning services.**

(A) Services for the provision of case management transitioning services to existing members are considered to be inpatient psychiatric services, when services exceed and do not duplicate ordinary inpatient discharge planning during the last thirty (30) days of a covered acute or residential stay.

(B) Payment for case management transitioning services provided under arrangement with the inpatient provider will be directly reimbursed to a qualified community-based provider.

**(3) Evaluation and psychological testing by a licensed psychologist.**

(A) Services for the provision of evaluation and psychological testing by a licensed psychologist to existing members are considered to be inpatient psychiatric services, when services exceed and do not duplicate ordinary inpatient discharge planning during the last thirty (30) days of a covered acute or residential stay.

(B) Payment for evaluation and psychological testing by a licensed psychologist for services provided under arrangement with the inpatient provider will be directly reimbursed to a qualified provider in accordance with the Oklahoma Medicaid State Plan.

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

**SUBCHAPTER 15. PERSONAL CARE SERVICES**

**317:35-15-8.2. State Plan Personal Care Eligible Provider Exception**

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

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

(A) Another provider is not available; or

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

(2) The service must:

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

(B) Be necessary to avoid institutionalization;

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

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

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

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

(3) The legal guardian service provider complies with:

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

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

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

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

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

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

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

#### **SUBCHAPTER 17. ADVANTAGE WAIVER SERVICES**

##### **317:35-17-1. Overview of long-term medical care services; relationship to Qualified Medicare Beneficiary Plus (QMBP), Specified Low-Income Medicare Beneficiary (SLMB), and other Medicaid (SoonerCare) services eligibility**

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

(1) eareCare in a nursing facility. Refer to long-term care facility per Oklahoma Administrative Code (OAC) 317:35-19;

(2) eareCare in a public or private intermediate care facility for the intellectually disabled. Refer to (ICF/IID), per OAC 317:35-9;

(3) eareCare of persons age 65 years and sixty-five (65) years of age and older in mental health hospitals. Refer to, per OAC 317:35-9;

(4) Home and Community Based Services Waivers Community-Based waiver services for persons with intellectual disabilities. Refer to, per OAC 317:35-9;

(5) Personal Care services. Refer to, per OAC 317:35-15; and

(6) the Home and Community Based Services Waiver (ADvantage Waiver) Community-Based waiver services (ADvantage waiver) for frail elderly, (65 years of age or older), sixty-five (65) years of age and older; and a targeted group of adults with physical disabilities, 21 to 64 twenty-one (21) to sixty-four (64) years of age and older, who do not have an intellectual disability or a cognitive impairment related to a developmental disability. per OAC 317:35-17-3.

(b) When an individual is certified as eligible for SoonerCare coverage of long-term care, he or she is also eligible for other SoonerCare services. ADvantage Waiver waiver members do not have a copayment for ADvantage services except for prescription drugs. For members residing in an ADvantage Assisted Living

~~Center, assisted living center,~~ any income beyond ~~150~~one-hundred and fifty percent (150%) of the federal benefit rate is available to defray the cost of the assisted living services received. The member is responsible for payment to the assisted living services center provider for days of service, from the first day of each full-month in which services were received, until the vendor pay obligation is met. When an individual is aged, blind, or disabled and is determined eligible for long-term care, a separate eligibility determination must be made for QMBP or SLMB benefits. An ADvantage program member may reside in a licensed assisted living services center only when the assisted living services center is a certified ADvantage assisted living services center provider from whom the member is receiving ADvantage assisted living services.

### **317:35-17-3. ADvantage program services**

(a) The ADvantage program is a Medicaid Home and ~~Community Based Waiver~~Community-Based waiver used to finance non-institutional, long-term care services for the elderly and a targeted group of physically disabled adults when there is a reasonable expectation that within a ~~30-calendar~~thirty (30) calendar day period, the person's health, due to disease process or disability, would, without appropriate services, deteriorate and require ~~nursing~~long-term care (LTC) facility care to arrest the deterioration. Individuals may not be enrolled in ADvantage for the sole purpose of enabling them to obtain Medicaid eligibility. Eligibility for ADvantage program services is contingent on an individual requiring one (1) or more of the services offered in the ~~Waiver~~waiver, at least monthly, ~~in order~~ to avoid institutionalization.

(b) The number of individuals who may receive ADvantage services is limited.

(1) To receive ADvantage program services, individuals must meet one of the ~~following~~ categories ~~in (A) though (D) of this paragraph.~~ He or she must:

(A) ~~be 65~~Be sixty-five (65) years of age and older; or

(B) ~~be 21 to 64~~Be twenty-one (21) to sixty-four (64) years of age, ~~when physically disabled and not developmentally disabled or when 21 to 64 years of age and not physically disabled, the person has a clinically documented, progressive degenerative disease process that responds to treatment and previously required hospital or nursing facility (NF) level of care services for treatment related to the condition; and requires ADvantage services to maintain the treatment regimen to prevent health deterioration;~~ or

(C) ~~when~~When developmentally disabled, and ~~21 to 64~~twenty-

one (21) to sixty-four (64) years of age; and does not have an intellectual disability or a cognitive impairment related to the developmental disability-;

(D) Be twenty-one (21) to sixty-four (64) years of age, not physically disabled but has clinically documented, progressive, degenerative disease process that responds to treatment and previously required hospital or LTC facility level of care services to maintain the treatment regimen to prevent health deterioration.

(2) In addition, the individual must meet criteria in (A) through (C)- of this paragraph. He or she must:

(A) ~~require~~Require ~~nursing~~long-term care facility level of care. ~~Refer to,~~ per Oklahoma Administrative Code (OAC) 317:35-17-2;

(B) ~~meet~~Meet service eligibility criteria. ~~Refer to,~~ per OAC 317:35-17-3(f); and

(C) ~~meet~~Meet program eligibility criteria. ~~Refer to,~~ per OAC 317:35-17-3(g).

(c) ADvantage members are eligible for limited types of living arrangements. The specific living arrangements are set forth ~~below.~~ in (1) through (5) of this subsection.

(1) ADvantage program members are not eligible to receive services while residing in an unlicensed institutional living arrangement, such as a room and board home and/or facility; an institutional setting including, but not limited to, licensed facilities, such as a hospital, a ~~nursing~~LTC facility, licensed residential care facility, or licensed assisted living facility, unless the facility is an ADvantage Assisted Living Center ~~or in an unlicensed institutional living arrangement, such as a room and board home/facility.~~ assisted living center.

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

(3) ADvantage program members may receive services in a shelter or similar temporary-housing arrangement that may or may not meet the definition of ~~home/apartment,~~ home and/or apartment in emergency situations, for a period not to exceed ~~60-~~ sixty (60) calendar days during which location and transition to permanent housing is sought.

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

~~which~~ while the member is a student.

(5) Members may receive ADvantage respite services in a ~~nursing facility~~ LTC facility for a continuous period not to exceed ~~30 calendar~~ thirty (30) calendar days.

(d) ~~Home and Community Based Waiver Services~~ Community-Based waiver services are outside of the scope of Medicaid State Plan services. The Medicaid ~~Waiver~~ waiver allows ~~OHCA~~ the Oklahoma Health Care Authority (OHCA) to offer certain Home and ~~Community Based~~ Community-Based services to an annually capped number of persons, who are categorically needy, ~~refer to DHS Former~~ per Oklahoma Department of Human Services (OKDHS) Appendix C-1, Schedule VIII. B. 1., and without such services would be institutionalized. The estimated cost of providing an individual's care outside the ~~nursing facility~~ LTC facility cannot exceed the annual cost of caring for that individual in a ~~nursing facility~~ an LTC facility. When determining the ADvantage service plan cost cap for an individual, the comparable SoonerCare cost to serve that individual in a ~~NF~~ an LTC facility is estimated.

(e) Services provided through the ADvantage ~~Waiver~~ waiver are:

- (1) ~~case~~ Case management;
- (2) ~~respite~~ Respite;
- (3) ~~adult~~ Adult day health care;
- (4) ~~environmental~~ Environmental modifications;
- (5) ~~specialized~~ Specialized medical equipment and supplies;
- (6) ~~physical~~ Physical, occupational, or speech therapy or consultation;
- (7) ~~advanced — supportive/restorative — assistance~~ Advanced supportive and/or restorative assistance;
- (8) ~~nursing~~ Nursing;
- (9) ~~skilled~~ Skilled nursing;
- (10) ~~home-delivered~~ Home-delivered meals;
- (11) ~~hospice~~ Hospice care;
- (12) ~~medically~~ Medically necessary prescription drugs, within the limits of the ADvantage Waiver ~~waiver~~;
- (13) ~~personal~~ Personal care, State Plan, or ADvantage personal care;
- (14) A Personal Emergency Response System (PERS);
- (15) Consumer-Directed Personal Assistance Services and Supports (CD-PASS);
- (16) ~~Institution Transition Services~~;
- (17) ~~assisted~~ Assisted living; and
- (18) SoonerCare medical services for individuals, 21 ~~twenty-one~~ (21) years of age and over, within the State Plan scope of the State Plan.

(f) The ~~DHS~~ OKDHS area nurse or nurse designee makes a determination of service eligibility prior to evaluating the Uniform Comprehensive Assessment Tool (UCAT) assessment for ~~nursing~~ long-

term care facility level of care. The following criteria in (1) through (5) of this subsection are used to make the service eligibility determination, which includes:

(1) ~~an~~An open ADvantage Program Waiver~~program waiver~~ slot, as authorized by the ~~Waiver document approved by the Centers for Medicare and Medicaid Services (CMS),~~ which is available to ensure federal participation in payment for services to the individual. When the Oklahoma Department of Human Services/Aging Services (DHS/AS) (OKDHS/AS) determines all ~~ADvantage Waiver~~ slots are filled, the individual cannot be certified by ~~DHS~~OKDHS as eligible for ADvantage services, ~~the individual's~~ and his or her name is placed on a waiting list for entry when an open slot becomes available;

(2) ~~the individual is in the~~The ADvantage targeted~~waiver-~~targeted service group. The target group ~~are~~is individuals, who:

(A) ~~are~~Are frail and ~~65~~sixty-five (65) years of age and older; or

(B) ~~have a physical disability, are between 21 and 64~~Twenty-one to sixty-four years of age, ~~and do not have an intellectual disability or a cognitive impairment;~~ or physically disabled; or

(C) ~~have developmental disability, are 21 and 64 years of age, and does~~When developmentally disabled, and are twenty-one (21) to sixty-four (64) years of age and do not have an intellectual disability or cognitive impairment related to the developmental disability; or

(D) Are twenty-one (21) to sixty-four (64) years of age, not physically disabled but have a clinically documented, progressive, degenerative disease process that responds to treatment and previously required hospital or long-term care facility level of care services to maintain the treatment regimen to prevent health deterioration. The individual must meet criteria, per OAC 317:35-174-3(b) (2) (A through C).

(3) ~~the~~An ineligible individual ~~is not eligible~~ because he or she poses a physical threat to himself or herself or others as supported by professional documentation.

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

(5) ~~the~~An ineligible individual ~~is not eligible~~ when his or her living environment poses a physical threat to himself or herself or others as supported by professional documentation where applicable, and measures to correct hazardous conditions or assist ~~individuals~~the individual move are unsuccessful or not feasible.

(g) The State, as part of the ~~Waiver~~ ADvantage waiver program approval authorization, ensures ~~Centers for Medicare and Medicaid Services (CMS)~~ CMS that each member's health, safety, or welfare can be maintained in his or her home. When a member's identified needs cannot be met through provision of ADvantage program or Medicaid State Plan services and other formal or informal services are not in place or immediately available to meet those needs, the individual's health, safety, or welfare in ~~their~~ this or her home cannot be ensured. The ADvantage Administration (AA) determines ADvantage program eligibility through the service plan approval process. An individual is deemed ineligible for the ADvantage program based on ~~the following~~ criteria: (1) through (8) of this subsection.

(1) ~~the~~ The individual's needs, as identified by UCAT and other professional assessments, cannot be met through ADvantage program services, Medicaid State Plan services, ~~and/or~~ and other formal or informal services.

(2) ~~one~~ One (1) or more members of the individual's household pose a physical threat to ~~self~~ themselves or others as supported by professional documentation.

(3) ~~the~~ The individual or other household members use threatening, intimidating, degrading, or use sexually inappropriate ~~language/innuendo~~ language and/or innuendo or behavior towards service providers, either in the home or through other contact or communications, and significant efforts were attempted to correct such behavior, as supported by professional documentation or other credible documentation.

(4) ~~the~~ The individual or the individual's authorized agent is uncooperative or refuses to participate in service development or service delivery and these actions result in unacceptable increases of risk to the individual's health, safety, or welfare in his or her home, as determined by the individual, the interdisciplinary team, or the AA.

(5) ~~the~~ The individual's living environment poses a physical threat to self or others as supported by professional documentation and measures to correct hazardous conditions or assist the person to move are unsuccessful or are not feasible.

(6) ~~the~~ The individual provides false or materially inaccurate information necessary to determine program eligibility or withholds information necessary to determine program eligibility.

(7) ~~the~~ The individual does not require at least one ADvantage service monthly; ~~and~~.

(8) ~~the~~ The individual, his or her family member(s), associate(s), or any other person(s) or circumstances as relates to care and coordination in ~~the individual's~~ this or her living environment produces evidence of illegal drug activity

or substances used illegally as intoxicants. This includes:

(A) The use, possession, or distribution of illegal drugs;  
 (B) The abusive use of other drugs, such as medication prescribed by a doctor; ~~or~~

(C) The use of substances, such as inhalants including, but not limited to:

- (i) ~~typewriter~~Typewriter correction fluid;
- (ii) ~~air~~Air conditioning coolant;
- (iii) ~~gasoline~~Gasoline;
- (iv) ~~propane~~Propane
- (v) ~~felt tip~~Felt-tip markers;
- (vi) ~~spray~~Spray paint;
- (vii) ~~air~~Air freshener;
- (viii) ~~butane~~Butane;
- (ix) ~~cooking~~Cooking spray;
- (x) ~~paint~~Paint and
- (xi) ~~glue~~Glue;

(D) The observed intoxication, consumption or sensory indicators, such as smell of the use of ~~any~~any drug or intoxicant by the individual, family members, associates, or any other person(s) present at the time care is provided may be construed as evidence indicative of illegal drug activity or intoxication. This includes drug use or intoxicated activity that is menacing to the member or staff providing services;

(E) ~~the~~The observance of drug paraphernalia or any instrument used in the manufacturing, production, distribution, sale, or consumption of drugs or substances including, but not limited to:

- (i) ~~smoking~~Smoking pipes used to consume substances other than tobacco;
- (ii) ~~roach~~Roach clips containing marijuana cigarettes;
- (iii) ~~needles~~Needles and other implements used for injecting drugs into the body;
- (iv) ~~plastic~~Plastic bags or other containers used to package drugs;
- (v) ~~miniature~~Miniature spoons used to prepare drugs; or
- (vi) ~~kits~~Kits used in the production of synthetic controlled substances including descriptive materials that accompany the item, describing or depicting its use~~.~~

(F) ~~instructions, oral~~Instructions, verbal or written, concerning the item or device including, but not limited to, the manner in which the object is labeled and displayed for sale;

(G) ~~the~~The typical use of such items in the community; and/or

(H) ~~testimony~~Testimony of an expert witness regarding use of

the item.

(h) ~~the~~The case manager provides the AA with professional documentation or other credible documentation to support the recommendation for redetermination of program eligibility. The service providers continue providing services according to the person-centered service plan as provider safety permits until the individual is removed from the ADvantage program. As a part of the procedures requesting redetermination of program eligibility, ~~DHS~~OKDHS AS provides technical assistance to the provider for transitioning the individual to other services, ~~and~~.

(i) ~~individuals~~Individuals determined ineligible for ADvantage program services are notified in writing by ~~DHS~~OKDHS AS of the determination and of the right to appeal the decision.

**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY  
CHAPTER 40. DEVELOPMENTAL DISABILITIES SERVICES**

**SUBCHAPTER 9. SELF-DIRECTED SERVICES**

**317:40-9-1. Self-directed services (SDS)**

(a) **Applicability.** This Section applies to SDS provided through Home and Community-Based Services (HCBS) Waivers operated by the Oklahoma Department of Human Services ~~(DHS)~~OKDHS Developmental Disabilities Services (DDS).

(b) **Member option.** Traditional service delivery methods are available for eligible members who do not elect to self-direct services.

(c) **General information.** SDS are an option for members receiving HCBS through the In-Home Supports Waiver for Adults (IHSW-A), In-Home Supports Waiver for Children (IHSW-C), and the Community Waiver when the ~~adult~~ member lives in a non-residential setting. SDS provides a member the opportunity to exercise choice and control in identifying, accessing, and managing specific Waiver services and supports in accordance with his or her needs and personal preferences. SDS are Waiver services ~~DHSDDS~~OKDHS DDS specifies may be directed by the member or representative using employer and budget authority.

(1) SDS may be directed by:

(A) ~~an~~An adult member, when the member has the ability to self-direct;

(B) ~~a~~A member's legal representative including a parent, spouse or legal guardian; or

(C) ~~a~~A non-legal representative freely chosen by the member or his or her legal representative.

(2) The person directing services must:

(A) ~~be~~Be eighteen (18) years of age or older;

(B) ~~comply~~Comply with DDS and Oklahoma Health Care Authority (OHCA) rules and regulations;

(C) ~~complete~~Complete required DDS training for self-direction;

(D) ~~sign~~Sign an agreement with DDS;

(E) ~~be~~Be approved by the member or his or her legal representative to act in the capacity of a representative;

(F) ~~demonstrate~~Demonstrate knowledge and understanding of the member's needs and preferences; and

(G) ~~not~~Not serve as the ~~SDS-HTS~~Self-Directed (SD) Habilitation Training Specialist (HTS) for the member ~~her~~ whom he or she is directing services.

(d) **The SDS program includes:**

(1) The SDS budget. A plan of care is developed to meet the

member's needs without SDS consideration. The member may elect to self-direct part or the entire amount identified for traditional ~~Habilitation Training Specialist (HTS)~~ HTS services. This amount is under the control and discretion of the member in accordance with this policy and the approved plan of care, and is the allocated amount that may be used to develop the SDS budget. The SDS budget details the specific plan for spending.

(A) The SDS budget is developed annually at the time of the annual plan development and updated as necessary by the member, case manager, parent, legal guardian, and others the member invites to participate in the development of the budget.

(B) Payment may only be authorized for goods and services (GS) not covered by SoonerCare or other generic funding sources and must meet criteria of service necessity, per ~~OAC~~ Oklahoma Administrative Code (OAC) 340:100-3-33.1.

(C) The member's SDS budget includes the actual cost of administrative activities including fees for services performed by a financial management services (FMS) subagent, background checks, ~~workers' compensation~~ workers' compensation insurance, and the amount identified for ~~SD-HTS and SD-GS~~ SD-HTS and Self-directed goods and services (SD-GS).

(D) The SDS budget is added to the plan of care to replace any portion of traditional HTS services to be self-directed.

(2) The ~~SD-Habilitation Training Specialist (SD-HTS)~~ SD-HTS supports the member's self-care, and the daily living and leisure skills needed to reside successfully in the community. Services are provided in community-based settings in a manner that contributes to the member's independence, self-sufficiency, community inclusion, and well-being. SD-HTS services must be included in the approved SDS budget. Payment is not made for routine care and supervision that is normally provided by a family member or the member's spouse. SD-HTS services are provided only during periods when staff is engaged in purposeful activity that directly or indirectly benefits the member. SD-HTS services are limited to a daily average of no more than nine (9) hours per day, per OAC 340:100-5-35. At no time are SD-HTS services authorized for periods during which ~~the staff are~~ is allowed to sleep. Legally responsible persons may not provide services, per OAC 340:100-3-33.2. Other family members providing services must be employed by provider agencies per OAC 340:100-3-33.2. For the purpose of this ~~policy, rule,~~ family members include parents and siblings, ~~including step- and half-siblings~~ half-parents and siblings, and anyone living in the same home as the member. Payment does not

include room and board, maintenance, or upkeep or improvements to the member's or family's residence. A SD-HTS must:

- (A) ~~be~~Be eighteen (18) years of age;
- (B) ~~pass~~Pass a background check, per OAC 340:100-3-39;
- (C) ~~demonstrate~~Demonstrate competency to perform required tasks;
- (D) ~~complete~~Complete required training, per OAC 340:100-3-38 et seq.;
- (E) ~~sign~~Sign an agreement with DDS and the member;
- (F) ~~be~~Be physically able and mentally alert to carry out the duties of the job;
- (G) ~~not~~Not work more than 40forty (40) hours in any week in the capacity of a SD-HTS;
- (H) ~~not~~Not implement ~~restrictive or intrusive~~prohibited procedures, per OAC ~~340:100-5-57~~340:100-5-58;
- (I) ~~provide~~Provide services to only one (1) member at any given time. This does not preclude services from being provided in a group setting where services are shared among members of the group; and
- (J) ~~not~~Not perform any job duties associated with other employment including on-call duties at the same time they are providing ~~SD-HTS~~SD-HTS services.

(3) ~~Self-directed goods and services (SD-GS).~~ SD-GS are incidental, non-routine goods and services that promote the member's self-care, daily living, adaptive functioning, general household ~~activity~~activities, meal preparation, and leisure skills needed to reside successfully in the community and do not duplicate other services authorized in the member's plan of care. These ~~goods and services~~SD-GS must be included in the individual plan and approved SDS budget. SD-GS must meet the requirements listed in (A) through (F).

- (A) The item or service is justified by a recommendation from a licensed professional.
- (B) The item or service is not prohibited by ~~Federal~~federal or ~~State~~state statutes and regulations.
- (C) One (1) or more of the following additional criteria are met. The item or service would:
  - (i) ~~increase~~Increase the member's functioning related to the disability;
  - (ii) ~~increase~~Increase the member's safety in the home environment; or
  - (iii) ~~decrease~~Decrease dependence on other SoonerCare funded services.
- (D) SD-GS may include, but are not limited to:
  - (i) ~~fitness~~Fitness items that can be purchased at retail stores;
  - (ii) ~~personal emergency monitoring systems~~Short duration

camps lasting fourteen (14) consecutive calendar days or less;

(iii) ~~a~~A food catcher;

(iv) ~~a~~A specialized swing set;

(v) ~~toothettes~~Toothettes or an electric toothbrush;

(vi) ~~a~~A seat lift;

(vii) ~~weight~~Weight loss programs, or gym memberships when:

~~(viii) gym memberships when:~~

(I) ~~there~~There is an identified need for weight loss or increased physical activity;

(II) ~~justified~~Justified by outcomes related to weight loss, increased physical activity or stamina; and

(III) ~~in~~In subsequent plan of care year requests, documentation is provided that supports the member's progress toward weight loss or increased physical activity or stamina.; or

(viii) Swimming lessons.

(E) SD-GS may not be used for:

(i) ~~co-payments~~Co-payments for medical services;

(ii) ~~over-the-counter~~Over-the-counter medications;

(iii) ~~items~~Items or treatments not approved by the Food and Drug Administration;

(iv) ~~homeopathic~~Homeopathic services;

(v) ~~services~~Services available through any other funding source, such as SoonerCare, Medicare, private insurance, the public school system, rehabilitation services, or natural supports;

(vi) ~~room~~Room and board including deposits, rent, and mortgage payments;

(vii) ~~personal~~Personal items and services not directly related to the member's disability;

(viii) ~~vacation~~Vacation expenses;

(ix) ~~insurance~~Insurance;

(x) ~~vehicle~~Vehicle maintenance or other transportation related expense;

(xi) ~~costs~~Costs related to internet access;

(xii) ~~clothing~~Clothing;

(xiii) ~~tickets~~Tickets and related costs to attend recreational events;

(xiv) ~~services~~Services, goods, or supports provided to, or benefiting persons other than the member;

(xv) ~~experimental~~Experimental goods or services;

(xvi) ~~personal~~Personal trainers;

(xvii) ~~spa~~Spa treatments; or

(xviii) ~~goods~~Goods or services with costs that significantly exceed community norms for the same or similar goods or services.

(F) SD-GS are reviewed and approved by the DDS director or designee.

(e) **Member Responsibilities.** When the member chooses the SDS option, the member or member's representative is the employer of record and must:

(1) ~~enroll~~Enroll and complete the DDS-sanctioned self-direction training course in self-direction within forty-five (45) calendar days of SDS training enrollment. Exceptions to this timeframe may be approved by the DDS director or his/her designee. The training must be completed prior to the implementation of self-direction and covers:

(A) ~~staff~~Staff recruitment;

(B) ~~hiring~~Hiring of staff as an employer of record;

(C) ~~staff~~Staff orientation and instruction;

(D) ~~supervision of staff~~Staff supervision including scheduling and service provisions;

(E) ~~staff~~Staff evaluation;

(F) ~~staff~~Staff discharge;

(G) ~~philosophy~~Philosophy of self-direction;

(H) OHCA policy on self-direction;

(I) ~~individual~~Individual budgeting;

(J) ~~development~~Development of a self-directed support plan;

(K) ~~cultural~~Cultural diversity; and

(L) ~~rights,~~Rights, risks, and responsibilities.

(2) ~~sign~~Sign an agreement with DDS;

(3) ~~agree~~Agree to utilize the services of a FMS subagent;

(4) ~~agree~~Agree to pay administrative costs for background checks, FMS subagent fee, and workers' compensation insurance from his or her SDS budget;

(5) ~~comply~~Comply with federal and state employment laws and ensure no employee works more than ~~40~~forty (40) hours per week in the capacity of an SD-HTS;

(6) ~~ensure~~Ensure that each employee is qualified to provide the services for which he or she is employed and that all billed services are actually provided;

(7) ~~ensure~~Ensure that each employee complies with all DDS training requirements per OAC 340:100-3-38 et seq.;

(8) ~~recruit,~~Recruit, hire, supervise, and discharge all employees providing self-directed services, when necessary;

(9) ~~verify~~Verify employee qualifications;

(10) ~~obtain~~Obtain background screenings on all employees providing SD-HTS services per OAC 340:100-3-39;

(11) ~~send~~Send progress reports per OAC 340:100-5-52.

(12) ~~participate~~Participate in the Individual Plan and SDS budget process;

(13) ~~immediately~~Immediately notify the case manager of any ~~emergencies or~~ changes in circumstances ~~or emergencies~~ that may require modification of the type or amount of services provided for in the member's Individual Plan or SDS budget;

(14) ~~wait~~Wait for approval of budget modifications before implementing changes;

(15) ~~comply~~Comply with DDS and OHCA administrative rules;

(16) ~~cooperate~~Cooperate with DDS monitoring requirements per OAC 340:100-3-27;

(17) ~~cooperate~~Cooperate with FMS subagent requirements to ensure accurate records and prompt payroll processing including:

(A) ~~reviewing~~Reviewing and signing employee time cards;

(B) ~~verifying~~Verifying the accuracy of hours worked; and

(C) ~~ensuring~~Ensuring the appropriate expenditure of funds;

(18) ~~complete~~Complete all required documents within established timeframes;

(19) ~~pay~~Pay for services incurred in excess of the budget amount;

(20) ~~pay~~Pay for services not identified and approved in the member's SDS budget;

(21) ~~pay~~Pay for services provided by an unqualified provider;

(22) ~~determine~~Determine staff duties, qualifications, and specify service delivery practices consistent with SD-HTS Waiver service specifications;

(23) ~~orient~~Orient and instruct staff in duties;

(24) ~~evaluate~~Evaluate staff performance;

(25) ~~identify~~Identify and train back-up staff, when required;

(26) ~~determine~~Determine amount paid for services within ~~Plan~~plan limits;

(27) ~~schedule~~Schedule staff and the provision of services;

(28) ~~ensure~~Ensure SD-HTS do not implement ~~restrictive or intrusive~~prohibited procedures per OAC ~~340:100-5-57; 340:100-5-58~~; and

(29) ~~sign~~Sign an agreement with ~~DDS and~~ the SD-HTS.

(f) ~~Financial management services (FMS) subagent responsibilities. FMS.~~ The FMS subagent is an entity designated as an agent by DDS to act on behalf of members who have employer and budget authority for the purpose of managing payroll tasks for the member's employee(s) and for making payment of SD-GS as authorized in the member's ~~Plan.~~plan. FMS subagent duties include, but are not limited to:

(1) ~~compliance~~Compliance with all DDS and OHCA administrative rules and contract requirements;

(2) ~~compliance~~Compliance with DDS or OHCA random and targeted

audits conducted by DDS or the OHCA;

(3) ~~provision of financial management support to the member by tracking~~Tracking individual expenditures and monitoring SDS budgets;

(4) ~~processing~~Processing the member's employee payroll, withholding, filing and paying of applicable federal, state, and local employment-related taxes and insurance;

(5) ~~collection~~Collection and process of employee's time sheets and making payment to member's employees;

(6) ~~processing~~Processing and payment of invoices for SD-GS as authorized in the member's SDS budget;

(7) ~~providing~~Providing each member with information that assists with the SDS budget management;

(8) ~~providing~~Providing reports to members/representatives, as well as monthly to DDS and to OHCA upon request;

(9) ~~providing~~Providing DDS and OHCA authorities access to individual member's accounts through a web-based program;

(10) ~~assisting~~Assisting members in verifying employee citizenship status;

(11) ~~maintaining~~Maintaining separate accounts for each member's SDS budget;

(12) ~~tracking~~Tracking and reporting member funds, balances, and disbursements;

(13) ~~receiving~~Receiving and disbursing funds for SDS payment per OHCA agreement; and

(14) ~~executing~~Executing and maintaining a contractual agreement between DDS and the SD-HTS (employee).

(g) **DDS case management responsibilities in support of SDS.**

(1) The case manager develops the member's ~~Plan~~plan per OAC 340:100-5-50 through 340:100-5-58;

(2) The DDS case manager meets with the member, member's representative, or legal guardian, when applicable, to discuss the ~~following~~Waiver service delivery options in the ~~HCBS Waiver~~: (A) and (B) of this paragraph:

(A) ~~traditional~~Traditional Waiver services; and

(B) ~~self-directed~~Self-Directed services including information regarding scope of choices, options, rights, risks, and responsibilities associated with self-direction.

(3) When the member chooses self-direction, the case manager:

(A) ~~discusses~~Discusses with member or representative the available ~~amount~~amount in the budget;

(B) ~~assist~~Assists the member or representative with the development and modification of the SDS budget;

(C) ~~submits~~Submits request for SD-GS to the DDS director or designee for review and approval ~~prior to the case manager's approval of the SDS budget~~;

(D) ~~approves~~Develops the SDS budget and modifications;

(E) ~~assists~~Assists the member or representative develop or revise an emergency back-up plan;

(F) ~~provides the FMS subagent a copy of the member's authorized SDS budget and any modifications;~~

(G) ~~monitors~~Monitors implementation of the Planplan per OAC 340:100-3-27;

(H) ~~(G) ensures~~Ensures services are initiated within required time frames;

(I) ~~(H) conducts~~Conducts ongoing monitoring of Planplan implementation and the member's health and welfare; and

(J) ~~specifies additional employee qualifications in the Plan based on the member's needs and preferences when such qualifications are consistent with approved Waiver qualifications;~~

(K) ~~specifies in the Plan how services are provided;~~

(L) ~~refers potential SD-HTS providers to the FMS subagent for enrollment;~~

(M) ~~assists in locating and securing services and other community resources that promote community integration and independence as provided in the member's Plan; and~~

(N) ~~(I) ensures restrictive or intrusive~~Ensures prohibited procedures, per OAC ~~340:100-5-57~~340:100-5-58 are not implemented by the SD-HTS. If the Team determines restrictive or intrusive procedures are necessary, ~~SD-HTS is not appropriate to meet the member's needs and traditional services must be used.~~ to address behavioral challenges, requirements must be met, per OAC 340:100-5-57.

(h) **Government fiscal/employer agent model.** DDS serves as the Organized Health Care Delivery System (OHCDS) and FMS provider in a Centers for Medicare and Medicaid Services (CMS) approved government fiscal/employer agent model. DDS has an interagency agreement with OHCA.

(i) **Voluntary termination of self-directed services.** Members may discontinue self-directing services without disruption at any time, provided traditional Waiver services are in place. Members or representatives may not choose the self-directed option again until the next annual planning meeting, with services resuming no earlier than the beginning of the next plan of care. A member desiring to file a complaint must follow procedures per OAC 340:2-5-61.

(j) **Involuntary termination of self-directed services.**

(1) Members may be involuntarily terminated from self-direction and offered traditional Waiver services when it has been determined by the DDS director or designee that any of the following exist:

(A) ~~immediate~~Immediate health and safety risks associated with self-direction, such as, imminent risk of death or

irreversible or serious bodily injury related to Waiver services;

(B) ~~intentional~~Intentional misuse of funds following notification, assistance and support from DDS;

(C) ~~failure~~Failure to follow and implement policies of self-direction after receiving DDS technical assistance and guidance;

(D) ~~fraud~~Fraud;

(E) ~~it is determined that restrictive or intrusive procedures are essential for safety; or~~A member no longer receives a minimum of one (1) SDS Waiver service per month and DDS is unable to monitor the member; or

(F) ~~reliable~~Reliable information shows the employer of record or SD-HTS engaged in illegal activity.

(2) When action is taken to involuntarily terminate the member from self-directed services, the case manager assists the member access needed and appropriate services through the traditional Waiver services option, ensuring that no lapse in necessary services occurs for which the member is eligible.

(3) The Fair Hearing process, per OAC 340:100-3-13 applies.

(k) **Reporting requirements.** While operating as an ~~Organized Health Care Delivery System~~,OHCD, DDS provides OHCA reports detailing provider activity in the format and at times OHCA requires.

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

**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**

**PART 80. MOBILE AND/OR PORTAL DENTAL TREATMENT FACILITIES**

**317:30-5-706. Definitions**

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

"**Mobile and/or portable dental treatment facilities**" means the following, limited places of treatment, as authorized by the Oklahoma State Dental Act: group homes for juveniles; public and private schools; and mobile dental clinics. The rules in this Part expressly shall not apply to SoonerCare reimbursement of dental services provided at any other authorized place of service, including, but not limited to: "dental offices," as defined by 59 O.S. § 328.3; federal, tribal, state, or local public health facilities; federally qualified health centers; and hospitals or dental ambulatory surgery centers.

"**Individual provider**" means a dentist, dental hygienist, or dental assistant who provides dental services at a mobile and/or portable dental treatment facility.

**317:30-5-707. Eligible providers**

(a) In order for dental services provided at a mobile and/or portable dental treatment facility to be eligible for SoonerCare reimbursement, a dental group shall meet all applicable requirements set forth in the Oklahoma Board of Dentistry rules and the Oklahoma State Dental Act, including, but not limited to, all licensing and permitting requirements.

(1) All dentists and dental hygienists working at a mobile and/or portable dental treatment facility shall be currently licensed in good standing with the Oklahoma Board of Dentistry. All dental assistants working at a mobile and/or portable dental treatment facility shall be currently permitted by the Oklahoma Board of Dentistry.

(2) The license or permit (or a photocopy of the license or permit) of every individual provider shall be prominently displayed at the mobile and/or portable dental treatment facility, pursuant to 59 O.S. § 328.21.

(3) For services provided in a mobile dental clinic, the permit to operate the mobile dental clinic shall be prominently displayed in the mobile dental clinic vehicle, pursuant to 59 O.S. § 328.40a.

(b) In accordance with OAC 317:30-5-695.1, every dental group providing services at a mobile and/or portable dental treatment facility must be fully contracted with the OHCA as a dental group provider and must be fully contracted with OHCA as a mobile and/or portable dental treatment facility.

(c) Every individual dentist practicing at a mobile and/or portable dental treatment facility must be fully contracted with the OHCA as a dentist.

(d) Dental groups and individual providers providing dental services at a mobile and/or portable dental treatment facility shall comply with all state and federal Medicaid law, including, but not limited to, OHCA administrative rules, the Code of Federal Regulations, and the Oklahoma State Medicaid Plan.

### **317:30-5-708. Parental consent requirements**

Individual providers at a mobile and/or portable dental treatment facility shall not perform any service on a minor without having obtained, prior to the provision of services, a signed, written consent from the minor's parent or legal guardian, that includes, at a minimum, the:

(1) Name of the dental group and/or dentist providing the dental services at the mobile and/or portable dental treatment facility;

(2) Permanent business mailing address of the dental group and/or dentist providing the dental services at the mobile and/or portable dental treatment facility;

(3) Business telephone number of the dental group and/or dentist providing the dental services at the mobile and/or portable dental treatment facility. This telephone number must be available for emergency calls;

(4) Full printed name of the child to receive services;

(5) Child's SoonerCare Member ID number; and

(6) An inquiry of whether the child has had dental care in the past twelve (12) months and if the child has a dental appointment scheduled with his/her regular dentist. If applicable, parent should list the name and address of the dentist and/or dental office where the care is provided.

### **317:30-5-709. Coverage**

Payment is made only to contracted dental groups for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services provided to SoonerCare-eligible individuals under the age of twenty-one (21). All mobile and/or portable dental treatment facilities must have a SoonerCare-contracted, Oklahoma-licensed dentist onsite to supervise staff and provide certain services. Coverage for dental services provided to children/adolescents at

a mobile and/or portable dental treatment facility is limited to:

- (1) One (1) fluoride application per member per twelve (12) months;
- (2) One (1) dental assessment annually that is performed by a SoonerCare-contracted, Oklahoma-licensed dentist; and
- (3) Dental sealants on tooth numbers 2, 3, 14, 15, 18, 19, 30, and 31. The Oklahoma Health Care Authority (OHCA) will not reimburse the application of dental sealants for a given OHCA member more than once every thirty-six (36) months, regardless of whether the services are provided at a mobile and/or portable dental treatment facility, or at some other authorized place of service.

### **317:30-5-710. Post-care**

Each member receiving dental care at a mobile and/or portable dental treatment facility must receive an information sheet at the end of the visit. The information sheet must contain:

- (1) The name of the dentist, dental hygienist, and/or dental assistant who provided the dental services at the mobile and/or portable dental treatment facility;
- (2) A valid business telephone number and/or other emergency contact number for the dental group and/or dentist that provided the dental services at the mobile and/or portable dental treatment facility;
- (3) A listing of the treatment rendered, including, when applicable, billing codes, fees, and tooth numbers;
- (4) A description of any follow-up treatment that is needed or recommended; and
- (5) Referrals to specialists or other dentists if the individual providers were unable to provide the necessary treatment, and additional care is needed.

### **317:30-5-711. Billing**

Refer to Oklahoma Administrative Code (OAC) 317:30-5-704 through 317:30-5-705 for billing instructions and guidelines. Please note that for any dental service provided at a mobile and/or portable dental treatment facility that is billed to SoonerCare, the appropriate place of service must be identified on the claim.

**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY  
CHAPTER 25. SOONERCARE CHOICE**

**SUBCHAPTER 7. SOONERCARE**

**PART 1. GENERAL PROVISIONS**

**317:25-7-2. SoonerCare Choice: overview**

(a) The Oklahoma Health Care Authority (OHCA) operates a Primary Care Case Management (PCCM) system for SoonerCare Choice eligible members. PCCM is a managed care model in which each enrollee has a medical home with a primary care provider (PCP). Enrollees may select their own primary care provider or clinic as their PCP if that provider is enrolled with OHCA as a PCP and as a SoonerCare provider. ~~For those~~ Those who do not choose a PCP, ~~they will~~ may be assigned to one. (1). Members may change PCPs at any time.

(b) The PCP is paid a monthly care coordination payment in accordance with the conditions in the PCP's SoonerCare Choice contract to provide or otherwise assure the delivery of medically-necessary preventive and primary care medical services, including securing referrals for specialty services and prior authorizations for an enrolled group of eligible members, with the exception of services described in subsection (c) of this Section for which authorization is not required. The PCP assists the member in gaining access to the health care system and monitors the member's condition, health care needs and service delivery.

(c) Services which do not require a referral from ~~the~~ a PCP include preventive or primary care services rendered by another SoonerCare contracted provider, such as: outpatient behavioral health ~~agency~~ services; vision services for children; dental services; child abuse/sexual abuse examinations; prenatal and obstetrical services; family planning services; emergency physician and hospital services; ~~disease management services,~~ chronic disease prevention and management programs and other care coordination programs; and services delivered to Native Americans at ~~IHS,~~ Indian Health Service, tribal, or urban Indian clinics. Female members may access a SoonerCare women's health specialist without a referral for covered routine and preventive health care services. This is in addition to the enrollee's PCP if that source is not a woman's health specialist.

(d) SoonerCare Choice covered services delivered by ~~the~~ a PCP are reimbursed at the SoonerCare fee schedule rate under the procedure code established for each individual service. ~~To the extent~~ If services are provided or authorized by ~~the Primary Care Provider,~~ a PCP, the OHCA does not make SoonerCare Choice payments for services delivered outside the scope of coverage of the SoonerCare Choice program; thus, a referral by ~~the~~ a PCP does not guarantee payment.

(e) ~~The~~ A PCP may charge a co-payment for services provided to SoonerCare members in accordance with ~~OAC~~ Oklahoma Administrative Code (OAC) 317:30-3-5(d).

(f) Members with chronic conditions may elect to enroll in a health management program to improve their health.

(g) PCPs may elect to participate in Health Access Networks pursuant to Subchapter 9 to improve access to care.

(h) PCPs may elect to participate in a Health Management Program pursuant to Subchapter 11 to improve access to care.

### 317:25-7-3. Definitions

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

~~"Aged, Blind and Disabled"~~ **"Aged, Blind and Disabled (ABD)"** means the Medicaid covered populations under 42 U.S.C., United States Code (U.S.C.) Section 1396a (a)(10)(A)(i) and (F).

**"Board"** means the board designated by the Oklahoma legislature to establish policies and adopt and promulgate rules for the Oklahoma Health Care Authority.

~~"CEO" means the Chief Executive Officer of the Oklahoma Health Care Authority.~~

**"Custody"** means the custodial status, as reported by the Oklahoma Department of Human Services.

**"Medicaid"** means the medical assistance program authorized by 42 U.S.C., Section 1396a et seq. The program provides medical benefits for certain low-income persons. It is jointly administered by the federal and state governments.

**"Medicare"** means the program defined at 42 U.S.C. § 1395 et seq.

**"OHCA"** means the Oklahoma Health Care Authority.

**"OKDHS"** means the Oklahoma Department of Human Services.

**"PCCM"** means Primary Care Case Management.

~~"PCP" means Primary Care Provider, including a Provider or Physician Group.~~

**"Primary Care Case Management"** means a managed care health service delivery system in which health services are delivered and coordinated by Primary Care Providers.

~~"Primary Care Provider"~~ **"Primary care provider (PCP)"** means a Primary Care Provider, including a provider or physician group, a provider under contract with the ~~Oklahoma Health Care Authority~~ OHCA to provide primary care services and case management, including securing all medically-necessary referrals for specialty services and prior authorizations.

~~"Provider or Physician Group"~~ **"physician group"** means a partnership, limited partnership, limited liability company, corporation or professional corporation, composed of doctors of medicine and/or doctors of osteopathy and/or advanced practice

registered nurses, and/or physician assistants who provide health care of the nature provided by independent practitioners and are permitted by state and federal law and regulations to receive SoonerCare provider payments.

"**SoonerCare**" means the Medicaid program administered by the ~~Oklahoma Health Care Authority.~~OHCA.

"**SoonerCare Choice**" means a comprehensive medical benefit plan featuring a medical home including a ~~Primary Care Provider~~PCP for each member.

### **317:25-7-5. Primary care providers (PCPs)**

For provision of health care services, the OHCA contracts with qualified ~~Primary Care Providers.~~PCPs. All providers serving as PCPs must have a valid SoonerCare Fee-for-Service contract as well as an exercised SoonerCare Choice addendum. Additionally, all PCPs, excluding ~~Provider~~provider or ~~Physician Groups,~~physician groups must agree to accept a minimum capacity of patients~~7;~~ provided, however, this does not guarantee PCPs a minimum patient volume. ~~Primary Care Providers~~PCPs are limited to:

(1) **Physicians.** Any physician licensed to practice medicine in the state in which he or she practices who is engaged in a general practice or in family medicine, general internal medicine or general pediatrics may serve as a PCP. ~~The Chief Executive Officer (CEO) of the OHCA may designate physicians to serve as PCPs who are licensed to practice medicine in the state in which they practice who are specialized in areas other than those described above. In making this determination, the CEO may consider such factors as the percentage of primary care services delivered in the physician's practice, the availability of primary care providers in the geographic area of the state in which the physician's practice is located, the extent to which the physician has historically provided services to SoonerCare members, and the physician's medical education and training.~~

(A) For physicians serving as SoonerCare Choice PCPs, the State caps the number of members per physician at ~~2,500.~~two thousand, five hundred (2,500) However, the CEO in his/her discretion may increase this number in under served areas based on a determination that this higher cap is in conformance with usual and customary standards for the community. If a physician practices at multiple sites, the capacity at each site is determined based on the number of hours per week the physician holds office hours, not to exceed one (1) FTE. Thus, the physician cannot exceed a maximum total capacity of ~~2500~~two thousand, five hundred (2,500) members.

(B) In areas of the ~~State~~state where cross-state utilization patterns have developed because of limited provider capacity

in the ~~State,~~ state the ~~CEO~~ OHCA may authorize contracts with out-of-state providers for PCP services. ~~Out-of-State~~ Out-of-state PCPs are required to comply with all access standards imposed on Oklahoma physicians, ~~as well as Oklahoma Administrative Code (OAC) 317:30-3-89 through 317:30-3-92.~~

(2) **Advanced Practice Registered Nurses (APRNs).** ~~Advanced Practice Nurses~~ APRNs who have prescriptive authority may serve as PCPs for the Primary Care Case Management delivery system if licensed to practice in the state in which he or she practices. ~~Advanced Practice Nurses~~ APRNs who have prescriptive authority may serve as PCPs for a maximum number of ~~1,250~~ one thousand, two hundred and fifty (1,250) members. ~~However, the CEO in his/her discretion may increase this number.~~

(3) **Physician Assistants (PAs).** ~~Physician Assistants~~ PAs may serve as PCPs if licensed to practice in the state in which he or she practices. ~~Physician Assistants~~ PAs may serve as PCPs for a maximum number of ~~1,250~~ one thousand, two hundred and fifty (1,250) members. ~~However, the CEO in his/her discretion may increase this number.~~

(4) **Indian Health Service (IHS) Facilities and Federally Qualified Health Center (FQHC) provider groups and Rural Health Clinics (RHC).**

(A) ~~Indian Health Service~~ IHS facilities whose professional staff meet the general requirements in paragraphs (1) through (3) of this Section and the provider participation requirements at OAC 317:30-5-1088 may serve as PCPs.

(B) ~~Federally Qualified Health Centers~~ FQHCs whose professional staff meet the general requirements in paragraphs (1) through (3) of this Section and the provider participation requirements in OAC 317:30-5-660.2 may serve as PCPs.

(C) RHCs whose professional staff meet the general requirements in paragraphs (1) through (3) of this Section and the provider participation requirements in OAC 317:30-5-355 may serve as PCPs.

(5) **Provider or physician group capacity and enrollment.**

(A) Provider or physician groups must agree to accept a minimum enrollment capacity and may not exceed ~~2,500~~ two thousand, five hundred (2,500) members per physician participating in the provider group.

(B) If licensed ~~physician assistants~~ PAs or ~~advanced practice nurses~~ APRNs are members of a group, the capacity may be increased by ~~1,250~~ one thousand, two hundred and fifty (1,250) members if the provider is available full-time.

(C) Provider or physician groups must designate a medical director to serve as the primary contact with OHCA.

### PART 3. ENROLLMENT CRITERIA

#### 317:25-7-10. Enrollment with a Primary Care Provider (PCP)

(a) All SoonerCare Choice members described in ~~OAC~~Oklahoma Administrative Code (OAC) 317:25-7-12 may enroll with a PCP. SoonerCare Choice applicants have the opportunity to select a PCP during the application process. Enrollment with a PCP may begin any day of the month.

(1) The OHCA offers all members the opportunity to choose a PCP from a directory which lists available PCPs.

(2) When a notice of PCP enrollment is sent to a member, the member is advised of the right to change ~~the~~the PCP at any time.

(b) Members may receive services from ~~the~~the PCP or from a provider to which the member has been referred by ~~the~~the PCP. Notwithstanding this provision, subject to limitations which may be placed on services by the OHCA, members may ~~self-refer~~self-refer for preventive or primary care services rendered by another SoonerCare contracted provider, outpatient behavioral health ~~agency~~ services, vision services for children, dental services, child abuse/sexual abuse examinations, prenatal and obstetrical services, family planning services, services delivered to Native Americans at ~~IHS~~Indian Health Service, tribal, or urban Indian clinics, chronic disease prevention and management programs and other care coordination programs, and emergency physician and hospital services.

#### 317:25-7-13. Enrollment ineligibility

Members in certain categories are excluded from participation in the SoonerCare Choice program. All other members ~~are~~may be enrolled in the SoonerCare Choice program and subject to the provisions of this Subchapter. Members excluded from participation in SoonerCare Choice include:

(1) Individuals receiving services in a ~~nursing~~long-term care facility, in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), or through a Home and Community Based Waiver; ~~;~~

~~(2) Individuals privately enrolled in an HMO.~~

~~(3) Individuals who would be traveling more than 45 miles or an average of 45 minutes to obtain primary care services.~~

~~(4)~~(2) Individuals in the former foster care children's group ~~(see OAC 317:35-5-2)~~. [see Oklahoma Administrative Code (OAC) 317:35-5-2];

~~(5)~~(3) Individuals ~~who are eligible for SoonerCare solely due to presumptive eligibility in benefit programs with limited scope, such as Tuberculosis, Family Planning, or pregnancy only;~~

~~(6)~~(4) Non-qualified or ineligible aliens ~~;~~

~~(7)~~(5) Children in subsidized adoptions ~~;~~

~~(8)~~(6) Individuals who are dually-eligible for SoonerCare and

Medicare-;

~~(9)~~ (7) Individuals who are in an Institution for Mental Disease (IMD)-; and/or

~~(10)~~ (8) Individuals who have other ~~primary~~ medical insurance-creditable coverage.

## **PART 5. ENROLLMENT PROCESS**

### **317:25-7-25. Member enrollment process**

(a) SoonerCare eligible individuals whose eligibility is based on one (1) of the aid categories ~~included in the program as~~ defined in OAC Oklahoma Administrative Code (OAC) 317:25-7-12 ~~must~~ are eligible to enroll with a PCP, primary care physician (PCP). Parents or guardians will choose on behalf of minor members in the household. Families with more than one (1) enrollee may choose a different PCP for each family member.

(b) Until the effective date of enrollment with a PCP, services for a newborn are reimbursed at a fee-for-service rate. Upon eligibility determination, newborns may enroll with a PCP who is in general practice, family practice, or general pediatrics. Enrollment materials will advise the parent or guardian of the right to change ~~the~~ a PCP after the effective date of enrollment.

(c) A description of the PCCM program and the PCP directory ~~is provided by the OHCA to OKDHS for distribution to OKDHS county offices.~~ are available on the Oklahoma Health Care Authority's (OHCA) website.

(d) For purposes of determining the member's choice of PCP, the most recent PCP selection received by the OHCA determines the PCP with which the member is enrolled ~~with~~, as long as capacity is available. If capacity is not available or the member does not choose, the member is assigned according to the assignment mechanism as defined by the OHCA. A member who is eligible for SoonerCare Choice but is not assigned, may request enrollment with a PCP by contacting the SoonerCare Helpline- or through the member's mySoonerCare.org account, if applicable.

(e) PCPs may not refuse an assignment, seek to disenroll a member, or otherwise discriminate against a member on the basis of age, sex, race, physical or mental disability, national origin, or type of illness or condition, unless that condition can be better treated by another provider type, except that ~~IHS,~~ Indian Health Service, tribal or urban Indian programs may provide services to ~~Native American~~ IHS members consistent with federal law.

### **317:25-7-26. Automatic re-enrollment**

SoonerCare members who become disenrolled from a PCP solely by virtue of becoming temporarily ~~(for 365 days or less)~~ [for three hundred and sixty-five (365) days or less] ineligible for SoonerCare services, ~~are automatically~~ may be re-enrolled with

their previously-selected PCP, subject to capacity. The member is notified of the ~~automatic re-enrollment~~ enrollment and any right to disenroll from that PCP, or change to another PCP.

**317:25-7-27. Changing ~~PCPs~~ Primary care providers (PCPs)**

(a) The ~~OHCA~~ Oklahoma Health Care Authority (OHCA) is responsible for changing a member's enrollment from one (1) PCP to another:

- (1) ~~without~~ Without cause upon the member's request; or
- (2) ~~upon~~ Upon demonstration of good cause. For purposes of this paragraph, good cause means:

- (A) ~~those~~ Those members who are habitually non-compliant with the documented medical directions of the provider; or
- (B) ~~those~~ Those members who pose a threat to employees, or other patients of the PCP; or
- (C) ~~as~~ As a result of a grievance determination by the OHCA; or
- (D) ~~in~~ In those cases where reliable documentation demonstrates that the physician-patient relationship has so deteriorated that continued service would be detrimental to the member, the provider or both; or
- (E) ~~the~~ The member's illness or condition would be better treated by another type of provider; or

- (3) when the state imposes an intermediate sanction.

(b) A written request by the PCP to change the enrollment of a member is acted upon by the OHCA within ~~30~~ thirty (30) days of its receipt. The decision to change PCPs for cause is made at the discretion of the OHCA, subject to appeals policies delineated at ~~OC~~ Oklahoma Administrative Code 317:2-1. The effective date of change is set so as to avoid the issue of abandonment.

(c) In the event a SoonerCare PCP contract is terminated by OHCA for any reason, or the PCP terminates participation in the SoonerCare Choice program ~~the CEO may, at his or her discretion, assign members to a participating PCP when it is determined to be in the best interests of the member whose PCP has terminated.~~ the panel members formerly aligned with the terminating PCP shall be enrolled with a different PCP.

**317:25-7-28. Disenrolling a member from SoonerCare Choice**

(a) The ~~OHCA~~ Oklahoma Health Care Authority (OHCA) may disenroll a member from SoonerCare Choice if:

- (1) ~~the~~ The member is no longer eligible for SoonerCare Choice services;
- (2) ~~the~~ The member ~~has been~~ is incarcerated;
- (3) ~~the~~ The member dies;
- (4) ~~disenrollment~~ Disenrollment is determined to be necessary by the OHCA;
- (5) ~~the~~ The status of the member changes, rendering him/her ineligible for SoonerCare;

(6) ~~the~~The member is authorized to receive services in a nursing facility, in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or through a Home and Community Based Waiver;

(7) ~~the~~The member becomes dually-eligible for SoonerCare and Medicare; or

(8) ~~the~~The member becomes covered under other ~~primary medical insurance, creditable coverage.~~

(b) The OHCA may disenroll the member at any time if the member is disenrolled for good cause, as it is defined in ~~OAC~~Oklahoma Administrative Code (OAC) 317:25-7-27. The OHCA will inform the PCP of any disenrollments from his or her member roster.

(c) OHCA may disenroll a member upon the PCP's request as described in (1) through (5) of this subsection.

(1) ~~The~~A PCP primary care provider (PCP) may file a written request asking OHCA to take action, including, but not limited to, disenrolling a member when the member:

(A) ~~is~~Is physically or verbally abusive to office staff, providers, and/or other patients;

(B) ~~is~~Is habitually non-compliant with the documented medical directions of ~~the~~a PCP; or

(C) ~~regularly~~Regularly fails to arrive for scheduled appointments without cancelling and the PCP has made all reasonable efforts to accommodate the member.

(2) The request from ~~the~~a PCP for disenrollment of a member must include ~~one of~~one (1) or more of the following:

(A) ~~documentation~~Documentation of the difficulty encountered with the member, including the nature, extent, and frequency of abusive or harmful behavior, violence, and/or inability to treat or engage the member;

(B) ~~identification~~Identification and documentation of unique religious or cultural issues that may be ~~effecting~~affecting ~~the~~a PCP's ability to provide treatment effectively to the member; or

(C) ~~documentation~~Documentation of special assistance or intervention offered.

(3) ~~The~~A PCP may not request disenrollment because of a change in the member's health status, the member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from the member's special needs except when the member's enrollment with ~~the~~a PCP seriously impairs his/her ability to furnish services to this member or other members.

(4) ~~The~~A PCP must document efforts taken to inform the member orally or in writing of any actions that have interfered with the effective provision of covered services, as well as efforts to explain what actions or language of the member are acceptable and unacceptable and the consequences of unacceptable behavior,

including disenrollment from ~~the~~a PCP.

(5) The OHCA will give written notice of the disenrollment request to the member.

## **PART 7. COORDINATION AND CONTINUITY OF CARE**

### **317:25-7-29. Screening, diagnosis and preventive benefits** **[REVOKED]**

~~(a) The PCP is responsible for coordinating or delivering preventive and primary care services which are medically necessary to all SoonerCare members enrolled with him/her.~~

~~(b) School and health department clinics may conduct EPSDT screening examinations on children who have not been screened by their PCP pursuant to the EPSDT periodicity schedule. If it is ascertained that a child is not current, the school or health department clinic must first contact the PCP and attempt to set up an appointment for the child within three weeks. If the PCP cannot meet this condition, the clinic will be permitted to conduct the screen and bill fee for service.~~

~~(1) The school or health department clinic must submit a claim for reimbursement, as well as documentation that:~~

~~(A) the PCP was contacted and an examination could not be conducted by the PCP within the specified guidelines; and~~

~~(B) the PCP has forwarded information for the patient file regarding the diagnosis, services rendered and need for follow-up. This documentation must be returned to the child's record for verification that PCPs have first been contacted and that school and health department clinics are providing PCPs with the information necessary to ensure continuity of care.~~

~~(2) The school-based clinic or health department must conduct the screening examination within three weeks from the date the determination was made that the PCP could not conduct the exam within the specified guidelines.~~

### **317:25-7-30. Obtaining SoonerCare Choice services**

(a) Medical services which are not the responsibility of the ~~PCP~~primary care provider (PCP) to authorize under the care coordination component of SoonerCare, Choice, as described in OAC Oklahoma Administrative Code (OAC) 317:25-7-10(b), are obtained in the same manner as under the regular SoonerCare fee-for-service program.

~~(b) Authorization for out-of-state transportation for primary care and specialty care is determined by the OHCA Medical Director. For policy regarding out-of-state transportation for primary and specialty care, refer to OAC 317:30-3-89 through 317:30-3-92.~~

(c) An American Indian/Alaska Native (AI/AN) eligible SoonerCare member may choose a PCP from the provider directory, including the

~~IHS, Indian Health Service (IHS), tribal and Urbanurban Indian clinics that participate as SoonerCare PCPs. The member needs to have the Certified Degree of Indian Blood information in order to enroll. An American IndianAI/AN member in SoonerCare may enroll with a PCP who is not an IHS, tribal, or urban Indian clinic and still use the IHS, tribal, or urban Indian clinic for medical care. A referral from thea PCP is needed for services that the clinic cannot provide, except for self-referred services.~~

(d) If an IHS, tribal, or urban Indian clinic is unable to deliver a service to a SoonerCare enrollee and must refer the member for the service to a non-IHS, tribal, or urban Indian clinic, SoonerCare reimbursement is made only to the specialist when the service ~~is~~ has been referred by thea PCP, unless PCP authorization is not required under OAC ~~317:25-7-10(b)~~. 317:25-7-2 (c).

(e) ~~TheA~~ PCP is not obligated to provide emergency services and is not responsible for authorization or approval for payment for members seen in the emergency room. ~~TheA~~ PCP may not require members to seek prior authorization (PA) for emergency services. However, thea PCP may provide emergency care in an emergency setting, within his/her legal scope of practice.

(f) ~~Some outpatient procedures require prior authorization. The PCP is responsible for obtaining a list before an outpatient procedure is done. A PA is required for some medical procedures, equipment, medications, and specialty services. The PCP and/or requesting provider are responsible for submitting the PA request to SoonerCare. The member and requesting provider will be notified of SoonerCare's decision to authorize the requested services. A PA is not a guarantee of payment.~~

## PART 9. REIMBURSEMENT

### 317:25-7-40. SoonerCare Choice reimbursement

(a) **Care coordination component.** Participating ~~PCPs~~ primary care providers (PCPs) are paid a monthly care coordination payment to assure the delivery of medically-necessary preventive and primary care medical services, including referrals for specialty services for an enrolled group of eligible members. The PCP assists the member in gaining access to the health care system and monitors the member's condition, health care needs and service delivery.

(b) **Visit-based fee-for-service component.** SoonerCare Choice covered services provided by thea PCP are reimbursed at the SoonerCare fee schedule rate under the procedure code established for each individual service. To the extent services are authorized by thea PCP, the ~~OHCA~~ Oklahoma Health Care Authority (OHCA) does not make SoonerCare Choice payments for services delivered outside the scope of coverage of the SoonerCare Choice program, ~~thus~~. In other words, a referral by thea PCP does not guarantee payment.

(c) **Incentive program component.** Subject to the availability of

funds, OHCA will develop a bonus payment program to encourage coordination of services, to reward improvement in health outcome and promote efficiency.

(d) **SoonerCare networks.** For every PCP who participates in an OHCA approved ~~health care access network,~~ Health Access Network, a per-member-per-month payment is established by OHCA and paid to the network.

## SUBCHAPTER 9. HEALTH ACCESS NETWORKS

### 317:25-9-1. Purpose

The purpose of this Subchapter is to describe the rules governing the Health Access Networks ~~(HAN's)~~ (HANs) participating in the statewide SoonerCare program. The rules provide assurances that ~~Health Access Networks~~ HANs will work with providers to coordinate and improve the quality of care for SoonerCare members. ~~The use of Health Access Networks is a limited pilot program with the purpose of enhancing the development of comprehensive medical homes for Oklahoma SoonerCare Choice members.~~

### 317:25-9-2. Requirements

~~(a)~~ Health Access Networks (HANs) are non-profit, administrative entities that work with providers to coordinate and improve the quality of care for SoonerCare members. The HAN must:

(1) ~~be~~ Be organized for the purpose of restructuring and improving the access, quality, and continuity of care to SoonerCare members;

(2) ~~offer patients~~ Facilitate members' access to all levels of care, including primary, outpatient, specialty, certain ancillary services, and acute inpatient care, within a community or across a broad spectrum of providers across a service region or the ~~State,~~ state through improved access to specialty care, telehealth, and expended quality improvement strategies;

~~(3) submit an application to the OHCA as specified in (c) of this Section;~~

~~(4) offer core components of electronic medical records, improved access to specialty care, telemedicine, and expanded quality improvement strategies;~~

~~(5) have an organized and systematic quality improvement process, including the identification of measurable performance targets; and~~

~~(6)~~ (3) offer Offer care management/care coordination to persons in the HANs. This includes care management for specified members with complex health care needs as approved by OHCA. The HAN will not provide care management services to HMP members in the HAN, as these members will receive care management from HMP health coaches or from the OHCA internal Chronic Care Unit. with complex health care needs as specified in the state-HAN provider agreement.

~~(b) Networks must meet at least two of the following:~~

- ~~(1) have a formal affiliation agreement/partnership at the community level with traditional and non-traditional providers;~~
  - ~~(2) have a formal program to promote public health principles, community development, and local educational programs to address the challenges of rural and underserved populations; and~~
  - ~~(3) have 501(c)3 or not-for-profit status.~~
- ~~(c) In order to qualify to participate as a SoonerCare contracted HAN's, the network must submit an application to the OHCA that details how the network plans to:~~
- ~~(1) reduce costs associated with the provision of health care services to SoonerCare, uninsured and underinsured individuals;~~
  - ~~(2) improve access to, and the availability of, health care services provided to individuals served by the health access network;~~
  - ~~(3) enhance the quality and coordination of health care services provided to such individuals through mutually defined quality improvement initiatives;~~
  - ~~(4) improve the health status of communities served by the health access network;~~
  - ~~(5) reduce health disparities in such communities;~~
  - ~~(6) identify all PCPs, specialty providers, and other provider types affiliated with the health access network.~~
- ~~(d) The application to participate as a SoonerCare contracted HAN's will be accepted and approved at the sole discretion of OHCA with implementation initiated after completion of a readiness review by OHCA staff and approval by OHCA's Medical Advisory Taskforce (MAT).~~

### **317:25-9-3. Reimbursement**

~~(a) In order to be eligible for payment, HAN's Health Access Networks (HANs) must have on file with OHCA, the Oklahoma Health Care Authority (OHCA) an approved Provider Agreement. Through this agreement, the HAN assures that OHCA's requirements are met and assures compliance with all applicable Federal federal and Statestate regulations. These agreements are renewed annually with each provider.~~

~~(b) The HAN will be reimbursed a per member per month (PMPM) rate based on the number of member months paid to the PCPs affiliated with the HAN. OHCA reserves the right to limit reimbursement based on availability of funds.~~

## **SUBCHAPTER 11. HEALTH MANAGEMENT PROGRAM**

### **317:25-11-1. Purpose**

The purpose of this Subchapter is to describe the rules governing the Health Management Program (HMP) participating in the statewide SoonerCare program. The rules provide assurances that the HMP will work with providers to coordinate and improve the quality of care for SoonerCare members.

### **317:25-11-2. Requirements**

(a) The Health Management Program (HMP) is a voluntary program offered statewide and serves SoonerCare Choice members ages four (4) through sixty-three (63) with or at risk for chronic illness who are at the highest risk for adverse outcome and increased health care expenditures.

(b) HMP services are grounded in motivational interviewing and evidence-based guidelines. The HMP services are designed by the HMP vendor and approved by the Oklahoma Health Care Authority (OHCA). The HMP vendor's activities may include services delivered directly to SoonerCare Choice members or activities in connection with health care providers that are designed to benefit SoonerCare Choice members. HMP activities/services can include:

- (1) Health coaching;
- (2) Practice facilitation;
- (3) Health navigation;
- (4) Performance improvement projects; and
- (5) Transition of care assistance.

### **317:25-11-3. Reimbursement**

The Health Management Program (HMP) vendor must have an approved Provider Agreement on file. Through this agreement, the HMP assures that the Oklahoma Health Care Authority's requirements are met and assures compliance with all applicable federal and state regulations. HMPs are not a service delivery system.

**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY  
CHAPTER 45. INSURE OKLAHOMA**

**SUBCHAPTER 9. INSURE OKLAHOMA ESI EMPLOYEE ELIGIBILITY**

**317:45-9-1.1 Certification of newborn child deemed eligible**

(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 Employer Sponsored Insurance (ESI) 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 ESI. The child's SoonerCare eligibility is based on the original eligibility determination of the mother for Insure Oklahoma ESI 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.

**SUBCHAPTER 11. INSURE OKLAHOMA IP**

**PART 1. INDIVIDUAL PLAN PROVIDERS**

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

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 decision to charge a co-payment for a missed visit is at the provider's discretion;~~
- ~~(3)~~ (2) The provider may collect the member's co-payment in addition to the SoonerCare reimbursement for services provided; and.

~~(4) The provider may refuse to see members based on their inability to pay their co-payment.~~

## **PART 5. INSURE OKLAHOMA IP MEMBER ELIGIBILITY**

### **317:45-11-21.1. Certification of newborn child deemed eligible**

(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. PCP Primary Care Physician (PCP) choices**

(a) The applicant ~~(and dependents if also applying for Insure Oklahoma IP)~~ ~~is~~ and any covered dependent(s) are required to select a valid PCP.

(b) If a valid PCP is selected by the applicant or dependents and they are not enrolled with the first PCP choice, they are enrolled with the next available PCP choice. The applicant is notified in writing why their initial choice was not selected. The applicant and any covered dependent(s) must make a PCP selection through their mysooner.org account.

(c) After initial enrollment in Insure Oklahoma ~~IP~~, Individual Plan the applicant ~~or dependents~~ can ~~any~~ covered dependent(s) may change their PCP selection through their mysooner.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.

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

**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**

**PART 8. REHABILITATION HOSPITALS**

**317:30-5-111. Coverage for adults**

For persons ~~21~~twenty-one (21) years of age or older, payment is made to hospitals for inpatient services as described in this section.

(1) All general inpatient hospital services which are not provided under the Diagnosis Related Group (DRG) payment methodology for all persons ~~21~~twenty-one (21) years of age or older is limited to ~~24~~ninety (90) days per person per state fiscal year (July 1 through June 30). The ~~24~~ninety (90) day limitation applies to both hospital and physician services. No exceptions or extensions will be made to the ~~24~~ninety (90) day inpatient services limitation.

(2) All inpatient stays are subject to post-payment utilization review by the ~~OHCA's~~Oklahoma Health Care Authority's (OHCA) designated Quality Improvement Organization (QIO). These reviews are based on severity of illness and intensity of treatment.

(A) It is the policy and intent of OHCA to allow hospitals and physicians the opportunity to present any and all documentation available to support the medical necessity of an admission and/or extended stay of a SoonerCare member. If the QIO, upon their initial review determines the admission should be denied, a notice is issued to the facility and the attending physician advising them of the decision. This notice also advises that a reconsideration request may be submitted within the specified time frame on the notice and consistent with the Medicare guidelines. Additional information submitted with the reconsideration request is reviewed by the QIO that utilizes an independent physician advisor. If the denial decision is upheld through this review of additional information, the QIO sends written notification of the denial decision to the hospital, attending physician and the OHCA. Once the OHCA has been notified, the overpayment is processed as per the final denial determination.

(B) If the hospital or attending physician did not request reconsideration from the QIO, the QIO informs OHCA there has been no request for reconsideration and as a result their initial denial decision is final. OHCA, in turn, processes the overpayment as per the denial notice sent to the OHCA by the QIO.

(C) If an OHCA, or its designated agent, review results in

denial and the denial is upheld throughout the appeal process and refund from the hospital and physician is required, the member cannot be billed for the denied services.

(3) If a hospital or physician believes that a hospital admission or continued stay is not medically necessary and thus not compensable but the member insists on treatment, the member should be informed that he/she will be personally responsible for all charges. If a claim is filed and paid and the service is later denied, the patient is not responsible.

(4) Payment is made to a participating hospital for hospital based physician's services. The hospital must have a Hospital-Based Physician's contract with OHCA for this method of billing.

(5) Outpatient services for adults are covered as listed in ~~OAC~~Oklahoma Administrative Code 317:30-5-42.1.

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

**SUBCHAPTER 1. GENERAL PROVISIONS**

**317:30-1-3. Description of rules**

How to use this Chapter. This Chapter contains basic information concerning the ~~Oklahoma Title XIX Medical Assistance~~ SoonerCare Program (~~Medicaid~~). It is intended for use by all providers of medical and health related services participating in the program.

(1) The Chapter contains Sections dealing with ~~the organization, administration and financing of the program, recipient eligibility, provider policies,~~ coverage of medical and health services, and other general program policies and procedures applicable to all providers. ~~Rules and procedures applicable to particular provider groups and billing instructions are distributed to providers according to the type of services rendered.~~

(2) Providers and their office staff are urged to familiarize themselves with the contents of this Chapter and to refer to it when questions arise. Use of the Chapter will ~~do much to eliminate~~ reduce misunderstandings concerning the coverage, ~~status and reimbursement of SoonerCare services, recipient eligibility and proper billing procedures all of which can result in delays in payment, incorrect payment or denial of payment and the Agency's expectations of providers.~~ As users of the rules in this Chapter, OHCA also solicits suggestions and comments from providers.

**317:30-1-4. Definitions**

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

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

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

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

**SUBCHAPTER 1. GENERAL PROVISIONS**

**317:35-1-2. Definitions**

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

**"Acute Care Hospital"** means an institution that meets the requirements of ~~42 CFR, Section 440.10 and~~defined in Section (§) 440.10 of Title 42 of the Code of Federal Regulations (C.F.R.) and:

- (A) is maintained primarily for the care and treatment of patients with disorders other than mental diseases;
- (B) is formally licensed or formally approved as a hospital by an officially designated authority for state standard setting; and
- (C) meets the requirements for participation in Medicare as a hospital.

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

**"ADvantage Administration (AA)"** means the Oklahoma Department of Human Services ~~(OKDHS)~~(DHS) which performs certain administrative functions related to the ADvantage Waiver.

**"Aged"** means an individual whose age is established as ~~65~~sixty-five (65) years or older.

**"Agency partner"** means an agency or organization contracted with the OHCA that will assist those applying for services.

**"Aid to Families with Dependent Children (AFDC)"** means the group of low income families with children described in Section 1931 of the Social Security Act. The Personal Responsibility and Work Opportunity Act of 1996 established the new eligibility group of low income families with children and linked eligibility income and resource standards and methodologies and the requirement for deprivation for the new group to the State plan for ~~Aid to Families with Dependent Children~~AFDC in effect on July 16, 1996. Oklahoma has elected to be less restrictive for all SoonerCare members related to AFDC. Effective January 1, 2014, children covered under Section 1931 are related to the children's group, and adults covered under Section 1931 are related to the parent and caretaker relative group. The Modified Adjusted Gross Income (MAGI) methodology is used to determine

eligibility for these groups.

**"Area nurse"** means a registered nurse in the ~~OKDHS~~DHS Aging Services Division, designated according to geographic areas who evaluates the ~~UCAT~~Uniform Comprehensive Assessment Tool (UCAT) and determines medical eligibility for Personal Care, ADvantage Waiver, and Nursing Facility services. The area nurse also approves care plan and service plan implementation for Personal Care services.

**"Area nurse designee"** means a registered nurse selected by the area nurse who evaluates the UCAT and determines medical eligibility for Personal Care, ADvantage Waiver, and Nursing Facility services.

**"Authority"** means the ~~Oklahoma Health Care Authority~~ (OHCA)OHCA.

**"Blind"** means an individual who has central visual acuity of 20/200 or less in the better eye with the use of a correcting lens.

**"Board"** means the ~~Oklahoma Health Care Authority~~OHCA Board.

**"Buy-in"** means the procedure whereby the OHCA pays the member's Medicare premium.

(A) **"Part A Buy-in"** means the procedure whereby the OHCA pays the Medicare Part A premium for individuals determined eligible as Qualified Medicare Beneficiaries Plus (QMBP) who are enrolled in Part A and are not eligible for premium free enrollment as explained under Medicare Part A. This also includes individuals determined to be eligible as Qualified Disabled and Working Individuals (QDWI).

(B) **"Part B Buy-in"** means the procedure whereby the OHCA pays the Medicare Part B premium for categorically needy individuals who are eligible for Part B Medicare. This includes individuals who receive TANF or the State Supplemental Payment to the Aged, Blind or Disabled, and those determined to be Qualified Medicare Beneficiary Plus (QMBP), Specified Low Income Medicare Beneficiaries (SLMB) or Qualifying Individual-1 (QI-1). Also included are individuals who continue to be categorically needy under the PICKLE amendment and those who retain eligibility after becoming employed.

**"Caretaker relative"** means a person other than the biological or adoptive parent with whom the child resides who meets the specified degree of relationship within the fifth degree of kinship.

**"Case management"** means the activities performed for members to assist them in accessing services, advocacy and problem solving related to service delivery.

**"Categorically needy"** means that income and, when applicable,

resources are within the standards for the category to which the individual is related.

**"Categorically related" or "related"** means the individual meets basic eligibility requirements for an eligibility group.

**"Certification period"** means the period of eligibility extending from the effective date of certification to the date of termination of eligibility or the date of the next periodic redetermination of eligibility.

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

**"County"** means the ~~Oklahoma Department of Human Services~~ DHS' office or offices located in each county within the State.

**"Custody"** means the custodial status, as reported by ~~the Oklahoma Department of Human Services~~ DHS.

**"Deductible/Coinsurance"** means the payment that must be made by or on behalf of an individual eligible for Medicare before Medicare payment is made. The coinsurance is that part of the allowable medical expense not met by Medicare, which must be paid by or on behalf of an individual after the deductible has been met.

(A) For Medicare Part A (Hospital Insurance), the deductible relates to benefits for inpatient services while the patient is in a hospital or nursing facility. After the deductible is met, Medicare pays the remainder of the allowable cost.

(B) For Medicare Part B (Medical Insurance), the deductible is an annual payment that must be made before Medicare payment for medical services. After the deductible is met, Medicare pays ~~80%~~ eighty percent (80%) of the allowable charge. The remaining ~~20%~~ twenty percent (20%) is the coinsurance.

**"Disabled"** means an individual who is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death, or which has lasted (or can be expected to last) for a continuous period of not less than ~~12~~ twelve (12) months.

**"Disabled child"** means for purposes of Medicaid Recovery a child of any age who is blind, or permanently and totally disabled according to standards set by the Social Security Administration.

**"Estate"** means all real and personal property and other assets included in the member's estate as defined in Title 58 of the Oklahoma Statutes.

**"Gatekeeping"** means the performance of a comprehensive

assessment by the ~~OKDHS~~DHS nurse utilizing the ~~Uniform Comprehensive Assessment Tool (UCAT)~~UCAT for the determination of Medical eligibility, care plan development, and the determination of Level of Care for Personal Care, Advantage Waiver and Nursing Facility services.

**"Ineligible Spouse"** means an individual who is not eligible for ~~SSI~~Supplemental Security Income (SSI) but is the husband or wife of someone who is receiving SSI.

**"Local office"** means the Oklahoma ~~Department of Human Services~~DHS' office or offices located in each county within the State.

**"LOCEU"** means the Oklahoma Health Care Authority's Level of Care Evaluation Unit.

**"MAGI eligibility group"** means an eligibility group whose financial eligibility is determined through the Modified Adjusted Gross Income (MAGI) methodology. The groups subject to MAGI are defined in ~~42 CFR 435.603~~42 C.F.R. § 436.603 and listed in OAC 317:35-6-1.

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

**"Medicare"** means the federally funded health insurance program also known as Title XVIII of the Social Security Act. It consists of four (4) separate programs. Part A is Hospital Insurance, Part B is Medical Insurance, Part C is Medicare Advantage Plans, and Part D is Prescription Drug Coverage.

(A) **"Part A Medicare"** means Hospital Insurance that covers services for inpatient services while the patient is in a hospital or nursing facility. Premium free enrollment is provided for all persons receiving OASDI or Railroad Retirement income who are age ~~65~~sixty-five (65) or older and for those under age ~~65~~sixty-five (65) who have been receiving disability benefits under these programs for at least ~~24~~twenty-four (24) months.

(i) Persons with end stage renal disease who require dialysis treatment or a kidney transplant may also be covered.

(ii) Those who do not receive OASDI or Railroad Retirement income must be age ~~65~~sixty-five (65) or over and pay a large premium for this coverage. Under Authority rules, these individuals are not required to enroll for Part A to be eligible for SoonerCare benefits as categorically needy. They must, however, enroll for Medicare Part B. Individuals eligible as a QMBP or as a ~~Qualified Disabled and Working Individual (QDWI)~~QDWI under Medicaid are required to enroll for Medicare Part A. The Authority will pay Part A premiums

for QMBP individuals who do not qualify for premium free Part A and for all QDWI's.

(B) **"Part B Medicare"** means Supplemental Medical Insurance that covers physician and related medical services other than inpatient or nursing facility care. Individuals eligible to enroll in Medicare Part B are required to do so under OHCA policy. A monthly premium is required to keep this coverage in effect.

**"Minor child"** means a child under the age of ~~18~~eighteen (18).

**"Nursing Care"** for the purpose of Medicaid Recovery is care received in a nursing facility, an intermediate care facility for individuals with intellectual disabilities (ICF/IIDs) or other medical institution providing nursing and convalescent care, on a continuing basis, by professional personnel who are responsible to the institution for professional medical services.

**"OCSS"** means the Oklahoma ~~Department of Human Services~~DHS' Oklahoma Child Support Services (formerly Child Support Enforcement Division).

**"OHCA"** means the Oklahoma Health Care Authority.

**"OHCA Eligibility Unit"** means the group within the ~~Oklahoma Health Care Authority~~OHCA that assists with the eligibility determination process.

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

~~"OKDHS nurse"~~ **"nurse"** means a registered nurse in the ~~OKDHS~~ Aging Services Division who meets the certification requirements for UCAT Assessor and case manager, and who conducts the uniform assessment of individuals utilizing the ~~Uniform Comprehensive Assessment Tool (UCAT)~~UCAT for the purpose of medical eligibility determination. The ~~OKDHS~~ nurse also develops care plans and service plans for Personal Care services based on the UCAT.

**"Qualified Disabled and Working Individual (QDWI)"** means individuals who have lost their Title II OASDI benefits due to excess earnings, but have been allowed to retain Medicare coverage.

**"Qualified Medicare Beneficiary Plus (QMBP)"** means certain aged, blind or disabled individuals who may or may not be enrolled in Medicare Part A, meet the Medicaid QMBP income and resource standards and meet all other Medicaid eligibility requirements.

**"Qualifying Individual"** means certain aged, blind or disabled individuals who are enrolled in Medicare Part A, meet the Medicaid Qualifying Individual income and resource standards and meet all other Medicaid eligibility requirements.

**"Qualifying Individual-1"** means a Qualified Individual who meets the Qualifying Individual-1 income and resource standards.

**"Reasonably compatible"** means that there is no significant discrepancy between information declared by a member or applicant and other information available to the agency. More specific policies and procedures for determining whether a declaration is reasonably compatible are detailed in Oklahoma's Verification Plan.

**"Recipient lock-in"** means when a member is restricted to one primary physician and/or one pharmacy. It occurs when the OHCA determines that a SoonerCare member has used multiple physicians and/or pharmacies in an excessive manner over a ~~12-month~~twelve (12) month period.

**"Scope"** means the covered medical services for which payment is made to providers on behalf of eligible individuals. The Oklahoma Health Care Authority Provider Manual (OAC 317:30) contains information on covered medical services.

**"Specified Low Income Medicare Beneficiaries (SLMB)"** means individuals who, except for income, meet all of the eligibility requirements for QMBP eligibility and are enrolled in Medicare Part A.

**"TEFRA"** means the Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97-248). TEFRA provides coverage to certain disabled children living in the home who would qualify for SoonerCare if residents of nursing facilities, ICF/IIDs, or inpatient acute care hospital stays are expected to last not less than ~~60~~sixty (60) days.

**"Worker"** means the OHCA or OKDHS worker responsible for assisting in eligibility determinations.

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

**SUBCHAPTER 3. GENERAL PROVIDER POLICIES**

**PART 3. GENERAL MEDICAL PROGRAM INFORMATION**

**317:30-3-57. General SoonerCare coverage - categorically needy**

The following are general SoonerCare coverage guidelines for the categorically needy:

- (1) Inpatient hospital services other than those provided in an institution for mental diseases.
  - (A) Adult coverage for inpatient hospital stays as described at OAC 317:30-5-41.
  - (B) Coverage for members under twenty-one (21) years of age is not limited. All admissions must be medically necessary. All psychiatric admissions require prior authorization for an approved length of stay.
- (2) Emergency department services.
- (3) Dialysis in an outpatient hospital or free standing dialysis facility.
- (4) Outpatient therapeutic radiology or chemotherapy for proven malignancies or opportunistic infections.
- (5) Outpatient surgical services - facility payment for selected outpatient surgical procedures to hospitals which have a contract with the Oklahoma Health Care Authority (OHCA).
- (6) Outpatient mental health services for medical and remedial care including services provided on an outpatient basis by certified hospital based facilities that are also qualified mental health clinics.
- (7) Rural health clinic services and other ambulatory services furnished by rural health clinic.
- (8) Optometrists' services - only as listed in Subchapter 5, Part 45, Optometrist specific rules of this Chapter.
- (9) Maternity clinic services.
- (10) Outpatient diagnostic x-rays and lab services. Other outpatient services provided to adults, not specifically addressed, are covered only when prior authorized by the agency's Medical Authorization Unit.
- (11) Medically necessary screening mammography. Additional follow-up mammograms are covered when medically necessary.
- (12) Nursing facility services (other than services in an institution for tuberculosis or mental diseases).
- (13) Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT) are available for members under twenty-one (21) years of age to provide access to regularly scheduled

examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth. Federal regulations also require that diagnosis and treatment be provided for conditions identified during a screening whether or not they are covered under the State Plan, as long as federal funds are available for these services. These services must be necessary to ameliorate or correct defects and physical or mental illnesses or conditions and require prior authorization. EPSDT/OHCA Child Health services are outlined in OAC 317:30-3-65.2 through 317:30-3-65.4.

(A) Child health screening examinations for eligible children by a medical or osteopathic physician, physician assistant, or advanced practice nurse practitioner.

(B) Diagnostic x-rays, lab, and/or injections when prescribed by a provider.

(C) Immunizations.

(D) Outpatient care.

(E) Dental services as outlined in OAC 317:30-3-65.8.

(F) Optometrists' services. The EPSDT periodicity schedule provides for at least one (1) visual screening and glasses each twelve (12) months. In addition, payment is made for glasses for children with congenital aphakia or following cataract removal. Interperiodic screenings and glasses at intervals outside the periodicity schedule for optometrists are allowed when a visual condition is suspected. Payment is limited to two (2) glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.

(G) Hearing services as outlined in OAC 317:30-3-65.9.

(H) Prescribed drugs.

(I) Outpatient psychological services as outlined in OAC 317:30-5-275 through 317:30-5-278.

(J) Inpatient psychiatric services as outlined in OAC 317:30-5-95 through 317:30-5-97.

(K) Transportation. Provided when necessary in connection with examination or treatment when not otherwise available.

(L) Inpatient hospital services.

(M) Medical supplies, equipment, appliances and prosthetic devices beyond the normal scope of SoonerCare.

(N) EPSDT services furnished in a qualified child health center.

(14) Family planning services and supplies for members of child-bearing age, including counseling, insertion of intrauterine device, implantation of subdermal contraceptive device, and sterilization for members twenty-one (21) years of age and older who are legally competent, not institutionalized and have

signed the "Consent Form" at least thirty (30) days prior to procedure. Reversal of sterilization procedures for the purposes of conception is not covered. Reversal of sterilization procedures are covered when medically indicated and substantiating documentation is attached to the claim.

(15) Physicians' services whether furnished in the office, the member's home, a hospital, a nursing facility, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), or elsewhere. For adults, payment is made for compensable hospital days described at OAC 317:30-5-41. Office visits for adults are limited to four (4) per month except when in connection with conditions as specified in OAC 317:30-5-9(b).

(16) Medical care and any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law. See applicable provider section for limitations to covered services for:

- (A) Podiatrists' services
- (B) Optometrists' services
- (C) Psychologists' services
- (D) Certified Registered Nurse Anesthetists
- (E) Certified Nurse Midwives
- (F) Advanced Practice Nurses
- (G) Anesthesiologist Assistants

(17) Free-standing ambulatory surgery centers.

(18) Prescribed drugs not to exceed a total of six (6) prescriptions with a limit of two (2) brand name prescriptions per month. Exceptions to the six (6) prescription limit are:

- (A) unlimited medically necessary monthly prescriptions for:
  - (i) members under the age of twenty-one (21) years; and
  - (ii) residents of nursing facilities or ICF/IID.

(B) seven (7) medically necessary generic prescriptions per month in addition to the six (6) covered under the State Plan (including three (3) brand name prescriptions) are allowed for adults receiving services under the 1915(c) Home and Community Based Services Waivers (HCBS). These additional medically necessary prescriptions beyond the three (3) brand name or thirteen (13) total prescriptions are covered with prior authorization.

(19) Rental and/or purchase of durable medical equipment.

(20) Adaptive equipment, when prior authorized, for members residing in private ICF/IID's.

(21) Dental services for members residing in private ICF/IID's in accordance with the scope of dental services for members under age twenty-one (21).

(22) Prosthetic devices limited to catheters and catheter accessories, colostomy and urostomy bags and accessories,

tracheostomy accessories, nerve stimulators, hyperalimentation and accessories, home dialysis equipment and supplies, external breast prostheses and support accessories, oxygen/oxygen concentrator equipment and supplies, respirator or ventilator equipment and supplies, and those devices inserted during the course of a surgical procedure.

(23) Standard medical supplies.

(24) Eyeglasses under EPSDT for members under age twenty-one (21). Payment is also made for glasses for children with congenital aphakia or following cataract removal. Payment is limited to two (2) glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.

(25) Blood and blood fractions for members when administered on an outpatient basis.

(26) Inpatient services for members age sixty-five (65) or older in institutions for mental diseases, limited to those members whose Medicare, Part A benefits are exhausted for this particular service and/or those members who are not eligible for Medicare services.

(27) Nursing facility services, limited to members preauthorized and approved by OHCA for such care.

(28) Inpatient psychiatric facility admissions for members under twenty-one (21) are limited to an approved length of stay effective July 1, 1992, with provision for requests for extensions.

(29) Transportation and subsistence (room and board) to and from providers of medical services to meet member's needs (ambulance or bus, etc.), to obtain medical treatment.

(30) Extended services for pregnant women including all pregnancy-related and postpartum services to continue to be provided, as though the women were pregnant, for sixty (60) days after the pregnancy ends, beginning on the last date of pregnancy.

(31) Nursing facility services for members under twenty-one (21) years of age.

(32) Personal care in a member's home, prescribed in accordance with a plan of treatment and rendered by a qualified person under supervision of a Registered Nurse (RN).

(33) Part A deductible and Part B Medicare Coinsurance and/or deductible.

(34) HCBS for the intellectually disabled.

(35) Home health services limited to thirty-six (36) visits per year and standard supplies for one (1) month in a twelve (12) month period. The visits are limited to any combination of RN and nurse aide visits, not to exceed thirty-six (36) per year.

(36) Medically necessary ~~solid~~ organ and ~~bone marrow/stem~~

~~cell~~tissue transplantation services for children and adults are covered services based upon the conditions listed in (A)-~~(D)~~ (E) of this paragraph:

~~(A) Transplant procedures, except kidney and cornea, must be prior authorized to be compensable.~~

~~(B) To be prior authorized all procedures are reviewed based on appropriate medical criteria.~~

~~(C) To be compensable under the SoonerCare program, all transplants must be performed at a facility which meets the requirements contained in Section 1138 of the Social Security Act.~~

~~(D) Finally, procedures considered experimental or investigational are not covered.~~

(A) All transplantation services, except kidney and cornea, must be prior authorized;

(B) All transplant procedures are reviewed and prior authorization is based upon appropriate medical criteria;

(C) All organ transplants must be performed at a Medicare approved transplantation center;

(D) Procedures considered experimental or investigational are not covered; and

(E) Donor search and procurement services are covered for transplants consistent with the methods used by the Medicare program for organ acquisition costs.

(37) HCBS for intellectually disabled members who were determined to be inappropriately placed in a nursing facility (Alternative Disposition Plan - ADP).

(38) Case management services for the chronically and/or severely mentally ill.

(39) Emergency medical services including emergency labor and delivery for illegal or ineligible aliens.

(40) Services delivered in Federally Qualified Health Centers. Payment is made on an encounter basis.

(41) Early intervention services for children ages zero (0) to three (3).

(42) Residential behavior management in therapeutic foster care setting.

(43) Birthing center services.

(44) Case management services through the Oklahoma Department of Mental Health and Substance Abuse Services.

(45) HCBS for aged or physically disabled members.

(46) Outpatient ambulatory services for members infected with tuberculosis.

(47) Smoking and tobacco use cessation counseling for children and adults.

(48) Services delivered to American Indians/Alaskan Natives in I/T/Us. Payment is made on an encounter basis.

(49) OHCA contracts with designated agents to provide disease state management for individuals diagnosed with certain chronic conditions. Disease state management treatments are based on protocols developed using evidence-based guidelines.

## SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

### PART 3. HOSPITALS

#### 317:30-5-41.2. Organ transplants

~~Solid organ and bone marrow/stem cell~~ Organ and tissue transplants are covered when appropriate and medically necessary.

~~(1) Transplant procedures, except kidney and cornea, must be prior authorized to be compensable.~~

~~(2) To be prior authorized all procedures are reviewed based on appropriate medical criteria.~~

~~(3) To be compensable under the SoonerCare program all transplants must be performed at a facility which meets the requirements contained in Section 1138 of the Social Security Act.~~

~~(4) Procedures considered experimental or investigational are not covered.~~

~~(5) Donor search and procurement services are covered for transplants consistent with the methods used by the Medicare program for organ acquisition costs.~~

(1) All transplantation services, except kidney and cornea, must be prior authorized;

(2) All transplant procedures are reviewed and prior authorization is based upon appropriate medical criteria;

(3) All organ transplants must be performed at a Medicare approved transplantation center;

(4) Procedures considered experimental or investigational are not covered; and

(5) Donor search and procurement services are covered for transplants consistent with the methods used by the Medicare program for organ acquisition costs.

**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY  
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**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**

**PART 62. PRIVATE DUTY NURSING**

**317:30-5-555. ~~Eligible providers~~Private Duty Nursing (PDN)**

~~(a) An organization who desires to be paid by SoonerCare for private duty nursing must meet the following requirements prior to providing services to eligible SoonerCare members:~~

- ~~(1) an executed contract with OHCA, and~~
- ~~(2) the organization must meet the requirements of OAC 317:30-5-545 or it must be licensed by the State Health Department as a Home Care Agency.~~

~~(b) The provider of services within the organization must be a licensed practical nurse or a registered nurse.~~PDN is medically necessary care provided on a regular basis by a licensed practical nurse or registered nurse. PDN is the level of care that would routinely be provided by the nursing staff of a hospital or skilled nursing facility. PDN services are provided:

(1) In the member's primary residence, unless it is medically necessary for a nurse to accompany the individual in the community.

(A) The individual's place of residence is wherever the individual lives, whether the residence is the individual's own dwelling, a relative's home, or other type of living arrangement. The place of residence cannot include a hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities (ICF/IID).

(B) The place of service in the community cannot include the residence or business location of the provider of PDN services unless the provider of PDN is a live-in caregiver.

(2) To assist during transportation to routine, Medicaid-compensable health care appointments and/or to the nearest appropriate emergency room, but only when SoonerRide is unavailable, and a lack of PDN services during transportation would require transportation by ambulance pursuant to Oklahoma Administrative Code (OAC) 317:30-5-336.

(A) The private duty nurse may not drive the vehicle during transportation.

(B) PDN services are not available for non-routine extended home absences unrelated to medically necessary treatment or medical care. [Refer to Oklahoma Administrative Code 317:30-5-558(4) and(13)].

**317:30-5-556. ~~Definitions~~Eligible providers**

~~Private duty nursing is medically necessary care provided on a regular basis by a Licensed Practical Nurse or Registered Nurse in~~

~~the member's primary residence or to assist outside the home during transport to medical appointments and emergency room visits in lieu of transport by ambulance.~~ (a) A home health agency that desires to be reimbursed by SoonerCare for private duty nursing (PDN) must meet the following requirements prior to providing services to eligible SoonerCare members:

(1) The agency must be fully contracted with OHCA as a provider; and,

(2) The agency must meet the requirements of Oklahoma Administrative Code (OAC) 317:30-5-545, and it must be licensed by the Oklahoma State Health Department (OSDH) as a home care agency.

(b) The provider of PDN services, within the agency, must be a licensed practical nurse or a registered nurse who is currently licensed and in good standing in the state in which services are provided.

### **317:30-5-558. Private duty nursing (PDN) coverage limitations**

The following ~~regulations~~provisions apply to all ~~private duty nursing~~PDN services and provide coverage limitations:

(1) All services must be prior authorized to receive payment from the Oklahoma Health Care Authority (OHCA). Prior authorization means authorization in advance of services provided in accordance with Oklahoma Administrative Code (OAC) 317:30-3-31 and 317:30-5-560.1;

(2) A treatment plan must be completed by the ~~Nursing~~home health agency before requesting prior authorization and must be updated at least annually and signed by the physician;

(3) A telephonic interview and/or personal visit by an OHCA care management nurse is required prior to the authorization for services;

(4) Care in excess of the designated hours per day granted in the prior authorization is not SoonerCare compensable. Prior-authorized but unused service hours cannot be "banked," "saved," or otherwise "accumulated" for use at a future date or time. If such hours or services are provided, they are not SoonerCare compensable.

(5) Any medically necessary PDN care provided outside of the home is limited to ~~must be counted in and cannot exceed~~ assisting during transport to medical appointments and emergency room visits in lieu of transport by ambulance and is limited to the number of hours requested on the treatment plan and approved by OHCA.

(6) ~~Private duty nursing~~PDN services do not include office time or administrative time in providing the service. The time billed is for direct nursing services only.

(7) Staff must be engaged in purposeful activity that directly benefits the member receiving services. Staff must be physically able and mentally alert to carry out the duties of the job. At no time will OHCA compensate an organization for nursing staff

time when sleeping.

(8) OHCA will not approve ~~Private Duty Nursing~~ PDN services if all health and safety issues cannot be met in the ~~home~~ setting in which services are provided.

(9) A provider must not misrepresent or omit facts in a treatment plan.

(10) It is outside the scope of coverage to deliver care in a manner outside of the treatment plan or to deliver units over the authorized units of care.

(11) ~~Private duty nursing~~ PDN is not authorized in excess of ~~sixteen~~ 16 (16) hours per day ~~except immediately following a hospital stay or the temporary incapacitation of the primary caregiver. Under these two exceptions, care in excess of 16 hours is authorized for a period up to 30 days. As expressed in this subsection, incapacity means an involuntary ability to provide care. There may be approval for additional hours for a period not to exceed thirty (30) days, if:~~

(A) The member has an acute episode that would otherwise require hospitalization or immediately following a hospital stay; or

(B) The primary caregiver is temporarily and involuntarily unable to provide care.

(C) The OHCA has discretion and the final authority to approve or deny any additional PDN hours and will take into consideration that the additional hours are not to be a substitute for institutionalized care.

(12) Family and/or caregivers and/or guardians (hereinafter, "caregivers") are required to provide some of the nursing care to the member without compensation. PDN services shall not be provided solely to allow the member's caregiver to work or go to school, nor solely to allow respite for the caregiver.

(13) PDN services will not be approved for overnight trips away from the member's primary residence that are unrelated to medically necessary treatment or medical care.

(A) For a member to receive Medicaid-reimbursable PDN services on an overnight trip that is related to medically necessary treatment or medical care, all provisions of this Part must be met. If said trip occurs out of state, OAC 317:30-3-89 through 317:30-3-92 must also be met.

(B) In instances in which the member's family is temporarily absent due to vacations, any additional PDN hours must be paid for by the family, or provided by other trained family members without SoonerCare reimbursement.

(14) PDN services will not be approved when services are reimbursed or reimbursable by other insurance, other governmental programs, or Medicaid program services that the member receives or is eligible to receive. For example, if a member receives Medicaid-reimbursable PDN services pursuant to an Individualized Education Program (IEP) in a public school, then those PDN school hours will be counted in the member's

daily allotment of PDN services.

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

**SUBCHAPTER 3. GENERAL PROVIDER POLICIES**

**PART 4. EARLY AND PERIODIC SCREENING, ~~DIAGNOSIS~~DIAGNOSTIC  
AND TREATMENT (EPSDT) PROGRAM/CHILD-HEALTH SERVICES**

**317:30-3-65. Early and Periodic Screening, ~~Diagnosis~~Diagnostic and Treatment (EPSDT) program/Child-health Services**

Payment is made to eligible providers for Early and Periodic Screening, ~~Diagnosis~~Diagnostic and Treatment (EPSDT) services on behalf of eligible individuals under the age of ~~21~~twenty-one (21).

(1) The EPSDT program is a comprehensive child-health program, designed to ensure the availability of, and access to, required health care resources and help parents and guardians of Medicaid-eligible children and adolescents use these resources. An effective EPSDT program assures that health problems are diagnosed and treated early before they become more complex and their treatment more costly. The physician plays a significant role in educating parents and guardians about all services available through the EPSDT program. The receipt of an identified EPSDT screening makes the member eligible for all necessary follow-up care that is within the scope of the SoonerCare program. Early and Periodic Screening, ~~Diagnosis~~Diagnostic and Treatment (EPSDT) covers services, supplies, or equipment that are determined to be medically necessary for a child or adolescent, and which are included within the categories of mandatory and optional services in Section 1905(a) of Title XIX, regardless of whether such services, supplies, or equipment are listed as covered in ~~Oklahoma's State Plan~~Oklahoma's Medicaid State Plan.

(2) Federal regulations also require that the State set standards and protocols for each component of EPSDT services. The standards must provide for services at intervals which meet reasonable standards of medical and dental practice. The standards must also provide for EPSDT services at other intervals as medically necessary to determine the existence of certain physical or behavioral health illnesses or conditions.

(3) SoonerCare providers who perform EPSDT screenings must assure that the screenings they provide meet the minimum standards established by the Oklahoma Health Care Authority in order to be reimbursed at the level established for EPSDT services.

(4) An EPSDT screening is considered a comprehensive examination. A provider billing SoonerCare for an EPSDT screen may not bill any other Evaluation and Management Current Procedure Terminology (CPT) code for that patient on that same day. It is expected that the screening provider will perform

necessary treatment as part of the screening charge. However, there may be other additional diagnostic procedures or treatments not normally considered part of a comprehensive examination, including diagnostic tests and administration of immunizations, required at the time of screening. Additional diagnostic procedures or treatments may be billed independently from the screening. Some services as set out in this section may require prior authorization.

(5) For an EPSDT screening to be considered a completed reimbursable service, providers must perform, and document, all required components of the screening examination. Documentation of screening services performed must be retained for future review.

(6) All comprehensive screenings provided to individuals under age ~~21~~twenty-one (21) must be filed on HCFA-1500 using the appropriate preventive medicine procedure code or an appropriate Evaluation and Management code from the Current Procedural Terminology Manual (CPT) accompanied by the appropriate "V" diagnosis code.

(7) For EPSDT services in a school-based setting that are provided pursuant to an IEP, please refer to Part 103, Qualified Schools As Providers Of Health-Related Services, in Oklahoma Administrative Code 317:30-5-1020 through 317:30-5-1028.

## SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

### PART 103. QUALIFIED SCHOOLS AS PROVIDERS OF HEALTH-RELATED SERVICES

#### 317:30-5-1022. Periodicity schedule [REVOKED]

~~(a) The SoonerCare program has adopted the recommendations of the American Academy of Pediatrics' Bright Futures' periodicity schedule for services.~~

~~(b) Children and adolescents enrolled in SoonerCare are referred to their SoonerCare provider for services. In cases where the SoonerCare provider authorizes the school to perform the screen or fails to schedule an appointment within three (3) weeks and a request has been made and documented by the school, the school may then furnish the Early and Periodic Screening, Diagnosis and Treatment child health screening and bill it as a fee-for-service activity. Results of the child health screening are forwarded to the member's SoonerCare provider.~~

#### 317:30-5-1023. Coverage by category

(a) **Adults.** There is no coverage for services rendered to adults twenty-one (21) years of age and older.

(b) **Children.** For non-Individualized Education Program (IEP) medical services that can be provided in a school setting, refer to Part 4, Early and Periodic Screening, Diagnostic and Treatment

program, of Oklahoma Administrative Code at 317:30-3-65 through 317:30-3-63.12. Payment is made for the following compensable services rendered by qualified school providers:

~~(1) **Child health screening.** An initial screening may be requested by an eligible member at any time and must be provided without regard to whether the member's age coincides with the established periodicity schedule. Coordination referral is made to the SoonerCare provider to assure at a minimum, that periodic screens are scheduled and provided in accordance with the periodicity schedule following the initial screening. Child-health screening must adhere to the following requirements:~~

~~(A) Children and adolescents enrolled in SoonerCare must be referred to their SoonerCare provider for child health screenings. In cases where the SoonerCare provider authorizes the school to perform this screen or fails to schedule an appointment within three (3) weeks and a request has been made and documented by the school, the school may then furnish the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) child-health screening. Written notification must be mailed to the SoonerCare member's primary care provider (PCP) prior to the school's intent to furnish and bill for the screen. Results of this screening must be forwarded to the member's SoonerCare provider.~~

~~(B) Child health screenings must be provided by a state-licensed physician (M.D. or D.O.), state-licensed nurse practitioner with prescriptive authority, or state-licensed physician assistant. Screening services must include the following:~~

~~(i) Comprehensive health and developmental history, including assessment of both physical and mental health development;~~

~~(ii) Comprehensive unclothed physical exam;~~

~~(iii) Appropriate immunizations according to the age and health history;~~

~~(iv) Laboratory test, including blood level assessment; and~~

~~(v) Health education, including anticipatory guidance.~~

~~(C) Mass screenings for any school based service are not billable to SoonerCare, nor are screenings that are performed as a child or adolescent find activity pursuant to an Individuals with Disabilities Education Act (IDEA) requirement. There must be a documented referral in place that indicates the child or adolescent has an individualized need that warrants a screening to be performed.~~

~~(2) **Child health encounter.** The child health encounter may include a diagnosis and treatment encounter, a follow-up health encounter, or a home visit. A child-health encounter may include any of the following services:~~

~~(A) vision;~~

~~(B) hearing;~~

- ~~(C) dental;~~
- ~~(D) a health history;~~
- ~~(E) physical examination;~~
- ~~(F) developmental assessment;~~
- ~~(G) nutrition assessment and counseling;~~
- ~~(H) social assessment and counseling;~~
- ~~(I) genetic evaluation and counseling;~~
- ~~(J) indicated laboratory and screening tests;~~
- ~~(K) screening for appropriate immunizations; or~~
- ~~(L) health counseling and treatment of childhood illness and conditions.—~~

~~(3)~~ (1) **Diagnostic encounters.** Diagnostic encounters are defined as those services necessary to fully evaluate defects, physical or behavioral health illnesses, or conditions discovered by the screening. Approved diagnostic encounters may include the following:

(A) **Hearing and hearing aid evaluation.** Hearing evaluation includes pure tone air, bone, and speech audiometry. Hearing evaluations must be provided by a state-licensed audiologist who:

- (i) ~~holds~~  Holds a Certificate of Clinical Competence from the American Speech-Language-Hearing Association (ASHA); or
- (ii) ~~has~~  Has completed the equivalent educational requirements and work experience necessary for the certificate; or
- (iii) ~~has~~  Has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

(B) **Audiometry test.** Audiometric test (Immittance [Impedance] audiometry or tympanometry) includes bilateral assessment of middle ear status and reflex studies (when appropriate) provided by a state-licensed audiologist who:

- (i) ~~holds~~  Holds a Certificate of Clinical Competence from ASHA; or
- (ii) ~~has~~  Has completed the equivalent educational requirements and work experience necessary for the certificate; or
- (iii) ~~has~~  Has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

(C) **Ear impression (for earmold).** Ear impression (for earmold) includes taking an impression of a member's ear and providing a finished earmold ~~which is, to be~~ used with the member's hearing aid as provided by a state-licensed audiologist who:

- (i) ~~holds~~  Holds a Certificate of Clinical Competence from the ASHA; or
- (ii) ~~has~~  Has completed the equivalent educational

requirements and work experience necessary for the certificate; or

(iii) ~~has~~Has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

(D) **Vision screening.** Vision screening in schools includes application of tests and examinations to identify visual defects or vision disorders. The vision screening may be performed by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) under the supervision of an RN, ~~or state-certified vision impairment teacher.~~ The service can be billed when a SoonerCare member has an individualized documented concern that warrants a screening. A vision examination must be provided by a state-licensed Doctor of Optometry (O.D.) or licensed physician specializing in ophthalmology (M.D. or D.O.). This vision examination, at a minimum, includes diagnosis and treatment for defects in vision.

(E) **Speech-language evaluation.** Speech-language evaluation is for the purpose of identification of children or adolescents with speech or language disorders and the diagnosis and appraisal of specific speech and language services. Speech-language evaluations must be provided by state-licensed speech-language pathologist who:

(i) ~~holds~~ Holds a Certificate of Clinical Competence from the ASHA; or

(ii) ~~has~~Has completed the equivalent educational requirements and work experience necessary for the certificate; or

(iii) ~~has~~Has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

(F) **Physical therapy evaluation.** Physical therapy evaluation includes evaluating the student's ability to move throughout the school and to participate in classroom activities and the identification of movement dysfunction and related functional problems ~~and must be provided by a state-licensed physical therapist.~~ It must be provided by a state-licensed physical therapist. Physical therapy evaluations must adhere to guidelines found at OAC 317:30-5-291.

(G) **Occupational therapy evaluation.** Occupational therapy evaluation services include determining what therapeutic services, assistive technology, and environmental modifications a student requires for participation in the special education program and must be provided by a state-licensed occupational therapist.

(H) ~~**Psychological evaluation and testing.**~~ Psychological evaluation and testing are for the purpose of diagnosing and determining if emotional, behavioral, neurological, or

~~developmental issues are affecting academic performance and for determining recommended treatment protocol. Evaluation/testing for the sole purpose of academic placement (e.g. diagnosis of learning disorders) is not a compensable service. Psychological evaluation and testing must be provided by state-licensed, board-certified psychologist or school psychologist certified by Oklahoma State Department of Education (OSDE).~~ **Evaluation and testing.** Evaluation and testing by psychologists and certified school psychologists are for the purpose of assessing emotional, behavioral, cognitive, or developmental issues that are affecting academic performance and for determining recommended treatment protocol. Evaluation or testing for the sole purpose of academic placement (e.g., diagnosis of learning disorders) is not a compensable service. These evaluations and tests must be provided by a state-licensed, board-certified psychologist or a certified school psychologist certified by the State Department of Education (SDE).

~~(4)(2) Child-guidance treatment encounter.~~ **Child-guidance treatment encounter.** A child-guidance treatment encounter may occur through the provision of individual, family, or group treatment services to children and adolescents who are identified as having specific disorders or delays in development, emotional or behavioral problems, or disorders of speech, language, or hearing. These types of encounters are initiated following the completion of a diagnostic encounter and subsequent development of a treatment plan, or as a result of an ~~Individualized Education Program (IEP)~~ IEP and may include the following:

(A) **Hearing and vision services.** Hearing and vision services may include provision of habilitation activities, such as: auditory training; aural and visual habilitation training; including Braille, and communication management; orientation and mobility; and counseling for vision and hearing losses and disorders. Services must be provided by or under the direct guidance of one (1) of the following individuals practicing within the scope of his or her practice under state law:

(i) ~~state-licensed, Master's Degree Audiologist~~ master's degree audiologist who:

(I) ~~holds~~  Holds a Certificate of Clinical Competence from the ASHA; or

(II) ~~has~~  Has completed the equivalent educational requirements and work experience necessary for the certificate; or

(III) ~~has~~  Has completed the academic program and is acquiring supervised work experience to qualify for the certificate;

(ii) ~~state-licensed~~ State-licensed, ~~Master's Degree Speech-Language Pathologist~~ master's degree speech-language

pathologist who:

(I) ~~holds~~ Holds a Certificate of Clinical Competence from the ASHA; or

(II) ~~has~~ Has completed the equivalent educational requirements and work experience necessary for the certificate; or

(III) ~~has~~ Has completed the academic program and is acquiring supervised work experience to qualify for the certificate; and

~~(iii) state-certified deaf education teacher;~~

~~(iv) (iii) certified~~ Certified orientation and mobility specialists; and

~~(v) state-certified vision impairment teachers.~~

(B) **Speech-language therapy services.** Speech-language therapy services include provisions of speech and language services for the habilitation or prevention of communicative disorders. Speech-language therapy services must be provided by or under the direct guidance and supervision of a state-licensed ~~Speech-Language Pathologist~~speech-language pathologist within the scope of his or her practice under state law who:

(i) ~~holds~~ Holds a Certificate of Clinical Competence from the ASHA; or

(ii) ~~has~~ Has completed the equivalent educational requirements and work experience necessary for the certificate; or

(iii) ~~has~~ Has completed the academic program and is acquiring supervised work experience to qualify for the certificate; or

(C) **Physical therapy services.** Physical therapy services are provided for the purpose of preventing or alleviating movement dysfunction and related functional problems that adversely affect the member's education. Physical therapy services must adhere to guidelines found at OAC 317:30-5-291 and must be provided by or under the direct guidance and supervision of a state-licensed physical therapist; services may also be provided by a ~~Physical Therapy Assistant~~physical therapy assistant who has been authorized by the Board of Examiners working under the supervision of a licensed ~~Physical Therapist~~physical therapist. The licensed ~~Physical Therapist~~physical therapist may not supervise more than ~~three~~ three (3) physical therapy assistants.

(D) **Occupational therapy services.** Occupational therapy may include provision of services to improve, develop, or restore impaired ability to function independently. Occupational therapy services must be provided by or under the direct guidance and supervision of a state-licensed ~~Occupational Therapist~~occupational therapist; services may also be

provided by an ~~Occupational Therapy Assistant~~occupational therapy assistant who has been authorized by the Board of Examiners, working under the supervision of a licensed ~~Occupational Therapist~~occupational therapist.

(E) **Nursing services.** Nursing services may include provision of services to protect the health status of children and adolescents, correct health problems and assist in removing or modifying health-related barriers, and must be provided by a RN or LPN under supervision of a RN. Services include medically necessary procedures rendered at the school site, such as catheterization, suctioning, tube feeding, and administration and monitoring of medication.

(F) **Psychotherapy**Counseling services. ~~Psychotherapy services are the provision of counseling for children and parents. All services must be for the direct benefit of the member. Psychotherapy~~Counseling services must be provided by a state-licensed ~~Social Worker~~social worker, a state-licensed ~~Professional Counselor~~professional counselor, a state-licensed ~~Psychologist~~psychologist or ~~School Psychologist~~certified by the OSDESDE-certified school psychologist, a state-licensed ~~Marriage and Family Therapist~~marriage and family therapist, or a state-licensed ~~Behavioral Practitioner~~behavioral health practitioner, or under Board supervision to be licensed in one (1) of the above-stated areas.

(G) **Assistive technology.** Assistive technology ~~are~~is the provision of services that help to select a device and assist a student with disability(ies) to use an assistive technology device, including coordination with other therapies and training of member and caregiver. Services must be provided by a:

(i) ~~state-licensed, ~~Speech Language Pathologist~~State-licensed speech-language pathologist~~ who:

(I) ~~holds~~Has a Certificate of Clinical Competence from the ASHA; or

(II) ~~has~~Has completed the equivalent educational requirements and work experience necessary for the certificate; or

(III) ~~has~~Has completed the academic program and is acquiring supervised work experience to qualify for the certificate;

(ii) ~~state-licensed ~~Physical Therapist~~State-licensed physical therapist~~; or

(iii) ~~state-licensed ~~Occupational Therapist~~State-licensed occupational therapist~~.

(H) **Personal care.** Provision of personal care services (PCS) allow students with disabilities to safely attend school; ~~includes, but is not limited to, assistance with toileting, oral feeding, positioning, hygiene, and riding the school~~

~~bus, to handle medical or physical emergencies. Services include, but are not limited to: dressing, eating, bathing, assistance with transferring and toileting, positioning, and instrumental activities of daily living such as preparing meals and managing medications. PCS also includes assistance while riding a school bus to handle medical or physical emergencies. Services must be provided by registered paraprofessionals/assistants that have completed training approved or provided by OSDESDE, or Personal Care Assistants, personal care assistants, including LPNs, who have completed on-the-job training specific to their duties. Personal Care services dePCS does not include behavioral monitoring. Paraprofessionals are not allowed to administer medication, nor are they allowed to assist with or provide therapy services to SoonerCare members. Tube feeding of any type may only be reimbursed if provided by a RN or LPN. Catheter insertion and Catheter/Ostomy care may only be reimbursed when done by a RN or LPN. All PCS must be prior authorized.~~

(I) **Therapeutic behavioral services (TBS).** ~~Therapeutic behavioral services are interventions to modify the non-adaptive behavior necessary to improve the student's ability to function in the community as identified on the plan of care. Medical necessity must be identified and documented through assessment and annual evaluations/re-evaluations. Services encompass behavioral management, redirection, and assistance in acquiring, retaining, improving, and generalizing socialization, communication and adaptive skills. Services are goal-directed activities for each client to restore, retain and improve the self-help, socialization, communication, and adaptive skills necessary to reside successfully in home and community-based settings. It also includes problem identification and goal setting, medication support, restoring function, and providing support and redirection when needed. TBS activities are behavioral interventions to complement more intensive behavioral health services and may include the following components: basic living and self-help skills; social skills; communication skills; organization and time management; and transitional living skills. This service must be provided by a Behavioral Health School Aide behavioral health school aide (BHSA) who has a high school diploma or equivalent and has successfully completed the paraprofessional training approved by the OSDE and a training curriculum in behavioral interventions for pervasive developmental disorders as recognized by OHCA.SDE, and in collaboration with the Oklahoma Department of Mental Health and Substance Abuse Services, along with corresponding continuing education. BHSA must be supervised by a bachelor's level individual with a special education certification. BHSA must have CPR and First Aid certification. Six (6) additional~~

hours of related continuing education are required per year.  
~~(J) **Immunization.** Immunizations must be coordinated with the PCP for children and adolescents enrolled in SoonerCare. An administration fee, only, can be paid for immunizations provided by the schools.~~

(c) **Members eligible for Part B of Medicare.** EPSDT school health-related services provided to Medicare eligible members are billed directly to the fiscal agent.

**317:30-5-1024. Periodic screening examination [REVOKED]**

~~At a minimum, referrals to **SoonerCare** providers for periodic screening must be completed and provided in accordance with the periodicity schedule following the initial screening.~~

**317:30-5-1025. Interperiodic screening examination [REVOKED]**

~~Interperiodic screenings must be provided when medically necessary to determine the existence of suspected physical or mental illnesses or conditions. They may include physical, mental or dental conditions. The determination of whether an interperiodic screen is medically necessary may be made by a health, developmental or educational professional who comes into contact with the child outside of the formal health care system. Children enrolled in SoonerCare are referred to their SoonerCare provider for these services. In cases where the SoonerCare provider authorizes the School to perform the screen or fails to schedule an appointment within three weeks and a request has been made and documented by the School, the School may then furnish the EPSDT child health screening and bill it as a fee for services activity. Results of this interperiodic screening are forwarded to the child's SoonerCare provider.~~

**317:30-5-1026. Reporting of suspected child abuse/neglect**

~~Instances of child abuse and/or neglect discovered through screenings and regular examinations are to be reported in accordance with State law. Section 7103 of Title 10 of the Oklahoma Statutes mandates reporting suspected abuse or neglect to the Oklahoma Department of Human Services. Section 7104 of Title 10 of the Oklahoma Statutes further requires reporting of criminally injurious conduct to the nearest law enforcement agency. Instances of child abuse and/or neglect are to be reported in accordance with state law, including, but not limited to, 10A Oklahoma Statute (O.S.) § 1-2-101 and 43A O.S. § 10-104. Any person suspecting child abuse or neglect shall immediately report it to the Oklahoma Department of Human Services (OKDHS) hotline, at 1-800-522-3511; any person suspecting abuse, neglect, or exploitation of a vulnerable adult shall immediately report it to the local DHS County Office, municipal or county law enforcement authorities, or, if the report occurs after normal business hours, the OKDHS hotline. Health care professionals who are requested to report~~

incidents of domestic abuse by adult victims with legal capacity shall promptly make a report to the nearest law enforcement agency, per 22 O.S. § 58.

### **317:30-5-1027. Billing**

~~(a) Each service has a specified unit of service (unit) for billing purposes which represents the actual time spent providing a direct service. Direct service must be face-to face with the child. There is no reimbursement for time reviewing/completing paperwork and/or documentation related to the service or for staff travel to/from the site of service, unless otherwise specified.~~

~~(1) Most units of service are time-based, meaning that the service must be of a minimum duration in order to be billed. A unit of service that is time-based is continuous minutes; the time cannot be aggregated throughout the day.~~

~~(2) There are no minimum time requirements for evaluation services, for which the unit of service is generally a completed evaluation. The only exception is the Psychological Evaluationevaluation and testing (OAC 317:30-5-1023(b)(1)(H), which is billed in hourly increments.~~

~~(b) The following units of service are billed on the appropriate claim form:~~

~~(1) Service: Child Health Screening; Unit: Completed comprehensive screening.~~

~~(2) Service: Interperiodic Child Health Screening; Unit: Completed interperiodic screening.~~

~~(3) Service: Child Health Encounter; Unit: per encounter; limited to 3 encounters per day.~~

~~(4) Service: Individual Treatment Encounter; Unit: 15 minutes, unless otherwise specified.~~

~~(A) Hearing and Vision Services.~~

~~(B) Speech Language Therapy; Unit: per session, limited to one per day.~~

~~(C) Physical Therapy.~~

~~(D) Occupational Therapy.~~

~~(E) Nursing Services; Unit: up to 15 minutes; maximum 32 units per day.~~

~~(F) Psychotherapy Services; maximum 8 units per day.~~

~~(G) Assistive Technology.~~

~~(H) Therapeutic Behavioral Services.~~

~~(5) Service: Group Treatment Encounter; no more than 5 members per group, Unit: 15 minutes, unless otherwise specified. A daily log/list must be maintained and must identify the SoonerCare participants for each group therapy session.~~

~~(A) Hearing and Vision Services.~~

~~(B) Speech Language Therapy; Unit: per session, limited to one per day.~~

~~(C) Physical Therapy.~~

~~(D) Occupational Therapy.~~

~~(E) Psychotherapy Services; maximum 8 units per day.~~

- ~~(6) Service: Administration only, Immunization; Unit: one administration.~~
- ~~(7) Service: Hearing Evaluation; Unit: Completed Evaluation.~~
- ~~(8) Service: Hearing Aid Evaluation; Unit: Completed Evaluation.~~
- ~~(9) Service: Audiometric Test (Impedance); Unit: Completed Test (Both Ears).~~
- ~~(10) Service: Tympanometry and acoustic reflexes.~~
- ~~(11) Service: Ear Impression Mold; Unit: 2 molds (one per ear).~~
- ~~(12) Service: Vision Screening; Unit: one examination, by state licensed O.D., M.D., or D.O.~~
- ~~(13) Service: Speech Language Evaluation; Unit: one evaluation.~~
- ~~(14) Service: Physical Therapy Evaluation; Unit: one evaluation.~~
- ~~(15) Service: Occupational Therapy Evaluation; Unit: one evaluation.~~
- ~~(16) Service: Psychological Evaluation and Testing; Unit: one hour.~~
- ~~(17) Service: Personal Care Services; Unit: 10 minutes, 32 units daily.~~
- ~~(18) Service: Nursing Assessment/Evaluation (Acute episodic care); Unit: one assessment/evaluation, 18 yearly.~~
- ~~(19) Service: Psychological Evaluation and Testing; Unit: per hour of psychologist time, 8 hours yearly.~~

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

**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**

**PART 79. DENTISTS**

**317:30-5-695. Eligible dental providers and definitions**

- (a) Eligible dental providers in Oklahoma's SoonerCare program are:
- (1) ~~individuals~~Individuals licensed as dentists under Title 59 of Oklahoma Statutes (O.S.), Sections (§§) 328.21, 328.22, and 328.23 (licensed dentists, specialty dentists and out of state dentists);
  - (2) ~~individuals~~Individuals issued permits as dental interns under 59 O.S. § 328.26;
  - (3) ~~individuals~~Individuals who are third and fourth year dental students at an accredited Oklahoma dental college; and
  - (4) ~~any~~Any individual issued a license in another state as a dentist.
- (b) All eligible providers must be in good standing with regard to their license. Any revocation or suspension status of a provider referenced in subsection (a) above renders the provider ineligible for payment or subject to recoupment under SoonerCare.
- (c) Eligible providers must document and sign records of services rendered in accordance with guidelines found at Oklahoma Administrative Code (OAC) 317:30-3-15.
- (d) The American Dental Association's version of Code on Dental Procedures and Nomenclature (CDT) is used by the Oklahoma Health Care Authority (OHCA) to communicate information related to codes, and procedures for administration. Definitions, nomenclature, and descriptors as listed in the CDT will apply, with the exception of more specific definitions or limitations set forth.
- (1) **"Decay"** means carious lesions in a tooth; decomposition and/or dissolution of the calcified and organic components of the tooth structure.
  - ~~(2) **"Emergency Dental Care"** means, but is not limited to, the immediate service that must be provided to relieve the member from pain due to an acute infection, swelling, trismus or trauma.~~
  - ~~(3) **"Emergency Extraction"** means, but is not limited to, an extraction of a tooth due to presence of pathology, trauma, severe periodontal involvement, significant caries or to relieve pain or infection.~~
  - (2) **"Medically necessary oral healthcare"** means treatment deemed necessary by a physician or dentist when a patient's medical condition or treatment is or will be likely complicated by an untreated oral health problem.
  - (3) **"Medically necessary extractions"** means, but is not limited to, an extraction of a tooth that has met medically necessity

criteria due to the presence of pathology, trauma, severe periodontal involvement, significant caries, pain or infection.

(4) **"Images"** means radiographs and diagnostic imaging that are part of the clinical record. Images should only be taken for clinical reasons as determined by the dentist and must be of diagnostic quality, properly identified, and dated.

(5) **"Palliative Treatment" treatment** means action that relieves pain but is not curative. Palliative ~~Treatment~~treatment is an all-inclusive service. No other codes are reimbursable on the same date of service.

(6) **"Radiographic Caries" caries** means dissolution of the calcified and organic components of tooth tissue that has penetrated the enamel and is approaching the dentinoenamel junction.

(7) **"Unbundling"** means billing separately for several individual procedures that are included within one (1) CDT or Current Procedural Terminology (CPT) code.

(8) **"Upcoding"** means reporting a more complex and/or higher cost procedure than actually performed.

### **317:30-5-696. Coverage by category**

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

#### (1) **Adults.**

(A) Dental coverage for adults is limited to:

(i) ~~Emergency~~Medically necessary extractions, as defined in Oklahoma Administrative Code (OAC) 317:30-5-695. Tooth extraction must have medical need documented;

(ii) ~~limited~~Limited oral examinations and medically necessary images, as defined in OAC 317:30-5-695, associated with the ~~emergency~~ extraction or with a clinical presentation with reasonable expectation that an ~~emergency~~ extraction will be needed;

(iii) Smoking and ~~Tobacco Use Cessation Counseling~~tobacco use cessation counseling; and

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

(B) Payment is made for dental care for adults residing in private ~~Intermediate Care Facilities for Individuals with Intellectual Disabilities~~intermediate care facilities for individuals with intellectual disabilities (ICF/IID) and who have been approved for ICF/IID level of care, similar to the scope of services available to individuals under age twenty-one (21).

(C) Limited dental services are available for members who meet all medical criteria, but need dental clearance to obtain organ transplant approval. Providers must obtain prior

authorization before delivery of dental service, with the exception of evaluation and extractions. All requests must be filed on the currently approved American Dental Association (ADA) form and must include diagnostic images, six-point periodontal charting, narratives and comprehensive treatment plans. The ~~OHCA~~Oklahoma Health Care Authority (OHCA) will notify the provider of determination using OHCA Prior Authorization Request Decision form. Prior authorized services must be billed exactly as they appear on the prior authorization request. The following dental services are available:

- (i) ~~comprehensive~~Comprehensive oral evaluation~~;~~;
- (ii) ~~two image bitewings~~Two (2) bitewing images;
- (iii) ~~prophylaxis~~Prophylaxis~~;~~;
- (iv) ~~fluoride~~Fluoride application~~;~~;
- (v) ~~limited~~Limited restorative procedures~~;~~; and
- (vi) ~~periodontal~~Periodontal scaling/root planing.

(2) **Home and community-based services (HCBS) waiver for the intellectually disabled.** All providers participating in the HCBS must have a separate contract with the OHCA to provide services under the HCBS. Dental services are defined in each waiver and must be prior authorized.

(3) **Children.** The OHCA Dental Program provides the basic medically necessary treatment. The services listed below are compensable for members under twenty-one (21) years of age without prior authorization. All other dental services must be prior authorized. Anesthesia services are covered for children in the same manner as adults. All providers performing preventive services must be available to perform needed restorative services for those members receiving any evaluation and preventive services.

(A) **Comprehensive oral evaluation.** This procedure should precede any images, and chart documentation must include image interpretations, caries risk assessment and both medical and dental health history of member. The comprehensive treatment plan should be the final ~~results~~result of this procedure.

(B) **Periodic oral evaluation.** This procedure may be provided for a member of record ~~if not seen by the dentist for more than~~once every six (6) months. An examination should precede any images, and chart documentation must include image interpretations, caries risk assessment, and both medical and dental health history of member. The comprehensive treatment plan should be the final ~~results~~result of this procedure.

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

(D) **Images.** To be SoonerCare compensable, images must be of diagnostic quality and medically necessary. A clinical examination must precede any images, and chart documentation must include member history, prior images, caries risk assessment, and both dental and general health needs of the member. The referring dentist is responsible for providing properly identified images of acceptable quality with a referral, if that provider chooses to expose and submit for reimbursement prior to referral. Periapical images must include at least three (3) millimeters beyond the apex of the tooth being imaged. Panoramic films and two (2) bitewings are considered full mouth images. Full mouth images as noted above or traditional ~~(minimum of twelve (12) periapical films and two (2) posterior bitewings)~~ [minimum of twelve (12) periapical films and two (2) posterior bitewings] are allowable once in a three (3) year period and must be of diagnostic quality. Individually listed intraoral images by the same dentist/dental office are considered a complete series if the number of individual images equals or exceeds the traditional number for a complete series. Panoramic films are only compensable when chart documentation clearly indicates reasons for the exposure based on clinical findings. This type of exposure is not to rule out or evaluate caries. Prior authorization and a detailed medical need narrative are required for additional panoramic films taken within three (3) years of the original set.

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

(F) **Interim caries arresting medicament application.** This service is available for primary and permanent teeth once every one hundred eighty-four (184) days for two (2) occurrences per tooth in a lifetime. The following criteria must be met for reimbursement:

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

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

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

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

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

~~(F)~~ (G) Dental prophylaxis. This procedure is provided once every ~~184~~ one hundred eighty-four (184) days along with topical application of fluoride.

~~(G)~~ (H) Stainless steel crowns for primary teeth. The use of any stainless steel crowns is allowed as follows:

(i) Stainless steel crowns are allowed if:

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

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

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

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

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

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

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

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

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

~~(H)~~ (I) Stainless steel crowns for permanent teeth. The use of any stainless steel crowns is allowed as follows:

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

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

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

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

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

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

~~(I)~~ (J) Pulpotomies and pulpectomies.

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

- (I) Primary molars having at least ~~70~~seventy percent (70%) or more of their root structure remaining or more than twelve (12) months prior to normal exfoliation;
- (II) Tooth numbers O and P before age five (5) years;
- (III) Tooth numbers E and F before six (6) years;
- (IV) Tooth numbers N and Q before five (5) years;
- (V) Tooth numbers D and G before five (5) years.

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

~~(J)~~ (K) **Endodontics.** Payment is made for the services provided in accordance with the following:

(i) This procedure is allowed when there are no other missing anterior teeth in the same arch requiring replacement.

(ii) The provider documents history of member's improved oral hygiene and flossing ability in records.

(iii) Prior authorization is required for members who have a treatment plan requiring more than two (2) anterior and/or ~~two~~ (2) any posterior root canals.

(iv) Pre and post-operative periapical images must be available for review.

(v) Pulpal debridement may be performed for the relief of pain while waiting for the decision from the OHCA.

(vi) Providers are responsible for any follow-up treatment required due to a failed root canal therapy for twenty-four (24) month post completion.

(vii) Endodontically treated teeth should be restored to limited occlusal function and all contours should be replaced. These teeth are not automatically approved for any type of crown.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(M)~~ (N) **Pulp caps.** Indirect and direct pulp cap must be ADA accepted calcium hydroxide or ~~Mineral Trioxide~~ Aggregatemineral trioxide aggregate (MTA) materials, not a

cavity liner or chemical used for dentinal hypersensitivity. Indirect and direct pulp cap codes require specific narrative support addressing materials used, intent and reasons for use. Application of chemicals used for dentinal hypersensitivity is not allowed as indirect pulp cap. Utilization of these codes is verified by post payment review.

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

~~(O)~~ (P) **Smoking and Tobacco Use Cessation Counseling**~~tobacco use cessation counseling~~. Smoking and ~~Tobacco Use Cessation Counseling~~tobacco use cessation counseling is covered when performed utilizing the five (5) intervention steps of asking the member to describe his/her smoking, advising the member to quit, assessing the willingness of the member to quit, assisting with referrals and plans to quit, and arranging for follow-up. Up to eight (8) sessions are covered per year per individual who has documented tobacco use. It is a covered service when provided by physicians, physician assistants, nurse practitioners, certified nurse midwives, ~~Oklahoma State Health Department and FQHC nursing, and Maternal/Child Health Licensed Clinical Social Workers with a certification as a Tobacco Treatment Specialist Certification (CTTS)~~ staff in addition to other appropriate services rendered Oklahoma State Health Department (OSDH) and Federally Qualified Health Center (FQHC) nurses, and maternal/child health licensed clinical social workers with a Tobacco Treatment Specialist Certification (TTS-C). Chart documentation must include a separate note that addresses the 5A's, separate signature, and the member specific information addressed in the five (5) steps and the time spent by the practitioner performing the counseling. Anything under three (3) minutes is considered part of a routine visit.

~~(P)~~ (Q) **Diagnostic casts and/or oral/facial images.** Diagnostic casts ~~and/or oral/facial images~~ may be requested by OHCA or representatives of OHCA. If cast ~~and/or~~ images are received they will be considered supporting documentation and may be used to make a determination for authorization of services. Submitted documentation used to base a decision will not be returned. Providers will be reimbursed for either the study model or images.

- (i) Documentation of photographic images must be kept in the client's medical record and medical necessity identified on the submitted electronic or paper claim.

(ii) Oral/facial photographic images are allowed under the following conditions:

(I) When radiographic images do not adequately support the necessity for requested treatment.

(II) When photo images better support medical necessity for the requested treatment rather than diagnostic models.

(III) If a comprehensive orthodontic workup has not been performed.

(iii) For photographic images, the oral/facial portfolio must include a view of the complete lower arch, complete upper arch, and left and right maximum intercuspation of teeth.

(I) Maximum intercuspation refers to the occlusal position of the mandible in which the cusps of the teeth of both arches fully interpose themselves with the cusps of the teeth of the opposing arch.

(II) Intercuspation defines both the anterior-posterior and lateral relationships of the mandible and the maxilla, as well as the superior-inferior relationship known as the vertical dimension of occlusion.

(iv) Study models or photographic images not in compliance with the above described diagnostic guidelines will not be compensable. The provider may be allowed to resubmit new images that adhere to the diagnostic guidelines. If the provider does not provide appropriate documentation, the request for treatment will be denied.

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

(a) Providers must have prior authorization for certain specified services before delivery of that service, unless the service is provided on an emergency basis [See ~~OAC~~Oklahoma Administrative Code (OAC) 317:30-5-695(d)(2)]. Requests for dental services requiring prior authorization must be accompanied by sufficient documentation. ~~Images with an indication of the left side of member, six point periodontal charting and copy of the comprehensive treatment plans are required.~~

(b) Requests for prior authorization are filed on the currently approved ~~ADA~~American Dental Association (ADA) form. ~~OHCA notifies the provider on the determination of prior authorization using OHCA Prior Authorization Request Decision form.~~ Prior authorized services must be billed exactly as they appear on the prior authorization. Payment is not made for any services provided prior to receiving authorization except for the relief of pain.

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

(d) Listed below are examples of services requiring prior authorization for members under ~~21~~twenty-one (21) and eligible ~~ICF/ID~~intermediate care facilities for individuals with

intellectual disabilities (ICF/IID) residents. Minimum required records to be submitted with each request are right and left mounted bitewings and periapical films or images of tooth/teeth involved or the edentulous areas if not visible in the bitewings. Images ~~must be submitted with film mounts and each film or print~~ must be of diagnostic quality. Images must be identified by the tooth number and include date of exposure, member name, member ID, provider name, and provider ID. All images, regardless of the media, must be submitted together with a completed and signed comprehensive treatment plan that details all needed treatment at the time of examination, and a completed current ADA form requesting all treatments requiring prior authorization. The images, digital media, photographs, or printouts must be of sufficient quality to clearly demonstrate for the reviewer, the pathology which is the basis for the authorization request. If radiographs are not taken, provider must include in narrative sufficient information to confirm diagnosis and treatment plan.

(1) **Endodontics.** Root canal therapy is not considered an emergency procedure unless due to trauma to an anterior tooth. The provider must document the member's oral hygiene and flossing ability in the member's records. Pulpal debridement may be performed for the relief of pain while waiting for the decision from the ~~OHCA~~ Oklahoma Health Care Authority (OHCA) on request for endodontics.

(A) **Anterior endodontics.** Prior authorization is required for members who have a treatment plan requiring more than two (2) anterior root canals. All rampant, active caries ~~must~~ should be removed prior to requesting anterior endodontics. Payment is made for services provided in accordance with the following:

- (i) Permanent teeth only~~;~~;
- (ii) Accepted ADA materials must be used~~;~~;
- (iii) Pre and post-operative periapical images must be available for review~~;~~;
- (iv) Providers are responsible for any follow-up treatment required by a failed endodontically treated tooth within ~~24~~ twenty-four (24) months post completion~~;~~;
- (v) A tooth will not be approved if it appears there is not adequate natural tooth structure remaining to establish good tooth/restorative margins or if crown to root ratio is poor~~;~~ and
- (vi) An endodontic procedure may not be approved if the tooth requires a post and core to retain a crown.

(B) **Posterior endodontics.** The guidelines for this procedure are as follows:

- (i) The provider must document the member's oral hygiene and flossing ability in the member's records.
- (ii) Teeth that require pre-fabricated post and cores to retain a restoration due to lack of natural tooth

structure should not be treatment planned for root canal therapy.

(iii) Pre and post-operative periapical images must be available for review.

(iv) Providers are responsible for any follow-up treatment required by a failed endodontically treated tooth within ~~24~~twenty-four (24) months post completion.

(v) A tooth will not be approved if it appears there is not adequate natural tooth structure remaining to establish good tooth/restorative margins or if there is a poor crown to root ratio or weakened root furcation area. Approval of second molars is contingent upon proof of medical necessity.

(vi) Only ADA accepted materials are acceptable under the OHCA policy.

(vii) Posterior endodontic procedure may not be approved if the tooth requires a post and core in order to present adequate structure to retain a crown.

(viii) Endodontics will not be considered if:

(I) ~~an~~An opposing tooth has super erupted;

(II) ~~loss~~Loss of tooth space is one third or greater;

(III) ~~opposing~~Opposing second molars are involved unless prior authorized; ~~or~~

(IV) ~~the~~The member has multiple teeth failing due to previous inadequate root canal therapy or follow-up; or

(V) ~~all~~All rampant, active caries must be removed prior to requesting posterior endodontics.

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

(2) **Crowns for permanent teeth.** Crowns are compensable for restoration of natural teeth for members who are ~~16~~sixteen (16) years of age or older and adults residing in private ~~Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)~~ICF/IID and who have been approved for ~~(ICF/IID)~~ICF/IID level of care. Certain criteria and limitations apply.

(A) The following conditions must exist for approval of this procedure ~~:-~~:

(i) All rampant, active caries must be removed prior to requesting any type of crown ~~:-~~;

(ii) The tooth must be decayed to such an extent to prevent proper cuspal or incisal function ~~:-~~;

(iii) The clinical crown is fractured or destroyed by one-half or more ~~:-~~; and

(iv) Endodontically treated teeth must have ~~three~~three (3) or more surfaces restored or lost due to carious activity

to be considered for a crown.

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

(C) Routine build-up(s) for authorized crowns are included in the fee for the crown. Non authorized restorative codes may be used if available.

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

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

(F) The provider must document the member's oral hygiene and flossing ability in the member's records.

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

(3) **Cast frame partial dentures.** This appliance is the treatment of choice for replacement of missing anterior permanent teeth or two (2) or more missing posterior teeth in the same arch for members ~~16~~ sixteen (16) through ~~20~~ twenty (20) years of age. Provider must indicate which teeth will be replaced. Members must have improved oral hygiene documented for at least ~~12~~ twelve (12) months in the provider's records and submitted with prior authorization request to be considered. Provider is responsible for any needed follow up for a period of two (2) years post insertion.

(4) **Acrylic partial.** This appliance is the treatment of choice for replacement of three (3) or more missing teeth in the same arch for members ~~12~~ twelve (12) through ~~16~~ sixteen (16) years of age. Provider must indicate tooth numbers to be replaced. This appliance includes all necessary clasps and rests.

(5) **Occlusal guard.** Narrative of medical necessity must be sent with prior authorization. Model should not be made or sent unless requested.

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

(7) **Periodontal scaling and root planing.** Procedure is designed for the removal of calculus or tissue that is contaminated and ~~requires~~may require anesthesia and some soft tissue removal. This procedure requires that each tooth have three (3) or more of the six point measurements five (5) millimeters or greater, ~~or~~and have multiple areas of image supported bone loss, subgingival calculus and must involve two (2) or more teeth per quadrant for consideration. This procedure is not allowed on members under the age ~~12~~twelve (12). This procedure is not allowed in conjunction with any other periodontal surgery.

### **317:30-5-700. Orthodontic services**

(a) In order to be eligible for SoonerCare ~~Orthodontic~~orthodontic services, members must be referred through a primary care dentist using the DEN-2 form found on the Oklahoma Health Care Authority (OHCA) website; a member can receive a referral from a primary care dentist to the orthodontist only after meeting the following:

- (1) ~~the~~The member has had a caries free initial visit; or
- (2) ~~has~~Has all decayed areas restored and has remained caries free for twelve 12 months; and
- (3) ~~has~~Has demonstrated competency in maintaining an appropriate level of oral hygiene.

(b) Member with cleft palate can be referred directly by their treating physician without a dental referral and are exempt from above requirements.

(c) The ~~Oklahoma~~-SoonerCare Orthodontic Program limits orthodontic services to handicapping malocclusions determined to be severe enough to warrant medically necessary treatment. The orthodontic provider has the ability to determine if members may qualify with a visual screening. Diagnostic record accumulation and/or submission should only occur for members with high potential for acceptance. These orthodontic services include the following:

- (1) ~~a~~A handicapping malocclusion, as measured on the ~~Handicapping Labio-Lingual Deviation Index (HLD)~~Oklahoma Health Care Authority (OHCA) Handicapping Labio-Lingual Deviation Index of Malocclusion (DEN-6) form, with a minimum score of ~~30~~thirty (30);
- (2) ~~any~~Any classification secondary to cleft palate or other maxillofacial deformity;
- (3) ~~if~~If a single tooth or anterior crossbite is the only medical need finding, service will be limited to interceptive treatment;
- (4) ~~fixed~~Fixed appliances only; and
- (5) ~~permanent~~Permanent dentition with the exception of cleft defects.

(d) Reimbursement for ~~Orthodontic~~orthodontic services is limited to:

- (1) Orthodontists, or
- (2) General or Pediatric dental practitioners who have completed at least ~~200~~two-hundred (200) certified hours of continuing

education in the field of orthodontics practice and submit for review at least ~~25~~twenty-five successfully completed comprehensive cases. Of these ~~25~~twenty-five comprehensive cases, ten or more must be extraction cases. An applicant for this certification must practice in an OHCA deemed under-served area. The comprehensive cases submitted should be of a complexity consistent with type of handicapping malocclusion likely to be treated in the SoonerCare program.

(A) Cases submitted must include at least one (1) of each of the following types:

- (i) ~~deep~~Deep overbite where multiple teeth are impinging upon the soft tissue of the palate;
- (ii) ~~impacted~~Impacted canine or molar requiring surgical exposure;
- (iii) ~~bilateral~~Bilateral posterior crossbite requiring fixed rapid palatal expansion; and
- (iv) ~~skeletal~~Skeletal class II or III requiring orthognathic surgery.

(B) As with all dental or orthodontia treatment performed and reimbursed by SoonerCare, all pre and post orthodontic records must be available for review.

(C) The OHCA requires all general dentists providing comprehensive orthodontic care to submit a copy of the Oklahoma Board of Dentistry continuing education report and verification that at least ~~20~~twenty (20) continuing education hours in the field of orthodontics has been completed per reporting period. All verification reports must be submitted to OHCA Dental ~~unit~~Unit every three (3) years, no later than August 30. In addition, verification of adequate progress for all active orthodontic cases will be reviewed by the OHCA Dental Unit upon completion of ~~24~~twenty-four (24) months of therapy.

(e) The following limitations apply to orthodontic services:

(1) Cosmetic orthodontic services are not a covered benefit of the SoonerCare ~~Program~~program and no requests should be submitted;

(2) All orthodontic procedures require prior authorization for payment;

(3) Prior authorization for orthodontic treatment is not a notification of the member's eligibility and does not guarantee payment. Payment for authorized services depends on the member's eligibility at the beginning of each treatment year. Treatment year is determined by date of banding; and

(4) The member must be SoonerCare-eligible and under ~~18~~eighteen (18) years of age at the time the request for prior authorization for treatment is received by the OHCA. Services cannot be added or approved after eligibility has expired. It is the orthodontist's responsibility to verify that the member has current SoonerCare eligibility and the date of birth indicates the member is under age ~~18~~eighteen (18).

(f) Orthodontic services are an elective procedure. The orthodontist must interview the prospective member as to his/her understanding of and willingness to cooperate fully in a lengthy treatment program.

(g) The interview information is unavailable to OHCA except through the provider's recommendation of treatment. The interview process for OHCA members is equivalent to that of private pay patients.

(h) Providers are not obligated to accept a member when it appears that the member will not cooperate in the orthodontic hygiene treatment program, does not return to the general dentist for preventive visits or is not willing to keep eligibility for SoonerCare current.

### **317:30-5-700.1. Orthodontic prior authorization**

(a) The following records and documentation, plainly labeled with the member's full name, recipient identification number (RID), and the orthodontist's name are required for prior authorization of orthodontic services and must be submitted to the Dental Unit of the ~~OHCA~~Oklahoma Health Care Authority (OHCA) Dental Program when the member has a total score of not less than ~~30~~thirty (30) points or meets other eligibility criteria in paragraph (d).

(1) Completed currently approved ~~ADA~~American Dental Association (ADA) dental claim form;

(2) Complete and scored Handicapping Labio-Lingual Deviations~~Deviation~~ (HDL) Index with Diagnosis of Angle's classification;

(3) Detailed description of any oral maxillofacial anomaly;

(4) Estimated length of treatment;

(5) Intraoral photographs showing teeth in centric occlusion and/or photographs of trimmed anatomically occluded diagnostic casts. A lingual view of casts may be included to verify impinging overbites;

(6) Cephalometric images with tracing, and panoramic film, with a request for prior authorization of comprehensive orthodontic treatment;

(7) Completed OHCA caries risk assessment form;

~~(7)~~(8) If diagnosed as a surgical case, submit an oral surgeon's written opinion that orthognathic surgery is indicated and the surgeon is willing to provide this service; and

~~(8)~~(9) Additional pertinent information as determined necessary by the orthodontist or as requested by the OHCA.

(b) All images and required documentation must be submitted in one (1) package. OHCA is not responsible for lost or damaged materials.

(c) All records and documentation submitted in a request for prior authorization for orthodontic treatment are reviewed by the OHCA ~~Orthodontic Consultant~~orthodontic consultant for compensability and length of treatment. Any documentation on which a decision is made will not be returned.

(d) Some children not receiving a minimum score of ~~30~~thirty (30) on the ~~Handicapping Labio-Lingual Deviation Index (HLD)~~HDL Index may

have other conditions to be considered. In the event an orthodontist believes there are other medical, social, or emotional conditions impacting the general health of the child, he/she refers to the conditions listed on the Early and Periodic Screening, ~~Diagnosis~~Diagnostic and Treatment (EPSDT) exception section found on the HLD. The following guidelines and restrictions apply to other conditions:

(1) Other medical, social, or emotional conditions are limited to those conditions that affect the medical, social or emotional function of the child-;

(2) Other medical, social, or emotional conditions are not scored if the sole condition sought to be improved is the cosmetic appearance of the child-;

(3) Such other medical, social, or emotional conditions must be demonstrated by objective evidence such as supported documentation outside the child's immediate family (e.g., a child's teacher, primary care physician, behavioral health provider, school counselor)-;

(4) Objective evidence must be submitted with the HLD-;

(5) When such other medical, social, or emotional conditions are reflected on the HLD, the OHCA ~~Orthodontic Consultant~~orthodontic consultant must review the data and use his or her professional judgment to score the value of the conditions-; and

(6) The OHCA ~~Orthodontic Consultant~~orthodontic consultant may consult with and utilize the opinion of the orthodontist who completes the form.

(e) If it is determined that the malocclusion is not severe enough to warrant medically necessary orthodontic services or the member's age precludes approval, a computer generated notice is issued to the provider and member with notice of the denial, the reason for the denial, and appeal rights ~~(see OAC 317:2-1 for grievance procedures and process)~~[see Oklahoma Administrative Code (OAC) 317:2-1 for grievance procedures and processes].

(f) Orthodontic treatment and payment for the services are approved within the scope of the SoonerCare program. If orthodontic treatment is approved, a computer generated notice is issued authorizing the first year of treatment.

(1) Approval of orthodontic treatment is given in accordance with the following:

(A) Authorization for the first year begins on the date of banding and includes the placement of appliances, arch wires, and a minimum of six (6) adjustments. It is expected that orthodontic members be seen every four (4) to eight (8) weeks for the duration of active treatment.

(B) Subsequent adjustments will be authorized in one (1) year intervals and the treating orthodontist must provide a comprehensive progress report at the ~~24~~twenty-four (24) month interval.

(C) All approved treatment is included on the original prior authorization and will include the total payment for that

treatment year.

(2) Claim and payment are made as follows:

(A) Payment for comprehensive treatment includes the banding, wires, adjustments as well as all ancillary services, including the removal of appliances, and the construction and placing of retainers.

(B) Payment is not made for comprehensive treatment beyond ~~36~~thirty-six (36) months.

(g) If the member moves from the geographic area or shows a need to change their provider, then the provider who received the yearly payment is financially responsible until completion of that member's orthodontic treatment for the current year.

(h) If the provider who received yearly payment does not agree to be financially responsible, then the ~~Oklahoma Health Care Authority~~ OHCA may recoup funds paid for the member's orthodontic treatment.

(i) All orthodontic services are subject to post-utilization review. This review may include a request by the OHCA to submit medical documentation necessary to complete the review. After review is completed, these materials are returned to the orthodontist.

(j) Study models or oral/facial images must be diagnostic and meet the following requirements:

(1) Study models must be properly poured and adequately trimmed without large voids or positive bubbles present.

(2) Centric occlusion must be clearly indicated by pencil lines on the study models, making it possible to occlude the teeth on the models in centric occlusion.

(3) 3-D model images are preferred.

(4) All measurements are made or judged on the basis of greater than or more than the minimal criteria. Measurement, counting, recording, or consideration is performed only on teeth that have erupted and may be seen on the study models.

(5) For photographic images, the oral/facial portfolio must show a view of the complete lower arch, complete upper arch, and left and right maximum intercuspation of teeth.

(A) Maximum intercuspation refers to the occlusal position of the mandible in which the cusps of the teeth of both arches fully interpose themselves with the cusps of the teeth of the opposing arch.

(B) Intercuspation defines both the anterior-posterior and lateral relationships of the mandible and the maxilla, as well as the superior-inferior relationship known as the vertical dimension of occlusion.

### **317:30-5-704. Billing instructions**

(a) **HCPCS Codes.** The Oklahoma Health Care Authority (OHCA) utilizes the Medicare Level II ~~HCPCS Codes~~ Healthcare Common

Procedure Coding System (HCPCS) codes. All claim submissions must be in compliance with this coding system.

(b) **Prior authorization.** Where applicable, the appropriate arch, quadrant, or tooth surface and tooth number must be included on the claim. Diagnosis codes are requested to be listed in box 34 of ~~ADA~~ the current American Dental Association (ADA) dental claim form 2012. For mailed prior authorizations, a completed HCA-13D form is required.

(c) **Images.** Any type of film or prints submitted will not be returned. All images must be dated, mounted and have patient's name, recipient identification number (RID), provider name and provider number.

### **317:30-5-705. Billing**

Billing for dental services may be submitted on the currently approved version of the American Dental Association (ADA) claim form. Diagnosis codes are requested to be listed in box 34 of the current ADA dental claim form-2012. Electronic submission must be made on the HIPPA compliant Form 837D.

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

**SUBCHAPTER 3. GENERAL PROVIDER POLICIES**

**PART 1. GENERAL SCOPE AND ADMINISTRATION**

**317:30-3-31. Prior authorization for health care-related goods and services**

(a) Under the ~~Oklahoma~~ SoonerCare program, there are health care-related goods and services that require prior authorization (PA) by the Oklahoma Health Care Authority (OHCA). PA is a process to determine if a prescribed good or service is medically necessary; it is not, however, a guarantee of member eligibility or of SoonerCare payment. All goods or services requiring PA will be authorized on the basis of information submitted to OHCA, including:

(1) ~~the~~The relevant code, as is appropriate for the good or service requested (for example, Current Procedural Terminology (CPT) codes for services; Healthcare Common Procedure Coding System (HCPCS) codes, for durable medical equipment; or National Drug Codes (NDC), for drugs); and/or

(2) ~~any~~Any other information required by OHCA, in the format as prescribed. The OHCA authorization file will reflect the codes that have been authorized.

(b) The OHCA staff will issue a determination for each requested good or service requiring a PA. The provider will be advised of that determination, either through the provider portal, or for requests made for out-of-state services, meals, mileage, transportation and lodging, by letter or other written communication. The member will be advised by letter. Policy regarding member appeal of a denied PA is available at Oklahoma Administrative Code (OAC) 317:2-1-2.

(c) The following is an inexhaustive list of the goods and services that may require a PA, for at least some SoonerCare member populations, under some circumstances. This list is subject to change, with OHCA expressly reserving the right to add a PA requirement to a covered good or service or to remove a PA requirement from a covered good or service.

- (1) Physical therapy for children;
- (2) Speech therapy for children;
- (3) Occupational therapy for children;
- (4) High Tech Imaging (for ex. CT, MRA, MRI, PET);
- (5) Some dental procedures, including, but not limited to orthodontics (orthodontics are covered for children only);
- (6) Inpatient psychiatric services;
- (7) Some prescription drugs ~~and/or~~, physician administered, and/or high-investment drugs;
- (8) Ventilators;

- (9) Hearing aids (covered for children only);
  - (10) Prosthetics;
  - (11) High risk ~~Ob~~Obstetrical (OB) services;
  - (12) Drug testing;
  - (13) Enteral therapy (covered for children only);
  - (14) Hyperalimentation;
  - (15) Early and Periodic Screening, ~~Diagnosis~~Diagnostic and Treatment (EPSDT) services, supplies, or equipment that are determined to be medically necessary for a child or adolescent, and which are included within the categories of mandatory and optional services in Section 1905(a) of Title XIX, regardless of whether such services, supplies, or equipment are listed as covered in ~~Oklahoma's~~the Oklahoma Medicaid State Plan;
  - (16) Adaptive equipment for persons residing in private ~~Intermediate Care Facilities for Individuals with Intellectual Disabilities~~intermediate care facilities for individuals with intellectual disabilities (ICF/IID);
  - (17) Some ancillary services provided in a ~~long term~~long-term care hospital or in a long term care facility;
  - (18) Rental of hospital beds, support surfaces, oxygen and oxygen related products, continuous positive airway pressure devices (CPAP and BiPAP), pneumatic compression devices, and lifts;
  - (19) Allergy testing and immunotherapy;
  - (20) Bariatric surgery;
  - (21) Genetic testing;
  - (22) Out-of-state services; and
  - (23) Meals, travel, and lodging.
- (d) ~~Providers should refer to the relevant Part of OAC 317:30-5 for additional, provider specific guidance on PA requirements. Providers may also refer to the OHCA Provider Billing and Procedure Manual, available on OHCA's website, and the SoonerCare Medical Necessity Criteria for Inpatient Behavioral Health Services Manual to see how and/or where to submit PA requests, as well as to find information about documentation. Providers should refer to the provider-specific Part for PA requirements. For additional PA information and submission requests, providers may refer to the OHCA Provider Billing and Procedure Manual and the SoonerCare Medical Necessity Criteria for Inpatient Behavioral Health Services Manual available at <https://okhca.org>.~~

## SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

### PART 3. HOSPITALS

#### **317:30-5-42.20. High-investment drugs - outpatient hospitals**

(a) The Oklahoma Health Care Authority (OHCA) designates certain high-investment drugs to be reimbursed separately pursuant to the Oklahoma Medicaid State Plan for members receiving services at an

outpatient hospital.

(b) The list of OHCA-designated high-investment drugs is set forth on the Pharmacy page of the OHCA website, which is available at <https://okhca.org>. This list may be updated as deemed necessary.

(c) All high-investment drugs require prior authorization [refer to Oklahoma Administrative Code (OAC) 317:30-3-31], and the outpatient hospital stay continues to be subject to applicable medical necessity criteria requirements [refer to OAC 317:30-3-1(f)].

(d) OHCA-designated high-investment drugs provided to eligible members, when treated in out-of-state outpatient hospitals, may be reimbursed in the same manner as in-state hospitals. Out-of-state outpatient hospitals must meet applicable out-of-state conditions of payment set forth in OAC 317:30-3-89 through 317:30-3-92, and in the Oklahoma Medicaid State Plan.

### **317:30-5-47. Reimbursement for inpatient hospital services**

Reimbursement will be made for inpatient hospital services in the following manner:

(1) Covered inpatient services provided to eligible SoonerCare members admitted to in-state acute care and critical access hospitals will be reimbursed the lesser of the billed charges or the Diagnosis Related Group (DRG) amount. In addition to the billed charges or DRG payment, whichever is less, an outlier payment may be made to the hospital for very high cost stays. Additional outlier payment is applicable if either the amount billed by the hospital or DRG payment, whichever applies, is less than a threshold amount of the hospital cost. Each inpatient hospital claim is tested to determine whether the claim qualified for a cost outlier payment. Payment is equal to a percentage of the cost after the threshold is met.

(2) The lesser of the billed charges or DRG amount and outlier, if applicable, represent full reimbursement for all non-physician services provided during the inpatient stay. Payment includes but is not limited to:

(A) ~~laboratory~~Laboratory services;

(B) ~~prosthetic~~Prosthetic devices, including pacemakers, lenses, artificial joints, cochlear implants, implantable pumps;

(C) ~~technical~~Technical component on radiology services;

(D) ~~transportation~~Transportation, including ambulance, to and from another facility to receive specialized diagnostic and therapeutic services;

(E) ~~pre-admission~~Pre-admission diagnostic testing performed within ~~72~~seventy-two (72) hours of admission; and

(F) ~~organ~~Organ transplants.

(3) Hospitals may submit a claim for payment only upon the final discharge of the patient or upon completion of a transfer of the patient to another hospital.

(4) Covered inpatient services provided to eligible members of the ~~Oklahoma~~ SoonerCare program, when treated in out-of-state

hospitals will be reimbursed in the same manner as in-state hospitals. Refer to OAC 317:30-3-90 and 317:30-3-91.

(5) Cases which indicate transfer from one (1) acute care hospital to another will be monitored under a retrospective utilization review policy to help ensure that payment is not made for inappropriate transfers.

(6) The transferring hospital will be paid the lesser of the calculated transfer fee or the DRG base payment amount for a non-transfer.

(7) If the transferring or discharge hospital or unit is exempt from the DRG, that hospital or unit will be reimbursed according to the method of payment applicable to the particular facility or units.

(8) Covered inpatient services provided in out-of-state specialty hospitals may be reimbursed at a negotiated rate not to exceed ~~100%~~ one-hundred percent (100%) of the cost to provide the service. Negotiation of rates will only be allowed when the OHCA determines that the specialty hospital or specialty unit provides a unique (non-experimental) service required by SoonerCare members and the provider will not accept the DRG payment rate. Prior authorization is required.

(9) New providers entering the SoonerCare program will be assigned a peer group and will be reimbursed at the peer group base rate for the DRG payment methodology or the statewide median rate for per diem methods.

(10) All inpatient services are reimbursed per the methodology described in this ~~section~~ Section and/or as approved under the Oklahoma ~~State~~ Medicaid State Plan.

(11) For high-investment drugs, refer to OAC 317:30-5-47.6

### **317:30-5-47.6. High-investment drugs - inpatient hospitals**

(a) The Oklahoma Health Care Authority (OHCA) designates certain high-investment drugs to be reimbursed separately pursuant to the Oklahoma Medicaid State Plan for members receiving services at an inpatient hospital.

(b) The list of OHCA-designated high-investment drugs is set forth on the Pharmacy page of the OHCA website, which is available at <https://okhca.org>. This list may be updated as deemed necessary.

(c) All high-investment drugs require prior authorization [refer to Oklahoma Administrative Code (OAC) 317:30-3-31], and the inpatient hospital stay continues to be subject to applicable medical necessity criteria requirements [refer to OAC 317:30-3-1(f)].

(d) OHCA-designated high-investment drugs provided to eligible members, when treated in out-of-state inpatient hospitals, may be reimbursed in the same manner as in-state hospitals. Out-of-state inpatient hospitals must meet applicable out-of-state conditions of payment set forth in OAC 317:30-3-89 through 317:30-3-92, and in the Oklahoma Medicaid State Plan.

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

**SUBCHAPTER 6. SOONERCARE FOR PREGNANT WOMEN AND  
FAMILIES WITH CHILDREN**

**PART 6. COUNTABLE INCOME FOR MAGI**

**317:35-6-51. Exceptions to Internal Revenue Code rules**

(a) The following sources of income are excluded from household income for SoonerCare eligibility under ~~MAGI~~Modified Adjusted Gross Income (MAGI), regardless of whether they are included in MAGI in Section 36B of the Internal Revenue Code:

(1) Scholarships, awards, or fellowship grants used for education purposes and not for living expenses; and

(2) The following types of American Indian / Alaska Native income:

(A) Distributions from any property held in trust, subject to Federal restrictions, located within the most recent boundaries of a prior Federal reservation, or otherwise under the supervision of the Secretary of the Interior;

(B) Distributions and payments from rents, leases, rights of way, royalties, usage rights, or natural resource extraction and harvest from:

(i) Rights of ownership or possession in any lands described in Paragraph (a) (2) (A) of this section; or

(ii) Federally protected rights regarding off-reservation hunting, fishing, gathering, or usage of natural resources;

(C) Distributions resulting from real property ownership interests related to natural resources and improvements:

(i) Located on or near a reservation or within the most recent boundaries of a prior Federal reservation; or

(ii) Resulting from the exercise of federally-protected rights relating to such real property ownership interests;

(D) Payments resulting from ownership interests in or usage rights to items that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable Tribal Law or custom;

(E) Student financial assistance provided under the Bureau of Indian Affairs education programs; and

(F) Distributions from Alaska Native Corporations and Settlement Trusts.

(b) Amounts received as a lump sum are counted as income only in the month received (see also ~~OAC~~Oklahoma Administrative Code (OAC) 317:35-10-26), with the exception of certain lottery or gambling winnings as specified in OAC 317:35-6-55. If a lump sum amount is received from an income source that is not counted in MAGI according to section 36B(d)(2)(B) of the Internal Revenue Code or the exceptions listed in this section, the amount is not counted.

**317:35-6-55. Treatment of Qualified Lottery or Qualified Gambling Winnings**

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

(1) "Qualified lottery winnings" means winnings from a sweepstakes, lottery, or pool described in paragraph three (3) of Section 4402 of the Internal Revenue Code of 1986 or a lottery operated by a multistate or multijurisdictional lottery association paid out in a single payout and not in installments over a period of time.

(2) "Qualified gambling winnings" means monetary winnings from gambling, as defined by Section (§) 1955(b)(4) of Title 18 of the United States Code (U.S.C.).

(3) "Undue hardship" means circumstances resulting from a loss or denial of SoonerCare eligibility that would deprive an individual of medical care, such that the individual's health or life would be endangered, or that would deprive the individual or his or her financially dependent family members of food, clothing, shelter, or other necessities of life.

(b) **Income determinations.** In accordance with 42 U.S.C. § 1396a(e)(14)(K), qualified lottery and gambling winnings shall be considered as income in determining the financial eligibility of individuals whose eligibility is determined based on the application of Modified Adjusted Gross Income (MAGI), as follows:

(1) Winnings less than \$80,000 are counted in the month received;

(2) Winnings greater than or equal to \$80,000, but less than \$90,000, are counted as income over two (2) months, with an equal amount counted in each month;

(3) Winnings greater than or equal to \$90,000, but less than \$100,000, are counted as income over three (3) months, with an equal amount counted in each month;

(4) Winnings greater than or equal to \$100,000 are counted as income over three (3) months, with one (1) additional month for every increment of \$10,000 in winnings received over \$100,000, with an equal amount counted in each month; and

(5) The maximum period of time over which winnings may be

counted is one hundred and twenty (120) months, which would apply to winnings greater than or equal to \$1,260,000.

(c) **Treatment of household members.** Qualified lottery and gambling winnings shall be counted as household income for all household members in the month of receipt; however, the requirement to count qualified lottery and gambling winnings in household income over multiple months applies only to the individual receiving the winnings.

(d) **Undue hardship.** An individual who loses or is denied eligibility due to qualified lottery or gambling winnings may timely file a member appeal, in accordance with Oklahoma Administrative Code 317:2-1-2. If, as part of that appeal, the individual proves by a preponderance of the evidence that loss or denial of eligibility would result in undue hardship, eligibility shall be restored or approved, provided all other conditions of eligibility have been met.

(e) **Notice.** SoonerCare members or applicants who are determined financially ineligible due to the counting of lottery or gambling winnings will receive a notice of the date on which the lottery or gambling winnings will no longer be counted for eligibility purposes. The notice will also inform the member or applicant of the undue hardship exemption and of their opportunity to enroll in a Qualified Health Plan on the Federally Facilitated Exchange.

## **SUBCHAPTER 10. OTHER ELIGIBILITY FACTORS FOR FAMILIES WITH CHILDREN AND PREGNANT WOMEN**

### **PART 5. INCOME**

#### **317:35-10-26. Income**

##### **(a) General provisions regarding income.**

(1) The income of categorically needy individuals who are related to the children, parent or caretaker relative, SoonerPlan, or Title XIX and XXI pregnancy eligibility groups does not require verification, unless questionable. If the income information is questionable, it must be verified. If there appears to be a conflict in the information provided, the worker must investigate the situation to determine if income verification is necessary.

(2) All available income, except that required to be disregarded by law or OHCA's policy, is taken into consideration in determining need. Income is considered available both when actually available and when the applicant or member has a legal interest in a liquidated sum and has the legal ability to make such sum available for support and maintenance. When an individual's income is reduced due to recoupment of an

overpayment or garnishment, the gross amount before the recoupment or garnishment is counted as income. The member is responsible for reporting all income, the source, amount and how often received.

(A) Income received on behalf of a member of the benefit group by another individual such as, but not limited to, a guardian or conservator, is considered available to the benefit group.

(B) Money received and used for the care and maintenance of a third party who is not included in the benefit group is not counted as income if it can be identified and verified as intended for third party use.

(C) If it appears any member of the benefit group or an individual whose income is considered when determining eligibility is eligible for any type of income or benefits, the benefit group must be notified in writing by the Oklahoma Health Care Authority (OHCA). The notice must contain the information that failure to apply for and take all appropriate steps to obtain such benefits within ten (10) days from the date of the notice will result in a determination of ineligibility. An application for Supplemental Security Income (SSI) is not required.

(D) If the member and spouse are living together or they are living apart but there has not been a clear break in the family relationship, income received by either spouse and income received jointly is considered as family income. Income cannot be diverted to a household member who is not included in the household size for health benefits. Consideration is not given to a SSI recipient's income in computing eligibility for the AFDC or Pregnancy related unit. The ~~MAGI~~ Modified Adjusted Gross Income (MAGI) methodology rules determine whose income is considered in a particular household for MAGI eligibility groups as defined in ~~OAC~~ Oklahoma Administrative Code (OAC) 317:35-6-1.

(E) Income which can reasonably be anticipated to be received is considered to be available for the month its receipt is anticipated.

(F) Income produced from resources must be considered as unearned income.

(3) Income that must be verified is verified by the best available information such as pay stubs presented by the member or an interview with the employer. If OHCA is unable to verify income through the Employment Securities Commission, then pay stubs may only be used for verification if they have the member's name and/or social security number indicating that the pay stubs are in fact the member's wages. The stubs should

also include the date(s) of the pay period and the amount of income before deductions. If this information is not included, employer verification is required. The worker verifies medical insurance which may be available at the same time that income is verified. When a member of the benefit group accepts employment and has not received any wages, verification (if necessary) of the amount of income to be considered and the anticipated date of receipt must be obtained from the employer and provided to OHCA within ten (10) days. Income which is expected to be received during a month is considered available to the benefit group and is counted in determining eligibility for the month of receipt.

(4) Monies received in a lump sum from any source are considered income in the month received, with the exception of certain lottery or gambling winnings as specified in OAC 317:35-6-55. Changing a resource from one form to another, such as converting personal property to cash, is not considered a lump sum payment. Exception: lump sum payments used to establish dedicated bank accounts by representative payees in order to receive and maintain retroactive SSI benefits for disabled/blind children under age eighteen (18) are excluded as income. The interest income generated from dedicated bank accounts is also excluded.

(A) Whether a source of income is countable for MAGI eligibility groups is determined in accordance with Part 6 of Subchapter 6 of this Chapter.

(B) Whether a source of income is countable is determined in accordance with Part 6 of Subchapter 6 of this Chapter.

(C) When a lump sum is received by a stepparent not included in the household size, only the stepparent's contribution is considered in accordance with the stepparent's liability policy. Income received by a stepparent is considered in accordance with MAGI household and income counting rules.

(D) When a third party reveals that a lump sum payment has been received or is expected to be received by the applicant or member, adverse action notification is given or mailed to the applicant/member and appropriate action taken.

(E) Recurring lump sum income received from any source for a period covering more than one (1) month, that is received in a lump sum recurrently (such as annual rentals from surface or minerals, Windfall Profits tax refund, etc.) is prorated over a period of time it is intended to cover, beginning with the month of receipt of a lump sum payment.

(F) Net income from oil and gas production (gross minus production taxes withheld), received in varying amounts on a regular or irregular basis for the past six (6) months, will be averaged and considered as income for the next six

(6) months. In instances where an applicant or a member receives new income from oil and gas production and verification for the past six (6) months is not available, the worker accepts the available verification and averages over the period of time intended to cover. Net income may be verified by seeing the individual's production check stub, or by contacting the oil and gas company. Whether a source of income is countable is determined in accordance with Part 6 of Subchapter 6 of this Chapter.

(5) Income that is based on the number of hours worked, as opposed to income based on regular monthly wages, must be computed as irregular income. The income received irregularly or in varying amounts will be averaged using the past two (2) months to establish the amount to be anticipated and considered for prospective budgeting.

(6) MAGI household rules are used to determine whether a caretaker relative or stepparent is included in a household.

(A) MAGI household and income counting rules are used to determine whether a caretaker relative and his/her spouse or a stepparent are included in the household and whether their income is considered for the children.

(B) MAGI household and income counting rules are used to determine whose income is considered and whether that income is counted. If an individual is eligible in the parent or caretaker relative group, his/her spouse, if living with him/her, is also related to the parent or caretaker relative group.

(7) A stepparent, if living with the parent or caretaker relative, can also be related to the parent or caretaker relative group, regardless of whether the parent is incapacitated or not in the home.

(8) MAGI household and income counting rules are used to determine whose income is considered and whether that income is counted.

(b) **Earned income.** The term "earned income" refers to monies earned by an individual through the receipt of wages, salary, commission or profit from activities in which the individual is engaged as self-employed or as an employee. Whether income is countable for MAGI eligibility groups is determined using MAGI income counting rules in Part 6 of Subchapter 6 of this Chapter.

(1) **Earned income from self-employment.** For MAGI eligibility groups, the calculation of countable self-employment income is determined in accordance with MAGI income counting rules in Part 6 of Subchapter 6 of this Chapter.

(2) **Earned income from wages, salary or commission.** Countable income for MAGI eligibility groups is determined in accordance

with MAGI income counting rules in Part 6 of Subchapter 6 of this Chapter.

(3) **Earned income from work and training programs.** Countable income for MAGI eligibility groups is determined in accordance with MAGI income counting rules in Part 6 of Subchapter 6 of this Chapter.

(4) **No individual earned income exemptions.** No earned income exemptions are subtracted to determine countable income for MAGI eligibility groups. The only deduction applied to determine net countable income under the MAGI methodology is the deduction of five percent (5%) of the FPL for the individual's household size as defined in OAC 317:35-6-39.

(5) **Formula for determining the individual's net earned income for MAGI eligibility groups.** To determine net income, see MAGI rules in OAC 317:35-6-39.

(c) **Unearned income.** Countable earned and unearned income for MAGI eligibility groups is determined in accordance with MAGI income counting rules in Part 6 of Subchapter 6 of this Chapter.

(d) **Income disregards.** For MAGI eligibility groups, whether a source of income is disregarded is determined in accordance with MAGI income counting rules in Part 6 of Subchapter 6 of this Chapter.

(g) In computing monthly income, cents will be rounded down at each step. Income which is received monthly but in irregular amounts is averaged using two month's income, if possible, to determine income eligibility. Less than two month's income may be used when circumstances (e.g., new employment, unpaid sick leave, etc.) would indicate that previous income amounts would not be appropriate to use in determining future income amounts. Income received more often than monthly is converted to monthly amounts as follows:

(1) **Daily.** Income received on a daily basis is converted to a weekly amount then multiplied by 4.3.

(2) **Weekly.** Income received weekly is multiplied by 4.3.

(3) **Twice a month.** Income received twice a month is multiplied by two (2).

(4) **Biweekly.** Income received every two (2) weeks is multiplied by 2.15.