Oklahoma Health Care Authority

It is very important that you provide your comments regarding the proposed rule change by the comment due date. Comments are directed to Oklahoma Health Care Authority (OHCA) Health Policy Unit http://www.okhca.org/proposed-rule-changes.aspx

OHCA COMMENT DUE DATE: May 2, 2011

The proposed policy is an Emergency Rule. This proposal is scheduled to be presented to the Medical Advisory Committee (MAC) on May 19, 2011 and the (OHCA) Board of Directors on June 9, 2011.
Reference: APA WF 11-02

SUMMARY:
Tax Credit Exemption— The Tax Relief, Unemployment Insurance Reauthorization, and Job Creation Act of 2010 requires state Medicaid agencies to disregard federal tax refunds or advance payments with respect to a refundable tax credits as income and as resources for purposes of determining eligibility. To bring Agency policy in compliance with this law, eligibility rules and income guidelines are revised to eliminate consideration of the Earned Income Tax Credit, which is the only refundable tax credits currently counted for eligibility purposes.

LEGAL AUTHORITY
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; Public Law 111-312, the Tax Relief, Unemployment Insurance Reauthorization, and Job Creation Act of 2010

RULE IMPACT STATEMENT:
TO: Traylor Rains
Health Policy

FROM: Joseph Fairbanks
Health Policy

SUBJECT: Rule Impact Statement
APA WF # 11-02

A. Brief description of the purpose of the rule:

The Tax Relief, Unemployment Insurance Reauthorization, and Job Creation Act of 2010 requires state Medicaid agencies to disregard federal tax refunds or advance payments with respect to

a refundable tax credits as income and as resources for purposes of determining eligibility. To bring Agency policy in compliance with this law, eligibility rules and income guidelines are revised to eliminate consideration of the Earned Income Tax Credit, which is the only refundable tax credits currently counted for eligibility purposes.

B. A description of the classes of persons who most likely will be affected by the proposed rule, including classes that will bear the cost of the proposed rule, and any information on cost impacts received by the agency from any private or public entities:

Applicants for SoonerCare services categorically-related to Aged, Blind, or Disabled who are on the income margins of eligibility and who receive the Earned Income Tax. They will bear no costs as a result of the proposed rule.

C. A description of the classes of persons who will benefit from the proposed rule:

Applicants for SoonerCare services categorically-related to Aged, Blind, or Disabled who are on the income margins of eligibility and who receive the Earned Income Tax.

D. A description of the probable economic impact of the proposed rule upon the affected classes of persons or political subdivisions, including a listing of all fee changes and, whenever possible, a separate justification for each fee change:

There is no economic impact and there are no fee changes associated with the rule change for the above classes of persons or any political subdivision.

E. The probable costs and benefits to the agency and to any other agency of the implementation and enforcement of the proposed rule, the source of revenue to be used for implementation and enforcement of the proposed rule, and any anticipated affect on state revenues, including a projected net loss or gain in such revenues if it can be projected by the agency:

The rule change will not result in any additional costs to the agency. The proposed rule simply ensures those who are eligible for SoonerCare services will be deemed eligible by eligibility workers and systems. The effect on state revenues, if any, will be negligible.

F. A determination of whether implementation of the proposed rule will have an economic impact on any political subdivisions or require their cooperation in implementing or enforcing the rule:

There is no economic impact on political subdivisions.

G. A determination of whether implementation of the proposed rule will have an adverse effect on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act:

There is no adverse economic impact on small businesses as a result of this rule.

H. An explanation of the measures the agency has taken to minimize compliance costs and a determination of whether there are less costly or non-regulatory methods or less intrusive methods for achieving the purpose of the proposed rule:

The agency has taken measures to determine that there is no less costly or non-regulatory method or less intrusive method for achieving the purpose of the proposed rule.

I. A determination of the effect of the proposed rule on the public health, safety and environment and, if the proposed rule is designed to reduce significant risks to the public health, safety and environment, an explanation of the nature of the risk and to what extent the proposed rule will reduce the risk:

The proposed rule should have no effect on the public health, safety, and environment.

J. A determination of any detrimental effect on the public health, safety and environment if the proposed rule is not implemented:

OHCA does not believe there is a detrimental effect on the public health and safety if the rule is not passed.

K. The date the rule impact statement was prepared and if modified, the date modified:

The rule impact statement was prepared April 6, 2011.

RULE TEXT

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME
PART 3. NON-MEDICAL ELIGIBILITY REQUIREMENTS

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

(a) **General.** The term income is defined as that gross gain or gross recurrent benefit which is derived from labor, business, property, retirement and other benefits, and many other forms which can be counted on as currently 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.

(1) If it appears the applicant or SoonerCare member is eligible for any type of income (excluding SSI) or resources, he/she must be notified in writing by the Agency of his/her potential eligibility. The notice must contain the information that failure to file for and take all appropriate steps to obtain such benefit within 30 days from the date of the notice will result in a determination of ineligibility.

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

(3) If only one spouse in a couple is eligible and the couple ceases to live together, only the income and

resources of the ineligible spouse that are actually contributed to the eligible spouse beginning with the month after the month which they ceased to live 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 OASDI benefits.

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

(1) The coupon allotment under the Food Stamp Act of 1977;

(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 (BIA) 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) 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 approves the plan, the amount of income excluded and the period of time approved. A plan can be approved for an initial period of 18 months. The plan may be extended for an additional 18 months if needed, and an additional 12 months (total 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; and

(31) Wages paid by the Census Bureau for temporary employment related to Census activities.

(c) **Determination of income.** 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.

(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 the mentally retarded 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 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 lump sum) covering a period of more than one 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, including SSI (with the exception of dedicated bank accounts for disabled/blind children under age 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, retroactive OASDI, VA benefits, Workers' Compensation, bonus lease payments and annual rentals from land and/or minerals.

(ii) 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 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.

(iii) 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.

(iv) 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 months' royalty income is computed and used to determine income eligibility. 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 month's 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 rent property is treated as unearned income.

(iii) When property rental 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) Advance payments of EITC or refunds of EITC received as a result of filing a federal income tax return are considered as earned income in the month after they are received.~~

~~(ii)~~ (i) Work study received by an individual who is attending school is considered as earned income with appropriate earned income disregards applied.

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

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

(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)).

~~(v)~~ (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.

(F) **Inconsequential or irregular income.** Inconsequential or irregular receipt of income in the amount of $10 or less per month or $30 or less per quarter is disregarded. The disregard is applied per individual for each type of inconsequential or irregular income. To determine whether the income is inconsequential or irregular, the gross amount of earned income and the gross minus business expense of self-employed income are considered.

(G) **Monthly income received in fluctuating amounts.** 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:

(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 2.

(iv) **Biweekly**. Income received every two 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.

(d) **Computation of income.**

(1) **Earned income.** The general income exclusion of $20 per month is allowed on the combined earned income of the eligible individual and eligible or ineligible spouse. See paragraph (6) of this subsection if there are ineligible minor children. After the $20 exclusion, deduct $65 and one-half of the remaining combined earned income.

(2) **Unearned income.** The total gross amount of unearned income of the eligible individual and eligible or ineligible spouse is considered. See paragraph (6) of this subsection if there are ineligible minor children.

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

(4) **Deeming computation for disabled or blind minor child(ren).** 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 18.

(A) A mentally retarded 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.

(5) **Premature infants.** Premature infants (i.e., 37 weeks or less) whose birth weight is less than 1200 grams (approximately 2 pounds 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.

(6) **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.

(7) **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 broad categories:

(A) transportation to and from work;

(B) job performance; and

(C) job improvement.

Oklahoma Health Care Authority

It is very important that you provide your comments regarding the proposed rule change by the comment due date. Comments are directed to Oklahoma Health Care Authority (OHCA) Health Policy Unit http://www.okhca.org/proposed-rule-changes.aspx

OHCA COMMENT DUE DATE: Wednesday, October 19, 2011.

The proposed policy is a Permanent Rule. This proposal is scheduled to be presented to the Medical Advisory Committee (MAC) on November 16th, 2011 and the (OHCA) Board of Directors on February 9th, 2012.
Reference: APA WF 11-03

SUMMARY:
OHCA rules for the SoonerPlan Family Planning Program are revised to remove references to the Family Planning Waiver. Section 2303 of the Patient Protection and Affordable Care Act allows individuals receiving Family Planning Waiver services to receive those same services plus additional family planning and family planning related services under the Title XIX State Plan rather than a waiver program. In addition to a broader service package, the State Plan option allows a more efficient way of making future changes to the SoonerPlan program. If approved, the rule change will allow over 32,000 SoonerPlan members and future members to receive the enhanced package of State Plan Family Planning services. The rule revision also includes the removal of language relating to family planning centers, clarification of eligibility rules and other minor policy corrections.

LEGAL AUTHORITY
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; Section 2303 of the Patient Protection and Affordable Care Act

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

TO: Tywanda Cox
Policy Development

From: Brent Johnson

SUBJECT: Rule Impact Statement
(Reference APA WF # 11-03)

A. Brief description of the purpose of the rule:

The Oklahoma Health Care Authority obtained a waiver from the Centers for Medicare and Medicaid Services (CMS) in 2005 to provide family planning services to men and women who do not otherwise qualify for SoonerCare. Section 2303 of the Patient Protection and Affordable Care Act allows those individuals to receive the same waiver services plus additional family planning and family planning related services under the Title XIX State Plan for Medicaid. In addition to a broader service package, the State Plan option allows a more efficient way of making future changes to the SoonerPlan program. If approved, the rule change will allow over 32,000 SoonerPlan members and future members to receive an enhanced package of State Plan family planning services.

B. A description of the classes of persons who most likely will be affected by the proposed rule, including classes that will bear the cost of the proposed rule, and any information on cost impacts received by the agency from any private or public entities:

There are no specific classes of persons who will be affected by the proposed rule. The cost of the proposed rule change, in state tax dollars, is estimated to be minimal and will not be borne by any specific classes of persons.

C A description of the classes of persons who will benefit from the proposed rule:

The specific classes of person who will benefit from the proposed rule change are non-pregnant women and men ages 19 and older who are eligible to receive SoonerPlan program services. These individuals will receive a broader range of family planning services as a result of the rule change.

D. A description of the probable economic impact of the proposed rule upon the affected classes of persons or political subdivisions, including a listing of all fee changes and, whenever possible, a separate justification for each fee change:

There is no probable economic impact of the proposed rules upon any classes of persons or political subdivisions, nor are any fees associated with this rule change.

E. The probable costs and benefits to the agency and to any other agency of the implementation and enforcement of the proposed rule, the source of revenue to be used for implementation and enforcement of the proposed rule, and any anticipated affect on state revenues, including a projected net loss or gain in such revenues if it can be projected by the agency:

The proposed rule change will cost an estimated $171,887 in State tax revenue and will be matched by approximately 1,246,000 in federal funding. The majority of family planning services will be provided through the Oklahoma State Department of Health and city/county and county health departments. The State Department of Health will provide the State matching dollars.

F. A determination of whether implementation of the proposed rule will have an economic impact on any political subdivisions or require their cooperation in implementing or enforcing the rule:

The proposed rule will not have an economic impact on any political subdivision or require their cooperation in implementing or enforcing the rule.

G. A determination of whether implementation of the proposed rule will have an adverse effect on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act:

The proposed rule will not have an adverse effect on small businesses as provided by the Oklahoma Small Business Regulatory Flexibility Act.

H. An explanation of the measures the agency has taken to minimize compliance costs and a determination of whether there are less costly or nonregulatory methods or less intrusive methods for achieving the purpose of the proposed rule:

There are no other legal methods to minimize compliance costs.

I. A determination of the effect of the proposed rule on the public health, safety and environment and, if the proposed rule is designed to reduce significant risks to the public health, safety and environment, an explanation of the nature of the risk and to what extent the proposed rule will reduce the risk:

The proposed rule should have no effect on the public health, safety, or environment.

J. A determination of any detrimental effect on the public health, safety and environment if the proposed rule is not implemented:

The agency does not anticipate any detrimental effects on the public health, safety, or environment.

K. The date the rule impact statement was prepared and if modified, the date modified:

This rule impact statement was prepared on August 27th, 2011.

RULE TEXT

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 1. PHYSICIANS

317:30-5-12. Family planning
~~(a) Pregnancy tests are covered.~~
~~(b) Reverse vasectomy is not covered.~~
~~(c) Reversal of sterilization procedures for the purpose of conception are not covered.~~
(a) **Adults.** Payment is made for the following family planning services:

(1) physical examination to determine the general health of the member and most suitable method of contraception;
(2) complete general history of the member and pertinent history of immediate family members;
(3) laboratory services for the determination of pregnancy, detection of certain sexually transmitted infections and detection of cancerous or pre-cancerous conditions of the reproductive anatomy;
(4) education and counseling regarding issues related to reproduction and contraception;
(5) annual supply of chosen contraceptive;
(6) insertion and removal of contraceptive devices;
(7) vasectomy and Tubal Ligation procedures; and
(8) additional visits for members experiencing difficulty with a particular contraceptive method or having concerns related to their reproductive health.

(b) **Children.** Payment is made for children as set forth in this Section for adults. However payment cannot be made for the sterilization of persons under the age of 21.

(c) **SoonerPlan Members.** Non-pregnant women and men ages 19 and older not enrolled in SoonerCare may apply for the SoonerPlan program. Eligible members receive family planning services set forth in this Section as well as family planning related services (vaccinations for the prevention of certain sexually transmitted infections and male exams). SoonerPlan eligibility requirements are found at OAC 317:35-7-48.

(d) Individuals eligible for Part B of Medicare. Payment is made utilizing the Medicaid allowable for comparable services. Claims for services which are not covered by Medicare should be filed directly with the Fiscal Agent for payment within the scope of the program.

PART 49. FAMILY PLANNING CENTERS [REVOKED]

317:30-5-465. Eligible providers [REVOKED]

~~In order to be eligible for participation the family planning center must meet the Oklahoma State Health Department Standards and Criteria for Family Planning Centers. The center must declare whether they will bill independently or through a computer billing arrangement with the Oklahoma State Department of Health.~~

317:30-5-466. Coverage by category [REVOKED]

~~Payment is made to family planning centers as set forth in this Section.~~

(1) **Adults.** Payment is made for adults on an encounter basis. Each encounter is all inclusive of the following and payment includes all services provided:

(A) **Initial examination services.** Initial examination services that are provided to new family planning patients include:

(i) Complete physical examination including assessment of height, weight, blood pressure, thyroid, extremities, heart, lungs, breasts, abdomen, pelvic examination, including visualization of the cervix, external genitalia, bimanual exam, and rectal exam as indicated. (Male clients receive examination of genitals and rectum including palpation of the prostate in lieu of pelvic exam given females.)

(ii) Complete general history of patient and pertinent history of immediate family members. This general history addresses allergies, immunizations, past illnesses, hospitalizations, surgery, review of systems, use of alcohol, tobacco and drugs. Reproductive function history in female patients includes menstrual history, sexual activity, sexually transmitted diseases, contraceptive use, pregnancies, and in utero exposure to DES. Male reproductive general history includes sexual activity, sexually transmitted diseases, fertility, and exposure to DES.

(iii) Laboratory services to include hematocrit, dip stick urinalysis, pap smear, gonorrhea culture, serologic test for syphilis and rubella screening if indicated.(iv) Education and counseling are offered to provide information regarding reproductive anatomy, range of clinic services, risks benefits and side effects of various methods of contraception, and health promotion/disease prevention topics as needed.

(v) Provision for an annual supply of chosen contraceptive method to include, but not limited to, injections (administration and medication), oral contraceptive, IUD, diaphragm, foam, condoms or natural family planning.

(vi) Treatment of minor gynecological problems, infections, and other conditions.

(vii) Referral to appropriate providers for problems or conditions which are beyond the scope of the clinic to treat.

(B) **Annual examination services.** Annual examination services are provided to continuing patients to include:

(i) Annual update physical examination to include height, weight, blood pressure, extremities, and

examination of breasts and pelvic organs. If required, a complete physical examination may be provided as described under the initial visit services above.

(ii) A medical history update is taken to update the general history and includes noting the patient's adaptation to and correct use of contraceptive method, menstrual history, specific warning signs and other side effects related to the contraceptive method. If indicated, a complete general history of the patient will be taken at the annual visit.

(iii) Laboratory services to include pap smear, gonorrhea culture, hematocrit, and serologic test for syphilis.

(iv) Education and counseling regarding specific problems, risks and side effects of the method in use.

(v) Provision for an annual supply of chosen contraceptive method to include, but not limited to, injections (administration and medication), oral contraceptive, IUD, diaphragm, foam, condoms or natural family planning.

(vi) Treatment of minor gynecological problems, infections, and other conditions.

(vii) Referral to appropriate providers for problems or conditions which are beyond the scope of the clinic to treat.

(C) **Encounter visits.**

(i) Encounter visits covers services provided to patients which are not part of the initial/annual examinations. This may include:

(I) A follow-up visit for all new patients to insure they understand and are experiencing no problems with their particular contraceptive method.

(II) A scheduled revisit for a new or continuing patient who may have conditions which places the patient in a high risk category requiring more intensive medical management as outlined in the program medical protocol.

(ii) Encounter visits may also be scheduled at the request of the patient as they are encouraged to return to the clinic at any time they experience difficulty with a particular contraceptive method or have concerns related to their reproductive health. Pregnancy diagnosis and counseling services are also provided under this category.

(D) **Vasectomy.** For vasectomies, payment will be made as an all-inclusive rate for all services provided in connection with the surgery. Claims must have the Federally mandated consent form properly completed and attached.

(E) **Tubal ligations.** For tubal ligations, payment will be made as an all-inclusive rate for the cost of the surgeon, anesthesiologist, pre and post-operative care and outpatient surgery facility. Claims must have the properly completed Federally mandated consent form attached.

(2) **Children.** Payment is made for children as set forth for adults. However payment cannot be made for the sterilization of persons under the age of 21.

(3) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the Medicaid allowable for comparable services. Claims for services which are not covered by Medicare should be filed directly with the Fiscal Agent for payment within the scope of the program.

317:30-5-467. Coverage limitations [REVOKED]

(a) Sterilizations require proper consent form and are not compensable for patients under 21 years of age.

(b) The following coverage limitations apply to services provided by family planning centers:

(1) Service: Initial Examination; Unit: Completed Examination and Services; Limitation: one initial examination.

(2) Service: Annual; Unit: Completed Examination and Services; Limitation: one annual examination.

(3) Service: Encounter Visit; Unit: Completed Examination and Services; Limitation: one per day.

(4) Service: Vasectomy; Unit: Completed Examination and Services; Limitation: one each (required consent restricted to persons age 21 and over, at time consent form is signed).

(5) Service: Tubal Ligation; Unit: Completed Examination and Services; Limitation: one each (required consent restricted to persons age 21 and over, at time consent form is signed).

PART 75. FEDERALLY QUALIFIED HEALTH CENTERS

317:30-5-664.5. Health Center encounter exclusions and limitations

(a) Service limitations governing the provision of all services apply pursuant to OAC 317:30. Excluded from the definition of reimbursable encounter core services are:

(1) Services provided by an independently CLIA certified and enrolled laboratory.
(2) Radiology services including nuclear medicine and diagnostic ultrasound services.
(3) Venipuncture for lab tests is considered part of the encounter and cannot be billed separately. When a member is seen at the clinic for a lab test only, use the appropriate CPT code. A visit for "lab test only" is not considered a Center encounter.
(4) Durable medical equipment or medical supplies not generally provided during the course of a Center visit such as diabetic supplies. However, gauze, band-aids, or other disposable products used during an office visit are considered as part of the cost of an encounter and cannot be billed separately under SoonerCare.
(5) Supplies and materials that are administered to the member are considered a part of the physician's or other health care practitioner's service.
(6) Drugs or medication treatments provided during a clinic visit are included in the encounter rate. For example, a member has come into the Center with high blood pressure and is treated at the Center with a hypertensive drug or drug samples provided to the Center free of charge are not reimbursable services and are included in the cost of an encounter. Prescriptions are not included in the encounter rate and must be billed through the pharmacy program by a qualified enrolled pharmacy.
(7) Administrative medical examinations and report services;
(8) Emergency services including delivery for pregnant members that are eligible under the Non-Qualified (ineligible) provisions of OAC 317:35-5-25;
(9) ~~Family~~ SoonerPlan family planning services ~~provided to individuals enrolled in the Family Planning Waiver~~;
(10) Optometry and podiatric services other than for dual eligible for Part B of Medicare;
(11) Other services that are not defined in this rule or the State Plan.

(b) In addition, the following limitations and requirements apply to services provided by Health Centers:
(1) Physician services are not covered in a hospital.
(2) Behavioral health case management and psychosocial rehabilitation services are limited to Health Centers enrolled under the provider requirements in OAC 317:30-5-240, and 317:30-5-595 and contracted with OHCA as an outpatient behavioral health agency.

PART 112. PUBLIC HEALTH CLINIC SERVICES

317:30-5-1154. CHD/CCHD services/limitations

CHD/CCHD service limitations are:

(1) Child Guidance services (see OAC 317:30-3-65 through OAC 317:30-3-5-65.11 for specifics regarding program requirements).

(2) Dental services [OAC 317:30-3-65.4(7)].

(3) Early Periodic Screening, Diagnosis, and Treatment services (including blood lead testing and follow-up services) (see OAC 317:30-3-65 through OAC 30-3-65.11 for specific coverage).

(4) Environmental investigations.

(5) Family Planning ~~services~~ and ~~Family Planning Waiver Services~~ SoonerPlan Family Planning services (see ~~OAC 317:30-5-465 through OAC 317:30-5-467~~ OAC 317:30-5-12 for specific coverage and ~~limitations~~ guidelines).

(6) Immunizations (adult and child).

(7) Blood lead testing (see OAC 317:30-3-65.4 for specific coverage).

(8) Newborn hearing screening.

(9) Newborn metabolic screening.

(10) Maternity services (see OAC 317:30-5-22 for specific coverage).

(11) Public health nursing services.

(12) Tuberculosis case management and directly observed therapy.

(13) Laboratory services.

(14) Targeted case management.

CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS
SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME
PART 1. DETERMINATION OF QUALIFYING CATEGORICAL RELATIONSHIPS

317:35-5-2. Categorically related programs

(a) Categorical relationship is established using the same definitions of age, disability and blindness as used by the Social Security Administration (SSA) in determining eligibility for Supplemental Security Income (SSI) or SSA benefits. If the individual is a SSA/SSI recipient in current payment status (including presumptive eligibility), a TANF recipient, or is under age 19, categorical relationship is automatically established. Categorical relationship to pregnancy-related services is established when the determination is made by medical evidence that the individual is or has been pregnant. Pregnancy-related services include all medical services provided within the scope of the program during the prenatal, delivery and postpartum periods. For an individual age 19 or

over to be related to AFDC, the individual must have a minor dependent child. Categorical relationship to Refugee services is established in accordance with OAC 317:35-5-25. Categorical relationship for the Breast and Cervical Cancer Treatment program is established in accordance with OAC 317:35-21. Categorical relationship for the SoonerPlan Family Planning ~~Waiver~~ Program is established in accordance with OAC 317:35-5-8. Categorical relationship for pregnancy related benefits covered under Title XXI is established in accordance with OAC 317:35-22. Benefits for pregnancies covered under Title XXI medical services are provided within the scope of the program during the prenatal, delivery and postpartum care when included in the global delivery payment. To be eligible for SoonerCare benefits, an individual must be related to one of the following:

(1) Aged
(2) Disabled
(3) Blind
(4) Pregnancy
(5) Aid to Families with Dependent Children
(6) Refugee
(7) Breast and Cervical Cancer Treatment program
(8) SoonerPlan Family Planning ~~Waiver~~ Program
(9) Benefits for pregnancies covered under Title XXI.

(b) The Authority may provide SoonerCare to reasonable categories of individuals under age 21 who are not receiving cash assistance under any program but who meet the income requirement of the State's approved AFDC plan.

(1) Individuals eligible for SoonerCare benefits include individuals between the ages of 19 and 21:

(A) for whom a public agency is assuming full or partial financial responsibility who are in custody as reported by the Oklahoma Department of Human Services (OKDHS) and in foster homes, private institutions or public facilities; or

(B) in adoptions subsidized in full or in part by a public agency; or

(C) individuals under age 21 receiving active treatment as inpatients in public psychiatric facilities or programs if inpatient psychiatric services for individuals under age 21 are provided under the State Plan and the individuals are supported in full or in part by a public agency; or

(2) Individuals eligible for SoonerCare benefits include individuals between the ages of 18 and 21 if they are in custody as reported by OKDHS on their 18th birthday and living in an out of home placement.

317:35-5-8. Determining categorical relationship for the SoonerPlan Family Planning ~~Waiver~~ Program

All ~~uninsured~~ non-pregnant women and men ages 19 and older, ~~who have not undergone a sterilization procedure~~, regardless of pregnancy or paternity history, with family income at or below 185% of the federal poverty level and who are otherwise ineligible for SoonerCare ~~benefits~~ are categorically related to the SoonerPlan Family Planning ~~Waiver~~ Program. If eligible for SoonerCare benefits, the individual can choose to enroll only in ~~the Family Planning Waiver Program~~ SoonerPlan with the option of applying for SoonerCare at any time.

SUBCHAPTER 7. MEDICAL SERVICES
PART 5. DETERMINATION OF ELIGIBILITY FOR MEDICAL SERVICES

317:35-7-37. Financial eligibility of individuals categorically related to AFDC, or pregnancy-related services ~~or Family Planning Waiver Program~~

~~(a)~~ AFDC and/or pregnancy-related services.

(1) In determining financial eligibility for an individual related to AFDC or pregnancy-related services, the income of the following persons (if living together or if living apart as long as there has been no break in the family relationship) are considered. These persons include:

(A) the individual;

(B) the spouse of the individual;

(C) the biological or adoptive parent(s) of the individual who is a minor dependent child. Income of the stepparent of the minor dependent child is determined according to OAC 35-10-26(a)(8);

(D) minor dependent children of the individual if the children are being included in the case for Medicaid. If the individual is 19 years or older and not pregnant, at least one minor dependent child must be living in the home and included in the case for the individual to be categorically related to AFDC;

(E) blood related siblings, of the individual who is a minor child, if they are included in the case for Medicaid;

(F) a caretaker relative and spouse (if any) and minor dependent children when the caretaker relative is to be included for coverage.

(2) The family has the option to exclude minor dependent children or blood related siblings see [OAC 317:35-7-37(1)(D) and (E)] and their income from the eligibility process. However, for the adult to be eligible, at least

one minor child and his/her income [see OAC 317:35-7-37(a)(4)] must be included in the case. ~~The worker has the responsibility to inform the family of the most advantageous consideration in regard to coverage and income.~~ When determining financial eligibility for an individual related to AFDC or pregnancy-related services, consideration is not given to income of any person who is aged, blind or disabled and is determined to be categorically needy.

(3) An individual categorized as aged, blind, or disabled who is not an SSI recipient has an option to be categorically related to either AFDC or ABD. The individual may be included in the AFDC related benefit group pending determination of eligibility for ABD or SSI if all eligibility requirements are met.

(4) An individual who receives SSI cannot be included in the AFDC related benefit group. When the only dependent child is receiving SSI, the natural or adoptive parent(s) or caretaker relative may be related to AFDC if all other factors of eligibility are met. The benefit group will consist of the adult(s) only. Applicants and ~~recipients~~ members are informed of their responsibility to report to the OKDHS if any member of the benefit group makes application for SSI or becomes eligible for SSI.

~~(b) **Family Planning Program.** In determining financial eligibility for the FPW program the income of the individual and spouse (if any) is considered. The individual has the option to include or exclude minor dependent children and their income in the eligibility process. The worker has the responsibility to inform the individual of the most advantageous consideration in regard to coverage and income.~~

317:35-7-48. Eligibility for the SoonerPlan Family Planning ~~Waiver~~ Program

(a) ~~Women~~ Non-pregnant women and men ages 19 and above are eligible to receive family planning services if they meet all of the conditions of eligibility in paragraphs (1), (2), (3), and (4) of this Subsection. This is regardless of pregnancy or paternity history and includes women who gain eligibility for SoonerCare family planning services due to a pregnancy, but whose eligibility ends 60 days postpartum.

(1) The countable income is at or below 185% of the federal poverty level. The standard deduction for work related expenses such as income tax payments, Social Security taxes, and transportation to and from work, is $240 per each full-time or part-time employed member of the benefit group. Deductions for work related expenses for self-employed individuals are found at OAC 317:35-10-26(b)(1).

(2) In determining financial eligibility for the SoonerPlan Family Planning program the income of the individual and spouse (if any) is considered. The individual has the option to include or exclude minor dependent children and their income in the eligibility process.

~~(2)~~ (3) Individuals eligible for SoonerCare can choose to enroll only in the SoonerPlan Family Planning ~~Waiver~~ Program with the option of applying for SoonerCare at any time.

~~(3)~~ (4) ~~The individual is uninsured~~. Persons who have Medicare or creditable health insurance coverage are not ~~eligible~~ precluded from applying for the SoonerPlan Family Planning ~~Waiver~~ program. ~~A stand alone policy such as dental, vision or pharmacy is not considered creditable health insurance coverage.~~

~~(4) The individual has not undergone a sterilization procedure.~~

(b) All health insurance is listed on the OKDHS computer system in order for OHCA Third Party Liability Unit to verify insurance coverage. The OHCA is the payer of last resort.

(c) Income for the SoonerPlan Family Planning ~~Waiver~~ Program does not require verification, unless questionable. If the income is questionable the worker must verify the income.

(d) There is not an asset test for the SoonerPlan Family Planning ~~Waiver~~ Program.

PART 7. CERTIFICATION, REDETERMINATION AND NOTIFICATION

317:35-7-60. Certification for ~~Medical Services~~ SoonerCare

(a) The rules in this Section apply to all categories of eligibles **EXCEPT**:

(1) categorically needy SoonerCare ~~Health Benefit recipients~~ members who are categorically related to AFDC or Pregnancy Related Services, AND

(2) who if eligible, would be enrolled in SoonerCare, or

(3) individuals categorically related to the Family Planning ~~Waiver~~ Program.

(b) An individual determined eligible for ~~Medical Services~~ SoonerCare may be certified for a medical service provided on or after the first day of the third month prior to the month of application if all eligibility criteria are met during the three month period. The certification period is determined beginning with the month the medical service was received or expected to be received or the month of application for categorically needy cases in which a medical service has not been received. The period of certification may cover retroactive or future months. ~~Assignment of the certification period is dependent on the categorical relationship. Form MA-~~

~~2, Medical Assistance Computation Work Sheet, is used to determine the certification period. The certification period in family cases is assigned for the shortest period of eligibility determined for any individual in the case.~~

(1) **Certification as categorically needy**. A categorically needy individual who is categorically related to ABD is assigned a certification period of 12 months. A categorically needy individual who is determined eligible for a State Supplemental Payment (SSP) is certified effective the month of application. If the individual is also eligible for payment for medical services received during the three months preceding the month of application, the ~~Medicaid~~ SoonerCare benefit is certified for the appropriate months. If the individual is not eligible for SSP, the first month of certification is the month that a medical service was provided or, if no medical service was provided, the month of application.

(A) **Certification of individuals categorically needy and categorically related to ABD**. The certification period for the individual categorically related to ABD can be assigned for up to 12 months. The individual must be determined as categorically needy for each month of the certification period. The certification period is 12 months unless the individual:

(i) is certified as eligible in a money payment case during the 12 month period;

(ii) is certified for long-term care during the 12 month period;

(iii) becomes ineligible for medical assistance after the initial month;

(iv) becomes ineligible as categorically needy; or

(v) is deceased.

(B) **Certification period**. If any of the situations listed in subparagraph (A) of this paragraph occur after the initial month, the case is closed by the worker.

(i) If income and/or resources change after certification causing the case to exceed the categorically needy maximums, the case is closed.

(ii) A pregnant individual included in an ABD case which closes continues to be eligible for pregnancy related services through the postpartum period.

(2) **Certification of individuals categorically related to ABD and eligible as Qualified Medicare Beneficiaries Plus**. The ~~Medicaid~~ SoonerCare benefit may be certified on the first day of the third month prior to the month of application or later. If the individual receives Medicare and is eligible for SSP, the effective date of certification

for the Medicare Part B premium buy-in is the month of certification for SSP. If the individual receives Medicare and is not eligible for SSP, the effective date of certification for the Medicare Part B premium buy-in is the first day of the month following the month in which the eligibility determination is made (regardless of when application was made).

(A) An individual determined eligible for QMBP benefits is assigned a certification period of 12 months. At any time during the certification period that the individual becomes ineligible, the case is closed using regular negative action procedures.

(B) At the end of the certification period a redetermination of QMBP eligibility is required, using the same forms and procedures as for ABD categorically needy individuals.

(3) **Certification of individuals categorically related to ABD and eligible as Qualified Disabled and Working Individual**. The Social Security Administration is responsible for referrals of individuals potentially eligible for QDWI. Eligibility factors verified by the SSA are Medicare Part A eligibility and discontinuation of disability benefits due to excessive earnings. When the OKDHS State Office receives referrals from SSA the county will be notified and is responsible for obtaining an application and establishing other factors of eligibility. If an individual contacts the county office stating he/she has been advised by SSA that ~~they are~~ he/she is a potential QDWI, the county takes a ~~Medicaid~~ SoonerCare application. ~~If the individual does not have verification of eligibility factors determined by SSA, the county contacts OKDHS, FSSD, State Office, for assistance in verifying those factors. The verification will be obtained by OKDHS State Office and sent to the county office.~~ The effective date of certification for QDWI benefits is based on the date of application and the date all eligibility criteria, including enrollment for Medicare Part A, are met. For example, if an individual applies for benefits in October and is already enrolled in Medicare Part A, eligibility can be effective October 1 (or up to three months prior to October 1, if all eligibility criteria are met during the three month period). However, if in the example, the individual's enrollment for Part A is not effective until November 1, eligibility cannot be effective until that date. Eligibility can never be effective prior to July 1, 1990, the effective date of this provision. These cases will be certified for a period of 12 months. At the end of the 12-month period, eligibility

redetermination is required. If the individual becomes ineligible at any time during the certification period, the case is closed. ~~The reason for closure is 69, and the worker completes the Notice to Client form.~~

(4) **Certification of individuals categorically related to ABD and eligible as Specified Low-Income Medicare Beneficiary (SLMB)**. The effective date of certification of SLMB benefits may begin on the first day of the third month prior to the month of application or later. A certification can never be earlier than the date of entitlement of Medicare Part A. An individual determined eligible for SLMB benefits is assigned a certification period of 12 months. At any time during the certification period the individual becomes ineligible, the case is closed using standard negative action procedures. At the end of the certification period a redetermination of SLMB eligibility is required. A redetermination of SLMB eligibility must also be done at the same time a dually eligible individual has a redetermination of eligibility for other ~~Medicaid~~ SoonerCare benefits such as long-term care.

(5) **Certification of individuals categorically related to disability and eligible for TB related services.**

(A) An individual determined eligible for TB related services may be certified the first day of the third month prior to the month of application or later, but no earlier than the first day of the month the ~~as long as verification is received of a diagnosis of~~ TB infection is diagnosed.

(B) A certification period of 12 months will be assigned. At any time during the certification period that the individual becomes ineligible, the case is closed using the regular negative action procedures.

(C) At the end of the certification period a new application will be required if additional treatment is needed.

(6) **Certification of individuals categorically related to ABD and eligible as Qualifying Individuals.** The effective date of certification for the QI-1 may begin on the first day of the third month prior to the month of application or later. A certification can never be earlier than the date of entitlement of Medicare Part A. An individual determined eligible for QI benefits is assigned a certification period of 12 months. At any time during the certification period the individual becomes ineligible, the case is closed using standard negative action procedures. At the end of the certification period, a redetermination of QI eligibility is required.

(A) Since the State's allotment to pay Medicare premiums for this group of individuals is limited, the State must limit the number of QIs so that the amount of assistance provided during the year does not exceed the State's allotment for that year.

(B) Persons selected to receive assistance are entitled to receive assistance with their Medicare premiums for the remainder of the federal fiscal year, but not beyond, as long as they continue to qualify. The fact that an individual is selected to receive assistance at any time during the year does not entitle the individual to continued assistance for any succeeding year.

(7) **Certification of individuals Related to Aid to the Disabled for TEFRA.** The certification period for individuals categorically related to the Disabled for TEFRA is 12 months.

317:35-7-60.1. Certification for the SoonerPlan Family Planning ~~Waiver~~ Program.

The effective date of certification for the SoonerPlan Family Planning ~~Waiver~~ Program is the date of application or later. The period of certification may not be for a retroactive period. An individual determined eligible for the SoonerPlan Family Planning ~~Waiver~~ Program is assigned a certification period of 12 months. At any time during the certification period the individual becomes ineligible, the case is closed using standard negative action procedures. At the end of the certification period, a redetermination of eligibility is required.

Oklahoma Health Care Authority

It is very important that you provide your comments regarding the proposed rule change by the comment due date. Comments are directed to Oklahoma Health Care Authority (OHCA) Health Policy Unit http://www.okhca.org/proposed-rule-changes.aspx

OHCA COMMENT DUE DATE: November 6, 2011

The proposed policy is a Permanent Rule. This proposal is scheduled to be presented to the Medical Advisory Committee (MAC) on November 16, 2011 and the (OHCA) Board of Directors on January 12, 2012.
Reference: APA WF 11-04

SUMMARY:
11-04– OHCA rules are revised to change language in policy that references "mental retardation" to "intellectual disabilities". Revisions are necessary to comply with federal regulation Public Law 111-256(Rosa's Law) that replaces the term mental retardation with intellectual disability, in federal education, health and labor laws.

LEGAL AUTHORITY
The Oklahoma Health Care Authority Board; Then Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; Public Law 111-256

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

TO: Tywanda Cox
Policy Development

From: LeKenya Samilton

SUBJECT: Rule Impact Statement
APA WF # 11-04

A. Brief description of the purpose of the rule:

OHCA rules are revised to change language in policy that references "mental retardation" to "intellectual

disabilities". Revisions are necessary to comply with federal regulation Public Law 111-256(Rosa's Law) that replaces the term mental retardation with intellectual disability, in federal education, health and labor laws.
OHCA rules are revised to change language in pole

B. A description of the classes of persons who most likely will be affected by the proposed rule, including classes that will bear the cost of the proposed rule, and any information on cost impacts received by the agency from any private or public entities:

The classes of persons most affected by this rule will be SoonerCare members who are diagnosed as mentally retarded. These individuals will be referenced as having an intellectual disability, which is a less offensive term.

C. A description of the classes of persons who will benefit from the proposed rule:

The persons who will most likely benefit from the proposed rule are SoonerCare members who have been diagnosed with intellectual disabilities.

D. A description of the probable economic impact of the proposed rule upon the affected classes of persons or political subdivisions, including a listing of all fee changes and, whenever possible, a separate justification for each fee change:

There is no probable economic impact of the proposed rule upon any classes of persons or political subdivisions.

E. The probable costs and benefits to the agency and to any other agency of the implementation and enforcement of the proposed rule, the source of revenue to be used for implementation and enforcement of the proposed rule, and any anticipated affect on state revenues, including a projected net loss or gain in such revenues if it can be projected by the agency:

There is no budgetary impact as a result of this rule.

F. A determination of whether implementation of the proposed rule will have an economic impact on any political subdivisions or require their cooperation in implementing or enforcing the rule:

The proposed rule will not have an economic impact on any political subdivision or require their cooperation in implementing or enforcing the rule.

G. A determination of whether implementation of the proposed rule will have an adverse effect on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act:

The proposed rule will not have an adverse effect on small businesses as provided by the Oklahoma Small Business Regulatory Flexibility Act.

H. An explanation of the measures the agency has taken to minimize compliance costs and a determination of whether there are less costly or nonregulatory methods or less intrusive methods for achieving the purpose of the proposed rule:

There agency has taken measures to determine that there is no less costly or non-regulatory method or less intrusive method for achieving the purpose of the proposed rule.

I. A determination of the effect of the proposed rule on the public health, safety and environment and, if the proposed rule is designed to reduce significant risks to the public health, safety and environment, an explanation of the nature of the risk and to what extent the proposed rule will reduce the risk:

The proposed rule should have no effect on the public health, safety, or environment.

J. A determination of any detrimental effect on the public health, safety and environment if the proposed rule is not implemented:

The agency does not anticipate any detrimental effects on the public health, safety, or environment.

K. The date the rule impact statement was prepared and if

modified, the date modified:

This rule impact statement was prepared on October 10, 2011.

RULE TEXT

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 3. GENERAL PROVIDER POLICIES
PART 3. GENERAL MEDICAL PROGRAM INFORMATION

317:30-3-40. Home and Community-Based Services Waivers for persons with intellectual disabilities ~~(mental retardation)~~ or certain persons with related conditions

(a) **Introduction to HCBS Waivers for ~~Persons~~ persons with intellectual disabilities.** The Medicaid Home and Community-Based Services (HCBS) Waiver programs are authorized in accordance with Section 1915(c) of the Social Security Act.

(1) Oklahoma Department of Human Services Developmental Disabilities Services Division (DDSD) operates HCBS Waiver programs for persons with ~~(mental retardation)~~ intellectual disabilities and certain persons with related conditions. Oklahoma Health Care Authority (OHCA), as the State's single Medicaid agency, retains and exercises administrative authority over all HCBS Waiver programs.

(2) Each waiver allows for the provision of specific SoonerCare-compensable services that assist members to reside in the community and avoid institutionalization.

(3) Waiver services:

(A) complement and supplement services available to members through the Medicaid State Plan or other federal, state, or local public programs, as well as informal supports provided by families and communities;

(B) can only be provided to persons who are Medicaid eligible, outside of a nursing facility, hospital, or institution; and

(C) are not intended to replace other services and supports available to members.

(4) Any waiver service must be:

(A) appropriate to the member's needs; and

(B) included in the member's Individual Plan (IP).

(i) The IP:

(I) is developed annually by the member's Personal Support Team, per OAC 340:100-5-52; and

(II) contains detailed descriptions of services provided, documentation of amount and frequency of

services, and types of providers to provide services.

(ii) Services are authorized in accordance with OAC 340:100-3-33 and 340:100-3-33.1.

(5) DDSD furnishes case management, targeted case management, and services to members as a Medicaid State Plan service under Section 1915(g)(1) of the Social Security Act in accordance with OAC 317:30-5-1010 through 317:30-5-1012.

(b) **Eligible providers.** All providers must have entered into contractual agreements with OHCA to provide HCBS for persons with ~~mental retardation~~ an intellectual disability or related conditions.

(c) **Coverage.** All services must be included in the member's IP. Arrangements for services must be made with the member's case

317:30-3-42. Services in a Nursing Facility (NF)

Nursing facility services are those services furnished pursuant to a physician's orders which require the skills of technical or professional personnel, e.g., registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists or audiologists. This care is provided by nursing facilities licensed under State law to provide, on a regular basis, health related care and services to individuals who do not require hospitalization but whose physical or mental condition requires care and services above the level of room and board which can be made available to them only through a nursing facility.

(1) To be eligible for nursing facility services the individual must:

(A) Require a treatment plan involving the planning and administration of services which require skills of licensed technical or professional personnel that are provided directly or under the supervision of such personnel and are prescribed by the physician;

(B) Have a physical impairment or combination of physical and mental impairments;

(C) Require professional nursing supervision (medication, hygiene and dietary assistance);

(D) Lack the ability to care for self or communicate needs to others; and

(E) Require medical care and treatment in a nursing facility to minimize physical health regression and deterioration. A physician’s order and results from a standardized assessment which evaluates type and degree of disability and need for treatment must support the individual’s need for NF level of care. Only

standardized assessments approved by the OHCA and administered in accordance with Medicaid approved procedures shall be used to make the NF level of care determination.

(2) If the individual experiences mental illness or ~~mental retardation~~ an intellectual disability or a related condition, payment cannot be made for services in a nursing facility unless the individual has been assessed through the Preadmission Screening and Resident Review (PASRR) process and the appropriate MR or MI authority has determined that nursing facility services are required. If it is determined that the patient also requires specialized services, the state must provide or arrange for the provision of such services. These determinations must be made prior to the patient's admission to the nursing facility.

(3) Payment cannot be made for an individual who is actively psychotic or capable of imminent harm to self or others (i.e., suicidal or homicidal).

(4) Payment is made to licensed nursing facilities that have agreements with the Authority.

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 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 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 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 visual screening and glasses each 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.
(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 OAC 317:30-5-278.

(J) Inpatient Psychotherapy services and psychological testing as outlined in OAC 317:30-5-95 through OAC 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 21 years of age and older who are legally competent, not institutionalized and have signed the "Consent Form" at least 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, ICF/MR, 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 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 prescriptions with a limit of two brand name prescriptions per month. Exceptions to the six prescription limit are:

(A) unlimited medically necessary monthly prescriptions for:

(i) members under the age of 21 years; and

(ii) residents of Nursing Facilities or Intermediate Care Facilities for the Mentally Retarded.

(B) seven medically necessary generic prescriptions per month in addition to the six covered under the State Plan are allowed for adults receiving services under the 1915(c) Home and Community Based Services Waivers. These additional medically necessary prescriptions beyond the two brand name or thirteen 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/MR's.

(21) Dental services for members residing in private ICF/MR's in accordance with the scope of dental services for members under age 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 21. Payment is also made for glasses for children with congenital aphakia or following cataract removal.

(25) Blood and blood fractions for members when administered on an outpatient basis.

(26) Inpatient services for members age 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 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 60 days

after the pregnancy ends, beginning on the last date of pregnancy.
(31) Nursing facility services for members under 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 R.N.
(33) Part A deductible and Part B Medicare Coinsurance and/or deductible.
(34) Home and Community Based Waiver Services for the ~~mentally retarded~~ intellectually disabled.
(35) Home health services limited to 36 visits per year and standard supplies for 1 month in a 12-month period. The visits are limited to any combination of Registered Nurse and nurse aide visits, not to exceed 36 per year.
(36) Medically necessary solid organ and bone marrow/stem cell transplantation services for children and adults are covered services based upon the conditions listed in (A)-(D) of this paragraph:

(A) 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.

(37) Home and community-based waiver services for ~~mentally retarded~~ intellectually disabled members who were determined to be inappropriately placed in a NF (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 0-3.
(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) Home and Community-Based Waiver services 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 6. INPATIENT PSYCHIATRIC HOSPITALS

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 instate 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, ~~mentally retarded~~ 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.

PART 9. LONG TERM CARE FACILITIES

317:30-5-122. Levels of care

(a) This rule sets forth the criteria used to determine whether an individual who is seeking SoonerCare payment for long term care services needs services at the level of Skilled Nursing Facility, or Intermediate Care Facility for People with Mental Retardation (ICF/MR). The criteria set forth in this Section must be used when determining level of care for individuals seeking SoonerCare coverage of either facility-based

institutional long term care services or Home and Community Based Services (HCBS) Waivers.

(b) The level of care provided by a long term care facility or through a HCBS Waiver is based on the nature of the person's needs and the care, services, and treatment required from appropriately qualified personnel. The level of care review is a determination of an individual's physical, mental and social/emotional status to determine the appropriate level of care required. In addition to level of care requirements, other applicable eligibility criteria must be met.

(1) **Skilled Nursing facility.** When total payments from all other payers are less than the Medicaid rate, payment is made for the Part A coinsurance for Medicare covered skilled nursing facility care for dually eligible, categorically needy individuals.

(2) **Nursing Facility.** Care provided by a nursing facility to patients who require professional nursing supervision and a maximum amount of nonprofessional nursing care due to physical conditions or a combination of physical and mental conditions.

(3) **Intermediate Care Facility for the Mentally Retarded.** Care for persons with ~~mental retardation~~ intellectual disabilities or related conditions to provide health and/or habilitative services in a protected residential setting. To qualify for ICF/MR level of care, persons must have substantial functional limitations in three or more of the following areas of major life activity:

(A) Self-care. The individual requires assistance, training or supervision to eat, dress, groom, bathe, or use the toilet.

(B) Understanding and use of language. The individual lacks functional communication skills, requires the use of assistive devices to communicate, does not demonstrate an understanding of request or is unable to follow two-step instructions.

(C) Learning. The individual has a valid diagnosis of intellectual disability ~~(mental retardation)~~ as defined in the Diagnostic and Statistical Manual of Mental Disorders.

(D) Mobility. The individual requires the use of assistive devices to be mobile and cannot physically self-evacuate from a building during an emergency without assistive device.

(E) Self-direction. The individual is 7 years old or older and significantly at risk in making age appropriate decisions or an adult who is unable to provide informed consent for medical care, personal safety or for legal, financial, habilitative or residential issues and/or has

been declared legally incompetent. The individual is a danger to himself or others without supervision.

(F) Capacity for independent living. The individual who is 7 years old or older and is unable to locate and use a telephone, cross the street safely or understand that it is unsafe to accept rides, food or money from strangers or an adult who lacks basic skills in the areas of shopping, preparing food, housekeeping or paying bills.

PART 39. SKILLED NURSING SERVICES

317:30-5-390. Home and Community-Based Services Waivers for adults with ~~mental retardation~~ an intellectual disability or certain adults with related conditions

(a) **Introduction to waiver services.** Each Home and Community-Based Services (HCBS) Waiver that includes services for adults with ~~mental retardation~~ an intellectual disability or certain adults with related conditions allows payment for home health care services as defined in the waiver approved by Centers for Medicare and Medicaid Services.

(1) Home health care services are skilled nursing services provided to a member by a registered nurse or a licensed practical nurse that include:

(A) direct nursing care;

(B) assessment and documentation of health changes;

(C) documentation of significant observations;

(D) maintenance of nursing plans of care;

(E) medication administration;

(F) training of the member's health care needs;

(G) preventive and health care procedures; and

(H) preparing, analyzing, and presenting nursing assessment information regarding the member.

(2) The first 36 visits provided by the home health care agency are covered by the Medicaid State Plan.

(b) **Eligible providers.** Skilled nursing services providers must enter into contractual agreements with the Oklahoma Health Care Authority to provide HCBS for adults with ~~mental retardation~~ an intellectual disability or certain adults with related conditions.

(1) Individual providers must be currently licensed in Oklahoma as a:

(A) registered nurse; or

(B) licensed practical nurse.

(2) Agency providers must:

(A) have a current Medicaid HCBS home health care agency contract; or

(B) be certified by Oklahoma State Department of Health as a home health care agency.

PART 41. FAMILY SUPPORT SERVICES

317:30-5-410. Home and Community-Based Services Waivers for persons with ~~mental retardation~~ an intellectual disability or certain persons with related conditions

(a) The Oklahoma Health Care Authority (OHCA) administers Home and Community-Based Services (HCBS) Waivers for persons with ~~mental retardation~~ an intellectual disability and certain persons with related conditions that are operated by the Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDSD). Each waiver allows payment for family support services as defined in the waiver approved by the Centers for Medicare and Medicaid Services (CMS). Waiver services:

(1) when utilized with services normally covered by SoonerCare, other generic services, and natural supports provide for health and developmental needs of members who otherwise would not be able to live in a home or community setting;

(2) are provided with the goal of promoting independence through strengthening the member's capacity for self-care and self-sufficiency;

(3) are centered on the needs and preferences of the member and support the integration of the member within his/her community; and

(4) do not include room and board. The costs associated with room and board must be met by the member.

(b) The DDSD case manager develops the Individual Plan (IP) and Plan of Care (Plan) per OAC 340:100-5-53. The IP contains descriptions of the services provided, documentation of the amount, frequency and duration of the services, and types of service providers.

(1) Services:

(A) are authorized per OAC 340:100-3-33 and 100-3-33.1.

(B) provided prior to the development of the IP or not included in the IP are not compensable. The Plan may not be backdated;

(C) may be provided on an emergency basis when approved by the area manager or designee. The plan must be revised to reflect the additional services; and

(D) are provided by qualified provider entities contracted with the OHCA.

(2) Members have freedom of choice of providers and in the selection of HCBS or institutional services.

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

317:30-5-420. Home and Community-Based Services Waivers for persons with ~~mental retardation~~ an intellectual disability or certain persons with related conditions

The Oklahoma Health Care Authority (OHCA) administers Home and Community-Based Services (HCBS) Waivers for persons with ~~mental retardation~~ an intellectual disability and certain persons with related conditions that are operated by the Oklahoma Department of Human Services Developmental Disabilities Services Division (DDSD). The Community Waiver and Homeward Bound Waiver allow payment for residential supports as defined in the waiver approved by the Centers for Medicare and Medicaid Services (CMS).

317:30-5-423. Coverage limitations

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

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

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

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

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

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

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

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

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

PART 51. HABILITATION SERVICES

317:30-5-480. Home and Community-Based Services for persons with ~~mental retardation~~ an intellectual disability or certain persons with related conditions

The Oklahoma Health Care Authority (OHCA) administers Home and Community-Based Services (HCBS) Waivers for persons with ~~mental retardation~~ intellectual disabilities or certain persons with related conditions that are operated by the Oklahoma Department of Human Services Developmental Disabilities Services Division (DDSD). Each waiver allows Medicaid compensable services provided to persons who are:

(1) medically and financially eligible; and

(2) not covered through the OHCA's SoonerCare program.

PART 53. SPECIALIZED FOSTER CARE

317:30-5-495. Home and Community-Based Services Waivers for persons with ~~mental retardation~~ an intellectual disability or certain persons with related conditions

(a) **Introduction to waiver services.** The Oklahoma Health Care Authority (OHCA) administers Home and Community-Based Services (HCBS) Waivers for persons with ~~mental retardation~~ an intellectual disability or certain persons with related conditions that are operated by Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDSD). The Community Waiver and Homeward Bound Waiver allow payment for specialized foster care (SFC), also known as specialized family care, as defined in the waiver approved by Centers for Medicare and Medicaid Services.

(b) **Eligible providers.** All SFC providers must:

(1) enter into contractual agreements with the OHCA to provide HCBS for persons with ~~mental retardation~~ an intellectual disability or certain persons with related conditions;

(2) have an approved home profile per OAC 317:40-5-40;

(3) complete training per OAC 340:100-3-38;

(4) have the ability to implement the member's Individual Plan (IP); and

(5) be emotionally and financially stable, in good health, and of reputable character.

PART 55. RESPITE CARE

317:30-5-515. Home and Community-Based Services Waivers for persons with ~~mental retardation~~ an intellectual disability or certain persons with related conditions

The Oklahoma Health Care Authority administers Home and Community-Based Services (HCBS) Waivers for persons with ~~mental retardation~~ an intellectual disability or certain persons with related conditions that are operated by the Oklahoma Department of Human Services Developmental Disabilities Services Division. Each waiver allows payment for respite care as defined in the waiver approved by the Centers for Medicare and Medicaid Services.

PART 59. HOMEMAKER SERVICES

317:30-5-535. Home and Community-Based Services Waiver for persons with ~~mental retardation~~ an intellectual disability or certain persons with related conditions

(a) **Introduction to waiver services.** The Oklahoma Health Care Authority (OHCA) administers Home and Community-Based Services (HCBS) Waivers for persons with ~~mental retardation~~ an intellectual disability or certain persons with related conditions that are operated by the Oklahoma Department of Human Services Developmental Disabilities Services Division. Each waiver allows payment for homemaker or homemaker respite services as defined in the waiver approved by the Centers for Medicare and Medicaid Services.

(b) **Eligible providers.** All homemaker services providers must enter into contractual agreements with the OHCA to provide HCBS for persons with ~~mental retardation~~ an intellectual disability or related conditions.

PART 79. DENTISTS

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 extractions;

(ii) Smoking and Tobacco Use Cessation Counseling; and

(iii) medical and surgical services performed by a dentist, to the extent such services may be performed under State law either by a doctor of dental surgery or dental medicine, 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 the Mentally Retarded (ICF/MR) and who have been

approved for ICF/MR level of care, similar to the scope of services available to individuals under age 21.

(C) Pregnant women are covered under a limited dental benefit plan (Refer to (a)(4)of this Section).

(2) **Home and community based waiver services (HCBWS) for the ~~mentally retarded~~ intellectually disabled.** All providers participating in the HCBWS must have a separate contract with the OHCA to provide services under the HCBWS. 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 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 is performed for any member not seen by any dentist for more than 12 months.

(B) **Periodic oral evaluation.** This procedure may be provided for a member of record if she or he has not been seen for more than six months.

(C) **Emergency examination/limited oral evaluation.** This procedure is not compensable within two months of a periodic oral examination or if the member is involved in active treatment unless trauma or acute infection is the presenting complaint.

(D) **Radiographs (x-rays).** To be SoonerCare compensable, x-rays must be of diagnostic quality and medically necessary. A clinical examination must precede any radiographs, and chart documentation must include member history, prior radiographs, caries risk assessment and both dental and general health needs of the member. The referring dentist is responsible for providing properly identified x-rays of acceptable quality with a referral, if that provider chooses to expose and submit for reimbursement prior to referral. Panoramic films are allowable once in a three year period and must be of diagnostic quality. Panoramic films are only compensable when chart documentation clearly indicates the test is being performed to rule out or evaluate non-caries related pathology. Prior

authorization and a detailed medical need narrative are required for additional panoramic films taken within three 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 18 years of age and is compensable only once per lifetime. Replacement of sealants is not a covered service under the SoonerCare program.

(F) **Dental prophylaxis.** This procedure is provided once every 184 days including topical application of fluoride.

(G) **Composite restorations.**

(i) This procedure is compensable for primary incisors as follows:

(I) tooth numbers O and P to age 4 years;

(II) tooth numbers E and F to age 6 years;

(III) tooth numbers N and Q to 5 years; and

(IV) tooth numbers D and G to 6 years.

(ii) The procedure is also allowed for use in all vital and successfully treated non-vital permanent anterior teeth.

(iii) Class I and II composite restorations are allowed in posterior teeth; however, the OHCA has certain restrictions for the use of this restorative material. (See OAC 317:30-5-699).

(H) **Amalgam.** Amalgam restorations are allowed in:

(i) posterior primary teeth when:

(I) 50 percent or more root structure is remaining;

(II) the teeth have no mobility; or

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

(ii) any permanent tooth, determined as medically necessary by the treating dentist.

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

(i) Stainless steel crowns are allowed if:

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

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

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

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

(I) primary teeth with pulpotomies or pulpectomies, if the above conditions exist;

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

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

(iii) Stainless steel crowns are the treatment of choice on posterior permanent teeth that have completed endodontic therapy, if more than three surfaces of extensive decay exist or where cuspal occlusion are lost due to decay prior to age 16 years.

(iv) Preoperative periapical x-rays must be available for review, if requested.

(v) Placement of a stainless steel crown includes all related follow up service for a period of two years. No other prosthetic procedure on that tooth is compensable during that period of time. A stainless steel crown is not a temporizing treatment to be used while a permanent crown is being fabricated.

(J) **Pulpotomies and pulpectomies.**

(i) Therapeutic pulpotomies are allowable for molars and teeth numbers listed below. Pre and post operative periapical x-rays must be available for review, if requested.

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

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

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

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

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

(ii) Pulpectomies are allowed for primary teeth if exfoliation of the teeth is not expected to occur for at least one year or if 70 percent or more of root structure is remaining.

(K) **Anterior root canals.** Payment is made for the services provided in accordance with the following:

(i) This procedure is done for permanent teeth when there are no other missing anterior teeth in the same arch requiring replacement.

(ii) Acceptable ADA filling materials must be used.

(iii) Preauthorization is required if the member's treatment plan involves more than four anterior root canals.

(iv) Teeth with less than 50 percent of clinical crown should not be treatment-planned for root canal therapy.

(v) Pre and post operative periapical x-rays must be available for review.

(vi) Pulpotomy may be performed for the relief of pain while waiting for the decision from the OHCA.

(vii) Providers are responsible for any follow-up treatment required due to a failed root canal therapy for 24 month post completion.

(viii) Endodontic 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.

(ix) If there are three or more missing teeth in the arch that requires replacement, root therapy will not be allowed.

(L) **Space maintainers.** Certain limitations apply with regard to this procedure. Providers are responsible for recementation of any maintainer placed by them for six 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 or where the successor tooth would not normally erupt in the next 12 months.

(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 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 x-rays must be available for review.

(VI) Bilateral band and loop space maintainer is allowed if member does not have eruption of the four 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 multiple missing teeth exist in the same arch.

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

(III) Multiple missing upper anterior primary incisors may be replaced with the appliance to age ~~6.0~~ 6 years to prevent abnormal swallowing habits.

(IV) Pre and post operative x-rays must be available.

(iii) **Interim partial dentures.** This service is for anterior permanent tooth replacement or if the member is missing three or more posterior teeth to age 16 years.

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

(i) **Inhalation of nitrous oxide.** Use of nitrous oxide is compensable for four 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 need for this service must be documented in the member's record. This procedure is not covered when it is the dentist's usual practice to offer it to all patients.

(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.

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

(O) **Sedative restorations.** Sedative restorations include removal of decay, if present, and direct or indirect pulp cap, if needed. These services are reimbursable for the same tooth on the same date of service. Permanent restoration of the tooth is allowed after 30 days unless the tooth becomes symptomatic and requires pain relieving treatment.

(P) **History and physical.** Payment is made for services for the purpose of admitting a patient to a hospital for dental treatment.

(Q) **Local anesthesia.** This procedure is included in the fee for all services.

(R) **Smoking and Tobacco Use Cessation Counseling.** Smoking and Tobacco Use Cessation Counseling is covered when performed utilizing the five 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 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, nurse midwives, and Oklahoma State Health Department and FQHC nursing staff in addition to other appropriate services rendered. Chart documentation must include a separate note, separate signature, and the member specific information

addressed in the five steps and the time spent by the practitioner performing the counseling. Anything under three minutes is considered part of a routine visit.

(4) **Pregnant Women.** Dental coverage for this special population is provided regardless of age.

(A) Proof of pregnancy is required (Refer to OAC 317:35-5-6).

(B) Coverage is limited to a time period beginning at the diagnosis of pregnancy and ending upon 60 days post partum.

(C) In addition to dental services for adults, other services available include:

(i) Comprehensive oral evaluation must be performed and recorded for each new member, or established member not seen for more than 24 months;

(ii) Periodic oral evaluation as defined in OAC 317:30-5-696(3)(B);

(iii) Emergency examinations/limited oral evaluation. This procedure is not allowed within two months of an oral examination by the same provider for the same member, or if the member is under active treatment;

(iv) Radiographs as defined in OAC 317:30-5-696(3)(D);

(v) Dental prophylaxis as defined in OAC 317:30-5-696(3)(F);

(vi) Composite restorations:

(I) Any permanent tooth that has an opened lesion that is a food trap will be deemed medically necessary for this program and will be allowed for all anterior teeth.

(II) Class I posterior composite resin restorations are allowed in posterior teeth that qualify;

(vii) Amalgam. Any permanent tooth that has an opened lesion that is a food trap will be deemed as medically necessary and will be allowed; and

(viii) Analgesia. Analgesia services are reimbursable in accordance with OAC 317:30-5-696(iii)(M)

(D) Services requiring prior authorization (Refer to OAC 317:30-5-698).

(E) Periodontal scaling and root planing. Required that 50% or more of six point measurements be ~~4~~ 5 millimeters or greater. This procedure is designed

for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins and microorganism and requires anesthesia and some soft tissue removal.

(5) **Individuals eligible for Part B of Medicare.**

(A) Payment is made based on the member's coinsurance and deductibles.

(B) Services which have been denied by Medicare as non-compensable should be filed directly with the OHCA with a copy of the Medicare EOB indicating the reason for denial.

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 317:30-5-695(d)(2). Requests for dental services requiring prior authorization must be accompanied by sufficient documentation. X-rays, six point periodontal charting and comprehensive treatment plans are required. Study models and narratives may be requested by OHCA or representatives of OHCA. If the quality of the supporting material is such that a determination of authorization cannot be made, the material is returned to the provider. Any new documentation must be provided at the provider's expense. Submitted documentation used to base a decision will not be returned.

(b) Requests for prior authorization are filed on the currently approved 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 and eligible ICF/MR residents. Minimum required records to be submitted with each request are right and left mounted bitewing x-rays and periapical films of tooth/teeth involved or the edentulous areas if not visible in the bitewings. X-rays must be submitted with x-ray film mounts and each film or print must be of good readable quality. X-rays must be identified by left and right sides with the date, member name, member ID, provider name, and provider ID. All x-rays, regardless of the media, must be placed together in the same envelope with a completed

comprehensive treatment plan and a completed current ADA form requesting all treatments requiring prior authorization. The film, digital media or printout 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.** Pulpotomy may be performed for the relief of pain while waiting for the decision from the OHCA on request for endodontics. A permanent restoration is not billable to the OHCA when performing pulpotomy or pulpal debridement on a permanent tooth.

(A) **Anterior root canals.** This procedure is for members who have a treatment plan requiring more than four anterior and/or posterior root canals. Payment is made for services provided in accordance with the following:

(i) Permanent teeth numbered 6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26 and 27 are eligible for therapy if there are no other missing teeth in the same arch requiring replacement, unless numbers 6 , 11 , 22, or 27 are abutments for prosthesis.

(ii) Accepted ADA materials must be used.

(iii) Pre and post operative periapical x-rays must be available for review.

(iv) Providers are responsible for any follow-up treatment required by a failed endodontically treated tooth within 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.

(vi) An endodontic procedure may not be approved if the tooth requires a post and core to retain a crown.

(vii) If there are three or more missing teeth in the arch that requires replacement, root therapy will not be authorized.

(B) **Posterior endodontics.** The guidelines for this procedure are as follows:

(i) The provider documents that the member has improved oral hygiene and flossing ability in this member's records.

(ii) Teeth that would 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 x-rays must be available for review.

(iv) Providers are responsible for any follow-up treatment required by a failed endodontically treated tooth within 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 is limited to a maximum of five teeth. A request 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) there are missing teeth in the same arch requiring replacement;

(II) an opposing tooth has super erupted;

(III) loss of tooth space is one third or greater;

(IV) opposing second molars are involved unless prior authorized; or

(V) the member has multiple teeth failing due to previous inadequate root canal therapy or follow-up.

(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.

(x) a failing root canal is determined not medically necessary for re-treatment.

(2) **Cast metal crowns or ceramic-based crowns.** These procedures are compensable for restoration of natural teeth for members who are 16 years of age or older and adults residing in private Intermediate Care Facilities for the Mentally Retarded(ICF/MR) and who have been approved for (ICF/MR) level of care. Certain criteria and limitations apply.

(A) The following conditions must exist for approval of this procedure.

(i) The tooth must be fractured or decayed to such an extent to prevent proper cuspal or incisal function.

(ii) The clinical crown is destroyed by the above elements by one-half or more.

(iii) Endodontically treated teeth must have three or more surfaces restored or lost due to carious activity to be considered.

(B) The conditions listed in (A)(i) through (A)(iii) of this paragraph should be clearly visible on the submitted x-rays when a request is made for any type of crown.

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

(D) A crown will not be approved if adequate tooth structure does not remain to establish cleanable margins, poor crown to root ratio, or the tooth appears to retain insufficient amounts of natural tooth structure. Cast dowel cores are not allowed.

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

(F) Ceramic-metal based crowns will be considered only for tooth numbers 4 through 13 and 21 through 28.

(G) Porcelain/Ceramic substrate crowns are allowed on maxillary and mandibular incisors only.

(H) Full cast metal crowns are treatment for all posterior teeth,

(I) Provider is responsible for replacement or repair of all cast crowns if due to failure caused by poor laboratory processes or procedure by provider for 48 months post insertion.

(3) **Cast frame partial dentures.** This appliance is the treatment of choice for replacement of three or more missing permanent teeth in the same arch for members 16 through 20 years of age. Provider must indicate tooth number to be replaced and teeth to be clasped.

(4) **Acrylic partial.** This appliance is the treatment of choice for replacement of missing anterior permanent teeth or three or more missing teeth in the same arch for members 12 through 16 years of age and adults residing in private Intermediate Care Facilities for the Mentally Retarded (ICF/MR) and who have been approved for ICF/MR level of care. Provider must indicate tooth numbers to be replaced and teeth to be clasped. This appliance includes all necessary clasps and rests.

(5) **Occlusal guard.** Narrative of clinical findings must be sent with prior authorization request.

(6) **Fixed cast non-precious metal or porcelain/metal bridges.** Only members 17 through 20 years of age where the bite relationship precludes the use of removable partial dentures are considered. Members must have excellent oral hygiene documented in the requesting provider's records.

Provider is responsible for any needed follow up for a period of five years post insertion.

(7) **Periodontal scaling and root planing.** This procedure requires that 50% or more of the six point measurements be five millimeters or greater and must involve two or more teeth per quadrant for consideration. This procedure is allowed on members 12 to 20 years of age and requires anesthesia and some soft tissue removal. The procedure is not allowed in conjunction with any other periodontal surgery. Allowance may be made for submission of required authorization data post treatment if the member has a medical or emotional problem that requires sedation.

(8) **Additional prophylaxis.** The OHCA recognizes that certain physical conditions require more than two prophylaxes. The following conditions may qualify a member for one additional prophylaxis per year:

(A) dilantin hyperplasia;

(B) cerebral palsy;

(C) ~~mental retardation~~ intellectual disabilities;

(D) juvenile periodontitis.

PART 85. ADVANTAGE PROGRAM WAIVER SERVICES

317:30-5-760. ADvantage program

The ADvantage Program is a Medicaid Home and Community Based Services (HCBS) Waiver used to finance noninstitutional long-term care services through Oklahoma's Medicaid program for elderly and disabled individuals. To receive ADvantage Program services, individuals must meet the nursing facility (NF) level of care (LOC) criteria, be age 65 years or older, or age 21 or older if physically disabled and not developmentally disabled, or if developmentally disabled and between the ages of 21 and 65, not have ~~mental retardation~~ an intellectual disability or a cognitive impairment related to the developmental disability. ADvantage Program recipients must be Medicaid eligible. The number of recipients of ADvantage services is limited.

PART 101. TARGETED CASE MANAGEMENT SERVICES FOR PERSONS WITH ~~MENTAL RETARDATION~~ AN INTELLECTUAL DISABILITY AND/OR RELATED CONDITIONS

317:30-5-1011. Coverage by category

Payment is made for targeted case management service as set forth in this Section.

(1) **Adults.** Payment is made for services to persons with ~~mental retardation~~ an intellectual disability and/or related conditions as follows:

(A) The target group for Developmental Disabilities Services Division Targeted Case Management (DDSDTCM) services are Medicaid eligible individuals:

(i) served by the Home and Community Based Waivers operated by the Department of Human Services/Developmental Disabilities Services Division (DHS/DDSD); or

(ii) residing in institutions who:

(I) have requested Home and Community Based Waiver services operated by DHS/DDSD, and

(II) receive targeted case management services during a transition period not to exceed 180 consecutive days immediately prior to entering the Waiver; or

(iii) who are being assessed for admission to the Home and Community Based Waiver operated by DHS/DDSD.

(B) Targeted case management services may be provided when the client, the client's family as appropriate, the client's legal representative and case manager have worked together to achieve a plan.

(2) **Children.** Services for children are the same as for adults.

(3) **Individuals eligible for Part B of Medicare.** Case Management Services provided to Medicare eligible recipients are filed directly with the fiscal agent.

317:30-5-1076. Coverage by category

Payment is made for Nutritional Services as set forth in this section.

(1) **Adults.** Payment is made for six hours of medically necessary nutritional counseling per year by a licensed registered dietician. All services must be prescribed by a physician, physician assistant, advanced practice nurse, or nurse midwife and be face to face encounters between a licensed registered dietitian and the member. Services must be expressly for diagnosing, treating or preventing, or minimizing the effects of illness. Nutritional services for the treatment of obesity is not covered unless there is documentation that the obesity is a contributing factor in another illness.

(2) **Children.** Payment is made for medically necessary nutritional counseling as described above for adults. Nutritional services for the treatment of obesity may be covered for children as part of the EPSDT benefit. Additional services which are deemed medically necessary and allowable under federal regulations may be covered by the EPSDT benefit found at 317:30-3-65 and 317:30-3-65.11.

(3) **Home and Community Based Waiver Services for the ~~Mentally Retarded~~ Intellectually Disabled.** All providers participating in the Home and Community Based Waiver Services for the ~~Mentally Retarded~~ intellectually disabled program must have a separate contract with OHCA to provide Nutrition Services under this program. All services are specified in the individual's plan of care.

(4) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the Medicaid allowable for comparable services. Services which are not covered under Medicare should be billed directly to OHCA.

(5) **Obstetrical patients.** Payment is made for a maximum of six hours of medically necessary nutritional counseling per year by a licensed registered dietitian for members at risk for or those who have been recently diagnosed with gestational diabetes. The initial consultation may be in a group setting for a maximum of two hours of class time. Thereafter, four hours of nutritional counseling by a licensed registered dietitian may be provided to the individual if deemed medically necessary, which may include a post-partum visit, typically done at 6 weeks after delivery. All services must be prescribed by a physician, physician assistant, advanced practice nurse or a nurse midwife and be face-to-face between a licensed registered dietitian and the member(s). Services must be solely for the prevention, diagnosis, or treatment of gestational diabetes.

PART 113. LIVING CHOICE PROGRAM

317:30-5-1201. Benefits for members with ~~mental retardation~~ an intellectual disability

(a) Living Choice program participants with ~~mental retardation~~ an intellectual disability may receive a range of necessary medical and home and community based services for one year after moving from the institution. The one year period begins the day the member occupies a qualified residence in the community. Once this transition period is complete, the member receives services through the Community waiver.

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

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

(d) Services that may be provided to members with ~~mental retardation~~ intellectual disabilities are listed in paragraphs (1) through (28) of this subsection:

(1) assistive technology;
(2) adult day health care;
(3) architectural modifications;
(4) audiology evaluation and treatment;
(5) community transition;
(6) daily living support;
(7) dental services;
(8) family counseling;
(9) family training;
(10) group home;
(11) respite care;
(12) homemaker services;
(13) habilitation training services;
(14) home health care;
(15) intensive personal support;
(16) extended duty nursing;
(17) skilled nursing;
(18) nutrition services;
(19) therapy services including physical, occupational, and speech;
(20) psychiatry services;
(21) psychological services;
(22) agency companion services;
(23) non-emergency transportation;
(24) pre-vocational services;
(25) supported employment services;
(26) specialized foster care;
(27) specialized medical equipment and supplies; and
(28) SoonerCare compensable medical services.

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

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

(a) **General.** The term income is defined as that gross gain or gross recurrent benefit which is derived from labor, business, property, retirement and other benefits, and many other forms which can be counted on as currently 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.

(1) If it appears the applicant or SoonerCare member is eligible for any type of income (excluding SSI) or resources, he/she must be notified in writing by the Agency of his/her potential eligibility. The notice must contain the information that failure to file for and take all appropriate steps to obtain such benefit within 30 days from the date of the notice will result in a determination of ineligibility.

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

(3) If only one spouse in a couple is eligible and the couple ceases to live together, only the income and resources of the ineligible spouse that are actually contributed to the eligible spouse beginning with the month after the month which they ceased to live 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 OASDI benefits.

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

(1) The coupon allotment under the Food Stamp Act of 1977;

(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 (BIA) 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) 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 approves the plan, the amount of income excluded and the period of time approved. A plan can be approved for an initial period of 18 months. The plan may be extended for an additional 18 months if needed, and an additional 12 months (total 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; and

(31) Wages paid by the Census Bureau for temporary employment related to Census activities.

(c) **Determination of income.** 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.

(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 the mentally retarded 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 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 lump sum) covering a period of more than one 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, including SSI (with the exception of dedicated bank accounts for disabled/blind children under age 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, retroactive OASDI, VA benefits, Workers'

Compensation, bonus lease payments and annual rentals from land and/or minerals.

(ii) 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 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.

(iii) 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.

(iv) 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 months' royalty income is computed and used to determine income eligibility. 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 month's 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 rent property is treated as unearned income.

(iii) When property rental 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 expense and appropriate earned income disregards.

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

(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.

(F) **Inconsequential or irregular income.** Inconsequential or irregular receipt of income in the amount of $10 or less per month or $30 or less per quarter is disregarded. The disregard is applied per individual for each type of inconsequential or irregular income. To determine whether the income is inconsequential or irregular, the gross amount of earned income and the gross minus business expense of self-employed income are considered.

(G) **Monthly income received in fluctuating amounts.** 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:

(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 2.

(iv) **Biweekly.** Income received every two 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.

(d) **Computation of income.**

(1) **Earned income.** The general income exclusion of $20 per month is allowed on the combined earned income of the eligible individual and eligible or ineligible spouse. See paragraph (6) of this subsection if there are ineligible minor children. After the $20 exclusion, deduct $65 and one-half of the remaining combined earned income.

(2) **Unearned income.** The total gross amount of unearned income of the eligible individual and eligible or ineligible spouse is considered. See paragraph (6) of this subsection if there are ineligible minor children.

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

(4) **Deeming computation for disabled or blind minor child(ren).** 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 18.

(A) A ~~mentally retarded~~ 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.

(5) **Premature infants.** Premature infants (i.e., 37 weeks or less) whose birth weight is less than 1200 grams (approximately 2 pounds 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.

(6) **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.

(7) **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 broad categories:

(A) transportation to and from work;

(B) job performance; and

(C) job improvement.

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

PART 1. SERVICES

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

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

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

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

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

(b) Members receiving HCBS Waiver services per OAC 317:40-1-1 are subject to HCBS Waiver service conditions (1)-(11) of this

subsection. The rules in this subsection shall not be construed as a limitation of the rights of class members set forth in the Second Amended Permanent Injunction in Homeward Bound vs. The Hissom Memorial Center.

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

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

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

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

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

(4) Members receiving Waiver services must have full access to State plan services for which they are eligible including Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services when children participate in a Waiver.

(5) A member's room and board expenses may not be paid through a Waiver. Room and board expenses must be met from member resources or through other sources.

(6) A member must require at least one Waiver service per month or monthly case management monitoring in order to function in the community.

(7) Waiver services required by a member must be documented in advance of service delivery in a written plan of care.

(8) Members exercise freedom of choice by choosing Waiver services instead of institutional services.

(9) Members have the right to freely select from among any willing and qualified provider of Waiver services.

(10) The average costs of providing Waiver and non-Waiver SoonerCare services must be no more costly than the average costs of furnishing institutional (and other SoonerCare state plan) services to persons who require the same level of care.

(11) Members approved for services provided in a specific Waiver must be afforded access to all necessary services offered in the specific Waiver if the member requires the service.

PART 3. APPLICATION PROCEDURES

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

(a) **Application procedures for long-term medical care.** An application for these types of services consists of the Medical Assistance Application. The Medical Assistance Application is

signed by the patient, parent, spouse, guardian or someone else acting on the patient's behalf.

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

(2) At the request of an individual in an ICF/MR or receiving Home and Community Based Waiver Services for the ~~Mentally Retarded~~ Intellectually Disabled or the community spouse, if application for Medicaid is not being made, an assessment of the resources available to each spouse is made by use of DHS Form MA-11, Assessment of Assets. Documentation of resources must be provided by the individual and/or spouse. This assessment reflects all countable resources of the couple (owned individually or as a couple) and establishes the spousal share to be protected when subsequent determination of Medicaid eligibility is made. A copy of Form MA-11 is provided to each spouse for planning in regard to future eligibility. A copy is retained in the county office in case of subsequent application.

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

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

PART 5. DETERMINATION OF MEDICAL ELIGIBILITY FOR ICF/MR, HCBW/MR, AND INDIVIDUALS AGE 65 OR OLDER IN MENTAL HEALTH HOSPITALS

317:35-9-45. Determination of medical eligibility for care in a private Intermediate Care Facility for Persons with Mental Retardation

(a) **Pre-approval of medical eligibility.** Pre-approval of medical eligibility for private ICF/MR care is based on level of care requirements per OAC 317:30-5-122. Pre-approval is not necessary for individuals with a severe or profound intellectual disability ~~(mental retardation)~~. Pre-approval is made by Oklahoma Health Care Authority (OHCA) Level of Care Evaluation Unit (LOCEU) analysts.

(b) **Application for ICF/MR services.** Within 30 calendar days after services begin, the facility must submit:

(1) the original of the ICF/MR Level of Care Assessment form (LTC-300) to LOCEU. Required attachments include:

(A) Current (within 90 days of requested approval date) medical information signed by a physician.

(B) A current (within 12 months of requested approval date) psychological evaluation by a licensed Psychologist or State staff supervised by a licensed Psychologist. The evaluation must include intelligence testing that yields a full-scale intelligence quotient, a full-scale functional or adaptive assessment, as well as the age of onset.

(C) A copy of the pertinent section of the Individual Plan or other appropriate documentation relative to the ICF/MR admission and the need for ICF/MR level of care.

(D) A statement that the member is not an imminent threat of harm to self or others (i.e., suicidal or homicidal).

(2) If pre-approval was determined by LOCEU and the above information is received, medical approval will be entered on an electronic medical case list known as MEDATS. Pre-approval is not needed for individuals with a severe or profound intellectual disability ~~(mental retardation)~~.

(c) **Categorical relationship.** Categorical relationship must be established for determination of eligibility for long-term medical care. If categorical relationship has not already been established, the proper forms and medical information are submitted to LOCEU. (Refer to OAC 317:35-5-4). In such instances LOCEU will render a decision on categorical relationship using the same definition as used by the with SSA. A follow-up is required by the OKDHS social worker with the SSA to be sure that their disability decision agrees with the decision of LOCEU.

(d) **Medical eligibility for ICF/MR services.**

(1) Individuals must require active treatment per 42 CFR 483.440.

(2) Individuals must have a diagnosis of intellectual disability ~~(mental retardation)~~ or a related condition based on level of care requirements per OAC 317:30-5-122 and results of a current comprehensive psychological evaluation by a licensed Psychologist or State staff supervised by a licensed Psychologist.

(A) Per the Diagnostic and Statistical Manual of Mental Disorders, intellectual disability ~~(mental retardation)~~ is a condition characterized by a significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior and originating before 18 years of age.

(B) Per 42 CFR 435.1010, persons with related conditions means individuals who have a severe, chronic disability that meets the following conditions:

(i) It is attributable to cerebral palsy or epilepsy; or

(ii) it is attributable to any other condition, other than mental illness, found to be closely related to intellectual disability ~~(mental retardation)~~ because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with intellectual disability ~~(mental retardation)~~ and requires treatment or services similar to those required for these persons.

(iii) It is manifested before the person reaches age 22.

(iv) It is likely to continue indefinitely.

(v) It results in substantial functional limitations in three or more areas of major life activity per OAC 317:30-5-122.

(C) Conditions closely related to intellectual disability ~~(mental retardation)~~ include, but are not limited to the following:

(i) autism or autistic disorder, childhood disintegrative disorder, Rett syndrome and pervasive developmental disorder, not otherwise specified (only if "typical autism");

(ii)severe brain injury (acquired brain injury, traumatic brain injury, stroke, anoxia, meningitis);

(iii) fetal alcohol syndrome;

(iv) chromosomal disorders (Down syndrome, fragile x syndrome, Prader-Willi syndrome);and

(v) other genetic disorders (Williams syndrome, spina bifida, phenylketonuria).

(D) The following diagnoses do not qualify as conditions related to intellectual disability. ~~(mental retardation)~~ Nevertheless, a person with any of these conditions is not disqualified if there is a simultaneous occurrence of a qualifying condition:

(i) learning disability;

(ii) behavior or conduct disorders;

(iii) substance abuse;

(iv) hearing impairment or vision impairment;

(v) mental illness that includes psychotic disorders, adjustment disorders, reactive attachment disorders, impulse control disorders, and paraphilias;

(vi) borderline intellectual functioning, developmental disability that does not result in an intellectual impairment, developmental delay or "at risk" designations;

(vii) physical problems (such as multiple sclerosis, muscular dystrophy, spinal cord injuries and amputations);

(viii) medical health problems (such as cancer, acquired immune deficiency syndrome and terminal illnesses);

(ix) milder autism spectrum disorders (such as Asperger's disorder and pervasive developmental disorder not otherwise specified if not "atypical autism");

(x) neurological problems not associated with intellectual deficits (such as Tourette's syndrome, fetal alcohol effects and non-verbal learning disability);or

(xi) mild traumatic brain injury (such as minimal brain injury and post-concussion syndrome).

317:35-9-48.1 Determining ICF/MR institutional level of care for TEFRA children

In order to determine level of care for TEFRA children:

(1) The child must be age 18 years or younger and expected to meet the following criteria for at least 30 days.

(A) Applicants under age three must:

(i) have a diagnosis of a developmental disability; and

(ii) have been evaluated by the SoonerStart Early Intervention Program and found to have severe dysfunctional deficiencies with findings of at least

two standard deviations in at least two developmental areas.

(B) Applicants age three years and older must:

(i) have a diagnosis of ~~mental retardation~~ an intellectual disability or a developmental disability; and

(ii) have received a psychological evaluation by a licensed psychologist or school psychologist certified by the Oklahoma Department of Education (ODE) within the last 12 months. The evaluation must include intelligence testing that yields a full-scale intelligence quotient, and a full-scale functional or adaptive assessment that yields a composite functional age. Eligibility for TEFRA ICF/MR level of institutional care requires an IQ of 75 or less, and a full-scale functional assessment (Vineland or Battelle) indicating a functional age composite that does not exceed 50% of the child's chronological age. In no case shall eligibility be granted for a functional age greater than eight years.

(2) Psychological evaluations required for children who are approved for TEFRA under ICF/MR level of care. Children under age six will be required to undergo a full psychological evaluation, including both intelligence testing and adaptive/functional assessment, by a licensed psychologist or school psychologist certified by the ODE, at age three and again at age six to ascertain continued eligibility for TEFRA under the ICF/MR level of institutional care. The psychological evaluation must be completed and submitted to the LOCEU no later than 90 days following the child's third and sixth birthday.

317:35-9-49. Determination of medical eligibility for Home and Community Based Waiver Services for the ~~Mentally Retarded~~ Intellectually Disabled

Determinations of medical eligibility for Home and Community Based Waiver Services for the ~~Mentally Retarded (HCBW/MR)~~ Intellectually Disabled (HCBW/ID) is made through referral to the DHS DDSD case manager.

(1) **Referral.** If the county receives an application, Form K-13 is forwarded to the DDSD case manager, who is responsible for securing a ~~HCBW/MR~~ HCBW/ID medical determination and a disability decision, if needed.

(2) **Initial request.** If the initial request is through DDSD, Form K-13 is forwarded to the county for completing the application process.

(3) **Plan of care packet.** The DDSD case manager submits the necessary information to LOCEU for medical determination and a disability decision if needed.

(4) **County notification.** LOCEU notifies the county and DDSD case manager of determination by updating the MEDATS file.

(5) **Procedures for an individual returning home.** If referral is from a public ICF/MR for an individual returning to the home, the DDSD case manager forwards to the worker the medical eligibility determination for ~~HCBW/MR~~ HCBW/ID along with the latest application form and redetermination of eligibility form used to determine eligibility for institutional care. A new application will not be required. A case number will be assigned retaining the application date, certification date and redetermination of eligibility date.

(6) **Determination of continued eligibility for ~~HCBW/MR~~** HCBW/ID. The case manager is responsible for assuring that the individual's needs are re-evaluated and that recertification is established annually. Determination of continued medical eligibility is not necessary unless there is a significant change in the client's condition. The DDSD cases manager will notify LOCEU if this is the case.

PART 11. PAYMENT, BILLING, AND OTHER ADMINISTRATIVE PROCEDURES

317:35-9-97. Payment for Home and Community Based Waiver services for the ~~Mentally Retarded (HCBW/MR)~~ Intellectually Disabled (HCBW/ID)

Payment is made to ~~HCBW/MR~~ HCBW/ID providers who have been certified as eligible to provide such services by the DHS Developmental Disabilities Services Division (DDSD). Certification is made after the provider has completed required training or meets the State licensing requirements for that medical discipline. Each provider must enter into a contract to provide ~~HCBW/MR~~ HCBW/ID services. Payment is made on a procedure-based reimbursement methodology for each service. All services must be preauthorized before payment can be made.

SUBCHAPTER 10. OTHER ELIGIBILITY FACTORS FOR FAMILIES WITH CHILDREN AND PREGNANT WOMEN

PART 5. INCOME

317:35-10-38. Temporary absence from the home.

An individual who is temporarily absent from the home for the purpose of receiving training or education for employment, certain medical services, etc., may be considered part of the benefit group.

(1) Individuals temporarily absent from the home, receiving training or education for employment are considered part of the benefit group during the period of time the training or educational activities are taking place.
(2) Children temporarily absent from the home to attend boarding school are considered part of the benefit group during the school term.
(3) Individuals temporarily absent from the home because of entrance into a private facility for counseling, rehabilitation, behavioral problems or special training, etc., are considered part of the benefit group. If care is projected for a period exceeding 90 days, the absence is not considered temporary. At any time an absence is determined as not temporary or no longer temporary, the needs of the individual cannot be included in the benefit group.
(4) Individuals temporarily absent from the home for medical services, other than institutionalization for treatment of mental illness, ~~mental retardation~~ intellectual disability, or tuberculosis, are considered part of the benefit group for up to six months. Six-month extensions may be allowed when the worker's verification indicates the individual may return to the home within the next six months.

SUBCHAPTER 15. PERSONAL CARE SERVICES

317:35-15-1. Overview of long-term medical care services; relationship to QMB, SLMB and other SoonerCare service eligibility and spenddown calculation

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

met. Another application for QMB or SLMB benefits is not required.

SUBCHAPTER 17. ADVANTAGE WAIVER SERVICES

317:35-17-1. Overview of long-term medical care services; relationship to QMBP, SLMB, and other Medicaid services eligibility

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

(1) care in a nursing facility (refer to OAC 317:35-19);

(2) care in a public or private intermediate care facility for the mentally retarded (refer to OAC 317:35-9);

(3) care of persons age 65 years or older in mental health hospitals (refer to OAC 317:35-9);

(4) Home and Community Based Services Waivers for the ~~Mentally Retarded~~ Intellectually Disabled (refer to OAC 317:35-9);

(5) Personal Care services (refer to OAC 317:35-15); and

(6) the Home and Community Based Services Waiver for frail elderly, a targeted group of adults with physical disabilities age 21 and over who do not have ~~mental retardation~~ an intellectual disability or a cognitive impairment (ADvantage Waiver).

(b) Any time an individual is certified as eligible for SoonerCare coverage of long-term care, the individual is also eligible for other SoonerCare services. ADvantage Waiver members do not have a copayment for ADvantage services except for prescription drugs. For members residing in an ADvantage Assisted Living Center, any income beyond 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 month in which services have been received until the vendor pay obligation is met. Any time an aged, blind or disabled individual is determined eligible for long-term care, a separate eligibility determination must be made for Qualified Medicare Beneficiary Plus (QMBP) or Specified Low-Income Medicare Beneficiary (SLMB) benefits. An ADvantage program member may reside in a licensed assisted living facility only if the assisted living center is a certified ADvantage Assisted Living Services provider from whom the member is receiving ADvantage Assisted Living services.

317:35-17-2. Level of care medical eligibility determination

The OKDHS area nurse, or nurse designee, determines medical eligibility for ADvantage program services based on the Long Term Care (LTC) nurse's Uniform Comprehensive Assessment Tool (UCAT) III assessment and the determination that the client has unmet care needs that require ADvantage or NF services to assure client health and safety. ADvantage services are initiated to support the informal care that is being provided in the client's home, or, that based on the UCAT, can be expected to be provided in the client's home upon discharge of the client from a NF or hospital. These services are not intended to take the place of regular care provided by family members and/or by significant others. When there is an informal (not paid) system of care available in the home, ADvantage service provision will supplement the system within the limitations of ADvantage Program policy.

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

(A) **"ADL"** means the activities of daily living. Activities of daily living are activities that reflect the client's ability to perform self-care tasks essential for sustaining health and safety such as:

(i) bathing,
(ii) eating,
(iii) dressing,
(iv) grooming,
(v) transferring (includes getting in and out of a tub, bed to chair, etc.),
(vi) mobility,
(vii) toileting, and
(viii) bowel/bladder control.

(B) **"ADLs score in high risk range"** means the client's total weighted UCAT ADL score is 10 or more which indicates the client needs some help with 5 ADLs or that the client cannot do 3 ADLs at all plus the client needs some help with 1 other ADL.

(C) **"ADLs score at the high end of the moderate risk range"** means client's total weighted UCAT ADL score is 8 or 9 which indicates the client needs help with 4 ADLs or the client cannot do 3 ADLs at all.

(D) **"CHC"** means Comprehensive Home Care.

(E) **"Client Support high risk"** means client's UCAT Client Support score is 25 which indicates in the UCAT assessor's clinical judgment, excluding from consideration existing Ryan White CARE Act, Indian Health Service, Medicaid NF, ADvantage and/or State Plan

Personal Care services, very little or no support is available from informal and formal sources and the client requires additional care that is not available through Medicare, Veterans Administration, or other Federal entitlement programs.

(F) **"Client Support moderate risk"** means client's UCAT Client Support score is 15 which indicates in the UCAT assessor's clinical judgment, excluding from consideration existing Ryan White CARE Act, Indian Health Service, Medicaid NF, ADvantage and/or State Plan Personal Care services, support from informal and formal sources is available, but overall, it is inadequate, changing, fragile or otherwise problematic and the client requires additional care that is not available through Medicare, Veterans Administration, or other federal entitlement programs.

(G) **"Cognitive Impairment"** means that the person, as determined by the clinical judgment of the LTC Nurse or the AA, does not have the capability to think, reason, remember or learn required for self-care, communicating needs, directing care givers and/or using appropriate judgment for maintenance of their own health or safety. The clinical judgment of cognitive impairment is based on MSQ performance in combination with a more general evaluation of cognitive function from interaction with the person during the UCAT assessment.

(H) **"Developmental Disability"** means a severe, chronic disability of an individual that:

(i) is attributable to a mental or physical impairment or combination of mental and physical impairments;

(ii) is manifested before the individual attains age 22;

(iii) is likely to continue indefinitely;

(iv) results in substantial functional limitations in three or more of the following areas of major life activity:

(I) self-care;

(II) receptive and expressive language;

(III) learning;

(IV) mobility;

(V) self-direction;

(VI) capacity for independent living; and

(VII) economic self-sufficiency; and

(v) reflects the individual’s need for a combination and sequence of special, interdisciplinary, or generic services, supports, or other assistance that is of

lifelong or extended duration and is individually planned and coordinated.

(I) **"Environment high risk"** means client's UCAT Environment score is 25 which indicates in the UCAT assessor's clinical judgment, the physical environment is strongly negative or hazardous.

(J) **"Environment moderate risk"** means client's UCAT Environment score is 15 which indicates in the UCAT assessor's clinical judgment, many aspects of the physical environment are substandard or hazardous.

(K) **"Health Assessment high risk"** means client's UCAT health assessment score is 25 which indicates in the UCAT assessor's clinical judgment, the client has one or more chronic health conditions, whose symptoms are rapidly deteriorating, uncontrolled, or not well controlled and requiring a high frequency or intensity of medical care/oversight to bring under control and whose functional capacity is so limited as to require full time assistance or care performed daily, by, or under the supervision of professional personnel and has multiple unmet needs for services available only through the ADvantage program or a Nursing Facility (NF) and requires NF placement immediately if these needs cannot be met by other means.

(L) **"Health Assessment low risk"** means client's health assessment score is 5 which indicates, in the UCAT assessor's clinical judgment, the client has one or more chronic, stable, health conditions, whose symptoms are controlled or nearly controlled, which benefit from available, or usually available, medical treatment or corrective measures, and may have an unmet need for a service available only through the ADvantage program or a Nursing Facility (NF) but is not likely to enter a NF if these needs are not met.

(M) **"Health Assessment moderate risk"** means client's UCAT Health Assessment score is 15 which indicates in the UCAT assessor's clinical judgment, the client has one or more chronic changing health conditions, whose symptoms are fragile or worsening and require medical care/oversight, to bring under control or to maintain in a stable, controlled state and has multiple unmet needs for services available only through the ADvantage program or a Nursing Facility (NF) and is likely to enter a NF if these needs are not met.

(N) **"IADL"** means the instrumental activities of daily living.

(O) **"IADLs score in high risk range"** means client's total weighted UCAT IADL score is 12 or more which indicates the client needs some help with 6 IADLs or cannot do 4 IADLs at all.

(P) **"Instrumental activities of daily living"** means those activities that reflect the client's ability to perform household chores and tasks within the community essential for sustaining health and safety such as:

(i) shopping,
(ii) cooking,
(iii) cleaning,
(iv) managing money,
(v) using a telephone,
(vi) doing laundry,
(vii) taking medication, and
(viii) accessing transportation.

(Q) ~~**"Mental Retardation"**~~ **"Intellectual Disability"** means that the person has, as determined by a PASRR level II evaluation, substantial limitations in functional ability due to significantly sub-average intellectual functioning related to an event occurring before the age of 18.

(R) **"MSQ"** means the mental status questionnaire.

(S) **"MSQ score in high risk range"** means the client's total weighted UCAT MSQ score is 12 or more which indicates a severe orientation-memory-concentration impairment, or a severe memory impairment.

(T) **"MSQ score at the high end of the moderate risk range"** means the client's total weighted UCAT MSQ score is (10) or (11) which indicates an orientation-memory-concentration impairment, or a significant memory impairment.

(U) **"Nutrition high risk"** means a total weighted UCAT Nutrition score is 12 or more which indicates the client has significant eating difficulties combined with poor appetite, weight loss, and/or special diet requirements.

(V) **"Progressive degenerative disease process that responds to treatment"** means a process such as, but not limited to, Multiple Sclerosis (MS), Parkinson's Disease, Human Immunodeficiency Virus (HIV), or Acquired Immunodeficiency Syndrome (AIDS), that, untreated, systematically impairs normal body function which leads to acute illness and/or disability but that reacts positively to a medically prescribed treatment intervention (usually medication) which arrests or significantly delays the destructive action of the process.

(W) **"Social Resources high risk"** means a total weighted UCAT Social Resources score is 15 or more, which indicates the client lives alone, combined with none or very few social contacts and no supports in times of need.

(2) **Minimum UCAT criteria.** The minimum UCAT criteria for NF level of care criteria are:

(A) The UCAT documents need for assistance to sustain health and safety as demonstrated by:

(i) either the ADLs or MSQ score is in the high risk range; or

(ii) any combination of two or more of the following:

(I) ADLs score is at the high end of moderate risk range; or,

(II) MSQ score is at the high end of moderate risk range; or,

(III) IADLs score is in the high risk range; or,

(IV) Nutrition score is in the high risk range; or,

(V) Health Assessment is in the moderate risk range, and, in addition;

(B) The UCAT documents absence of support or adequate environment to meet the needs to sustain health and safety as demonstrated by:

(i) Client Support is moderate risk; or,

(ii) Environment is high risk; or,

(iii) Environment is moderate risk and Social Resources is in the high risk range; or, regardless of whether criteria under (A) of need and (B) of absence of support are met;

(C) The UCAT documents that:

(i) the client has a clinically documented progressive degenerative disease process that will produce health deterioration to an extent that the person will meet OAC 317:35-17-2(2)(A) criteria if untreated; and

(ii) the client previously has required Hospital or NF level of care services for treatment related to the condition; and

(iii) a medically prescribed treatment regimen exists that will significantly arrest or delay the disease process; and

(iv) only by means of ADvantage Program eligibility will the individual have access to the required treatment regimen to arrest or delay the disease process.

(3) **NF Level of Care Services.** To be eligible for NF level of care services, meeting the minimum UCAT criteria demonstrates the individual must:

(A) require a treatment plan involving the planning and administration of services that require the skills of licensed or otherwise certified technical or professional personnel, and are provided directly or under the supervision of such personnel;
(B) have a physical impairment or combination of physical, mental and/or functional impairments;
(C) require professional nursing supervision (medication, hygiene and/or dietary assistance);
(D) lack the ability to adequately and appropriately care for self or communicate needs to others;
(E) require medical care and treatment in order to minimize physical health regression or deterioration;
(F) require care that is not available through family and friends, Medicare, Veterans Administration, or other federal entitlement program with the exception of Indian Health Services; and
(G) require care that cannot be met through Medicaid State Plan Services, including Personal Care, if financially eligible.

317:35-17-3. ADvantage program services

(a) The ADvantage program is a Medicaid Home and Community Based Waiver used to finance non-institutional long-term care services for elderly and a targeted group of physically disabled adults when there is a reasonable expectation that within a 30 day period, the person's health, due to disease process or disability, would, without appropriate services, deteriorate and require nursing facility care to arrest the deterioration. ADvantage program members must be SoonerCare eligible and must not reside in an institution, room and board, licensed residential care facility, or licensed assisted living facility, unless the facility is an ADvantage Assisted Living Center. The number of individuals who may receive ADvantage services is limited.

(1) To receive ADvantage services, individuals must meet one of the following categories:
(A) be age 65 years or older, or
(B) be age 21 or older if physically disabled and not developmentally disabled or if the person has a clinically documented, progressive degenerative disease process that responds to treatment and previously has 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) if developmentally disabled and between the ages of 21 and 65, not have ~~mental retardation~~ an intellectual disability or a cognitive impairment related to the developmental disability.

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

(A) require nursing facility level of care [see OAC 317:35-17-2];

(B) meet service eligibility criteria [see OAC 317:35-17-3(d)]; and

(C) meet program eligibility criteria [see OAC 317:35-17-3(e)].

(b) Home and Community Based Waiver Services are outside the scope of Medicaid State Plan services. The Medicaid waiver allows the OHCA to offer certain Home and Community Based services to an annually capped number of persons who are categorically needy (refer to OKDHS form 08AX001E (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 cannot exceed the annual cost of caring for that individual in a nursing facility. When determining the ADvantage service plan cost cap for an individual, the comparable SoonerCare cost to serve that individual in a nursing facility is estimated. If the individual has Acquired Immune Deficiency Syndrome (AIDS) or if the individual requires ventilator care, the appropriate SoonerCare enhanced nursing facility rate to serve the individual is used to estimate the ADvantage cost cap.

(c) Services provided through the ADvantage waiver are:

(1) case management;

(2) respite;

(3) adult day health care;

(4) environmental modifications;

(5) specialized medical equipment and supplies;

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

(7) advanced supportive/restorative assistance;

(8) skilled nursing;

(9) home delivered meals;

(10) hospice care;

(11) medically necessary prescription drugs within the limits of the waiver;

(12) personal care (state plan) or ADvantage personal care;

(13) Personal Emergency Response System (PERS);

(14) Consumer-Directed Personal Assistance Services and Supports (CD-PASS);

(15) Institution Transition Services;

(16) assisted living; and

(17) SoonerCare medical services for individuals age 21 and over within the scope of the State Plan.

(d) The OKDHS area nurse or nurse designee makes a determination of service eligibility prior to evaluating the UCAT assessment for nursing facility level of care. The following criteria are used to make the service eligibility determination:

(1) an open ADvantage Program waiver slot, as authorized by the waiver document approved by the Centers for Medicare and Medicaid Services (CMS), is available to assure federal participation in payment for services to the individual. If the OKDHS/ASD determines all ADvantage waiver slots are filled, the individual cannot be certified on the OKDHS computer system as eligible for ADvantage services and the individual's name is placed on a waiting list for entry as an open slot becomes available. ADvantage waiver slots and corresponding waiting lists, if necessary, are maintained for persons that have a developmental disability and those that do not have a developmental disability.

(2) the individual is in the ADvantage targeted service group. The target group is an individual who is frail and 65 years of age or older or age 21 or older with a physical disability and who does not have ~~mental retardation~~ an intellectual disability or a cognitive impairment.

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

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

(e) The OKDHS/ASD determines ADvantage program eligibility through the service plan approval process. The following criteria are used to make the ADvantage program eligibility determination that an individual is not eligible:

(1) if the individual's needs as identified by UCAT and other professional assessments cannot be met through ADvantage program services, Medicaid State Plan services and other formal or informal services. The State, as part of the waiver program approval authorization, assures CMS that each waiver individual's health, safety, or welfare can be maintained in their home. If 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 home cannot be assured.

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

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

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

(5) if, after the service and care plan is developed, the risk to individual's health and safety is not acceptable to the individual, or to the interdisciplinary service plan team, or to the OKDHS/ASD.

(f) The case manager provides the OKDHS/ASD with professional documentation to support the recommendation for redetermination of program eligibility. The service providers continue providing services according to the service plan as provider safety permits until the individual is removed from the ADvantage program. As a part of the procedures requesting redetermination of program eligibility, the OKDHS/ASD will provide technical assistance to the Provider for transitioning the individual to other services.

(g) Individuals determined ineligible for ADvantage program services are notified in writing by OKDHS of the determination and of their right to appeal the decision.

SUBCHAPTER 19. NURSING FACILITY SERVICES

317:35-19-3. Services in a Nursing Facility (NF)

(a) Nursing facility services are those services furnished pursuant to a physician's orders which require the skills of technical or professional personnel, e.g., registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists or audiologists. The care is provided by nursing facilities licensed under state law to provide, on a regular basis, health related care and services to individuals who do not require hospitalization but whose physical or mental condition requires care and services above the level of room and board which can be made available to them only through a nursing facility. To be eligible for nursing facility services, the UCAT demonstrates the individual must:

(1) require a treatment plan involving the planning and administration of services which require skills of licensed technical or professional personnel that are provided

directly or under the supervision of such personnel and are prescribed by the physician;
(2) have a physical impairment or combination of physical and mental impairments;
(3) require professional nursing supervision (medication, hygiene and dietary assistance);
(4) lack the ability to care for self or communicate needs to others; and
(5) require medical care and treatment in a nursing facility to minimize physical health regression and deterioration. A physician's order and results from a standardized assessment which evaluates type and degree of disability and need for treatment must support the individual's need for NF level of care. Only standardized assessments approved by the OHCA and administered in accordance with Medicaid approved procedures shall be used to make the NF level of care determination.

(b) If the individual experiences mental illness or ~~mental retardation~~ an intellectual disability or a related condition, payment cannot be made for services in a nursing facility unless the individual has been assessed through the PASRR process and the appropriate MR or MI authority has determined that nursing facility services are required. If it is determined that the client also requires specialized services, the state must provide or arrange for the provision of such services. These determinations must be made prior to the patient's admission to the nursing facility. Payment cannot be made for an individual who is in imminent danger of harm to self or others.

(c) Payment is made to licensed nursing facilities that have agreements with the OHCA.

(d) Nursing facility clients are eligible for ADvantage waiver services and must be informed by the LTC nurse of the ADvantage waiver and given the option to apply for ADvantage services.

317:35-19-8. Pre-admission screening and resident review

(a) Federal Regulations govern the State's responsibility for Preadmission Screening and Resident Review (PASRR) of individuals with mental illness and ~~mental retardation~~ intellectual disabilities. PASRR applies to the screening or reviewing of all individuals for mental illness or ~~mental retardation~~ intellectual disability or related conditions who apply to or reside in Medicaid certified nursing facilities regardless of the source of payment for the nursing facility services and regardless of the individual's or resident's known diagnoses. The NF must independently evaluate the Level I PASRR Screen regardless of who completes the form and determine

whether or not to admit an individual to the facility. If an individual is admitted to the NF inappropriately, the NF is subject to recoupment of Medicaid funds and penalties imposed by CMS. Federal financial participation (FFP) may not be paid until results of any needed PASRR Level II evaluations are received. PASRR is a requirement for nursing facilities with dually certified (both Medicare and Medicaid) beds. There are no PASRR requirements for Medicare skilled beds that are not dually certified, nor is PASRR required for individuals seeking residency in an intermediate care facility for the mentally retarded (ICF/MR).
(b) For Medicaid applicants, medical and financial eligibility determinations are also required.

317:35-19-9. PASRR screening process

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

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

(A) The nursing facility administrator or co-administrator;

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

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

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

(3) The nursing facility is responsible for determining from the evaluation whether or not the patient can be admitted to the facility. A "yes" response to any question from Form LTC-300R, Section E, will require the nursing facility to contact the Level of Care Evaluation Unit (LOCEU) for a consultation to determine if a Level II assessment is needed. The NF is also responsible for consulting with the LOCEU regarding any ~~MI/MR~~ MI/ID /related condition information that becomes known either from completion of the MDS or throughout the resident's stay. The original Form

LTC-300R must be submitted to the LOCEU by mail within 10 days of the resident's admission. SoonerCare payment may not be made for a resident whose LTC-300R requirements have not been satisfied in a timely manner.

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

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

(1) Any one of the following three circumstances will allow a patient to enter the nursing facility without being subjected to a Level II PASRR assessment:

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

(B) The patient does not have a diagnosis of ~~mental retardation~~ an intellectual disability or related condition; or

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

Hospital Discharge is allowed only if all of the following three conditions are met:

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

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

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

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

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

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

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

(ii) Payment for NF services will not be made after the provisional admission ending date. If an

individual is determined to need a longer stay, the individual must receive a Level II evaluation before continuation of the stay may be permitted and payment made for days beyond the ending date.

(B) **Provisional admission in emergency situations.** Any person with a mental illness, ~~mental retardation~~ an intellectual disability or related condition, who is not a danger to self and/or others, may be admitted to a Medicaid certified nursing facility for a period not to exceed seven days pending further assessment in emergency situations requiring protective services. The request for Level II evaluation must be made immediately upon admission to the NF if a longer stay is anticipated. LOCEU must be provided with written documentation from Adult Protective Services or the nursing facility which supports the individual's emergency admission. Payment for NF services will not be made beyond the emergency admission ending date.

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

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

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

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

(1) The nursing facility's routine resident assessment will identify those individuals previously undiagnosed as ~~MR~~ intellectually disabled or MI. A new condition of ~~MR~~ intellectual disabilities or MI must be referred to LOCEU by

the NF for determination of the need for the Level II. The facility's failure to refer such individuals for a Level II assessment may result in recoupment of funds and/or penalties from CMS.

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

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

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

(d) **Results of pre-admission Level II assessment and Resident Review.** Through contractual arrangements between the Oklahoma Health Care Authority and the Mental Illness/Mental Retardation Authorities/Community Mental Health Centers, individualized assessments are conducted and findings presented in written evaluative reports. The reports recommend if nursing facility services are needed, if specialized services or less than specialized services are needed, and if the individual meets the federal PASRR definition of mental illness or ~~mental retardation~~ intellectual disability or related conditions. Evaluative reports are delivered to the OHCA's LOCEU within federal regulatory and state contractual timelines to allow the LOCEU to process formal, written notification to patient, guardian, NF and significant others.

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

patient enters the facility and nursing care is being requested:

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

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

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

SUBCHAPTER 23. LIVING CHOICE PROGRAM

317:35-23-2. Eligibility criteria

Adults with disabilities or long-term illnesses, members with ~~mental retardation~~ intellectual disabilities and members with physical disabilities are eligible to transition into the community through the Living Choice program if they meet all of the criteria in paragraphs (1) through (7) of this subsection.

(1) He/she must be at least 19 years of age.

(2) He/she must reside in an institution (nursing facility or public ICF/MR) for at least 90 consecutive days prior to the proposed transition date. If any portion of the 90 days includes time in a skilled nursing facility, those days cannot be counted toward the 90 day requirement, if the member received Medicare post-hospital extended care rehabilitative services.

(3) He/she must have at least one day of Medicaid paid long-term care services prior to transition.

(4)If transitioning from an out of state institution, he/she must be SoonerCare eligible.

(5) He/she requires at least the same level of care that necessitated admission to the institution.

(6) He/she must reside in a qualified residence after leaving the institution. A qualified residence is defined in (A) through (C) of this paragraph.

(A) a home owned or leased by the individual or the individual's family member;

(B) an apartment with an individual lease, with a locking entrance/exit, and which includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control; and

(C) a residence, in a community-based residential setting, in which no more than four unrelated individuals reside.

(7) His/her needs can be met by the Living Choice program while living in the community.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 40. DEVELOPMENTAL DISABILITIES SERVICES
SUBCHAPTER 1. GENERAL PROVISIONS

317:40-1-1. Home and Community-Based Services (HCBS) Waivers for persons with intellectual disabilities ~~(mental retardation)~~ or certain persons with related conditions

(a) **Applicability.** The rules in this Section apply to services funded through Medicaid HCBS Waivers per OAC 317:35-9-5 and as defined in Section 1915(c) of the Social Security Act. The specific waivers are the In-Home Supports Waiver (IHSW) for Adults, the In-Home Supports Waiver (IHSW) for Children, the Community Waiver, and the Homeward Bound Waiver.

(b) **Program provisions.** Each individual requesting services provided through a HCBS Waiver and his or her family or guardian are responsible for:

(1) accessing, with the assistance of OKDHS staff, all benefits available under Oklahoma's Medicaid State Plan or other payment sources prior to accessing funding for those same services under a HCBS Waiver program;

(2) cooperating in the determination of medical and financial eligibility, including prompt reporting of changes in income or resources; and

(3) choosing between services provided through a HCBS Waiver and institutional care.

(c) **Waiver Eligibility.** To be eligible for Waiver services, an applicant must meet the criteria established in paragraph (1) of this Subsection and the criteria for one of the Waivers established in Subparagraph (A), (B), or (C) of this Subsection.

(1) Services provided through a HCBS Waiver are available to Oklahoma residents meeting SoonerCare eligibility requirements established by law, regulatory authority, and policy within funding available through State or Federal resources. To be eligible for and receive services funded through any of the Waivers listed in subsection (a) of this Section, a person must meet conditions per OAC 317:35-9-5. The individual must be determined financially eligible for SoonerCare per OAC 317:35-9-68. The SoonerCare eligible individual may not simultaneously be enrolled in any other

Medicaid Waiver program or receiving services in an institution including a hospital, rehabilitation facility, mental health facility, nursing facility, residential care facility as described in Section 1-819 of Title 63 of Oklahoma Statutes, or Intermediate Care facility for persons with mental retardation (ICF/MR). The individual may not be receiving DDSD state-funded services such as the Family Support Assistance Payment, Respite Voucher Program, sheltered workshop services, community integrated employment services, or assisted living without waiver supports per OAC 340:100-5-22.2. The individual must also meet other Waiver-specific eligibility criteria.

(A) **In-Home Supports Waivers.** To be eligible for services funded through the In-Home Supports Waiver (IHSW), a person must:

(i) meet all criteria given in subsection (c) of this Section; and

(ii) be determined to have a disability and a diagnosis of intellectual disability ~~(mental retardation)~~ by the Social Security Administration (SSA); or

(iii) be determined to have a disability, and a diagnosis of intellectual disability ~~(mental retardation)~~ as defined in the Diagnostic and Statistical Manual of Mental Disorders by the OHCA Level of Care Evaluation Unit (LOCEU);

(iv) be three years of age or older;

(v) be determined by the OHCA/LOCEU to meet the ICF/MR Institutional Level of Care requirements per OAC 317:30-5-122;

(vi) reside in:

(I) the home of a family member or friend;

(II) his or her own home;

(III) an OKDHS Children and Family Services Division (CFSD) foster home; or

(IV) a CFSD group home; and

(vii) have critical support needs that can be met through a combination of non-paid, non-Waiver, and SoonerCare resources available to the individual, and with HCBS Waiver resources that are within the annual per capita Waiver limit agreed between the State of Oklahoma and the Centers for Medicare and Medicaid Services (CMS).

(B) **Community Waiver.** To be eligible for services funded through the Community Waiver, the person must:

(i) meet all criteria given in subsection (c) of this Section;

(ii) be determined to have a disability and a diagnosis of intellectual disability ~~(mental retardation)~~ by the SSA; or

(iii) have intellectual disability ~~(mental retardation)~~ as defined in the Diagnostic and Statistical Manual of Mental Disorders or a related condition by the DDSD and to be covered under the State's alternative disposition plan adopted under Section 1919(e)(7)(E) of the Social Security Act; or

(iv) be determined to have a disability and a diagnosis of intellectual disability ~~(mental retardation)~~ as defined in the Diagnostic and Statistical Manual of Mental Disorders or the OHCA/LOCEU; and

(v) be three years of age or older; and

(vi) be determined by the OHCA/LOCEU, to meet the ICF/MR Institutional Level of Care requirements per OAC 317:30-5-122; and

(vii) have critical support needs that can be met by the Community Waiver and cannot be met by IHSW services or other service alternatives, as determined by the DDSD Division Director or designee.

(C) **Homeward Bound Waiver.** To be eligible for services funded through the Homeward Bound Waiver, the person must:

(i) be certified by the United States District Court for the Northern District of Oklahoma as a member of the plaintiff class in *Homeward Bound et al. v. The Hissom Memorial Center*, Case No. 85-C-437-E;

(ii) meet all criteria for HCBS Waiver services given in subsection (c) of this Section; and

(iii) be determined to have a disability and a diagnosis of intellectual disability ~~(mental retardation)~~ by SSA; or

(iv) have an intellectual disability ~~(mental retardation)~~ as defined in the Diagnostic and Statistical Manual o Mental Disorders or a related condition per OAC 317:35-9-45 by DDSD and to be covered under the State's alternative disposition plan adopted under Section 1919(e)(7)(E) of the Social Security Act; or

(v) have a disability ~~(mental retardation)~~ as defined in the Diagnostic and Statistical Manual of Mental Disorders by the OHCA/LOCEU; and

(vi) meet the ICF/MR Institutional Level of Care requirements per OAC 317:30-5-122 by the OHCA/LOCEU.

(2) The person desiring services through any of the Waivers listed in subsection (a) of this Section participates in diagnostic evaluations and provides information necessary to determine HCBS Waiver services eligibility, including:

(A) a psychological evaluation, by a licensed Psychologist or State staff supervised by a licensed Psychologist, current within 12 months of requested approval date, that includes:

(i) a full scale functional and/or adaptive assessment; and

(ii) a statement of age of onset of the disability; and

(iii) intelligence testing that yields a full scale intelligence quotient.

(B) a social service summary, current within 12 months of requested approval date, that includes a developmental history; and

(C) a medical evaluation current within 90 days of requested approval date; and

(D) a completed ICF/MR Level of Care Assessment form (LTC-300); and

(E) proof of disability according to SSA guidelines. If a disability determination had not been made by SSA, the OHCA/LOCEU may make a disability determination using the same guidelines as SSA.

(3) The OHCA reviews the diagnostic reports listed in paragraph (2) of this subsection and makes a determination of eligibility for DDSD HCBS Waivers.

(4) For individuals who are determined to have intellectual disability ~~(mental retardation)~~ or a related condition by DDSD in accordance with the State's alternative disposition plan adopted under Section 1919(e)(7)(E) of the Social Security Act, DDSD reviews the diagnostic reports listed in paragraph (2) of this subsection and, on behalf of the OHCA, makes a determination of eligibility for DDSD HCBS Waiver services and ICF/MR level of care.

(5) A determination of need for ICF/MR Institutional Level of Care does not limit the opportunities of the person receiving services to participate in community services. Individuals are assured of the opportunity to exercise informed choice in the selection of services.

(d) **Request list.** When State DDSD resources are unavailable for new persons to be added to services funded through a HCBS Waiver, persons are placed on a statewide Request for Waiver Services List.

(1) The Request for Waiver Services List is maintained in chronological order based on the date of receipt of a written request for services.

(2) The Request for Waiver Services List for persons requesting services provided through a HCBS Waiver is administered by DDSD uniformly throughout the state.

(3) An individual is removed from the Request for Waiver Services List if the individual:

(A) is found to be ineligible for services;

(B) cannot be located by OKDHS;

(C) does not provide required information to OKDHS;

(D) is not a resident of the state of Oklahoma at the time of requested Waiver approval date; or

(E) declines an offer of Waiver services

(e) **Applications.** When resources are sufficient for initiation of HCBS Waiver services, DDSD ensures action regarding a request for services occurs within 45 days. If action is not taken within the required 45 days, the applicant may seek resolution as described in OAC 340:2-5.

(1) Applicants are allowed 60 days to provide information requested by DDSD to determine eligibility for services.

(2) If requested information is not provided within 60 days, the applicant is notified that the request has been denied, and the individual is removed from the Request for Waiver Services List.

(f) **Admission protocol.** Initiation of services funded through a HCBS Waiver occurs in chronological order from the Request for Waiver Services List in accordance with subsection (d) of this Section based on the date of DDSD receipt of a completed request for services, as a result of the informed choice of the person requesting services or his or her legal guardian, and upon determination of eligibility, in accordance with subsection (c) of this Section. Exceptions to the chronological requirement may be made when:

(1) an emergency situation exists in which the health or safety of the person needing services, or of others, is endangered, and there is no other resolution to the emergency. An emergency exists when:

(A) the person is unable to care for himself or herself and:

(i) the person's caretaker, as defined in Section 10-103 of Title 43A of the Oklahoma Statutes:

(I) is hospitalized;

(II) has moved into a nursing facility;

(III) is permanently incapacitated; or

(IV) has died; and

(ii) there is no caretaker to provide needed care to the individual; or

(iii) an eligible person is living at a homeless shelter or on the street;

(B) the OKDHS finds that the person needs protective services due to experiencing ongoing physical, sexual, or emotional abuse or neglect in his or her present living situation, resulting in serious jeopardy to the person's health or safety;

(C) the behavior or condition of the person needing services is such that others in the home are at risk of being seriously harmed by the person. For example, the person is routinely physically assaultive to the caretaker or others living in the home and sufficient supervision cannot be provided to ensure the safety of those in the home or community; or

(D) the person's medical, psychiatric, or behavioral challenges are such that the person is seriously injuring or harming himself or herself, or is in imminent danger of doing so.

(2) the Legislature has appropriated special funds with which to serve a specific group or a specific class of individuals under the provisions of a HCBS Waiver;

(3) Waiver services are required for people who transition to the community from a public or ICF/MR who are children in the State's custody receiving services from OKDHS. Under some circumstances Waiver services related to accessibility may be authorized in advance of transition, but may not be billed until the day the member leaves the ICF/MR and enters the Waiver;

(4) individuals subject to the provisions of Public Law 100-203 residing in nursing facilities for at least 30 continuous months prior to January 1, 1989,and who are determined by Preadmission Screening and Resident Review (PASRR) evaluation conducted pursuant to the provisions of 42 CFR 483.100 et seq to have intellectual disability ~~(mental retardation)~~ or a related condition, who are covered under the State's alternative disposition plan adopted under Section 1919(e)(7)(E) of the Social Security Act, choose to receive services funded through the Community or Homeward Bound Waiver.

(g) **Movement between DDSD HCBS Waiver programs.** A person's movement from services funded through one HCBS Waiver to services funded through another DDSD-administered HCBS Waiver is explained in this subsection.

(1) When a member receiving services funded through the IHSW for children becomes 18 years of age, services through the IHSW for adults become effective.

(2) Change to services funded through the Community Waiver from services funded through the IHSW occurs only when:

(A) a member has critical support needs that cannot be met by IHSW services, non-Waiver services, or other resources as determined by the DDSD Director or designee; and

(B) funding is available per OAC 317:35-9-5..

(3) Change to services funded through the IHSW from services funded through the Community Waiver may only occur when a member's history of annual service utilization has been within the per capita allowance of the IHSW.

(4) When a member served through the Community Waiver has support needs that can be met within the per capita Waiver allowance of the applicable IHSW and through a combination of non-Waiver resources, the individual may choose to receive services through the IHSW.

(h) **Continued eligibility for HCBS Waiver services.** Eligibility for members receiving services provided through the HCBS Waiver is re-determined by the OHCA/LOCEU when a determination of disability has not been made by the Social Security Administration. The OHCA/LOCEU determines categorical relationship to the SoonerCare disabled category according to Social Security Administration guidelines. OHCA/LOCEU also approves level of care per OAC 317:30-5-122 and confirms a diagnosis of intellectual disability ~~(mental retardation)~~ as defined in the Diagnostic and Statistical Manual of Mental Disorders. DDSD may require a new diagnostic evaluation in accordance with paragraph (c)(2) of this subsection and re-determination of eligibility at any time when a significant change of condition, disability, or psychological status determined under paragraph (c)(2) of this Section has been noted.

(i) **HCBS Waiver services case closure.** Services provided through a HCBS Waiver are terminated:

(1) when a member or the member's legal guardian chooses to no longer receive Waiver services;

(2) when a member is incarcerated;

(3) when a member is financially ineligible to receive Waiver services;

(4) when a member is determined by the Social Security Administration to no longer have a disability qualifying the individual for services under these Waivers;

(5) when a member is determined by the OHCA/LOCEU to no longer be eligible;

(6) when a member moves out of state, or the custodial parent or guardian of a member who is a minor moves out of state;
(7) when a member is admitted to a nursing facility, ICF/MR, residential care facility, hospital, rehabilitation facility, or mental health facility for more than 30 consecutive days;
(8) when the guardian of a member who is a minor or adjudicated adult fails to cooperate during the annual review process as described in OAC 340:100-5-50 through 340:100-5-58;
(9) when the guardian of a member who is a minor or adjudicated adult fails to cooperate in the implementation of OKDHS policy or service delivery in a manner that places the health or welfare of the member at risk, after efforts to remedy the situation through Adult Protective Services or Child Protective Services have not been effective;
(10) when the member is determined to no longer be SoonerCare eligible; or
(11) when there is sufficient evidence that the member or his/her legal representative has engaged in fraud or misrepresentation, failed to use resources as agreed on in the Individual Plan, or knowingly misused public funds associated with these services;
(12) when the member or his/her legal representative either cannot be located, has not responded to, or has not allowed case management to complete plan development or monitoring activities as required by policy and the member or his/her legal representative:
   (A) does not respond to the notice of intent to terminate; or
   (B) the response prohibits case management (the case manager) from being able to complete plan development or monitoring activities as required by policy;
(13) when the member or his/her legal representative fails to cooperate with the case manager to implement a Fair Hearing decision;
(14) when it is determined that services provided through a HCBS Waiver are no longer necessary to meet the member's needs and professional documentation provides assurance that the member's health, safety, and welfare can be maintained without Waiver supports;
(15) when the member or his/her legal representative fails to cooperate with service delivery;
(16) when a family member, authorized representative, other individual in the member's household or persons who

routinely visit, pose a threat of harm or injury to provider staff or official representatives of OKDHS; or

(17) when a member no longer receives a minimum of one Waiver service per month and DDSD is unable to monitor member on a monthly basis.

(j) **Reinstatement of services.** Waiver services are reinstated when:

(1) the situation resulting in case closure of a Hissom class member is resolved;

(2) a member is incarcerated for 90 days or less;

(3) a member is admitted to a nursing facility, ICF/MR, residential care facility, hospital, rehabilitation facility, or mental health facility for 90 days or less; or

(4) a member's SoonerCare eligibility is re-established within 90 days of the date of SoonerCare ineligibility.

SUBCHAPTER 5. MEMEBER SERVICES
PART 11. OTHER COMMUNITY RESIDENTIAL SUPPORTS

317:40-5-152. Group home services for persons with ~~mental retardation~~ an intellectual disability or certain persons with related conditions

(a) **General Information.** Group homes provide a congregate living arrangement offering up to 24-hour per day supervision, supportive assistance, and training in daily living skills to persons who are eligible 18 years of age or older. Upon approval of the Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDSD) director or designee, persons younger than 18 may be served.

(1) Group homes ensure members reside and participate in the community. Services are provided in homes located in close proximity to generic community services and activities.

(2) Group homes must be licensed by DDSD in accordance with Section 1430.1 et seq. of Title 10 of the Oklahoma Statutes.

(3) Residents of group homes receive no other form of residential supports.

(4) Habilitation training specialist (HTS) services or homemaker services for residents of group homes may be approved only by the DDSD director or designee to resolve a temporary emergency when no other resolution exists.

(b) **Minimum provider qualifications.** Approved providers must have a current contract with the Oklahoma Health Care Authority (OHCA) to provide DDSD Home and Community-Based Services (HCBS) Waiver for persons with ~~mental retardation~~ an intellectual disability or related conditions.

(1) Group home providers must have a completed and approved application to provide DDSD group home services.

(2) Group home staff must:

(A) complete the OKDHS DDSD-sanctioned training curriculum per OAC 340:100-3-38; and

(B) fulfill requirements for pre-employment screening per OAC 340:100-3-39.

(c) **Description of services.**

(1) Group home services:

(A) meet all applicable requirements of OAC 340:100; and

(B) are provided in accordance with each member's Individual Plan (IP) developed per OAC 340:100-5-50 through 340:100-5-58.

(i) Health care services are secured for each member per OAC 340:100-5-26.

(ii) Members are offered recreational and leisure activities maximizing the use of generic programs and resources, including individual and group activities.

(2) Group home providers:

(A) follow protective intervention practices per OAC 340:100-5-57 and 340:100-5-58;

(B) in addition to the documentation required per OAC 340:100-3-40, must maintain:

(i) staff time sheets that document the hours each staff was present and on duty in the group home; and

(ii) documentation of each member's presence or absence on the daily attendance form provided by DDSD; and

(C) ensure program coordination staff (PCS) meet staff qualifications and supervise, guide, and oversee all aspects of group home services per OAC 340:100-5-22.6 and 340:100-6, as applicable.

(d) **Coverage limitations.** Group home services are provided up to 366 days per year.

(e) **Types of group home services.** There are three types of group home services provided through HCBS Waivers.

(1) **Traditional group homes.** Traditional group homes serve no more than 12 members per OAC 340:100-6.

(2) **Community living homes.** Community living homes serve no more than 12 members.

(A) Members who receive community living home services have:

(i) needs that cannot be met in a less structured setting; and

(ii) a diagnosis of a severe or profound ~~mental retardation~~ intellectual disability requiring frequent assistance in the performance of activities necessary for daily living or continual supervision to ensure the member's health and safety; or

(iii) complex needs requiring frequent:

(I) assistance in the performance of activities necessary for daily living, such as frequent assistance of staff for positioning, bathing, or other necessary movement; or

(II) supervision and training in appropriate social and interactive skills in order to remain included in the community.

(B) Services offered in a community living home include:

(i) 24-hour awake supervision when a member's IP indicates it is necessary; and

(ii) program supervision and oversight including hands-on assistance in performing activities of daily living, transferring, positioning, skill-building, and training.

(3) **Alternative group homes.** Alternative group homes serve no more than four members who have evidence of behavioral or emotional challenges in addition to ~~mental retardation~~ an intellectual disability and require extensive supervision and assistance in order to remain in the community.

(A) Members who receive alternative group home services must meet criteria per in OAC 340:100-5-22.6.

(B) A determination must be made by the DDSD Community Services Unit that alternative group home services are appropriate.

SUBCHAPTER 7. EMPLOYMENT SERVICES THROUGH HOME AND COMMUNITY-BASED SERVICES WAIVERS

317:40-7-4. Services provided through Waiver Employment Services

(a) Employment Services are offered under the Medicaid Home and Community-Based Waiver for persons with ~~mental retardation~~ intellectual disabilities at rates prescribed by the Oklahoma Health Care Authority.

(b) Types of Waiver Employment Services offered include:

(1) Vocational Habilitation Training Specialist (VHTS), Supplemental Support;

(2) Employment Training Specialist (ETS);

(3) Center-Based Services;

(4) Community-Based Services;

(5) Enhanced Community-Based Services;

(6) Job Coaching;

(7) Enhanced Job Coaching; and

(8) Stabilization Services.

(c) State-funded services described in OAC 340:100-17-30 may supplement Employment Services funded through the Community Waiver.

CHAPTER 50. HOME AND COMMUNITY BASED SERVICES WAIVERS
SUBCHAPTER 1. MEDICALLY FRAGILE WAIVER SERVICES

317:50-1-2. Definitions

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

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

(A) bathing,
(B) eating,
(C) dressing,
(D) grooming,
(E) transferring (includes getting in and out of a tub, bed to chair, etc.),
(F) mobility,
(G) toileting, and
(H) bowel/bladder control.

(2) **"Cognitive Impairment"** means that the person, as determined by the clinical judgment of the LTC Nurse or the AA, does not have the capability to think, reason, remember or learn required for self-care, communicating needs, directing care givers and/or using appropriate judgment for maintenance of their own health or safety. The clinical judgment of cognitive impairment is based on MSQ performance in combination with a more general evaluation of cognitive function from interaction with the person during the UCAT assessment.

(3) **"Developmental Disability"** means a severe, chronic disability of an individual that:

(A) is attributable to a mental or physical impairment or combination of mental and physical impairments;
(B) is manifested before the individual attains age 22;
(C) is likely to continue indefinitely;
(D) results in substantial functional limitations in three or more of the following areas of major life activity:

(i) self-care;
(ii) receptive and expressive language;
(iii) learning;
(iv) mobility;

(v) self-direction;
(vi) capacity for independent living; and
(vii) economic self-sufficiency; and

(E) reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services, supports, or other assistance that is of lifelong or extended duration and is individually planned and coordinated.

(4) **"IADL"** means the instrumental activities of daily living.

(5) **"Instrumental activities of daily living"** means those activities that reflect the member's ability to perform household chores and tasks within the community essential for sustaining health and safety such as:

(A) shopping,
(B) cooking,
(C) cleaning,
(D) managing money,
(E) using a telephone,
(F) doing laundry,
(G) taking medication, and
(H) accessing transportation.

(6) **" Level of Care Service**s." To be eligible for level of care services, meeting the minimum UCAT criteria established for SNF or hospital level of care demonstrates the individual must:

(A) require a treatment plan involving the planning and administration of services that require the skills of licensed or otherwise certified technical or professional personnel, and are provided directly or under the supervision of such personnel;

(B) have a physical impairment or combination of physical, mental and/or functional impairments;

(C) require professional nursing supervision (medication, hygiene and/or dietary assistance);

(D) lack the ability to adequately and appropriately care for self or communicate needs to others;

(E) require medical care and treatment in order to minimize physical health regression or deterioration;

(F) require care that is not available through family and friends, Medicare, Veterans Administration, or other federal entitlement program with the exception of Indian Health Services; and

(G) require care that cannot be met through Medicaid State Plan Services, including Personal Care, if financially eligible.

(7) ~~**"Mental Retardation"**~~ "Intellectual Disability" means that the person has, as determined by a PASRR level II evaluation, substantial limitations in functional ability due to significantly sub-average intellectual functioning related to an event occurring before the age of 18.

(8) **"MSQ"** means the mental status questionnaire.

(9) **"Progressive degenerative disease process that responds to treatment"** means a process such as, but not limited to, Multiple Sclerosis (MS), Parkinson's Disease, Human Immunodeficiency Virus (HIV), or Acquired Immunodeficiency Syndrome (AIDS), that, untreated, systematically impairs normal body function which leads to acute illness and/or disability but that reacts positively to a medically prescribed treatment intervention (usually medication) which arrests or significantly delays the destructive action of the process.

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

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

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

(A) be 19 years of age or older;

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

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

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

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

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

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

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

(b) Home and Community Based Waiver Services are outside the scope of state plan Medicaid services. The Medicaid waiver allows the OHCA to offer certain Home and Community Based services to an annually capped number of persons who are categorically needy (refer to OKDHS form 08AX001E, Schedule VIII. B. 1) and without such services would be institutionalized.

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

(1) case management;

(2) respite;

(3) adult day health care;

(4) environmental modifications;

(5) specialized medical equipment and supplies;

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

(7) advanced supportive/restorative assistance;

(8) skilled nursing;

(9) home delivered meals;

(10) hospice care;

(11) medically necessary prescription drugs within the limits of the waiver;

(12) personal care (state plan), Medically Fragile Waiver personal care;

(13) Personal Emergency Response System (PERS);

(14) Self Direction; and

(15) SoonerCare medical services within the scope of the State Plan.

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

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

and corresponding waiting lists, if necessary, are maintained.

(2) the member is in the Medically Fragile Waiver targeted service group. The target group is an individual who is age 19 or older with a physical disability and may also have ~~mental retardation~~ an intellectual disability or a cognitive impairment.

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

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

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

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

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

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

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

(5) if, after the service and care plan is developed, the risk to individual health and safety is not acceptable to the individual, or to the interdisciplinary service plan team, or to the OHCA.

(f) Professional documentation is provided to support the recommendation for redetermination of program eligibility. The service providers continue providing services according to the

service plan as provider safety permits until the member is removed from the Medically Fragile Waiver program. As a part of the procedures requesting redetermination of program eligibility, the OHCA will provide technical assistance to the Provider for transitioning the member to other services.
(g) Individuals determined ineligible for Medically Fragile Waiver program services are notified in writing of the determination and of their right to appeal the decision.

SUBCHAPTER 3. MY LIFE, MY CHOICE

317:50-3-2. Definitions

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

"ADL" means the activities of daily living. Activities of daily living are activities that reflect the member's ability to perform self-care tasks essential for sustaining health and safety such as:

(A) bathing,
(B) eating,
(C) dressing,
(D) grooming,
(E) transferring (includes getting in and out of a tub, bed to chair, etc.),
(F) mobility,
(G) toileting, and
(H) bowel/bladder control.

"ADLs score in high risk range" means the member's total weighted UCAT ADL score is 10 or more which indicates the member needs some help with 5 ADLs or that the member cannot do 3 ADLs at all plus the member needs some help with 1 other ADL.

"ADLs score at the high end of the moderate risk range" means member's total weighted UCAT ADL score is 8 or 9 which indicates the member needs help with 4 ADLs or the member cannot do 3 ADLs at all.

"Cognitive Impairment" means that the person, as determined by the clinical judgment of the LTC Nurse does not have the capability to think, reason, remember or learn required for self-care, communicating needs, directing care givers and/or using appropriate judgment for maintenance of their own health or safety. The clinical judgment of cognitive impairment is based on MSQ performance in combination with a more general evaluation of cognitive function from interaction with the person during the UCAT assessment.

"Developmental Disability" means a severe, chronic disability of an individual that:

(A) is attributable to a mental or physical impairment or combination of mental and physical impairments;

(B) is manifested before the individual attains age 22;

(C) is likely to continue indefinitely;

(D) results in substantial functional limitations in three or more of the following areas of major life activity:

(E) self-care;

(F) receptive and expressive language;

(G) learning;

(H) mobility;

(I) self-direction;

(J) capacity for independent living;

(K) economic self-sufficiency; and

(L) reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services, supports, or other assistance that is of lifelong or extended duration and is individually planned and coordinated.

"Environment high risk" means member's UCAT Environment score is 25 which indicates in the UCAT assessor's clinical judgment, the physical environment is strongly negative or hazardous.

"Environment moderate risk" means member's UCAT Environment score is 15 which indicates in the UCAT assessor's clinical judgment, many aspects of the physical environment are substandard or hazardous.

"Health Assessment high risk" means member's UCAT health assessment score is 25 which indicates in the UCAT assessor's clinical judgment, the member has one or more chronic health conditions, whose symptoms are rapidly deteriorating, uncontrolled, or not well controlled and requiring a high frequency or intensity of medical care/oversight to bring under control and whose functional capacity is so limited as to require full time assistance or care performed daily, by, or under the supervision of professional personnel and has multiple unmet needs for services available only through the My Life, My Choice program or a Nursing Facility (NF) and requires NF placement immediately if these needs cannot be met by other means.

"Health Assessment low risk" means member's health assessment score is 5 which indicates, in the UCAT assessor's clinical judgment, the member has one or more chronic, stable, health conditions, whose symptoms are controlled or nearly controlled, which benefit from

available, or usually available, medical treatment or corrective measures, and may have an unmet need for a service available only through the My Life, My Choice program or a Nursing Facility (NF) but is not likely to enter a NF if these needs are not met.

"Health Assessment moderate risk" means member's UCAT Health Assessment score is 15 which indicates in the UCAT assessor's clinical judgment, the member has one or more chronic changing health conditions, whose symptoms are fragile or worsening and require medical care/oversight, to bring under control or to maintain in a stable, controlled state and has multiple unmet needs for services available only through the My Life, My Choice program or a Nursing Facility (NF) and is likely to enter a NF if these needs are not met.

"IADL" means the instrumental activities of daily living.

"IADLs score in high risk range" means member's total weighted UCAT IADL score is 12 or more which indicates the member needs some help with 6 IADLs or cannot do 4 IADLs at all.

"Instrumental activities of daily living" means those activities that reflect the member's ability to perform household chores and tasks within the community essential for sustaining health and safety such as:

(A) shopping,
(B) cooking,
(C) cleaning,
(D) managing money,
(E) using a telephone,
(F) doing laundry,
(G) taking medication, and
(H) accessing transportation.

"Member Support high risk" means member's UCAT Member Support score is 25 which indicates in the UCAT assessor's clinical judgment, excluding from consideration existing Ryan White CARE Act, Indian Health Service, Medicaid NF, My Life, My Choice and/or State Plan Personal Care services, very little or no support is available from informal and formal sources and the member requires additional care that is not available through Medicare, Veterans Administration, or other Federal entitlement programs.

"Member Support moderate risk" means member's UCAT Member Support score is 15 which indicates in the UCAT assessor's clinical judgment, excluding from consideration existing Ryan White CARE Act, Indian Health Service, Medicaid NF, My Life, My Choice and/or State Plan Personal Care services, support from informal and formal sources is available, but

overall, it is inadequate, changing, fragile or otherwise problematic and the member requires additional care that is not available through Medicare, Veterans Administration, or other federal entitlement programs.

~~**"Mental Retardation"**~~ **"Intellectual Disability"** means that the person has, as determined by a PASRR level II evaluation, substantial limitations in functional ability due to significantly sub-average intellectual functioning related to an event occurring before the age of 18.

"MSQ" means the mental status questionnaire.

"MSQ score in high risk range" means the member's total weighted UCAT MSQ score is 12 or more which indicates a severe orientation-memory-concentration impairment, or a severe memory impairment.

"MSQ score at the high end of the moderate risk range" means the member's total weighted UCAT MSQ score is (10) or (11) which indicates an orientation-memory-concentration impairment, or a significant memory impairment.

"Nutrition high risk" means a total weighted UCAT Nutrition score is 12 or more which indicates the member has significant eating difficulties combined with poor appetite, weight loss, and/or special diet requirements.

"Progressive degenerative disease process that responds to treatment" means a process such as, but not limited to, Multiple Sclerosis (MS), Parkinson's Disease, Human Immunodeficiency Virus (HIV), or Acquired Immunodeficiency Syndrome (AIDS), that, untreated, systematically impairs normal body function which leads to acute illness and/or disability but that reacts positively to a medically prescribed treatment intervention (usually medication) which arrests or significantly delays the destructive action of the process.

"Social Resources high risk" means a total weighted UCAT Social Resources score is 15 or more, which indicates the member lives alone, combined with

in this subchapter, shall have the following meaning, unless the context clearly indicates otherwise:

"ADL" means the activities of daily living. Activities of daily living are activities that reflect the member's ability to perform self-care tasks essential for sustaining health and safety such as:

(A) bathing,

(B) eating,

(C) dressing,

(D) grooming,

(E) transferring (includes getting in and out of a tub, bed to chair, etc.), none or very few social contacts and no supports in times of need.

SUBCHAPTER 5. SOONER SENIORS

317:50-5-2. Definitions

The following words and terms when used

(F) mobility,

(G) toileting, and

(H) bowel/bladder control.

"ADLs score in high risk range" means the member's total weighted UCAT ADL score is 10 or more which indicates the member needs some help with 5 ADLs or that the member cannot do 3 ADLs at all plus the member needs some help with 1 other ADL.

"ADLs score at the high end of the moderate risk range" means member's total weighted UCAT ADL score is 8 or 9 which indicates the member needs help with 4 ADLs or the member cannot do 3 ADLs at all.

"Cognitive Impairment" means that the person, as determined by the clinical judgment of the LTC Nurse does not have the capability to think, reason, remember or learn required for self-care, communicating needs, directing care givers and/or using appropriate judgment for maintenance of their own health or safety. The clinical judgment of cognitive impairment is based on MSQ performance in combination with a more general evaluation of cognitive function from interaction with the person during the UCAT assessment.

"Environment high risk" means member's UCAT Environment score is 25 which indicates in the UCAT assessor's clinical judgment, the physical environment is strongly negative or hazardous.

"Environment moderate risk" means member's UCAT Environment score is 15 which indicates in the UCAT assessor's clinical judgment, many aspects of the physical environment are substandard or hazardous.

"Health Assessment high risk" means member's UCAT health assessment score is 25 which indicates in the UCAT assessor's clinical judgment, the member has one or more chronic health conditions, whose symptoms are rapidly deteriorating, uncontrolled, or not well controlled and requiring a high frequency or intensity of medical care/oversight to bring under control and whose functional capacity is so limited as to require full time assistance or care performed daily, by, or under the supervision of professional personnel and has multiple unmet needs for

services available only through the Sooner Seniors program or a Nursing Facility (NF) and requires NF placement immediately if these needs cannot be met by other means.

"Health Assessment low risk" means member's health assessment score is 5 which indicates, in the UCAT assessor's clinical judgment, the member has one or more chronic, stable, health conditions, whose symptoms are controlled or nearly controlled, which benefit from available, or usually available, medical treatment or corrective measures, and may have an unmet need for a service available only through the Sooner Seniors program or a Nursing Facility (NF) but is not likely to enter a NF if these needs are not met.

"Health Assessment moderate risk" means member's UCAT Health Assessment score is 15 which indicates in the UCAT assessor's clinical judgment, the member has one or more chronic changing health conditions, whose symptoms are fragile or worsening and require medical care/oversight, to bring under control or to maintain in a stable, controlled state and has multiple unmet needs for services available only through the Sooner Seniors program or a Nursing Facility (NF) and is likely to enter a NF if these needs are not met.

"IADL" means the instrumental activities of daily living.

"IADLs score in high risk range" means member's total weighted UCAT IADL score is 12 or more which indicates the member needs some help with 6 IADLs or cannot do 4 IADLs at all.

"Instrumental activities of daily living" means those activities that reflect the member's ability to perform household chores and tasks within the community essential for sustaining health and safety such as:

(A) shopping,
(B) cooking,
(C) cleaning,
(D) managing money,
(E) using a telephone,
(F) doing laundry,
(G) taking medication, and
(H) accessing transportation.

"Member Support high risk" means member's UCAT Member Support score is 25 which indicates in the UCAT assessor's clinical judgment, excluding from consideration existing Ryan White CARE Act, Indian Health Service, Medicaid NF, Sooner Seniors and/or State Plan Personal Care services, very little or no support is available from informal and formal sources and the member requires additional care that

is not available through Medicare, Veterans Administration, or other Federal entitlement programs.

"Member Support moderate risk" means member's UCAT Member Support score is 15 which indicates in the UCAT assessor's clinical judgment, excluding from consideration existing Ryan White CARE Act, Indian Health Service, Medicaid NF, Sooner Seniors and/or State Plan Personal Care services, support from informal and formal sources is available, but overall, it is inadequate, changing, fragile or otherwise problematic and the member requires additional care that is not available through Medicare, Veterans Administration, or other federal entitlement programs.

~~**"Mental Retardation"**~~ **"Intellectual Disability"** means that the person has, as determined by a PASRR level II evaluation, substantial limitations in functional ability due to significantly sub-average intellectual functioning related to an event occurring before the age of 18.

"MSQ" means the mental status questionnaire.

"MSQ score in high risk range" means the member's total weighted UCAT MSQ score is 12 or more which indicates a severe orientation-memory-concentration impairment, or a severe memory impairment.

"MSQ score at the high end of the moderate risk range" means the member's total weighted UCAT MSQ score is (10) or (11) which indicates an orientation-memory-concentration impairment, or a significant memory impairment.

"Nutrition high risk" means a total weighted UCAT Nutrition score is 12 or more which indicates the member has significant eating difficulties combined with poor appetite, weight loss, and/or special diet requirements.

"Progressive degenerative disease process that responds to treatment" means a process such as, but not limited to, Multiple Sclerosis (MS), Parkinson's Disease, Human Immunodeficiency Virus (HIV), or Acquired Immunodeficiency Syndrome (AIDS), that, untreated, systematically impairs normal body function which leads to acute illness and/or disability but that reacts positively to a medically prescribed treatment intervention (usually medication) which arrests or significantly delays the destructive action of the process.

"Social Resources high risk" means a total weighted UCAT Social Resources score is 15 or more, which indicates the member lives alone, combined with none or very few social contacts and no supports in times of need.

Oklahoma Health Care Authority

It is very important that you provide your comments regarding the proposed rule change by the comment due date. Comments are directed to Oklahoma Health Care Authority (OHCA) Health Policy Unit http://www.okhca.org/proposed-rule-changes.aspx

OHCA COMMENT DUE DATE: May 18, 2011

The proposed policy is an Emergency Rule. This proposal is scheduled to be presented to the Medical Advisory Committee (MAC) on May 19, 2011 and the (OHCA) Board of Directors on June 9, 2011.
Reference: APA WF 11-05

SUMMARY:
Insure Oklahoma—Native American Cost-Sharing— Insure Oklahoma cost-sharing rules are revised to comply with Federal law on Native American cost-sharing exemptions. Native Americans are exempt from Insure Oklahoma co-pays or premiums when they receive services provided by I/T/U providers or through referral by contract health services.

LEGAL AUTHORITY
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; Section 5006(a) of the American Recovery and Reinvestment Act; 42 CFR 457.535

RULE IMPACT STATEMENT:
TO: Traylor Rains
Health Policy

FROM: Joseph Fairbanks
Health Policy

SUBJECT: Rule Impact Statement
APA WF # 11-05

A. Brief description of the purpose of the rule:

Insure Oklahoma cost-sharing rules are revised to comply with Federal law on Native American cost-sharing exemptions. Native Americans are exempt from Insure Oklahoma co-pays or premiums when they receive services provided by I/T/U providers or through referral by contract health services.

B. A description of the classes of persons who most likely will be affected by the proposed rule, including classes that will bear the cost of the proposed rule, and any information on cost impacts received by the agency from any private or public entities:

Adult Native American applicants for Insure Oklahoma—Individual plan who receive services at an I/T/U facility or through contract referral services are affected. They will bear no cost, as they will be exempt from cost-sharing requirements in certain circumstances. Native American children in both Insure Oklahoma programs will also be affected. They will be exempt from cost-sharing requirements regardless of the location of services rendered.

C. A description of the classes of persons who will benefit from the proposed rule:

Native American adults and children who are enrolled in Insure Oklahoma programs. They will benefit through cost-sharing exemptions described in section B.

D. A description of the probable economic impact of the proposed rule upon the affected classes of persons or political subdivisions, including a listing of all fee changes and, whenever possible, a separate justification for each fee change:

There is no economic impact and there are no fee changes associated with the rule change for the above classes of persons or any political subdivision.E. The probable costs and benefits to the agency and to any other agency of the implementation and enforcement of the proposed rule, the source of revenue to be used for implementation and enforcement of the proposed rule, and any anticipated affect on state revenues, including a projected net loss or gain in such revenues if it can be projected by the agency:

The rule change will not result in any additional costs to the agency, nor will there be any revenue effects to the state.

F. A determination of whether implementation of the proposed rule will have an economic impact on any political

subdivisions or require their cooperation in implementing or enforcing the rule:

There is no economic impact on political subdivisions.

G. A determination of whether implementation of the proposed rule will have an adverse effect on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act:

There is no adverse economic impact on small businesses as a result of this rule.

H. An explanation of the measures the agency has taken to minimize compliance costs and a determination of whether there are less costly or non-regulatory methods or less intrusive methods for achieving the purpose of the proposed rule:

The agency has taken measures to determine that there is no less costly or non-regulatory method or less intrusive method for achieving the purpose of the proposed rule.

I. A determination of the effect of the proposed rule on the public health, safety and environment and, if the proposed rule is designed to reduce significant risks to the public health, safety and environment, an explanation of the nature of the risk and to what extent the proposed rule will reduce the risk:

The proposed rule should have no effect on the public health, safety, and environment.

J. A determination of any detrimental effect on the public health, safety and environment if the proposed rule is not implemented:

OHCA does not believe there is a detrimental effect on the public health and safety if the rule is not passed.

K. The date the rule impact statement was prepared and if modified, the date modified:

The rule impact statement was prepared April 11, 2011.

RULE TEXT

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 of their health plan premium. The employees are also responsible for up to 15 percent of their dependent's health plan premium if the dependent is included in the program. The combined portion of the employee's cost sharing for health 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.

SUBCHAPTER 11. INSURE OKLAHOMA IP
PART 3. Insure Oklahoma IP MEMBER HEALTH CARE BENEFITS

317:45-11-10. Insure Oklahoma IP adult benefits

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

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

(1) behavioral health services;

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

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

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

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

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

(c) IP covered adult benefits for in-network services, limits, and applicable co-payments are listed in this subsection. In addition to the benefit-specific limits, there is a maximum lifetime benefit of $1,000,000. Dependent children coverage is found at 317:45-11-12. Children are not held to the maximum lifetime benefit. Native American adults providing documentation of ethnicity who receive items and services furnished by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral

under contract health services are exempt from co-payments. Coverage includes:

(1) Anesthesia / Anesthesiologist Standby. Covered in accordance with 317:30-5-7. Eligible services are covered for covered illness or surgery including services provided by a Certified Registered Nurse Anesthetist (CRNA) or Anesthesiologist Assistant (AA).

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

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

(4) Diagnostic X-ray, including Ultrasound. Covered in accordance with 317:30-5-22(b)(2). PCP referral is required. Standard radiology (X-ray or Ultrasound): $0 co-pay. Specialized scanning and imaging (MRI, MRA, PET, or CAT Scan); $25 co-pay per scan.

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

(6) Inpatient Hospital Benefits. Covered in accordance with 317:30-5-41, 317:30-5-47 and 317:30-5-95; $50 co-pay per admission.

(7) Preventive Office Visit. For services of evaluation and medical management (wellness exam); one visit per year with a $10 co-pay. This visit counts as an office visit.

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

(9) Outpatient Hospital/Facility Services.

(A) Includes hospital surgery services in an approved outpatient facility including outpatient services and diagnostic services. Prior authorization required for certain procedures; $25 co-pay per visit.

(B) Therapeutic radiology or chemotherapy on an outpatient basis without limitation to the number of treatments per month for persons with proven malignancies or opportunistic infections; $10 co-pay per visit.

(C) Physical, Occupational and Speech Therapy services. Coverage is limited to one evaluation/re-evaluation visit (unit) per discipline per calendar year and 15 visits (units) per discipline per date of service per calendar year; $10 co-pay per visit.

(10) Maternity (Obstetric). Covered in accordance with 317:30-5-22. Nursery care paid separately under eligible child; $50 inpatient hospital co-pay.
(11) Laboratory/Pathology. Covered in accordance with 317:30-5-20; $0 co-pay.
(12) Mammogram (Radiological or Digital). Covered in accordance with 317:30-5-901; $0 co-pay.
(13) Immunizations. Covered in accordance with 317:30-5-2.
(14) Assistant Surgeon. Covered in accordance with 317:30-5-8.
(15) Dialysis, Kidney dialysis, and services and supplies, either at home or in a facility; $0 co-pay.
(16) Oral Surgery. Services are limited to the removal of tumors or cysts; Inpatient Hospital $50 or Outpatient Hospital/Facility; $25 co-pay applies.
(17) Behavioral Health (Mental Health and Substance Abuse) Treatment (Inpatient). Covered in accordance with 317:30-5-95.1; $50 co-pay per admission.
(18) Behavioral Health (Mental Health and Substance Abuse) Treatment (Outpatient).
(A) Agency services. Covered in accordance with 317:30-5-241 and 317:30-5-596; $10 co-pay per visit.
(B) Individual provider services. Licensed Behavioral Health Professionals (LBHPs) are defined as follows for the purpose of Outpatient Behavioral Health Services and Outpatient Substance Abuse Treatment:
(i) Allopathic or Osteopathic Physicians with a current license and board certification in psychiatry or board eligible in the state in which services are provided, or a current resident in psychiatry practicing as described in 317:30-5-2.
(ii) Practitioners with a license to practice in the state in which services are provided or those 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 licensing boards listed in (I) through (VI) below. The exemptions from licensure under 59 Okla. Stat. '1353(4) and (5), 59 '1903(C) and (D), 59 '1925.3(B) and (C), and 59 '1932(C) and (D) do not apply to Outpatient Behavioral Health Services.
(I) Psychology,
(II) Social Work (clinical specialty only),
(III) Professional Counselor,
(IV) Marriage and Family Therapist,
(V) Behavioral Practitioner, or

(VI) Alcohol and Drug Counselor.

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

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

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

(vi) LBHP services require prior authorization and are limited to 8 therapy services per month per member and 8 testing units per year per member; $10 co-pay per visit.

(19) Durable Medical Equipment and Supplies. Covered in accordance with 317:30-5-210 through 317:30-5-218. A PCP referral and prior authorization is required for certain items. DME/Supplies are covered up to a $15,000 annual maximum; exceptions from the annual DME limit are diabetic supplies, oxygen, home dialysis, and parenteral therapy; $5 co-pay for durable/non-durable supplies and $25 co-pay for durable medical equipment.

(20) Diabetic Supplies. Covered in accordance with 317:30-5-211.15; not subject to $15,000 annual DME limit; $5 co-pay per prescription.

(21) Oxygen. Covered in accordance with 317:30-5-211.11 through 317:30-5-211.12; not subject to $15,000 annual DME limit; $5 co-pay per month.

(22) Pharmacy. Covered in accordance with 317:30-5-72.1 and 317:30-5-72. Prenatal vitamins and smoking cessation products do not count against monthly prescription limits; $5/$10 co-pay per prescription.

(23) Smoking Cessation Products. Products do not count against monthly prescription limits. Covered in accordance with 317:30-5-72.1; $5/$10 co-pay per product.

(24) Nutrition Services. Covered in accordance with 317:30-5-1076; $10 co-pay per visit.

(25) External Breast Prosthesis, Bras and Prosthetic Garments. Covered in accordance with 317:30-5-211.13; $25 co-pay per prosthesis.

(26) Surgery. Covered in accordance with 317:30-5-8; $50 co-pay per inpatient admission and $25 co-pay per outpatient visit.

(27) Home Dialysis. Covered in accordance with 317:30-5-211.13; not subject to $15,000 annual DME limit; $0 co-pay.
(28) Parenteral Therapy. Covered in accordance with 317:30-5-211.14; not subject to $15,000 annual DME limit; $25 co-pay per month.
(29) Family Planning Services and Supplies, including Sterilizations. Covered in accordance with 317:30-3-57; $0 co-pay.
(30) Home Health Medications, Intravenous (IV) Therapy and Supplies. Covered in accordance with 317:30-5-211.15 and 317:30-5-42.16(b)(3).
(31) Fundus photography.
(32) Perinatal dental care for pregnant women. Covered in accordance with 317:30-5-696; $0 co-pay.

317:45-11-12. Insure Oklahoma IP children benefits

(a) IP covered child benefits for in-network services, limits, and applicable co-payments are listed in this Subsection. All IP benefits are subject to rules delineated in 317:30 except as specifically set out in this Section. All services provided must be medically necessary as defined in 317:30-3-1(f). The scope of IP child benefits described in this Section is subject to specific non-covered services listed in 317:45-11-13. Dependent children are not held to the maximum lifetime benefit of $1,000,000. Native American children providing documentation of ethnicity are exempt from co-payments. Coverage includes:

(1) Ambulance services. Covered as medically necessary; $50 co-pay per occurrence; waived if admitted.
(2) Blood and blood products. Processing, storage, and administration of blood and blood products in inpatient and outpatient settings.
(3) Chelation therapy. Covered for heavy metal poisoning only.
(4) Chemotherapy and radiation therapy. Covered as medically necessary; $10 co-pay per visit.
(5) Clinic services including renal dialysis services. Covered as medically necessary; $0 co-pay for dialysis services; $10 co-pay per office visit.
(6) Diabetic supplies. One glucometer, one spring-loaded lancet device, two replacement batteries per year - 100 glucose strips and lancets per month; not included in DME $15,000 max/year; $5 co-pay per billable service. Additional supplies require prior authorization.
(7) Diagnostic X-ray services. Covered as medically necessary; $25 co-pay per scan for MRI, MRA, PET, CAT scans only.

(8) Dialysis. Covered as medically necessary.
(9) Durable medical equipment and supplies. Covered as medically necessary with $15,000 annual maximum; $5 co-pay per item for durable/non-durable supplies; $25 co-pay per item for DME.
(10) Emergency department services. Covered as medically necessary; $30 co-pay per occurrence; waived if admitted.
(11) Family planning services and supplies. Birth control information and supplies; pap smears; pregnancy tests.
(12) Home health services. Home health visits limited to 36 visits per year, prior authorization required, includes medications IV therapy and supplies; $10 co-pay per visit, appropriate pharmacy and DME co-pays will apply.
(13) Hospice services. Covered as medically necessary, prior authorization required; $10 co-pay per visit.
(14) Immunizations. Covered as recommended by ACIP; $0 co-pay.
(15) Inpatient hospital services (acute care only). Covered as medically necessary; $50 co-pay per admission.
(16) Laboratory services. Covered as medically necessary.
(17) Psychological testing. Psychological, neurological and development testing; outpatient benefits per calendar year, prior authorization required issued in four unit increments - not to exceed eight units/hours per testing set; $0 co-pay.
(18) Mental health/substance abuse treatment-outpatient. All outpatient benefits require prior authorization. Outpatient benefits limited to 48 visits per calendar year. Additional units as medically necessary; $10 co-pay per outpatient visit.
(19) Mental health/substance abuse treatment-inpatient. Acute, detox, partial, and residential treatment center (RTC) with 30 day max per year, 2 days of partial or RTC treatment equals 1 day accruing to maximum. Additional units as medically necessary; $50 co-pay per admission. Requires prior authorization.
(20) Nurse midwife services. Covered as medically necessary for pregnancy-related services only; $0 co-pay.
(21) Nutrition services. Covered as medically necessary; $10 co-pay.
(22) Nutritional support. Covered as medically necessary; not included in DME $15,000 max/year. Parenteral nutrition covered only when medically necessary; $25 co-pay.
(23) Other medically necessary services. Covered as medically necessary.
(24) Oral surgery. Covered as medically necessary and includes the removal of tumors and cysts; $25 co-pay for outpatient; $50 co-pay for inpatient hospital.

(25) Outpatient hospital services. Covered as medically necessary and includes ambulatory surgical centers and therapeutic radiology or chemotherapy on an outpatient basis without limitation to the number of treatments per month for children with proven malignancies or opportunistic infections; $25 co-pay per visit; $10 co-pay per visit for therapeutic radiology or chemotherapy.

(26) Oxygen. Covered as medically necessary; not included in DME $15,000 max/year; $5 co-pay per month.

(27) PCP visits. Blood lead screen covered as medically necessary. Hearing services limited to one outpatient newborn screening. Well baby/well child exams follow recommended schedule to age 19; $0 co-pay for preventive visits and well baby/well child exams; $10 co-pay for all other visits.

(28) Physical, occupational, and speech therapy. Covered as medically necessary; prior authorization required; $10 co-pay per visit.

(29) Physician services, including preventive services. Covered as medically necessary; $0 co-pay for preventive visits; $10 co-pay for all other visits.

(30) Prenatal, delivery and postpartum services. Covered as medically necessary; $0 co-pay for office visits; $50 co-pay for delivery.

(31) Prescription drugs and insulin. Limited to six per month; generic preferred. Prenatal vitamins and smoking cessation products do not count toward the six prescription limit; $5-$10 co-pay.

(32) Smoking cessation products. Limited coverage; 90-day supply; products do not count against prescription drug limit; $5-$10 co-pay.

(33) Specialty clinic services. Covered as medically necessary; $10 co-pay.

(34) Surgery. Covered as medically necessary; $25 co-pay for outpatient facility; $50 co-pay for inpatient hospital.

(35) Tuberculosis services. Covered as medically necessary; $10 co-pay per visit.

(36) Ultraviolet treatment-actinotherapy. Covered as medically necessary; prior authorization required after one visit per 365 sequential days; $5 co-pay.

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

(1) behavioral health services;

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

(3) family planning supplies and services, meaning an office visit for a comprehensive family planning evaluation, including obtaining a Pap smear;
(4) women's routine and preventive health care services;
(5) emergency medical condition as defined in 317:30-3-1; and
(6) services delivered to American Indians at Indian Health Service, tribal, or urban Indian clinics.

PART 5. INSURE OKLAHOMA IP MEMBER ELIGIBILITY

317:45-11-24. Member cost sharing

(a) Members are given monthly invoices for health plan premiums. The premiums are due, and must be paid in full, no later than the 15th day of the month prior to the month of IP coverage.

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

(2) Working disabled individuals are responsible for their monthly premiums in an amount not to exceed four percent of their monthly gross household income, based on a family size of one and capped at 250 percent of the Federal Poverty Level. The increase from 200 to 250 percent of the FPL will be phased in over a period of time as determined by the Oklahoma Health Care Authority.

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

(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 Insufficient/Non-sufficient funds.

317: 45-11-25. Premium payment

IP health plan premiums are established by the OHCA. Employees and college students are responsible for up to 20 percent of their IP health plan premium. The employees are also responsible for up to 20 percent of their dependent's IP health plan premium if the dependent is included in the program. The combined portion of the employee's or college students cost sharing for IP health plan premiums cannot exceed four percent of his/her annual gross household income computed monthly. Native Americans providing documentation of ethnicity are exempt from premium payments.

SUBCHAPTER 13. INSURE OKLAHOMA DENTAL SERVICES

317:45-13-1. Dental services requirements and benefits

The Oklahoma Health Care Authority (OHCA) provides dental services to children who qualify for the Insure Oklahoma Individual Plan (IP). Dental coverage is obtained through direct purchase from the OHCA. The existing cost sharing requirements for IP qualified children apply. Native Americans children providing documentation of their ethnicity are exempt from dental co-pay requirements. Children obtaining medical coverage through IP receive Dental IP coverage. The OHCA contracts with Dental IP providers utilizing the SoonerCare network. The Dental IP providers are reimbursed pursuant to the SoonerCare fee schedule for rendered services.

(1) The Dental IP program is covered as medically necessary and includes coverage for Class A, B, C, and orthodontia services. All coverage is provided as necessary to prevent disease, promote and restore oral health, and treat emergency conditions. Dental services follow the American Academy of Pediatric Dentistry (AAPD) periodicity schedule. Prior authorization is required for certain services.

(2) Class A services are covered as medically necessary and include preventive, diagnostic care such as cleanings, check-ups, X-rays, and fluoride treatments, no co-pay is required.

(3) Class B services are covered as medically necessary and include basic, restorative, endodontic, periodontic, oral and maxillofacial surgery care such as fillings, extractions, periodontal care, and some root canal, $10 co-pay is required.

(4) Class C services are covered as medically necessary and include major, prosthodontic care such as crowns, bridges and dentures, $25 co-pay is required.

(5) Class D services are covered as medically necessary and include orthodontic care. Orthodontic care is not covered for cosmetic purposes or any purposes which are not medical in nature, $25 co-pay is required.

(6) Emergency dental services are covered as medically necessary, no co-pay is required.

Oklahoma Health Care Authority

It is very important that you provide your comments regarding the proposed rule change by the comment due date. Comments are directed to Oklahoma Health Care Authority (OHCA) Health Policy Unit http://www.okhca.org/proposed-rule-changes.aspx

OHCA COMMENT DUE DATE: May 18, 2011

The proposed policy is an Emergency Rule. This proposal is scheduled to be presented to the Medical Advisory Committee (MAC) on May 19, 2011 and the (OHCA) Board of Directors on June 9, 2011.
Reference: APA WF 11-07

SUMMARY:
PT/OT/ST Clarification—PT/OT/ST rules restrict individually-contracted provider services to children, though adults may receive such therapy services in an outpatient hospital setting. Rules are amended to ensure clarity in policy that there is no coverage for adults for services rendered by individually-contracted providers, but there is coverage for adults in an outpatient hospital setting.

LEGAL AUTHORITY
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; Public Law 111-312, the Tax Relief, Unemployment Insurance Reauthorization, and Job Creation Act of 2010

RULE IMPACT STATEMENT:
TO: Traylor Rains
Health Policy

FROM: Joseph Fairbanks
Health Policy

SUBJECT: Rule Impact Statement
APA WF # 11-07

A. Brief description of the purpose of the rule:

PT/OT/ST rules restrict individually-contracted provider services to children, though adults may receive such therapy services in an outpatient hospital setting. Rules are

amended to ensure clarity in policy that there is no coverage for adults for services rendered by individually-contracted providers, but there is coverage for adults in an outpatient hospital setting.

B. A description of the classes of persons who most likely will be affected by the proposed rule, including classes that will bear the cost of the proposed rule, and any information on cost impacts received by the agency from any private or public entities:

No classes of persons will be affected by the proposed rule and there is no cost associated with the proposed rule

C. A description of the classes of persons who will benefit from the proposed rule:

No classes of persons will benefit from the proposed rule. The proposed rule merely clarifies current policy.

D. A description of the probable economic impact of the proposed rule upon the affected classes of persons or political subdivisions, including a listing of all fee changes and, whenever possible, a separate justification for each fee change:

There is no economic impact and there are no fee changes associated with the rule change for the above classes of persons or any political subdivision.

E. The probable costs and benefits to the agency and to any other agency of the implementation and enforcement of the proposed rule, the source of revenue to be used for implementation and enforcement of the proposed rule, and any anticipated affect on state revenues, including a projected net loss or gain in such revenues if it can be projected by the agency:

The rule change will not result in any additional costs or revenue changes to the agency.

F. A determination of whether implementation of the proposed rule will have an economic impact on any political subdivisions or require their cooperation in implementing or enforcing the rule:

There is no economic impact on political subdivisions.

G. A determination of whether implementation of the proposed rule will have an adverse effect on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act:

There is no adverse economic impact on small businesses as a result of this rule.

H. An explanation of the measures the agency has taken to minimize compliance costs and a determination of whether there are less costly or non-regulatory methods or less intrusive methods for achieving the purpose of the proposed rule:

The agency has taken measures to determine that there is no less costly or non-regulatory method or less intrusive method for achieving the purpose of the proposed rule.

I. A determination of the effect of the proposed rule on the public health, safety and environment and, if the proposed rule is designed to reduce significant risks to the public health, safety and environment, an explanation of the nature of the risk and to what extent the proposed rule will reduce the risk:

The proposed rule should have no effect on the public health, safety, and environment.

J. A determination of any detrimental effect on the public health, safety and environment if the proposed rule is not implemented:

OHCA does not believe there is a detrimental effect on the public health and safety if the rule is not passed.

K. The date the rule impact statement was prepared and if modified, the date modified:

The rule impact statement was prepared May 4, 2011.

RULE TEXT

TITLE 317: OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 27. INDEPENDENT LICENSED PHYSICAL THERAPISTS

317:30-5-291. Coverage by category

Payment is made to registered physical therapists as set forth in this Section

(1) **Children.** Initial therapy evaluations do not require prior authorization. All therapy services following the initial evaluation must be prior authorized for continuation of service.

(2) **Adults.** There is no coverage for adults~~.~~ for services rendered by individually contracted providers. Coverage for adults is permitted in an outpatient hospital setting as described in 30-5-42.1.

(3) **Individuals eligible for Part B of Medicare.** Services provided to Medicare eligible recipients are filed directly with the fiscal agent.

PART 28. OCCUPATIONAL THERAPY SERVICES

317:30-5-296. Coverage by category

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

(1) **Children.** Initial therapy evaluations do not require prior authorization. All therapy services following the initial evaluation must be prior authorized for continuation of service.

(2) **Adults.** There is no coverage for adults~~.~~ for services rendered by individually contracted providers. Coverage for adults is permitted in an outpatient hospital setting as described in 30-5-42.1.

(3) **Individuals eligible for Part B of Medicare.** Services provided to Medicare eligible recipients are filed directly with the fiscal agent.

Oklahoma Health Care Authority

It is very important that you provide your comments regarding the proposed rule change by the comment due date. Comments are directed to Oklahoma Health Care Authority (OHCA) Health Policy Unit http://www.okhca.org/proposed-rule-changes.aspx

OHCA COMMENT DUE DATE: December 19, 2011

The proposed policy is a Permanent Rule. This proposal is scheduled to be presented to the Medical Advisory Committee (MAC) on January 19, 2012 and the (OHCA) Board of Directors on February 9, 2012.
Reference: APA WF 11-08

SUMMARY:
Date of Application Clarification– Eligibility rules are revised to provide clarification regarding dates of application for SoonerCare services. Current rules are difficult to interpret and, in some instances, obsolete. The revisions will make interpreting rules easier for OHCA staff, contracted agency partners, and applicants to understand when an application is considered received and completed. Rules are further amended to add the Notification of Date of Service feature for hospitals in official agency policy.

LEGAL AUTHORITY
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes

RULE IMPACT STATEMENT:
TO: Tywanda Cox
Health Policy

FROM: Joseph Fairbanks
Health Policy

SUBJECT: Rule Impact Statement
APA WF # 11-08

A. Brief description of the purpose of the rule:

Eligibility rules are revised to provide clarification regarding dates of application for SoonerCare services. Current rules are difficult to interpret and, in some

instances, obsolete. The revisions will make interpreting rules easier for OHCA staff, contracted agency partners, and applicants to understand when an application is considered received and completed. Rules are further amended to add the Notification of Date of Service feature for hospitals in official agency policy.

B. A description of the classes of persons who most likely will be affected by the proposed rule, including classes that will bear the cost of the proposed rule, and any information on cost impacts received by the agency from any private or public entities:

No classes of persons will be affected by the proposed rule and there is no cost associated with the proposed rule

C. A description of the classes of persons who will benefit from the proposed rule:

No classes of persons will benefit from the proposed rule. The proposed rule merely clarifies policy.

D. A description of the probable economic impact of the proposed rule upon the affected classes of persons or political subdivisions, including a listing of all fee changes and, whenever possible, a separate justification for each fee change:

There is no economic impact and there are no fee changes associated with the rule change for the above classes of persons or any political subdivision.

E. The probable costs and benefits to the agency and to any other agency of the implementation and enforcement of the proposed rule, the source of revenue to be used for implementation and enforcement of the proposed rule, and any anticipated affect on state revenues, including a projected net loss or gain in such revenues if it can be projected by the agency:

The rule change will not result in any additional costs or revenue changes to the agency. It will provide the added benefit of clarity in conducting business with contracted agency partners who use our rules to make eligibility decisions.

F. A determination of whether implementation of the proposed rule will have an economic impact on any political subdivisions or require their cooperation in implementing or enforcing the rule:

There is no economic impact on political subdivisions.

G. A determination of whether implementation of the proposed rule will have an adverse effect on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act:

There is no adverse economic impact on small businesses as a result of this rule.

H. An explanation of the measures the agency has taken to minimize compliance costs and a determination of whether there are less costly or non-regulatory methods or less intrusive methods for achieving the purpose of the proposed rule:

The agency has taken measures to determine that there is no less costly or non-regulatory method or less intrusive method for achieving the purpose of the proposed rule.

I. A determination of the effect of the proposed rule on the public health, safety and environment and, if the proposed rule is designed to reduce significant risks to the public health, safety and environment, an explanation of the nature of the risk and to what extent the proposed rule will reduce the risk:

The proposed rule should have no effect on the public health, safety, and environment.

J. A determination of any detrimental effect on the public health, safety and environment if the proposed rule is not implemented:

OHCA does not believe there is a detrimental effect on the public health and safety if the rule is not passed.

K. The date the rule impact statement was prepared and if modified, the date modified:

The rule impact statement was prepared November 3, 2011.

RULE TEXT

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
SUBCHAPTER 6. SOONERCARE FOR PREGNANT WOMEN AND FAMILIES WITH CHILDREN
PART 3. APPLICATION PROCEDURES

317:35-6-15. Application for SoonerCare for Pregnant Women and Families with Children; forms

(a) **Application**. An application for categorically needy pregnant women and families with children consists of the SoonerCare application. The application form is signed by the individual, parent, spouse, guardian, or someone else acting on the individual's behalf. A categorically needy individual does not have to have received a medical service nor expect to receive one to be certified for SoonerCare.

(1) An application may be made in a variety of locations, for example, a physician's office, a hospital or other medical facility, Health Department, in the county OKDHS office, or online. A face to face interview is not required. Applications are mailed to the OHCA Eligibility Unit. When an individual indicates a need for SoonerCare, the physician or facility may forward an application to the OHCA Eligibility Unit for processing. If the applicant is unable to sign the application, someone acting on his/her behalf may sign the application.

(2) OKDHS form 08MA005E, Notification of Needed Medical Services, is required only for preauthorization of medical services. Although not required, the form may be submitted by the physician or facility as notification for a need for medical service. The form also may be accepted as medical verification of pregnancy.

(3) Receipt of the SoonerCare Application form or OKDHS form 08MA005E constitutes an application for SoonerCare.

(4) If OKDHS form 08MA005E is received and a SoonerCare application cannot be completed, receipt of OKDHS form 08MA005E constitutes an application which must be registered and subsequently denied. The applicant and provider are notified by computer-generated notice.

(5) A hospital providing services may file an electronic Notification of Date of Service (NODOS) form with OHCA up to five days from the date services are rendered. The hospital, applicant, or someone acting on the applicant’s behalf has fifteen days from the date the NODOS form was received by OHCA to submit a completed SoonerCare

application. Filing a Notification of Date of Service does not guarantee coverage and if a completed application is not submitted within fifteen days, the NODOS is void.

(b) **Date of application**. When an application is made online, the date of application is the date the application is submitted online. ~~When application is made in the county office, the date of application is the date the applicant or someone acting on his/her behalf signs the application form. When the application is initiated outside the county office, the date of application is the date the application or OKDHS form 08MA005E is stamped with the date the application was received into the OHCA Eligibility Unit. When a request for SoonerCare is first made by an oral request to the county office, and the application form is signed later, the date of the oral request is entered in "red" on the application form above the date the form is signed. The date of the oral request is the date of application to be used. When OKDHS form 08MA005E is received in the OHCA Eligibility Unit prior to the completion of the application form, the date that OKDHS form 08MA005E is received is considered as the date of application and must be registered as an application. Certain providers may take applications and then forward them to the OHCA Eligibility Unit for SoonerCare eligibility determination. Under this circumstance, the application date is the date the applicant signed the application form for the provider.~~ The date of application for a paper application is the date a signed application is received and stamped in by contracted agency partners or OHCA. When a request for SoonerCare is made orally, and that request is followed within 20 days by a signed application, the documented date of the oral request is the date of application. When OKDHS form 08MA005E is received by OKDHS, or received by OHCA and forwarded to OKDHS, the earliest of the date stamps is considered the date of request and should be honored when followed within 20 days by a signed application for SoonerCare.

SUBCHAPTER 7. MEDICAL SERVICES
PART 3. APPLICATION PROCEDURES

317:35-7-15. Application for Medical Services; forms

(a) **Application**. An application for Medical Services consists of the Medical Assistance Application. The application form is signed by the individual, parent, spouse, guardian or someone else acting on the individual's behalf. A individual does not have to have received a medical service nor expect to receive one to be certified for SoonerCare.

(1) An application may be made in a variety of locations, for example, a physician's office, a hospital or other medical facility or in the county OKDHS office. An application may be made online by individuals who are pregnant, have children or are applying for family planning services only. A face to face interview is not required. SoonerCare applications for women who are pregnant, families with children and for family planning services only are mailed to the OHCA Eligibility Unit. Applications for other medical services may be mailed or faxed to the local county OKDHS office. If faxed, it is not necessary to send the original application. When an individual indicates a need for health benefits, the physician or facility may forward an application or 08MA005E to the OKDHS county office of the patient's residence for processing. The physician or facility may forward an application or 08MA005E for individuals who are pregnant, have children or are applying for family planning services only to the OHCA Eligibility Unit for processing. If the applicant is unable to sign the application, someone acting on his/her behalf may sign the application.

(2) OKDHS form 08MA005E, Notification of Needed Medical Services, is required only for preauthorization of medical services. Although not required, the form may be submitted by the physician or facility as notification for a need for medical service. The form also may be accepted as medical verification of pregnancy.

(3) Receipt of the SoonerCare Application form or OKDHS form 08MA005E constitutes an application for SoonerCare.

(4) If OKDHS form 08MA005E is received and an application cannot be completed, receipt of OKDHS form 08MA005E constitutes an application which must be registered and subsequently denied. The applicant and provider are notified by computer-generated notice.

(5) If the applicant also wishes to apply for a State Supplemental Payment, either the applicant or his/her guardian must sign the Medical Assistance Application form.

(b) **Date of application**. When an application is made online, the date of application is the date the application is submitted online. ~~When application is made in the county office, the date of application is the date the applicant or someone acting on his/her behalf signs the application form. When the application is initiated outside the county office, the date of application is the date the application or OKDHS form 08MA005E is stamped into the OHCA Eligibility Unit. When an application is faxed, the application date is the date the fax is received. When a request for SoonerCare is first made~~

~~by an oral request to the county office, and the application form is signed later, the date of the oral request is entered in "red" on the application form above the date the form is signed. The date of the oral request is the date of application to be used. When OKDHS form 08MA005E is received in the county office or the OHCA Eligibility Unit prior to the completion of the application form, the date that OKDHS form 08MA005E is received is considered as the date of application and must be registered as an application. Certain providers may take applications and then forward them to the OKDHS county office or the OHCA Eligibility Unit for SoonerCare eligibility determination. Under this circumstance, the application date is the date the member signed the application form for the provider.~~ The date of application for a paper application is the date a signed application is received and stamped in by contracted agency partners or OHCA. When a request for SoonerCare is made orally, and that request is followed within 20 days by a signed application, the documented date of the oral request is the date of application. When OKDHS form 08MA005E is received by OKDHS, or received by OHCA and forwarded to OKDHS, the earliest of the date stamps is considered the date of request and should be honored when followed within 20 days by a signed application for SoonerCare.

Oklahoma Health Care Authority

It is very important that you provide your comments regarding the proposed rule change by the comment due date. Comments are directed to Oklahoma Health Care Authority (OHCA) Health Policy Unit http://www.okhca.org/proposed-rule-changes.aspx

OHCA COMMENT DUE DATE: Monday, January 9th, 2012.

The proposed policy is a Permanent rule. This proposal is scheduled to be presented to the Medical Advisory Committee (MAC) on January 19th, 2012 and the (OHCA) Board of Directors on March 8th, 2012.
Reference: APA WF 11-13

SUMMARY:
OHCA rules for the My Life, My Choice Waiver are revised to clarify waiting list procedures for individuals who apply for services but cannot enter the waiver due to capacity limitations. The rules clarify that individuals applying for the waiver but unable receive services due to capacity limitations are placed on a waiting list and enter the waiver on a first on first off basis.

LEGAL AUTHORITY
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; Section 1915 (c) of the Social Security Act

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

TO: Tywanda Cox
Policy Development

From: Brent Johnson

SUBJECT: Rule Impact Statement
(Reference APA WF # 11-13)

A. Brief description of the purpose of the rule:
OHCA rules for the My Life, My Choice Waiver are revised to clarify waiting list procedures for individuals who apply for services but cannot enter the waiver due to capacity limitations. The rules clarify that individuals applying for the waiver but unable receive services due to capacity limitations are placed on a waiting list and enter the waiver on a first on first off basis.

B. A description of the classes of persons who most likely will be affected by the proposed rule, including classes that will bear the cost of the proposed rule, and any information on cost impacts received by the agency from any private or public entities:

The classes of persons who will be affected by the proposed rule change are individuals applying for My Life, My Choice Waiver services but unable to enter the waiver due to capacity limitations. There are no anticipated costs associated with the proposed rule change.

C. A description of the classes of persons who will benefit from the proposed rule:

The classes of persons who will benefit by the proposed rule change are individuals applying for My Life, My Choice Waiver services but unable to enter the waiver due to capacity limitations. Those individuals will benefit from a waiting list procedure that provides priority placement through a first on first off basis.

D. A description of the probable economic impact of the proposed rule upon the affected classes of persons or political subdivisions, including a listing of all fee changes and, whenever possible, a separate justification for each fee change:

There is no probable economic impact of the proposed rules upon any classes of persons or political subdivisions, nor are any fees associated with this rule change.

E. The probable costs and benefits to the agency and to any other agency of the implementation and enforcement of the proposed rule, the source of revenue to be used for implementation and enforcement of the proposed rule, and any anticipated affect on state revenues, including a projected net loss or gain in such revenues if it can be projected by the agency:

There are no probable costs to the agency or any other agency associated with this rule revision. The rule clarification will benefit the agency through the elimination of potential confusion regarding the waiting list procedures.

F. A determination of whether implementation of the proposed rule will have an economic impact on any political subdivisions or require their cooperation in implementing or enforcing the rule:

The proposed rule will not have an economic impact on any political subdivision or require their cooperation in implementing or enforcing the rule.

G. A determination of whether implementation of the proposed rule will have an adverse effect on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act:

The proposed rule will not have an adverse effect on small businesses as provided by the Oklahoma Small Business Regulatory Flexibility Act.

H. An explanation of the measures the agency has taken to minimize compliance costs and a determination of whether there are less costly or nonregulatory methods or less intrusive methods for achieving the purpose of the proposed rule:

There are no other legal methods to minimize compliance costs.

I. A determination of the effect of the proposed rule on the public health, safety and environment and, if the

proposed rule is designed to reduce significant risks to the public health, safety and environment, an explanation of the nature of the risk and to what extent the proposed rule will reduce the risk:

The proposed rule should have no effect on the public health, safety, or environment.

J. A determination of any detrimental effect on the public health, safety and environment if the proposed rule is not implemented:

The agency does not anticipate any detrimental effects on the public health, safety, or environment.

K. The date the rule impact statement was prepared and if modified, the date modified:

This rule impact statement was prepared on October 27th, 2011.

RULE TEXT

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 50. HOME AND COMMUNITY BASED SERVICES WAIVERS
SUBCHAPTER 3. MY LIFE, MY CHOICE

317:50-3-4. Application for My Life, My Choice Waiver services

(a) Within 60 days of completion of the Living Choice demonstration program, members choosing to stay in a home and community based setting may apply for transition into the My Life, My Choice Waiver. In order to transition from the Living Choice demonstration program to the My Life, My Choice Waiver, a recertification of eligibility is required. The member must meet all financial and medical eligibility requirements for recertification. The same application and eligibility processes used to certify members for SoonerCare long term care and Living Choice services will be reviewed to ensure any changes in member status will not affect eligibility for the My Life, My Choice Waiver. The original application and eligibility processes are set forth in 317:50-3-4(a)(1) through 317:50-3-6 below.

(1) The application process is initiated by the receipt of a UCAT, Part I or by an oral request for services. A written financial application is not required for an individual who

is a SoonerCare member at the time of application. A financial application for My Life, My Choice Waiver services consists of the Medical Assistance Application form. The form is signed by the applicant, parent, spouse, guardian or someone else acting on the applicant's behalf.

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

(B) An individual requesting waiver services, or the individual's community spouse may request an assessment of resources available to each spouse by using OKDHS form MA-11, Assessment of Assets, when SoonerCare application is not being made. The individual and/or spouse must provide documentation of resources. The assessment reflects all countable resources of the couple (owned individually or as a couple) and establishes the spousal share to be protected when subsequent determination of SoonerCare long-term care eligibility is made.

(C) When SoonerCare application is being made, an assessment of resources must be completed if it was not completed when the individual entered the NF or began receiving home and community based services. For applicants of the My Life, My Choice waiver, those resources owned by the couple the month the application was made determines the spousal share of resources. If the individual applied for SoonerCare at the time of entry into the Living Choice Program, Form MA-11 is not appropriate. However, the spousal share must be determined using the resource information provided on the SoonerCare application form and computed using OKDHS form MA-12, Title XIX Worksheet.

(2) The date of application is the date the signed application is received or the date when the request for SoonerCare is made orally and the financial application form is signed later. The date of the oral request is noted above the date the form is signed.

(b) **My Life, My Choice Waiver waiting list procedures.** My Life, My Choice Waiver Program ~~"available capacity in the month"~~ capacity is the number of ~~additional~~ members that may be

enrolled in the Program ~~in a given month~~ without exceeding, on an annualized basis, the maximum number authorized by the waiver to be served in the waiver year. If available waiver capacity has been realized, requests for services are not processed as applications, but placed on a waiting list. As available capacity permits, the OHCA selects in chronological order (first on, first off) requests for services from the waiting list to forward for application processing. When waiver capacity exceeds the number on the waiting list and after all persons on the waiting list have been processed, waiting list procedures are suspended.

Oklahoma Health Care Authority

It is very important that you provide your comments regarding the proposed rule change by the comment due date. Comments are directed to Oklahoma Health Care Authority (OHCA) Health Policy Unit http://www.okhca.org/proposed-rule-changes.aspx

OHCA COMMENT DUE DATE: Monday, January 9th, 2012.

The proposed policy is a Permanent rule. This proposal is scheduled to be presented to the Medical Advisory Committee (MAC) on January 19th, 2012 and the (OHCA) Board of Directors on March 8th, 2012.
Reference: APA WF 11-14

SUMMARY:
OHCA rules for the Sooner Seniors Waiver are revised to clarify waiting list procedures for individuals who apply for services but cannot enter the waiver due to capacity limitations. The rules clarify that individuals applying for the waiver but unable receive services due to capacity limitations are placed on a waiting list and enter the waiver on a first on first off basis.

LEGAL AUTHORITY
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; Section 1915 (c) of the Social Security Act

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

TO: Tywanda Cox
Policy Development

From: Brent Johnson

SUBJECT: Rule Impact Statement
(Reference APA WF # 11-14)

A. Brief description of the purpose of the rule:

OHCA rules for the Sooner Seniors Waiver are revised to clarify waiting list procedures for individuals who apply for services but cannot enter the waiver due to capacity limitations. The rules clarify that individuals applying for the waiver but unable receive services due to capacity limitations are placed on a waiting list and enter the waiver on a first on first off basis.

B. A description of the classes of persons who most likely will be affected by the proposed rule, including classes that will bear the cost of the proposed rule, and any information on cost impacts received by the agency from any private or public entities:

The classes of persons who will be affected by the proposed rule change are individuals applying for Sooner Senior Waiver services but unable to enter the waiver due to capacity limitations. There are no anticipated costs associated with the proposed rule change.

C. A description of the classes of persons who will benefit from the proposed rule:

The classes of persons who will benefit by the proposed rule change are individuals applying for Sooner Seniors Waiver services but unable to enter the waiver due to capacity limitations. Those individuals will benefit from a waiting list procedure that provides priority placement through a first on first off basis.

D. A description of the probable economic impact of the proposed rule upon the affected classes of persons or political subdivisions, including a listing of all fee changes and, whenever possible, a separate justification for each fee change:

There is no probable economic impact of the proposed rules upon any classes of persons or political

subdivisions, nor are any fees associated with this rule change.

E. The probable costs and benefits to the agency and to any other agency of the implementation and enforcement of the proposed rule, the source of revenue to be used for implementation and enforcement of the proposed rule, and any anticipated affect on state revenues, including a projected net loss or gain in such revenues if it can be projected by the agency:

There are no probable costs to the agency or any other agency associated with this rule revision. The rule clarification will benefit the agency through the elimination of potential confusion regarding the waiting list procedures.

F. A determination of whether implementation of the proposed rule will have an economic impact on any political subdivisions or require their cooperation in implementing or enforcing the rule:

The proposed rule will not have an economic impact on any political subdivision or require their cooperation in implementing or enforcing the rule.

G. A determination of whether implementation of the proposed rule will have an adverse effect on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act:

The proposed rule will not have an adverse effect on small businesses as provided by the Oklahoma Small Business Regulatory Flexibility Act.

H. An explanation of the measures the agency has taken to minimize compliance costs and a determination of whether there are less costly or nonregulatory methods or less intrusive methods for achieving the purpose of the proposed rule:

There are no other legal methods to minimize compliance costs.

I. A determination of the effect of the proposed rule on the public health, safety and environment and, if the proposed rule is designed to reduce significant risks to the public health, safety and environment, an explanation of the nature of the risk and to what extent the proposed rule will reduce the risk:

The proposed rule should have no effect on the public health, safety, or environment.

J. A determination of any detrimental effect on the public health, safety and environment if the proposed rule is not implemented:

The agency does not anticipate any detrimental effects on the public health, safety, or environment.

K. The date the rule impact statement was prepared and if modified, the date modified:

This rule impact statement was prepared on October 27th, 2011.

RULE TEXT

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 50. HOME AND COMMUNITY BASED SERVICES WAIVERS
SUBCHAPTER 5. SOONER SENIORS

317:50-5-4. Application for Sooner Seniors Waiver services

(a) Within 60 days of completion of the Living Choice demonstration program, members choosing to stay in a home and community based setting may apply for transition into the Sooner Seniors Waiver. In order to transition from the Living Choice demonstration program to the Sooner Seniors Waiver, a recertification of eligibility is required. The member must meet all financial and medical eligibility requirements for recertification. The same application and eligibility processes used to certify members for SoonerCare long term care and Living Choice services will be reviewed to ensure any changes in member status will not affect eligibility for the Sooner Seniors Waiver. The original application and eligibility processes are set forth in 317:50-5-4(a)(1) through 317:50-5-6 below.

(1) The application process is initiated by the receipt of a UCAT, Part I or by an oral request for services. A written financial application is not required for an individual who is a SoonerCare member at the time of application. A financial application for Sooner Seniors Waiver services consists of the Medical Assistance Application form. The form is signed by the applicant, parent, spouse, guardian or someone else acting on the applicant's behalf.

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

(B) An individual requesting waiver services, or the individual's community spouse may request an assessment of resources available to each spouse by using OKDHS form MA-11, Assessment of Assets, when SoonerCare application is not being made. The individual and/or spouse must provide documentation of resources. The assessment reflects all countable resources of the couple (owned individually or as a couple) and establishes the spousal share to be protected when subsequent determination of SoonerCare long-term care eligibility is made.

(C) When SoonerCare application is being made, an assessment of resources must be completed if it was not completed when the individual entered the NF or began receiving home and community based services. For applicants of the Sooner Seniors waiver, those resources owned by the couple the month the application was made determines the spousal share of resources. If the individual applied for SoonerCare at the time of entry into the Living Choice Program, Form MA-11 is not appropriate. However, the spousal share must be determined using the resource information provided on the SoonerCare application form and computed using OKDHS form MA-12, Title XIX Worksheet.

(2) The date of application is the date the signed application is received or the date when the request for SoonerCare is made orally and the financial application form is signed later. The date of the oral request is noted above the date the form is signed.

(b) **Sooner Seniors Waiver waiting list procedures.** Sooner Seniors Waiver Program ~~"available capacity in the month"~~ capacity is the number of ~~additional~~ members that may be enrolled in the Program ~~in a given month~~ without exceeding, on an annualized basis, the maximum number authorized by the waiver to be served in the waiver year. If available waiver capacity has been realized, requests for services are not processed as applications, but placed on a waiting list. As available capacity permits, the OHCA selects in chronological order (first on, first off) requests for services from the waiting list to forward for application processing. When waiver capacity exceeds the number on the waiting list and after all persons on the waiting list have been processed, waiting list procedures are suspended.

Oklahoma Health Care Authority

It is very important that you provide your comments regarding the proposed rule change by the comment due date. Comments are directed to Oklahoma Health Care Authority (OHCA) Health Policy Unit http://www.okhca.org/proposed-rule-changes.aspx

OHCA COMMENT DUE DATE: Wednesday, October 19th, 2011.

The proposed policy is a Permanent Rule. This proposal is scheduled to be presented to the Medical Advisory Committee (MAC) on November 16th, 2011 and the (OHCA) Board of Directors on February 9, 2012.
Reference: APA WF 11-15

SUMMARY:
Oklahoma Health Care Authority long-term care eligibility rules are revised to include a brief description of the Long-term Care Partnership program. The Long-term Care Partnership program (LTCP) allows individuals with qualified LTCP insurance policies the opportunity to protect certain assets in determining eligibility for SoonerCare long term care services.

LEGAL AUTHORITY
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; Oklahoma Long-term Care Partnership Act, 63 O.S. § 1-1955.1, et seq.

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

TO: Tywanda Cox
Health Policy

From: Brent Johnson

SUBJECT: Rule Impact Statement
(Reference APA WF # 11-15)

A. Brief description of the purpose of the rule:

OHCA eligibility rules are revised to include a brief description of the Long-term Care Partnership

program. The Long-term Care Partnership program (LTCP) allows individuals with qualified LTCP insurance policies the opportunity to protect certain assets in determining eligibility for SoonerCare long term care services.

B. A description of the classes of persons who most likely will be affected by the proposed rule, including classes that will bear the cost of the proposed rule, and any information on cost impacts received by the agency from any private or public entities:

There are no specific classes of persons who will bear the cost of the proposed rule change. The rule change is a policy clarification and is not anticipated to result in a significant increase in SoonerCare enrollment.

C A description of the classes of persons who will benefit from the proposed rule:

The classes of persons who will benefit by the proposed rule change are individuals with long term care needs, purchasing Long-term Care Partnership insurance policies. Additionally, carriers offering Long-term Care Partnership insurance policies may benefit from the sale of such policy.

D. A description of the probable economic impact of the proposed rule upon the affected classes of persons or political subdivisions, including a listing of all fee changes and, whenever possible, a separate justification for each fee change:

There is no probable economic impact of the proposed rules upon any classes of persons or political subdivisions nor is a fee change involved in the rule revision.

E. The probable costs and benefits to the agency and to any other agency of the implementation and enforcement of the proposed rule, the source of revenue to be used for implementation and enforcement of the proposed rule, and any anticipated affect on state revenues, including a projected net loss or gain in such revenues if it can be projected by the agency:

There is no anticipated cost to this or any other agency as the policy clarification is not expected to have a significant impact on the number of people qualifying for SoonerCare long term care services.

F. A determination of whether implementation of the proposed rule will have an economic impact on any political subdivisions or require their cooperation in implementing or enforcing the rule:

The proposed rule will not have an economic impact on any political subdivision or require their cooperation in implementing or enforcing the rule.

G. A determination of whether implementation of the proposed rule will have an adverse effect on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act:

The proposed rule will not have an adverse effect on small businesses as provided by the Oklahoma Small Business Regulatory Flexibility Act.

H. An explanation of the measures the agency has taken to minimize compliance costs and a determination of whether there are less costly or nonregulatory methods or less intrusive methods for achieving the purpose of the proposed rule:

There are no other legal methods to minimize compliance costs.

I. A determination of the effect of the proposed rule on the public health, safety and environment and, if the proposed rule is designed to reduce significant risks to the public health, safety and environment, an explanation of the nature of the risk and to what extent the proposed rule will reduce the risk:

The proposed rule should have no effect on the public health, safety, or environment.

J. A determination of any detrimental effect on the public health, safety and environment if the proposed rule is not implemented:

The agency does not anticipate any detrimental effects on the public health, safety, or environment.

K. The date the rule impact statement was prepared and if modified, the date modified:

This rule impact statement was prepared on September 6th, 2011.

Rule Text

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

317:35-5-41.8. Eligibility regarding long-term care services

(a) **Home Property**. In determining eligibility for long-term care services for applications filed on or after January 1, 2006, home property is excluded from resources unless the individual's equity interest in his or her home exceeds $500,000.

(1) Long-term care services include nursing facility services and other long-term care services. For purposes of this Section, other long-term care services include services detailed in (A) through (B) of this paragraph.

(A) A level of care in any institution equivalent to nursing facility services; and

(B) Home and community-based services furnished under a waiver.

(2) An individual whose equity interest exceeds $500,000 is not eligible for long-term care services unless one of the following circumstances applies:

(A) The individual has a spouse who is lawfully residing in the individual's home;

(B) The individual has a child under the age of twenty-one who is lawfully residing in the individual's home;

(C) The individual has a child of any age who is blind or permanently and totally disabled who is lawfully residing in the individual's home; or

(D) The denial would result in undue hardship. Undue hardship exists when denial of SoonerCare long-term care services based on an individual's home equity exceeding $500,000 would deprive the individual of medical care such that the individual's health or life would be

endangered; or of food, clothing, shelter, or other necessities of life.

(3) Absence from home due to nursing facility care does not affect the home exclusion as long as the individual intends to return home within 12 months from the time he/she entered the facility. The OKDHS Form 08MA010E, Acknowledgment of Temporary Absence/Home Property Policy, is completed at the time of application for nursing facility care when the applicant has home property. After explanation of temporary absence, the member, guardian or responsible person indicates whether there is or is not intent to return to the home and signs the form.

(A) If at the time of application the applicant states he/she does not have plans to return to the home, the home property is considered a countable resource. For members in nursing facilities, a lien may be filed in accordance with OAC 317:35-9-15 and OAC 317:35-19-4 on any real property owned by the member when it has been determined, after notice and opportunity for a hearing, that the member cannot reasonably be expected to be discharged and return home. However, a lien is not filed on the home property of the member while any of the persons described in OAC 317:35-9-15(b)(1) and OAC 317:35-19-4(b)(1) are lawfully residing in the home:

(B) If the individual intends to return home, he/she is advised that:

(i) the 12 months of home exemption begins effective with the date of entry into the nursing home regardless of when application is made for SoonerCare benefits, and

(ii) after 12 months of nursing care, it is assumed there is no reasonable expectation the member will be discharged from the facility and return home and a lien may be filed against real property owned by the member for the cost of medical services received.

(C) "Intent" in regard to absence from the home is defined as a clear statement of plans in addition to other evidence and/or corroborative statements of others.

(D) At the end of the 12-month period the home property becomes a countable resource unless medical evidence is provided to support the feasibility of the member to return to the home within a reasonable period of time (90 days). This 90-day period is allowed only if sufficient medical evidence is presented with an actual date for return to the home.

(E) A member who leaves the nursing facility must remain in the home at least three months for the home exemption to apply if he/she has to re-enter the facility.

(F) However, if the spouse, minor child(ren) under 18, or relative who is aged, blind or disabled or a recipient of TANF resides in the home during the individual's absence, the home continues to be exempt as a resource so long as the spouse or relative lives there (regardless of whether the absence is temporary).

(G) For purpose of this reference a relative is defined as: son, daughter, grandson, granddaughter, stepson, stepdaughter, in-laws, mother, father, stepmother, stepfather, half-sister, half-brother, niece, nephew, grandmother, grandfather, aunt, uncle, sister, brother, stepbrother, or stepsister.

(H) Once a lien has been filed against the property of an NF resident, the property is no longer considered as a countable resource.

(b) **Promissory notes, loans, or mortgages**. The rules regarding the treatment of funds used to purchase a promissory note, loan, or mortgage on or after February 8, 2006, are found in (1) through (2) of this subsection.

(1) Funds used to purchase a promissory note, loan, or mortgage on or after February 8, 2006, are treated as assets transferred for less than fair market value in the amount of the outstanding balance due on the note, loan, or mortgage as of the date of the individual's application for medical assistance unless the note, loan, or mortgage meets all of the conditions in paragraphs (A) through (C) of this paragraph.

(A) The note, loan, or mortgage has a repayment term that is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the United States Social Security Administration).

(B) The note, loan, or mortgage provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made.

(C) The note, loan, or mortgage prohibits the cancellation of the balance upon the death of the lender.

(2) Funds used to purchase a promissory note, loan, or mortgage for less than its fair market value are treated as assets transferred for less than fair market value regardless of whether:

(A) The note, loan, or mortgage was purchased before February 8, 2006; or

(B) The note, loan, or mortgage was purchased on or after February 8, 2006, and the conditions described in paragraph (1) of this subsection were met.

(c) **Annuities**. Treatment of annuities purchased on or after February 8, 2006.

(1) The entire amount used to purchase an annuity on or after February 8, 2006, is treated as assets transferred for less than fair market value unless the annuity meets one of the conditions described in (A) through (C) of this paragraph.

(A) The annuity is an annuity described in subsection (b) or (q) of Section 408 of the United States Internal Revenue Code of 1986.

(B) The annuity is purchased with proceeds from:

(i) An account or trust described in subsection (a), (c), or (p) of Section 408 of the United States Internal Revenue Code of 1986;

(ii) A simplified employee pension as defined in Section 408(k) of the United States Internal Revenue Code of 1986;

(iii) A Roth IRA described in Section 408A of the United States Internal Revenue Code of 1986.

(C) The annuity:

(i) is irrevocable and nonassignable;

(ii) is actuarially sound as determined in accordance with actuarial publications of the Office of the Chief Actuary of the United States Social Security Administration; and

(iii) provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made.

(2) In addition, the entire amount used to purchase an annuity on or after February 8, 2006, is treated as a transfer of assets unless the Oklahoma Health Care Authority is named as the remainder beneficiary either:

(A) in the first position for at least the total amount of medical assistance paid on behalf of the institutionalized individual; or

(B) in the second position after the community spouse, child under 21 years of age, or disabled child and in the first position if the spouse or a representative of the child disposes of any of the remainder for less than fair market value.

(d) **Life Estates**. This subsection pertains to the purchase of a life estate in another individual's home.

(1) The entire amount used to purchase a life estate in another individual's home on or after February 8, 2006, is

treated as assets transferred for less than fair market value, unless the purchaser resides in the home for at least one year after the date of the purchase.

(2) Funds used to purchase a life estate in another individual's home for less than its fair market value are treated as assets transferred for less than fair market value regardless of whether:

(A) The life estate was purchased before February 8, 2006; or

(B) The life estate was purchased on or after February, 8, 2006, and the purchaser resided in the home for one year after the date of purchase.

(e) **Oklahoma Long-Term Care Partnership (LTCP) Program.** This subsection pertains to individuals with Oklahoma Long-Term Care Partnership policies. The Oklahoma Insurance Department approves long-term care insurance policies as Long-term Care Partnership Program policies. The face page of the policy document will indicate if the insurance qualifies as a Long Term Care Partnership Program policy.

(1) Benefits from the LTCP policy must be exhausted before the individual can be eligible for long term care under the SoonerCare program.

(2) Assets in an amount equal to the amount paid out under the LTCP policy can be protected for the insured individual once the LTCP policy benefits are exhausted. Protected assets are disregarded when determining eligibility for the SoonerCare program per 317:35-5-41.9(26). A record of the amount paid on behalf of the policy holder is available through the OHCA or insurance company holding the LTCP policy.

(A) At the time of application for SoonerCare the individual must determine the asset(s) to be protected. The protected asset(s) cannot be changed. If the value of the protected asset(s) decreases, the individual does not have the option to select additional assets to bring the total up to the protected amount.

(B) If the protected asset(s) are income-producing, the income earned while on SoonerCare is counted in accordance with 317:35-5-42.

(C) The individual can choose to transfer the protected asset without incurring a transfer of assets penalty.

(D) When determining resource eligibility for a couple when one of them enters the nursing home or applies for a HCBS waiver, the LTCP protected asset(s) are disregarded in determining the total amount of the couple’s resources.

Oklahoma Health Care Authority

It is very important that you provide your comments regarding the proposed rule change by the comment due date. Comments are directed to Oklahoma Health Care Authority (OHCA) Health Policy Unit http://www.okhca.org/proposed-rule-changes.aspx

OHCA COMMENT DUE DATE: August 23, 2011

The proposed policy is a Permanent Rule. This proposal is scheduled to be presented to the Medical Advisory Committee (MAC) on September 15, 2011 and the (OHCA) Board of Directors on February 9, 2012.
Reference: APA WF 11-16

SUMMARY:
Pregnancy Cost-Sharing Clarification— SoonerCare cost-sharing rules are revised to clarify OHCA's current policy that pregnancy-related services are exempt from cost-sharing requirements. Confusion existed among providers as to when pregnant women may be charged a co-pay. This rule makes clear the visit must be pregnancy-related. The rules are also revised to remove reference to another section of policy that is no longer in effect.

LEGAL AUTHORITY
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 CFR 447.70

RULE IMPACT STATEMENT:
TO: Tywanda Cox
Health Policy

FROM: Joseph Fairbanks
Health Policy

SUBJECT: Rule Impact Statement
APA WF # 11-16

A. Brief description of the purpose of the rule:

SoonerCare cost-sharing rules are revised to clarify OHCA's current policy that pregnant women are exempt from co-pays when the services are pregnancy-related. Confusion existed among providers as to when pregnant women may be charged a

co-pay. This rule makes clear the visit must be pregnancy-related. The rules are also revised to remove reference to another section of policy that is no longer in effect.

B. A description of the classes of persons who most likely will be affected by the proposed rule, including classes that will bear the cost of the proposed rule, and any information on cost impacts received by the agency from any private or public entities:

This rule change is a clarification of existing policy and, therefore, will not affect any classes of person.

C. A description of the classes of persons who will benefit from the proposed rule:

No classes of person will benefit from this proposed rule. The proposed rule simply seeks to clarify existing policy on cost-sharing.

D. A description of the probable economic impact of the proposed rule upon the affected classes of persons or political subdivisions, including a listing of all fee changes and, whenever possible, a separate justification for each fee change:

There is no economic impact and there are no fee changes associated with the rule change for the above classes of persons or any political subdivision.

E. The probable costs and benefits to the agency and to any other agency of the implementation and enforcement of the proposed rule, the source of revenue to be used for implementation and enforcement of the proposed rule, and any anticipated affect on state revenues, including a projected net loss or gain in such revenues if it can be projected by the agency:

The rule change is budget neutral and will cost nothing.

F. A determination of whether implementation of the proposed rule will have an economic impact on any political subdivisions or require their cooperation in implementing or enforcing the rule:

There is no economic impact on political subdivisions.

G. A determination of whether implementation of the proposed rule will have an adverse effect on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act:

There is no adverse economic impact on small businesses as a result of this rule.

H. An explanation of the measures the agency has taken to minimize compliance costs and a determination of whether there are less costly or non-regulatory methods or less intrusive methods for achieving the purpose of the proposed rule:

The agency has taken measures to determine that there is no less costly or non-regulatory method or less intrusive method for achieving the purpose of the proposed rule.

I. A determination of the effect of the proposed rule on the public health, safety and environment and, if the proposed rule is designed to reduce significant risks to the public health, safety and environment, an explanation of the nature of the risk and to what extent the proposed rule will reduce the risk:

The proposed rule should have no effect on the public health, safety, and environment.

J. A determination of any detrimental effect on the public health, safety and environment if the proposed rule is not implemented:

OHCA does not believe there is a detrimental effect on the public health and safety if the rule is not passed.

K. The date the rule impact statement was prepared and if modified, the date modified:

The rule impact statement was prepared August 2, 2011.

RULE TEXT

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-5. Assignment and Cost Sharing

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

(1) **"Fee-for-service contract"** means the provider agreement specified in OAC 317:30-3-2. This contract is the contract between the Oklahoma Health Care Authority and medical providers which provides for a fee with a specified service involved.

(2) **"Within the scope of services"** means the set of covered services defined at OAC 317:25-7 and the provisions of the SoonerCare Choice contracts in the SoonerCare Program.

(3) **"Outside of the scope of the services"** means all medical benefits outside the set of services defined at OAC 317:25-7 and the provisions of the SoonerCare Choice contracts in the SoonerCare Program.

(b) **Assignment in fee-for-service.** The OHCA's Medicaid State Plan provides that participation in the medical program is limited to providers who accept, as payment in full, the amounts paid by OHCA plus any deductible, coinsurance, or co-payment required by the State Plan to be paid by the member and make no additional charges to the member or others.

(1) OHCA presumes acceptance of assignment upon receipt of an assigned claim. This assignment, once made, cannot be rescinded, in whole or in part by one party, without the consent of the other party.

(2) Once an assigned claim has been filed, the member must not be billed and the member is not responsible for any balance except the amount indicated by OHCA. The only amount a member may be responsible for is a co-payment, or the member may be responsible for services not covered under the medical programs. In any event, the member should not be billed for charges on an assigned claim until the claim has been adjudicated or other notice of action received by the provider. Any questions regarding amounts paid should be directed to OHCA, Provider Services.

(3) When potential assignment violations are detected, the OHCA will contact the provider to assure that all provisions of the assignment agreement are understood. When there are repeated or uncorrected violations of the assignment agreement, the OHCA is required to suspend further payment to the provider.

(c) **Assignment in SoonerCare.** Any provider who holds a fee for service contract and also executes a contract with a provider

in the SoonerCare Choice program must adhere to the rules of this subsection regarding assignment.

(1) If the service provided to the member is outside of the scope of the services outlined in the SoonerCare Contract, then the provider may bill or seek collection from the member.

(2) In the event there is a disagreement whether the services are in or out of the scope of the contracts referenced in (1) of this subsection, the Oklahoma Health Care Authority shall be the final authority for this decision. ~~The provider seeking payment under the SoonerCare Program may appeal to OHCA under the provisions of OAC 317:2-1-2.1.~~

(3) Violation of this provision shall be grounds for a contract termination in the fee-for-service and SoonerCare programs.

(d) **Cost Sharing-Copayment.** Section 1902(a)(14) of the Social Security Act permits states to require certain members to share some of the costs of SoonerCare by imposing upon them such payments as enrollment fees, premiums, deductibles, coinsurance, co-payments, or similar cost sharing charges. OHCA requires a co-payment of some SoonerCare members for certain medical services provided through the fee for service program. A co-payment is a charge which must be paid by the member to the service provider when the service is covered by SoonerCare. Section 1916(e) of the Act requires that a provider participating in the SoonerCare program may not deny care or services to an eligible individual based on such individual's inability to pay the co-payment. A person's assertion of their inability to pay the co-payment establishes this inability. This rule does not change the fact that a member is liable for these charges and it does not preclude the provider from attempting to collect the co-payment.

(1) Co-payment is not required of the following members:

(A) Individuals under age 21. Each member's date of birth is available on the REVS system or through a commercial swipe card system.

(B) Members in nursing facilities and intermediate care facilities for the mentally retarded.

~~(C) Pregnant women.~~

~~(D)~~(C) Home and Community Based Service waiver members except for prescription drugs.

~~(E)~~(D) Native Americans providing documentation of ethnicity in accordance with 317:35-5-25 who receive items and services furnished by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban

Indian Organization or through referral under contract health services.

(2) Co-payment is not required for the following services:

(A) Family planning services. Includes all contraceptives and services rendered.

(B) Emergency services provided in a hospital, clinic, office, or other facility.

(C) Services furnished to pregnant women, if those services relate to the pregnancy or to any other medical condition which may complicate the pregnancy.

(3) Co-payments are required in an amount not to exceed the federal allowable for the following:

(A) Inpatient hospital stays.

(B) Outpatient hospital visits.

(C) Ambulatory surgery visits including free-standing ambulatory surgery centers.

(D) Encounters with the following rendering providers:

(i) Physicians,

(ii) Advanced Practice Nurses,

(iii) Physician Assistants,

(iv) Optometrists,

(v) Home Health Agencies,

(vi) Certified Registered Nurse Anesthetists,

(vii) Anesthesiologist Assistants,

(viii) Durable Medical Equipment providers, and

(ix) Outpatient behavioral health providers.

(E) Prescription drugs.

(i) Zero for preferred generics.

(ii) $0.65 for prescriptions having a SoonerCare allowable payment of $0.00-$10.00.

(iii) $1.20 for prescriptions having a SoonerCare allowable payment of $10.01-$25.00.

(iv) $2.40 for prescriptions having a SoonerCare allowable payment of $25.01-$50.00.

(v) $3.50 for prescriptions having a SoonerCare allowable payment of $50.01 or more.

(F) Crossover claims. Dually eligible Medicare/SoonerCare members must make a co-payment in an amount that does not exceed the federal allowable per visit/encounter for all Part B covered services. This does not include dually eligible HCBS waiver members.

(4) Aggregate cost-sharing liabilities in a given calendar year may not exceed 5% of the member's gross annual income.

Oklahoma Health Care Authority

It is very important that you provide your comments regarding the proposed rule change by the comment due date. Comments are directed to Oklahoma Health Care Authority (OHCA) Health Policy Unit http://www.okhca.org/proposed-rule-changes.aspx

OHCA COMMENT DUE DATE: August 23, 2011

The proposed policy is a Permanent Rule. This proposal is scheduled to be presented to the Medical Advisory Committee (MAC) on September 15, 2011 and the (OHCA) Board of Directors on February 9, 2012.
Reference: APA WF 11-17

SUMMARY:
Prescription Exemption for Certain DME Repairs— SoonerCare provider rules are amended to exempt durable medical equipment repairs with a cost per item of less than $250.00 from the prescription requirement.

LEGAL AUTHORITY
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes

RULE IMPACT STATEMENT:
TO: Traylor Rains
Health Policy

FROM: Joseph Fairbanks
Health Policy

SUBJECT: Rule Impact Statement
APA WF # 11-17

A. Brief description of the purpose of the rule:

SoonerCare provider rules are amended to exempt durable medical equipment repairs with a cost per item of less than $250.00 from the prescription requirement. Current policy requires a prescription for all repairs made to DME. Thus, repairing a broken tire or replacing a dead battery on a wheelchair first requires a prescription from a physician, PA, or advanced practice nurse. This is often impractical for the provider and the member and it is unnecessary since

medical necessity has already been established. Eliminating the prescription requirement for repairs below the $250.00 threshold will reduce administrative burdens and improve timely patient access to care.

B. A description of the classes of persons who most likely will be affected by the proposed rule, including classes that will bear the cost of the proposed rule, and any information on cost impacts received by the agency from any private or public entities:

Durable medical equipment suppliers and their SoonerCare customers will be affected by the rule, but there will be no added cost to either.

C. A description of the classes of persons who will benefit from the proposed rule:

Durable medical equipment suppliers and their SoonerCare customers will benefit from the rule through reduced administrative burdens and improved timeliness of care.

D. A description of the probable economic impact of the proposed rule upon the affected classes of persons or political subdivisions, including a listing of all fee changes and, whenever possible, a separate justification for each fee change:

There is no economic impact and there are no fee changes associated with the rule change for the above classes of persons or any political subdivision.

E. The probable costs and benefits to the agency and to any other agency of the implementation and enforcement of the proposed rule, the source of revenue to be used for implementation and enforcement of the proposed rule, and any anticipated affect on state revenues, including a projected net loss or gain in such revenues if it can be projected by the agency:

The rule change is budget neutral and will cost nothing.

F. A determination of whether implementation of the proposed rule will have an economic impact on any political subdivisions or require their cooperation in implementing or enforcing the rule:

There is no economic impact on political subdivisions.

G. A determination of whether implementation of the proposed rule will have an adverse effect on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act:

There is no adverse economic impact on small businesses as a result of this rule.

H. An explanation of the measures the agency has taken to minimize compliance costs and a determination of whether there are less costly or non-regulatory methods or less intrusive methods for achieving the purpose of the proposed rule:

The agency has taken measures to determine that there is no less costly or non-regulatory method or less intrusive method for achieving the purpose of the proposed rule.

I. A determination of the effect of the proposed rule on the public health, safety and environment and, if the proposed rule is designed to reduce significant risks to the public health, safety and environment, an explanation of the nature of the risk and to what extent the proposed rule will reduce the risk:

The proposed rule should have no effect on the public health, safety, and environment.

J. A determination of any detrimental effect on the public health, safety and environment if the proposed rule is not implemented:

OHCA does not believe there is a detrimental effect on the public health and safety if the rule is not passed. However, we expect administrative burdens associated with the prescription requirement to slow access to durable medical equipment repairs and cause members and suppliers unnecessary inconvenience.

K. The date the rule impact statement was prepared and if modified, the date modified:

The rule impact statement was prepared August 2, 2011.

RULE TEXT

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 17. MEDICAL SUPPLIERS

317:30-5-211.2. Medical necessity

(a) **Coverage**. Coverage is subject to the requirement that the equipment be necessary and reasonable for the treatment of an illness or injury, or to improve the functioning ~~or~~ of a malformed body member. The member's diagnosis must warrant the type of equipment or supply being purchased or rented.

(b) **Prescription requirements**. All DME, except for equipment repairs with a cost per item of less than $250.00 total parts and labor and hearing aid batteries, require a prescription signed by a physician, a physician assistant, or an advanced practice nurse. Except as otherwise stated in state or federal law, the prescription must be in writing, or given orally and later reduced to writing by the provider filling the order. Prescriptions are valid for no more than one year from the date written. The prescription must include the following information:

(1) date of the order;
(2) name and address of the prescriber;
(3) name and address of the member;
(4) name or description and quantity of the prescribed item;
(5) diagnosis for the item requested;
(6) directions for use of the prescribed item; and
(7) prescriber's signature.

(c) **Certificate of medical necessity**. For certain items or services, the supplier must receive a signed CMN/OHCA CMN from the treating physician. The supplier must have a signed CMN/OHCA CMN in their records before they submit a claim for payment. The CMN/OHCA CMN may be faxed, copied or the original hardcopy.

(d) **Place of service.**

(1) OHCA covers DMEPOS for use in the member's place of residence except if the member's place of residence is a nursing facility.

(2) For members residing in a nursing facility, most medical supplies and/or DME are considered part of the facility's per diem rate. Refer to coverage for nursing facility residents at OAC 317:30-5-211.16.

Oklahoma Health Care Authority

It is very important that you provide your comments regarding the proposed rule change by the comment due date. Comments are directed to Oklahoma Health Care Authority (OHCA) Health Policy Unit http://www.okhca.org/proposed-rule-changes.aspx

OHCA COMMENT DUE DATE: Wednesday September 14, 2011

The proposed policy is an Emergency Rule. This proposal is scheduled to be presented to the Medical Advisory Committee (MAC) on September 15th, 2011 and the (OHCA) Board of Directors on October 13th, 2011.
Reference: APA WF 11-18

SUMMARY:
The Supplemental Hospital Offset Payment Program (SHOPP) authorizes the Oklahoma Health Care Authority (OHCA) to assess hospitals licensed in Oklahoma, unless exempted under state law an assessment fee not to exceed four percent (4%). Funds derived from the assessment are used to garner federal matching funds and supplement Medicaid payments to hospitals, in accordance with Section 3241.1 of Title 63 of the Oklahoma Statute. Participating hospitals that pay into the SHOPP fund will be eligible for supplemental Medicaid payment for inpatient and outpatient services. Payments will be made on a quarterly basis. Each participating hospital will receive a pro rata share of the assessment fund based on the hospital's Medicaid payments for services divided by the total Medicaid payments to all participating hospitals.

LEGAL AUTHORITY
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; Section 3241.1 of Title 63 of the Oklahoma statute and 42 CFR 433.68

RULE IMPACT STATEMENT:
TO: Tywanda Cox
Health Policy

From: Reginald Mason

SUBJECT: Rule Impact Statement
APA WF 11-18

A. Brief description of the purpose of the rule:

OHCA is mandated by Title 63 Okla. Stat. §§ 3241.1 through 3241.6 to implement the Supplemental Hospital Offset Payment Program (SHOPP). SHOPP is designed to assess all licensed hospitals in Oklahoma an assessment fee. Fees collected from the assessment are used to garner federal matching funds to supplement Medicaid payment to hospitals. Each participating hospital that pays into the SHOPP fund is eligible for supplemental Medicaid payment for inpatient and outpatient services.

B. A description of the classes of persons who most likely will be affected by the proposed rule, including classes that will bear the cost of the proposed rule, and any information on cost impacts received by the agency from any private or public entities:

The classes most likely to be affected by the proposed rule are hospitals subject to 63 Okla. Stat. §§ 3241.1 through 3241.6 who will be assessed and subsequently pay into the SHOPP fund as well as Critical Access hospitals, who qualify for SHOPP payments in accordance with Section 3241.4 of Title 63 of the Oklahoma Statutes.

C. A description of the classes of persons who will benefit from the proposed rule:

Those who will benefit from the proposed rule are the hospitals subject to 63 Okla. Stat. §§ 3241.1 through 3241.6 who will be assessed and subsequently pay into the SHOPP fund as well as Critical Access hospitals, who qualify for SHOPP payments in accordance with Section 3241.4 of Title 63 of the Oklahoma Statutes.

D. A description of the probable economic impact of the proposed rule upon the affected classes of persons or political subdivisions, including a listing of all fee changes and, whenever possible, a separate justification for each fee change:

OHCA is establishing a fee which will be assessed on all eligible hospitals participating in the Supplemental Hospital Offset Payment Program (SHOPP) as required by 63 Okla. Stat. §§ 3241.1 through 3241.6. The assessment is calculated as a percentage of each hospital's net hospital patient revenue. The assessment rate until December 31,

2012, is two and one-half percent (2.5%). At no time in subsequent years will the assessment rate exceed four percent (4%). The assessment is expected to generate approximately $151 million in state dollars, $30 million of which is allocated to the Medical Payments Cash Management Improvement Act Program Disbursing Fund and used to maintain SoonerCare provider reimbursement rates. After garnering federal matching dollars, $336 million will be available to make supplemental payments to participating hospitals in the state of Oklahoma and approximately $83 million will be available to maintain SoonerCare provider payments.

E. The probable costs and benefits to the agency and to any other agency of the implementation and enforcement of the proposed rule, the source of revenue to be used for implementation and enforcement of the proposed rule, and any anticipated affect on state revenues, including a projected net loss or gain in such revenues if it can be projected by the agency:

SHOPP legislation authorizes OHCA to implement and provide enforcement of the proposed rule and appropriates $200,000 of the assessment to be used towards any administrative cost. The $200,000 is matched with federal funds at the administrative rate of 50% for a total of $400,000 to be used towards administrative cost. Additionally, OHCA is authorized to retain approximately $83 million to be used to maintain current SoonerCare payments for all providers.

F. A determination of whether implementation of the proposed rule will have an economic impact on any political subdivisions or require their cooperation in implementing or enforcing the rule:

The proposed rule will not have an economic impact on any political subdivisions or require their cooperation in implementing or enforcing the rule.

G. An explanation of the measures the agency has taken to minimize compliance costs and a determination of whether there are less costly or nonregulatory methods or less intrusive methods for achieving the purpose of the proposed rule:

There are no other legal methods to minimize compliance cost.

H. A determination of the effect of the proposed rule on the public health, safety and environment and, if the proposed rule is designed to reduce significant risks to the public health, safety and environment, an explanation of the nature of the risk and to what extent the proposed rule will reduce the risk:

The proposed rule should have no effect on the public health, safety or environment.

I. A determination of any detrimental effect on the public health, safety and environment if the proposed rule is not implemented:

The agency does not anticipate any detrimental effect on the public health, safety or environment.

J. The date the rule impact statement was prepared and if modified, the date modified:
08-24-2011

RULE TEXT

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 3. HOSPITALS

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

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

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

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

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

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

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

(5) **"NET hospital patient revenue"** means the gross hospital revenue as reported on Worksheet G-2 (Columns 1 and 2, Lines 16, 17 and 18) of the Medicare Cost Report, multiplied by hospital's ratio of total net to gross revenue, as reported on Worksheet G-3(Column 1, Line 3)and Worksheet G-2 (Part I, Column 3, Line 25);

(6) **"Medicare Cost Report"** means form CMS-2552-96, the Hospital Cost Report, as it existed on January 1, 2010;

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

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

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

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

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

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

Partnerships in Partnership with the Centers for Medicaid and State operations.

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

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

(1) treatment of a neurological injury;

(2) treatment of cancer;

(3) treatment of cardiovascular disease;

(4) obstetrical or childbirth services; or

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

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

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

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

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

(2) OHCA will review and determine the amount of annual assessment in December of each year.
(3) A hospital may not charge any patient for any portion of the SHOPP assessment.
(4) The Method of collection is as follows:
(A) The OHCA will send a notice of assessment to each hospital informing the hospital of the assessment rate, the hospital's net hospital patient revenue calculation, and the assessment amount owed by the hospital for the applicable year.
(B) The hospital has thirty (30) days from the date of its receipt of a notice of assessment to review and verify the hospital's net patient revenue calculation, and the assessment amount.
(C) New hospitals will only be added at the beginning of each calendar year.
(D) The annual assessment imposed is due and payable on a quarterly basis. Each quarterly installment payment is due and payable by the fifteenth day of the first month of the applicable quarter (i.e. January 15th, April 15th, etc.)
(E) Failure to pay the amount by the 15th or failure to have the payment mailing postmarked by the 13th will result in a debt to the State of Oklahoma and is subject to penalties of 5% of the amount and interest of 1.25% per month. The SHOPP assessment must be received by OHCA no later than the 15th of the month. If the 15th falls upon a holiday or weekend (Saturday-Sunday), the assessment is due by 5 p.m. (Central Standard Time) of the following business day (Monday-Friday).
(F) If a hospital fails to timely pay the full amount of a quarterly assessment, OHCA will add to the assessment:
(i) a penalty assessment equal to five percent (5%) of the quarterly amount not paid on or before the due date, and
(ii) on the last day of each quarter after the due date until the assessed amount and the penalty imposed under section (i) of this paragraph are paid in full, an additional five percent (5%) penalty assessment on any unpaid quarterly and unpaid penalty assessment amounts.
(iii) the quarterly assessment including applicable penalties and interest must be paid regardless of any appeals action requested by the facility. If a provider fails to pay the OHCA the assessment

within the time frames noted on the invoice to the provider, the assessment, applicable penalty, and interest will be deducted from the facility's payment. Any change in payment amount resulting from an appeals decision will be adjusted in future payments. In accordance with OAC 317:2-1-15 SHOPP appeals.

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

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

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

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

(3) Penalties for false statements or misrepresentation made by or on behalf of the provider are provided at 42 U.S.C. Section 1320a-7b which states, in part, "Whoever...(2) at any time knowingly and willfully makes or causes to be made any false statement of a material fact for use in determining rights to such benefits or payment...shall (i) in the case of such statement, representation, failure, or conversion by any person in connection with furnishing (by the person) of items or services for which payment is or may be under this title (42 U.S.C. § 1320 et seq.), be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one year, or both."

(4) Net hospital patient revenue is determined using the data from each hospital's fiscal year 2009 Medicare Cost Report contained in the Centers for Medicare and Medicaid Services' Healthcare Cost Report Information System file.

(5) If a hospital's fiscal year 2009 Medicare Cost Report is not contained in the Centers for Medicare and Medicaid Services' Healthcare Cost Report Information

System file dated December 31,2010, the hospital will submit a copy of the hospital's 2009 Medicare Cost Report to the Oklahoma Health Care Authority (OHCA) in order to allow the OHCA to determine the hospital's net hospital patient revenue for the base year.

(6) If a hospital commenced operations after the due date for a 2009 Medicare Cost Report, the hospital will submit its initial Medicare Cost Report to Oklahoma Health Care Authority (OHCA) in order to allow the OHCA to determine the hospital's net patient revenue for the base year.

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

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

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

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

(2) Cost reports required under (e)(5),(e)(6),or (e)(8) of this subsection for assessment calculation must be submitted to OHCA by November 1,2011 for the 2012 assessment, and for subsequent years' assessment calculation by September 30 of the preceding year.

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

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

(A) In addition to any other funds paid to inpatient critical access hospital for services provided to SoonerCare members, each critical access hospital will receive hospital access payments equal to the amount by which the payment for these services was

less than one hundred one percent (101%) of the hospital's cost of providing these services.

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

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

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

(B) In addition to any other funds paid to hospitals for outpatient hospital services to SoonerCare members, each eligible hospital will receive outpatient hospital access payments each year equal to the hospital's pro rata share of the outpatient supplemental payment pool as reduced by payments distributed in paragraph (2) (A) of this Section. The pro rata share will be based upon the hospital's SoonerCare payment for outpatient services divided by the total SoonerCare payments for outpatient services of all eligible hospitals within each class of hospital; not to exceed the UPL for the class.

(3) If any retrospective audit determines that a class of hospitals has exceeded the inpatient and/or outpatient UPL the overpayment will be recouped and redistributed. If the overpayment cannot be redistributed due to all classes being paid at their UPL, the overpayment will be deposited in to the SHOPP fund.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 2. GRIEVANCE PROCEDURES AND PROCESS
SUBCHAPTER 1. RULES

317:2-1-2. Appeals

(a) **Member Process Overview.**

(1) The appeals process allows a member to appeal a decision which adversely affects their rights. Examples are decisions involving medical services, prior authorizations for medical services, or discrimination complaints.

(2) In order to file an appeal, the member files a LD-1 form within 20 days of the triggering event. The triggering event occurs at the time when the Appellant (Appellant is the person who files a grievance) knew or should have known of such condition or circumstance for appeal.

(3) If the LD-1 form is not received within 20 days of the triggering event, OHCA sends the Appellant a letter stating the appeal will not be heard because it is untimely. In the case of tax warrant intercept appeals, if the LD-1 form is not received within 30 days of written notice sent by OHCA according to Title 68 ~~O.S. '~~ Okla. Stat. § 205.2, OHCA sends the Appellant a letter stating the appeal will not be heard because it is untimely.

(4) If the LD-1 form is not completely filled out and necessary documentation not included, then the appeal will not be heard.

(5) The staff advises the Appellant that if there is a need for assistance in reading or completing the grievance form that arrangements will be made.

(6) Upon receipt of the member's appeal, a fair hearing before the Administrative Law Judge (ALJ) will be scheduled. The member will be notified in writing of the date and time for this procedure. The member must appear at this hearing and it is conducted according to 317:2-1-5. The ALJ's decision may be appealed to the Chief Executive Officer of the OHCA, which is a record review at which the parties do not appear (317:2-1-13).

(7) Member appeals are ordinarily decided within 90 days from the date OHCA receives the member's timely request

for a fair hearing unless the member waives this requirement. [Title 42 C.F.R. Section 431.244(f)]

(8) Tax warrant intercept appeals will be heard directly by the ALJ. A decision is normally rendered by the ALJ within 20 days of the hearing before the ALJ.

(b) **Provider Process Overview.**

(1) The proceedings as described in this Section contain the hearing process for those appeals filed by providers. These appeals encompass all subject matter cases contained in 317:2-1-2(c)(2).

(2) All provider appeals are initially heard by the OHCA Administrative Law Judge under 317:2-1-2(c)(2).

(A) The Appellant (Appellant is the provider who files a grievance) files an LD form requesting a grievance hearing within 20 days of the triggering event. The triggering event occurs at the time when the Appellant knew or should have known of such condition or circumstance for appeal. (LD-2 forms are for provider grievances and LD-3 forms are for nursing home wage enhancement grievances.)

(B) If the LD form is not received within 20 days of the triggering event, OHCA sends the Appellant a letter stating the appeal will not be heard because it is untimely.

(C) The staff advises the Appellant that if there is a need for assistance in reading or completing the grievance form that arrangements will be made.

(D) A decision will be rendered by the ALJ ordinarily within 45 days of the close of all evidence in the case.

(E) Unless an exception is provided in 317:2-1-13, the Administrative Law Judge's decision is appealable to OHCA's CEO under 317:2-1-13.

(c) **ALJ jurisdiction.** The administrative law judge has jurisdiction of the following matters:

(1) Member Appeals:

(A) Discrimination complaints regarding the SoonerCare program;

(B) Appeals which relate to the scope of services, covered services, complaints regarding service or care, enrollment, disenrollment, and reenrollment in the SoonerCare Program;

(C) Fee for Service appeals regarding the furnishing of services, including prior authorizations;

(D) Appeals which relate to the tax warrant intercept system through the Oklahoma Health Care Authority. Tax warrant intercept appeals will be

heard directly by the ALJ. A decision will be rendered by the Administrative Law Judge within 20 days of the hearing before the ALJ;

(E) Complaints regarding the possible violation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA);

(F) Proposed administrative sanction appeals pursuant to 317:35-13-7. Proposed administrative sanction appeals will be heard directly by the ALJ. A decision by the ALJ will ordinarily be rendered within 20 days of the hearing before the ALJ. This is the final and only appeals process for proposed administrative sanctions;

(G) Appeals which relate to eligibility determinations made by OHCA;

(H) Appeals of insureds participating in Insure Oklahoma which are authorized by 317:45-9-8(a); and

(2) Provider Appeals:

(A) Whether Pre-admission Screening and Resident Review (PASRR) was completed as required by law;

(B) Denial of request to disenroll member from provider's SoonerCare Choice panel;

(C) Appeals by Long Term Care facilities for nonpayment of wage enhancements, determinations of overpayment or underpayment of wage enhancements, and administrative penalty determinations as a result of findings made under 317:30-5-131.2(b)(5), (e)(8), and (e)(12);

(D) Petitions for Rulemaking;

(E) Appeals to the decision made by the Contracts manager related to reports of supplier non-compliance to the Central Purchasing Division, Oklahoma Department of Central Services and other appeal rights granted by contract;

(F) Drug rebate appeals;

(G) Nursing home contracts which are terminated, denied, or non-renewed;

(H) Proposed administrative sanction appeals pursuant to 317:30-3-19. Proposed administrative sanction appeals will be heard directly by the ALJ. A decision will normally be rendered by the ALJ within 20 days of the hearing before the ALJ. This is the final and only appeals process for proposed administrative sanctions;

(I) Contract award appeals;

(J) Provider appeals of OHCA audit findings pursuant to 317:2-1-7. This is the final and only appeals

process for appeals of OHCA audits; and
(K) Oklahoma Electronic Health Records Incentive program appeals related only to incentive payments, incentive payment amounts, provider eligibility determinations, and demonstration of adopting, implementing, upgrading, and meaningful use eligibility for incentives.
(L) Supplemental Hospital Offset Payment Program (SHOPP) annual assessment, Supplemental Payment, fees or penalties as specifically provided in OAC 317:2-1-15.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 2. GRIEVANCE PROCEDURES AND PROCESS
SUBCHAPTER 1. RULES

317:2-1-15. Supplemental Hospital Offset Payment Program (SHOPP) Appeals.

(a) In accordance with Title 63 of the Oklahoma Statutes Section 3241.4 OHCA is authorized to promulgate rules for appeals of annual assessments, fees and penalties to hospitals as defined by the statute. The rules in this Section describe those appeals rights.

(1) OAC 317:30-5-58 subsections (a) through (e) describe the SHOPP Assessments, fees and the penalties for non-payment of the fee or failure to file a cost report, as set out in 63 Okla. Stat. §§ 3241.3 and 3241.4

(2) Appeals filed under this Section are heard by an Administrative Law Judge (ALJ).

(3) To file an appeal, the provider hospital must file an LD-2 form within thirty (30) days of receipt of the notification from OHCA assessing the annual SHOPP Assessment, a fee or penalty. The penalty, fee or assessment is deducted from the hospital's payment if the assessment is unpaid at the time the appeal is filed. If the hospital prevails in the appeal the amount assessed will be returned to the hospital with their payment.

(4) The hearing will be conducted in accordance with OAC 317:2-1-5.

(b) An individual hospital may appeal an individual assessment at the time of its annual assessment. As provided for above in subsection (3), the appeal must be filed within thirty (30) days of receipt of the notification of assessment by OHCA to the hospital. If the hospital challenges the computation of the hospital's net

patient revenue, the assessment rate, or assessment amount then the appeal will proceed in accordance with subsection(4)above.

(c) Individual hospitals that appeal the quarterly assessment are limited to calculation errors in dividing the annual assessment into four (4) parts. Appeals must be filed within thirty 30 days of receipt of the notice of assessment by OHCA to the hospital. The appeal will proceed in accordance with subsection (4) above.

(d) If OHCA determines an overpayment of SHOPP payments has been made to an individual hospital, then the hospital may file an appeal within thirty (30) days of the notice of overpayment. Overpayments are deducted from the hospital's payment. The appeal will proceed in accordance with subsection (4) above.

(e) OHCA recognizes that some individual hospital's claims regarding an inappropriate assessment or overpayment may involve aggregate data. For example an appeal may involve one of the following issues:

(1) total hospitals in the entire SHOPP pool;

(2) total hospitals that are exempt from SHOPP;

(3) total hospitals classified as critical access hospitals;

(4) total net revenue from all hospitals in the pool;

(5) the total amount of monies allocated to each pool in the SHOPP; or

(6) the pro-rata distribution in a pool(s),

(f) If an individual hospital brings an aggregate appeals claim, there are two (2) elements of proof to be met. The ALJ must determine that the hospital can demonstrate by a preponderance of evidence:

(1) that data was made available before the hospital submitted the appeal; and

(2) a specific calculation error has been made statewide that can be shown by the hospital.

(g) The "Upper Payment Limit" and the "Upper Payment limit Gap" are not appealable in the administrative process.

Oklahoma Health Care Authority

It is very important that you provide your comments regarding the proposed rule change by the comment due date. Comments are directed to Oklahoma Health Care Authority (OHCA) Health Policy Unit http://www.okhca.org/proposed-rule-changes.aspx

OHCA COMMENT DUE DATE: December 28, 2011

The proposed policy is a Permanent Rule. This proposal is scheduled to be presented to the Medical Advisory Committee (MAC) on January 19, 2012 and the (OHCA) Board of Directors on February 9, 2012.
Reference: APA WF 11-19

SUMMARY:
End Stage Renal Disease Payment Methodology– Policy, the State Plan, and reimbursement methodology will be updated to correspond to new Medicare guidelines regarding payment to End Stage Renal Disease (ESRD) facilities. Currently policy and methodology utilizes Medicare's old composite rate for a defined set of ESRD items and services, while paying separately for services not included in the composite rate, such as drugs and laboratory tests. This payment system is replaced with a new bundled prospective payment system (PPS), in which a single bundled payment to the ESRD facility for each treatment will cover all renal dialysis services. If the change is not made, OHCA will be out of line with Medicare reimbursement rates for this provider type.

LEGAL AUTHORITY
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; Public Law 110-275, Section 153; 42 CFR Parts 410, 413, and 414; CMS-1418-F (Federal Register Vol. 75, No. 155)

RULE IMPACT STATEMENT:

TO: Tywanda Cox
Health Policy

FROM: Joseph Fairbanks
Health Policy

SUBJECT: Rule Impact Statement

APA WF # 11-19

A. Brief description of the purpose of the rule:

Policy, the State Plan, and reimbursement methodology will be updated to correspond to new Medicare guidelines regarding payment to End Stage Renal Disease (ESRD) facilities. Currently policy and methodology utilizes Medicare's old composite rate for a defined set of ESRD items and services, while paying separately for services not included in the composite rate, such as drugs and laboratory tests. This payment system is replaced with a new bundled prospective payment system (PPS), in which a single bundled payment to the ESRD facility for each treatment will cover all renal dialysis services. If the change is not made, OHCA will be out of line with Medicare reimbursement rates for this provider type.

B. A description of the classes of persons who most likely will be affected by the proposed rule, including classes that will bear the cost of the proposed rule, and any information on cost impacts received by the agency from any private or public entities:

No classes of persons will be affected by the proposed rule. There is a projected total cost of $959,000 associated with the proposed rule. Of that $959,000, it is projected the state will be responsible for $344,000 and the federal government will be responsible for the remainder.

C. A description of the classes of persons who will benefit from the proposed rule:

No classes of persons will benefit from the proposed rule.

D. A description of the probable economic impact of the proposed rule upon the affected classes of persons or political subdivisions, including a listing of all fee changes and, whenever possible, a separate justification for each fee change:

There is no economic impact. Bringing our rules and payment methodology in line with CMS regulations on ESRD payment—that is, changing it from the composite rate to the prospective payment system rate—will raise the reimbursement fee from an average of $175 to $211, which is the estimated

PPS rate set by CMS ($218) minus the 3.25% across-the-board rate reduction enacted by OHCA in 2010.

E. The probable costs and benefits to the agency and to any other agency of the implementation and enforcement of the proposed rule, the source of revenue to be used for implementation and enforcement of the proposed rule, and any anticipated affect on state revenues, including a projected net loss or gain in such revenues if it can be projected by the agency:

There will be a projected $344,000 cost to the state. Revenue from state appropriations to OHCA and matching federal financial participation will be used to enact this change.

F. A determination of whether implementation of the proposed rule will have an economic impact on any political subdivisions or require their cooperation in implementing or enforcing the rule:

There is no economic impact on political subdivisions.

G. A determination of whether implementation of the proposed rule will have an adverse effect on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act:

There is no adverse economic impact on small businesses as a result of this rule.

H. An explanation of the measures the agency has taken to minimize compliance costs and a determination of whether there are less costly or non-regulatory methods or less intrusive methods for achieving the purpose of the proposed rule:

The agency has taken measures to determine that there is no less costly or non-regulatory method or less intrusive method for achieving the purpose of the proposed rule.

I. A determination of the effect of the proposed rule on the public health, safety and environment and, if the proposed rule is designed to reduce significant risks to the public health, safety and environment, an explanation of the nature of the risk and to what extent the proposed rule will reduce the risk:

The proposed rule should have no adverse effect on the public health, safety, and environment.

J. A determination of any detrimental effect on the public health, safety and environment if the proposed rule is not implemented:

OHCA does not believe there is a detrimental effect on the public health and safety if the rule is not passed.

K. The date the rule impact statement was prepared and if modified, the date modified:

The rule impact statement was prepared December 1, 2011.

RULE TEXT

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 3. HOSPITALS

317:30-5-42.6. Dialysis

Payment for dialysis is made at the ~~all-inclusive~~ Medicare ~~allowable composite~~ prospective payment system wage adjusted base rate. This rate includes all services which Medicare has established as an integral part of the dialysis procedure~~, such as routine medical supplies, certain laboratory procedures, oxygen, etc. Payment is made separately for injections of Epoetin Alfa (EPO or Epogen)~~. The physician is reimbursed separately.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 29. RENAL DIALYSIS FACILITIES

317:30-5-306. Coverage by category

Payment is made to renal dialysis facilities as set forth in this Section.

(1) **Adults.** Payment is made for outpatient renal dialysis for adults at the ~~composite~~ PPS rate.

(2) **Children.** Coverage for children is the same as for adults.

(3) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the Medicaid allowable for comparable service.

317:30-5-307. Payment methodology

Payment of in-facility dialysis treatments and home dialysis treatment is made under the ~~composite~~ PPS rate reimbursement system ~~as established by Medicare~~.

(1) All items and services included under the ~~composite~~ PPS rate must be furnished by the facility, either directly or under arrangements, to all of its dialysis patients. If the facility fails to furnish (either directly or under arrangements) any part of the items and services covered under the rate, then the facility cannot be paid any amount for the part of the items and services that the facility does furnish. These items and services include:

(A) medically necessary dialysis equipment and dialysis support equipment;

(B) home dialysis support services including the delivery, installation, maintenance, repair, and testing of home dialysis equipment, and home support equipment;

(C) purchase and delivery of all necessary dialysis supplies;

(D) routine ESRD related laboratory tests~~,~~; and

(E) all dialysis services furnished by the facility's staff.

(2) Some examples (but not an all-inclusive list) of items and services that are included in the ~~composite~~ PPS rate and may not be billed separately when furnished by a dialysis facility are:

(A) staff time used to administer blood;

(B) declotting of shunts and any supplies used to declot shunts;

(C) oxygen and the administration of oxygen; and

(D) staff time used to administer nonroutine peritoneal items.

Oklahoma Health Care Authority

It is very important that you provide your comments regarding the proposed rule change by the comment due date. Comments are directed to Oklahoma Health Care Authority (OHCA) Health Policy Unit http://www.okhca.org/proposed-rule-changes.aspx

OHCA COMMENT DUE DATE: September 19, 2011

The proposed policy is a Permanent Rule. This proposal is scheduled to be presented to the Medical Advisory Committee (MAC) on November 16, 2011 and the (OHCA) Board of Directors on January 12, 2012.
Reference: APA WF 11-20

SUMMARY:
11-20 Provider Agreements Clarification – Provider agreement rules are revised to ensure clarity. Revisions are made to reflect language in 42 CFR 455.414; that provider agreements must be renewed at least every five years. Additionally, revisions are made to revise provider contracts contact information.

LEGAL AUTHORITY
The Oklahoma Health Care Authority Board; Then Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes;42 CFR 455.414

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

TO: Tywanda Cox
Policy Development

From: LeKenya Samilton

SUBJECT: Rule Impact Statement
APA WF # 11-20

A. Brief description of the purpose of the rule:

Provider agreement rules are revised to ensure clarity. Current rules define that provider

agreements are renewed annually. Revisions are made to reflect language in 42 CFR 455.414; that provider agreements must be renewed at least every five years. Additionally, revisions are made to revise provider contracts contact information. The revisions are necessary to align OHCA policy with federal regulations and ensure provider inquiries are handled promptly, without delay from delivery error.

B. A description of the classes of persons who most likely will be affected by the proposed rule, including classes that will bear the cost of the proposed rule, and any information on cost impacts received by the agency from any private or public entities:

The classes of persons most affected by this rule will be all contracted SoonerCare providers regardless of provider type.

C. A description of the classes of persons who will benefit from the proposed rule:

The persons who will most likely benefit from the proposed rule are both SoonerCare members and providers. Revalidating the enrollment of providers ensures that SoonerCare members receive quality health care from credentialed providers. Additionally, updating provider contracts contact information ensures that providers inquiries are delivered to the appropriate location which results in rapid resolution.

D. A description of the probable economic impact of the proposed rule upon the affected classes of persons or political subdivisions, including a listing of all fee changes and, whenever possible, a separate justification for each fee change:

There is no probable economic impact of the proposed rule upon any classes of persons or political subdivisions.

E. The probable costs and benefits to the agency and to any other agency of the implementation and enforcement of the proposed rule, the source of revenue to be used for implementation and enforcement of the proposed

rule, and any anticipated affect on state revenues, including a projected net loss or gain in such revenues if it can be projected by the agency:

There is no budgetary impact as a result of this rule.

F. A determination of whether implementation of the proposed rule will have an economic impact on any political subdivisions or require their cooperation in implementing or enforcing the rule:

The proposed rule will not have an economic impact on any political subdivision or require their cooperation in implementing or enforcing the rule.

G. A determination of whether implementation of the proposed rule will have an adverse effect on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act:

The proposed rule will not have an adverse effect on small businesses as provided by the Oklahoma Small Business Regulatory Flexibility Act.

H. An explanation of the measures the agency has taken to minimize compliance costs and a determination of whether there are less costly or non-regulatory methods or less intrusive methods for achieving the purpose of the proposed rule:

There agency has taken measures to determine that there is no less costly or non-regulatory method or less intrusive method for achieving the purpose of the proposed rule.

I. A determination of the effect of the proposed rule on the public health, safety and environment and, if the proposed rule is designed to reduce significant risks to the public health, safety and environment, an explanation of the nature of the risk and to what extent the proposed rule will reduce the risk:

The proposed rule should have no effect on the public health, safety, or environment.

J. A determination of any detrimental effect on the public health, safety and environment if the proposed

rule is not implemented:

The agency does not anticipate any detrimental effects on the public health, safety, or environment.

K. The date the rule impact statement was prepared and if modified, the date modified:

This rule impact statement was prepared on August 26, 2011.

RULE TEXT

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 3. GENERAL PROVIDER POLICIES
PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-2. Provider agreements

In order to be eligible for payment, providers must have on file with OHCA, an approved Provider Agreement. Through this agreement, the provider certifies all information submitted on claims is accurate and complete, assures that the State Agency's requirements are met and assures compliance with all applicable Federal and State regulations. These agreements are renewed ~~annually~~ at least every 5 years with each provider.

(1) The provider further assures compliance with Section 1352, Title 31 of the U.S. Code and implemented at 45 CFR Part 93 which provides that if payments pursuant to services provided under Medicaid are expected to exceed $100,000.00, the provider certifies federal funds have not been used nor will they be used to influence the making or continuation of the agreement to provide services under Medicaid. Upon request, the Authority will furnish a standard form to the provider for the purpose of reporting any non-federal funds used for influencing agreements.

(2) The provider assures in accordance with 31 ~~USCA~~ USC 6101, Executive Order 12549, that they are not presently or have not in the last three years been debarred, suspended, proposed for debarment or declared ineligible by any Federal department or agency.

(3) For information regarding ~~annual~~ Provider Agreements or for problems related to a current agreement, contact the Oklahoma Health Care Authority, Provider Enrollment, ~~P.O. Box 18299, Oklahoma City, Oklahoma 73154-0299, or call 1-800-871-9347 for out-of-state or 405-525-1092 from within the state.~~ P.O. Box 54015, Oklahoma City, Oklahoma 73154, or call 1-800-

522-0114 option 5 toll free or 405-522-6205 for the Oklahoma City area.

Oklahoma Health Care Authority

It is very important that you provide your comments regarding the proposed rule change by the comment due date. Comments are directed to Oklahoma Health Care Authority (OHCA) Health Policy Unit http://www.okhca.org/proposed-rule-changes.aspx

OHCA COMMENT DUE DATE: Thursday, February 23rd, 2012.

The proposed policy is a Permanent rule. This proposal is scheduled to be presented to the Medical Advisory Committee (MAC) on March 7th, 2012 and the (OHCA) Board of Directors on March 8th, 2012.
Reference: APA WF 11-21

SUMMARY:
OHCA rules for the Living Choice demonstration program are revised to clarify that individuals residing in a nursing facility or ICF/MR in lieu of incarceration are not eligible for the Living Choice program. Rules are also revised to clarify that Living Choice members who have completed their full 365 days of eligibility and are re-institutionalized for 90 consecutive days are eligible to re-apply for an additional 365 days of service.

LEGAL AUTHORITY
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of
Section 6071 of the Deficit Reduction Act of 2005
Section 2403 of the Affordable Care Act
June 1, 2011 CMS guidance correspondence

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

TO: Tywanda Cox
Policy Development

From: Brent Johnson

SUBJECT: Rule Impact Statement
(Reference APA WF # 11-21)

A. Brief description of the purpose of the rule:

OHCA rules for the Living Choice Demonstration program are revised to clarify that residents of nursing facilities or ICFs/MR that are institutionalized in lieu of incarceration are not eligible for the Living Choice program. Additionally rules are revised to clarify that Living Choice members who have completed their full 365 days of eligibility and are re-institutionalized for 90 consecutive days are eligible to re-apply for an additional 365 days of service.

B. A description of the classes of persons who most likely will be affected by the proposed rule, including classes that will bear the cost of the proposed rule, and any information on cost impacts received by the agency from any private or public entities:

The classes of persons affected by the rule change are residents of nursing facilities or ICFs/MR applying to receive Living Choice program services who will not qualify due to incarceration. Additionally individuals who have completed 365 days in the program and are seeking to re-enroll may be affected by the rule change. There are no specific classes of person who will bear the cost of the proposed rule change, nor have any cost impacts been received by the agency from private or public entities.

C A description of the classes of persons who will benefit from the proposed rule:

The classes of persons who will benefit by the rule change are individuals who have completed the initial 365 days in the Living Choice program, have been re-institutionalized for 90 consecutive days and are eligible for an additional 365 days in the program.

D. A description of the probable economic impact of the proposed rule upon the affected classes of persons or political subdivisions, including a listing of all fee changes and, whenever possible, a separate justification for each fee change:

There is no probable economic impact of the proposed rules upon any classes of persons or political subdivisions nor is a fee change involved in the rule revision.

E. The probable costs and benefits to the agency and to any other agency of the implementation and enforcement of the proposed rule, the source of revenue to be used for implementation and enforcement of the proposed rule, and any anticipated affect on state revenues, including a projected net loss or gain in such revenues if it can be projected by the agency:

The OHCA will benefit from enforcement of the proposed rule through the absence of individuals who may be a threat to providers or the community. A slight cost increase is expected due to a small number of individuals expected to re-enroll in the program each year. The additional annual cost is estimated to be $112,908 in Federal dollars and $14,866 in State dollars. The majority of individuals re-enrolling in the Living Choice program would likely receive waiver services that require at higher State matching share, if not for the Living Choice re-enrollment. Therefore, a savings in State dollars may actually be realized as a result of the policy change.

F. A determination of whether implementation of the proposed rule will have an economic impact on any political subdivisions or require their cooperation in implementing or enforcing the rule:

The proposed rule will not have an economic impact on any political subdivision or require their cooperation in implementing or enforcing the rule.

G. A determination of whether implementation of the proposed rule will have an adverse effect on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act:

The proposed rule will not have an adverse effect on small businesses as provided by the Oklahoma Small Business Regulatory Flexibility Act.

H. An explanation of the measures the agency has taken to minimize compliance costs and a determination of whether there are less costly or nonregulatory methods or less intrusive methods for achieving the purpose of the proposed rule:

There are no other legal methods to minimize compliance costs.

I. A determination of the effect of the proposed rule on the public health, safety and environment and, if the proposed rule is designed to reduce significant risks to the public health, safety and environment, an explanation of the nature of the risk and to what extent the proposed rule will reduce the risk:

The proposed rule should have no effect on the public health, safety, or environment.

J. A determination of any detrimental effect on the public health, safety and environment if the proposed rule is not implemented:

The agency does not anticipate any detrimental effects on the public health, safety, or environment.

K. The date the rule impact statement was prepared and if modified, the date modified:

This rule impact statement was prepared on January 13th, 2012.

Rule Text

TITLE 317: OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTR 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 113. LIVING CHOICE PROGRAM

317:30-5-1201. Benefits for members with ~~mental retardation~~ intellectual disabilities

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

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

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

(d) Services that may be provided to members with ~~mental retardation~~ intellectual disabilities are listed in paragraphs (1) through (28) of this subsection:

(1) assistive technology;

(2) adult day health care;

(3) architectural modifications;

(4) audiology evaluation and treatment;

(5) community transition;

(6) daily living support;

(7) dental services;

(8) family counseling;

(9) family training;

(10) group home;

(11) respite care;

(12) homemaker services;

(13) habilitation training services;

(14) home health care;

(15) intensive personal support;

(16) extended duty nursing;

(17) skilled nursing;

(18) nutrition services;

(19) therapy services including physical, occupational, and speech;

(20) psychiatry services;

(21) psychological services;

(22) agency companion services;
(23) non-emergency transportation;
(24) pre-vocational services;
(25) supported employment services;
(26) specialized foster care;
(27) specialized medical equipment and supplies; and
(28) SoonerCare compensable medical services.

CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
SUBCHAPTER 23. LIVING CHOICE PROGRAM

317:35-23-2. Eligibility criteria

Adults with disabilities or long-term illnesses, members with ~~mental retardation~~ intellectual disabilities and members with physical disabilities are eligible to transition into the community through the Living Choice program if they meet all of the criteria in paragraphs (1) through (7) of this subsection.

(1) He/she must be at least 19 years of age.

(2) He/she must reside in an institution (nursing facility or public ICF/MR) for at least 90 consecutive days prior to the proposed transition date. If any portion of the 90 days includes time in a skilled nursing facility, those days cannot be counted toward the 90 day requirement, if the member received Medicare post-hospital extended care rehabilitative services.

(3) He/she must have at least one day of Medicaid paid long-term care services prior to transition.

(4) If transitioning from an out of state institution, he/she must be SoonerCare eligible.

(5) He/she requires at least the same level of care that necessitated admission to the institution.

(6) He/she must reside in a qualified residence after leaving the institution. A qualified residence is defined in (A) through (C) of this paragraph.

(A) a home owned or leased by the individual or the individual's family member;

(B) an apartment with an individual lease, with a locking entrance/exit, and which includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control; and

(C) a residence, in a community-based residential setting, in which no more than four unrelated individuals reside.

(7) His/her needs can be met by the Living Choice program while living in the community.

(8) He/she must not be a resident of a nursing facility or ICF/MR in lieu of incarceration.

317:35-23-3. Participant disenrollment

(a) ~~Members are~~ A member is disenrolled from the program if he/she:

(1) is admitted to a hospital, nursing facility, ICF/MR, residential care facility or behavioral health facility for more than 30 consecutive days;

(2) is incarcerated;

(3) is determined to no longer meet SoonerCare financial eligibility for home and community based services;

(4) determined by the Social Security Administration or OHCA Level of Care Evaluation Unit to no longer have a disability that qualifies for services under the Living Choice program; or

(5) moves out of state.

(b) Payment cannot be made for an individual who is in imminent danger of harm to self or others.

317:35-23-4. Re-enrollment

(a) **Members in the Living Choice Program.**

(1) The member remains eligible during periods of institutionalization as long as the stay does not exceed 30 days.

~~(a)~~ (2) A member with an institutional stay longer than 30 days may re-enroll in the program without ~~residing in an institution for the six months prior~~ re-establishing the 90 day institutional residency requirement if:

~~(1)~~ (A) the necessity for the institutionalization is documented in the revised individual transition plan; and

~~(2)~~ (B) the member can safely return to the community as determined by the transition coordinator, the member and the transition planning team.

(3) The re-enrolled member is eligible to receive services for any remaining days up to the 365 day limit.

~~(b) The member remains eligible during hospitalization and convalescent care periods as long as the stay does not exceed six months~~.

(b) **Members no longer in the Living Choice Program.**

(1) Members who have completed 365 days in the Living Choice Program and have been re-institutionalized for a minimum of 90 consecutive days may be eligible for re-enrollment in the Living Choice Program. Before re-enrollment of a former member, a re-evaluation of the former member's plan of care

must be completed and a determination made if the plan of care could not be carried out as a result of:

(A) medical and/or behavioral changes resulting in the necessity of readmission into the inpatient facility;

(B) the lack of community services to support the member that were identified in the original plan of care; or

(C) the plan of care was not supported by the delivery of quality services.

(2) After determining the basis for re-institutionalization and creation of a new plan of care that ensures the health and safety of the former member, he/she may be re-enrolled for an additional 365 days.

Oklahoma Health Care Authority

It is very important that you provide your comments regarding the proposed rule change by the comment due date. Comments are directed to Oklahoma Health Care Authority (OHCA) Health Policy Unit http://www.okhca.org/proposed-rule-changes.aspx

OHCA COMMENT DUE DATE: November 7, 2011

The proposed policy is a Permanent Rule. This proposal is scheduled to be presented to the Medical Advisory Committee (MAC) on January 12, 2012 and the (OHCA) Board of Directors on March, 2012.
Reference: APA WF 11-24

SUMMARY:
11-24 Certified Alcohol and Drug Counselors – Rules are revised to reflect therapy services may only be provided by licensed professionals effective July 1, 2013. Currently, Certified Alcohol Drug Counselors (CADCs) may perform therapy services in accordance with their Licensure Act. Revisions are made to comply with 43A Oklahoma Statues 3-406.1

LEGAL AUTHORITY
The Oklahoma Health Care Authority Board; Then Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes;43A Oklahoma Statutes Section 3-406.1.

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

TO: Tywanda Cox
Policy Development

From: LeKenya Samilton

SUBJECT: Rule Impact Statement
APA WF # 11-24

A. Brief description of the purpose of the rule:

Outpatient behavioral health rules are revised to reflect therapy services may only be provided by

licensed professionals effective July 1, 2013. Currently, Certified Alcohol Drug Counselors (CADCs) may perform therapy services in accordance with their Licensure Act. Revisions are made to comply with 43A Oklahoma Statutes 3-406.1. The revisions are necessary to comply with Oklahoma Statues.

B. A description of the classes of persons who most likely will be affected by the proposed rule, including classes that will bear the cost of the proposed rule, and any information on cost impacts received by the agency from any private or public entities:

The classes of persons most affected by this rule will be all SoonerCare contracted Certified Alcohol and Drug Counselors (CADCs) that provide therapy services. The classes of persons who will bear the cost are those CADCs who further their education to obtain a Master's degree and become licensed to continue to provide therapy services.

C. A description of the classes of persons who will benefit from the proposed rule:

The persons who will most likely benefit from the proposed rule changes are SoonerCare members. Revising rules to require that therapy services are provided by licensed professionals ensures that member are receiving services from providers with extensive experience and education backgrounds.

D. A description of the probable economic impact of the proposed rule upon the affected classes of persons or political subdivisions, including a listing of all fee changes and, whenever possible, a separate justification for each fee change:

There is no probable economic impact of the proposed rule upon any classes of persons or political subdivisions.

E. The probable costs and benefits to the agency and to any other agency of the implementation and enforcement of the proposed rule, the source of revenue to be used for implementation and enforcement of the proposed rule, and any anticipated affect on state revenues,

including a projected net loss or gain in such revenues if it can be projected by the agency:

There is no budgetary impact as a result of this rule.

F. A determination of whether implementation of the proposed rule will have an economic impact on any political subdivisions or require their cooperation in implementing or enforcing the rule:

The proposed rule will not have an economic impact on any political subdivision or require their cooperation in implementing or enforcing the rule.

G. A determination of whether implementation of the proposed rule will have an adverse effect on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act:

The proposed rule will not have an adverse effect on small businesses as provided by the Oklahoma Small Business Regulatory Flexibility Act.

H. An explanation of the measures the agency has taken to minimize compliance costs and a determination of whether there are less costly or nonregulatory methods or less intrusive methods for achieving the purpose of the proposed rule:

There agency has taken measures to determine that there is no less costly or non-regulatory method or less intrusive method for achieving the purpose of the proposed rule.

I. A determination of the effect of the proposed rule on the public health, safety and environment and, if the proposed rule is designed to reduce significant risks to the public health, safety and environment, an explanation of the nature of the risk and to what extent the proposed rule will reduce the risk:

The proposed rule should have no effect on the public health, safety, or environment.

J. A determination of any detrimental effect on the public health, safety and environment if the proposed rule is not implemented:

The agency does not anticipate any detrimental effects on the public health, safety, or environment.

K. The date the rule impact statement was prepared and if modified, the date modified:

This rule impact statement was prepared on September 19, 2011.

RULE TEXT

TITLE 317: OKLAHOMA HEALTH CARE AUTHORTY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDER AND SPECIALTIES
PART 21. OUTPATIENT BEHAVIORAL HEALTH SERVICES

317:30-5-241.2. Psychotherapy

(a) **Individual/Interactive Psychotherapy.**

(1) **Definition.** Individual Psychotherapy is a face-to-face treatment for mental illnesses and behavioral disturbances, in which the clinician, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior and encourage growth and development. Insight oriented, behavior modifying and/or supportive psychotherapy refers to the development of insight of affective understanding, the use of behavior modification techniques, the use of supportive interactions, the use of cognitive discussion of reality, or any combination of these items to provide therapeutic change.

(2) **Definition.** Interactive Psychotherapy is individual psychotherapy that involves the use of play therapy equipment, physical aids/devices, language interpreter, or other mechanisms of nonverbal communication to overcome barriers to the therapeutic interaction between the clinician and the member who has not yet developed or who has lost the expressive language communication skills to explain his/her symptoms and response to treatment, requires the use of a mechanical device in order to progress in treatment, or the receptive communication skills to understand the clinician. The service may be used for adults who are hearing impaired and require the use of language interpreter.

(3) **Qualified professionals.** With the exception of a qualified interpreter if needed, only the member and the Licensed Behavioral Health Professional (LBHP) ~~or Certified Alcohol and Drug Counselor (CADC), for substance abuse (SA) only,~~ should be present and the setting must protect and assure confidentiality. CADCs are permitted to provide Individual/Interactive Psychotherapy for substance abuse (SA) only through June 30, 2013. Effective July 1, 2013 all Individual/Interactive Psychotherapy must be provided by LBHPs. Ongoing assessment of the member's status and response to treatment as well as psycho-educational intervention are appropriate components of individual counseling. The counseling must be goal directed, utilizing techniques appropriate to the service plan and the member's developmental and cognitive abilities. Individual/Interactive counseling must be provided by a LBHP ~~or CADC when treatment is for an alcohol or other drug disorder only~~. CADCs are permitted to provide Individual/Interactive counseling for an alcohol or other drug disorders only through June 30, 2013.

(4) **Limitations.** A maximum of 6 units per day per member is compensable.

(b) **Group Psychotherapy.**

(1) **Definition.** Group psychotherapy is a method of treating behavioral disorders using the interaction between the LBHP ~~or the CADC when treating alcohol and other drug disorders only~~, and two or more individuals to promote positive emotional or behavioral change. CADCs are permitted to provide group psychotherapy when treating alcohol and other drug disorders only through June 30, 2013; effective July 1, 2013 all group psychotherapy must be provided by LBHPs. The focus of the group must be directly related to the goals and objectives in the individual member's current service plan. This service does not include social or daily living skills development as described under Behavioral Health Rehabilitation Services.

(2) **Group sizes.** Group Psychotherapy is limited to a total of eight adult (18 and over) individuals except when the individuals are residents of an ICF/MR where the maximum group size is six. For all children under the age of 18, the total group size is limited to six.

(3) **Multi-family and conjoint family therapy.** Sessions are limited to a maximum of eight families/units. Billing is allowed once per family unit, though units may be divided amongst family members.

(4) **Qualified professionals.** Group psychotherapy will be provided by a LBHP ~~or CADC when treatment is for an alcohol~~

~~or other drug disorder only~~. CADCs are permitted to provide group psychotherapy when treating alcohol and other drug disorders only through June 30, 2013. Effective July 1, 2013 all group psychotherapy must be provided by LBHPs. Group Psychotherapy must take place in a confidential setting limited to the LBHP or CADC conducting the service, an assistant or co-therapist, if desired, and the group psychotherapy participants.

(5) **Limitations.** A maximum of 12 units per day per member is compensable.

(c) **Family Psychotherapy.**

(1) **Definition.** Family Psychotherapy is a face-to-face psychotherapeutic interaction between a LBHP ~~or CADC~~ and the member's family, guardian, and/or support system. CADCs are permitted to provide family psychotherapy through June 30, 2013; effective July 1, 2013 all family psychotherapies must be provided by LBHPs. It is typically inclusive of the identified member, but may be performed if indicated without the member's presence. When the member is an adult, his/her permission must be obtained in writing. Family psychotherapy must be provided for the direct benefit of the SoonerCare member to assist him/her in achieving his/her established treatment goals and objectives and it must take place in a confidential setting. This service may include the Evidence Based Practice titled Family Psychoeducation.

(2) **Qualified professionals.** Family Psychotherapy must be provided by a LBHP ~~or CADC when treatment is for an alcohol or other drug disorder only~~.

(3) **Limitations.** A maximum of 12 units per day per member/family unit is compensable.

(d) **Multi-Systemic Therapy (MST).**

(1) **Definition.** MST intensive outpatient program services are limited to children within an Office of Juvenile Affairs (OJA) MST treatment program which provides an intensive, family and community-based treatment targeting specific BH disorders in children with SED who exhibit chronic, aggressive, antisocial, and/or substance abusing behaviors, and are at risk for out of home placement. Case loads are kept low due to the intensity of the services provided.

(2) **Qualified professionals.** Masters level professionals who work with a team that may include bachelor level staff.

(e) **Children/Adolescent Partial Hospitalization Program (PHP).**

(1) **Definition.** Partial hospitalization services are services that (1) Are reasonable and necessary for the diagnosis or active treatment of the member's condition; (2) Are reasonably expected to improve or maintain the member's condition and functional level and to prevent relapse or

hospitalization and (3) Are provided in accordance with services outlined in 42 CFR 410.43.

(2) **Qualified professionals.** All services in the PHP are provided by a team of the following: physician, registered nurse, licensed behavioral health professional (LBHP), a case manager, or other certified Behavioral Health/Substance Abuse paraprofessional staff. Refer to OHCA BH Provider Manual for further requirements. The treatment plan is directed under the supervision of a physician.

(3) **Qualified providers.** Provider agencies for PHP must be accredited by one of the national accrediting bodies; The Joint Commission (TJC), Commission on Accreditation of Rehabilitation Facilities (CARF) or The Council on Accreditation (COA) for partial hospitalization and enrolled in SoonerCare. Staff providing these services are employees or contractors of the enrolled agency.

(4) **Limitations.** Services are limited to children 0-20 only. Services must be offered at a minimum of 3 hours per day, 5 days per week. Therapeutic services are limited to 4 billable hours per day and must be prior authorized. PHP services are all inclusive with the exception of physician services and drugs that cannot be self-administered, those services are separately billable. Refer to OHCA BH Provider Billing Manual for further definition.

(5) **Reporting.** Reporting requirements must be followed as outlined in the OHCA BH Provider Billing Manual.

(f) **Children/Adolescent Day Treatment Program.**

(1) **Definition.** Day Treatment Programs are for the stabilization of children and adolescents with severe emotional and/or behavioral disturbances. Treatment is designed for children who have difficulty functioning in mainstream community settings such as classrooms, and who need a higher intensity of services than outpatient counseling provides. Treatment is time limited and includes therapeutically intensive clinical services geared towards reintegration to the home, school, and community.

(2) **Qualified professionals.** All services in Day Treatment are provided by a team, which must be composed of one or more of the following participants: physician, registered nurse, licensed behavioral health professional (LBHP), a case manager, or other certified Behavioral Health/Substance Abuse paraprofessional staff. Refer to OHCA BH Provider Billing Manual for further requirements. Services are directed by an LBHP.

(3) **Qualified providers.** Provider agencies for Day Treatment must be accredited by one of the national accrediting bodies; The Joint Commission (TJC), Commission

on Accreditation of Rehabilitation Facilities (CARF) or The Council on Accreditation (COA).

(4) **Limitations.** Services must be offered at a minimum of 4 days per week at least 3 hours per day. Refer to OHCA BH Provider Billing Manual for further requirements.

Oklahoma Health Care Authority

It is very important that you provide your comments regarding the proposed rule change by the comment due date. Comments are directed to Oklahoma Health Care Authority (OHCA) Health Policy Unit http://www.okhca.org/proposed-rule-changes.aspx

OHCA COMMENT DUE DATE: January 14, 2012

The proposed policy is a Permanent Rule. This proposal is scheduled to be presented to the Medical Advisory Committee (MAC) on January 19, 2012 and the (OHCA) Board of Directors on March 8, 2012.
Reference: APA WF 11-25A

SUMMARY:
SoonerRide Clarification— SoonerCare non-emergency transportation rules are revised to clarify OHCA's current policy concerning meals and lodging, travel distance, and eligibility. This rule will assist with future cost savings and prevent abuse of services. This rule will also ensure services for current and future SoonerCare members.

LEGAL AUTHORITY
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 and Section 5051.3 of Title 63 of Oklahoma Statutes

RULE IMPACT STATEMENT:
TO: Tywanda Cox
Health Policy

FROM: Demetria Morrison
Health Policy

SUBJECT: Rule Impact Statement
APA WF # 11-25A

A. Brief description of the purpose of the rule:

SoonerCare non-emergency transportation rules are revised to clarify OHCA's current policy concerning meals and lodging, travel distance, and eligibility. This rule will assist with future cost savings and prevent abuse of services. This rule will also ensure services for current and future SoonerCare members.

B. A description of the classes of persons who most likely will be affected by the proposed rule, including classes that will bear the cost of the proposed rule, and any information on cost impacts received by the agency from any private or public entities:

There are no classes of persons that will be affected by the proposed rule. Further, this revision will have no impact on existing cost.

C. A description of the classes of persons who will benefit from the proposed rule:

The classes of persons that will most likely be affected by the proposed rule are the SoonerCare members that are eligible for SoonerRide non-emergency transportation services.

D. A description of the probable economic impact of the proposed rule upon the affected classes of persons or political subdivisions, including a listing of all fee changes and, whenever possible, a separate justification for each fee change:

There is no economic impact and there are no fee changes associated with the proposed rule for any classes of persons or political subdivisions.

E. The probable costs and benefits to the agency and to any other agency of the implementation and enforcement of the proposed rule, the source of revenue to be used for implementation and enforcement of the proposed rule, and any anticipated affect on state revenues, including a projected net loss or gain in such revenues if it can be projected by the agency:

There is no probable budget impact for the proposed rule as it is to clarify policy.

F. A determination of whether implementation of the proposed rule will have an economic impact on any political subdivisions or require their cooperation in implementing or enforcing the rule:

The proposed rule will not have an economic impact on any political subdivisions or require their cooperation in implementing or enforcing the rule.

G. A determination of whether implementation of the proposed rule will have an adverse effect on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act:

The proposed rule will not have an adverse effect on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act.

H. An explanation of the measures the agency has taken to minimize compliance costs and a determination of whether there are less costly or non-regulatory methods or less intrusive methods for achieving the purpose of the proposed rule:

The agency has taken measures to determine that there is no less costly or non-regulatory method or less intrusive method for achieving the purpose of the proposed rule.

I. A determination of the effect of the proposed rule on the public health, safety and environment and, if the proposed rule is designed to reduce significant risks to the public health, safety and environment, an explanation of the nature of the risk and to what extent the proposed rule will reduce the risk:

The proposed rule should have no effect on the public health, safety, and environment.

J. A determination of any detrimental effect on the public health, safety and environment if the proposed rule is not implemented:

The agency does not anticipate any detrimental effect on the public health or safety and environment.

K. The date the rule impact statement was prepared and if modified, the date modified:

This rule impact statement was prepared on October 18, 2011.

RULE TEXT

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 32. SOONERRIDE NON-EMERGENCY TRANSPORTATION

317:30-5-326.1. Definitions

The following words and terms, when used in this subchapter ~~have~~ shall have the following meaning, unless context clearly indicates otherwise.

"Attendant" means an employee of the nursing facility who is provided by and trained by the nursing facility at the nursing facility's expense.

"Emergency" means a serious situation or occurrence that happens unexpectedly and demands immediate action such as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected, by a reasonable and prudent layperson, to result in placing the members' health in serious jeopardy, serious impairment to bodily function, or serious dysfunction of any bodily organ or part.

"~~Escort~~ Medical escort" means a family member, ~~or~~ legal guardian, or volunteer whose presence is required and medically necessary to assist a member during transport and while at the place of treatment. ~~An~~ A medical escort voluntarily accompanies the member during transport and leaves the vehicle at its destination and remains with the member. ~~An~~ A medical escort must be of an age of legal majority recognized under State law.

"Member/eligible member" means any person eligible for SoonerCare and individuals considered to be Medicare/SoonerCare full dually eligible. This does not include ~~with the exception of~~ those individuals who are categorized only as Qualified Medicare Beneficiaries ~~Plus~~ ~~(QMBP)~~ (QMB), Specified Low Income Medicare Beneficiaries (SLMB), Qualifying Individuals-1 (QI-1), individuals who are in an institution for mental disease (IMD), inpatient, institutionalized, Home and Community Based Waiver members, with the exception of the In-home Supports Waiver for Children and the Advantage Waiver.

"Nearest appropriate facility" means a medical facility that is generally equipped and legally permitted to provide the needed care for the illness or injury involved that is the closest in geographical proximity to the members' residence with exceptions. In the case of approved hospital services, it also means that a physician or physician specialist is

available to provide the necessary care required to treat the member's condition. The fact that a particular physician does or does not have staff privileges in a hospital is not a consideration in determining whether the hospital has appropriate facilities. Thus, non-emergency transportation service to a more distant hospital, clinic, or physicians' office solely to avail a member of the service of a specific physician or physician specialist does not make the institution in which the physician has staff privileges the nearest institution with appropriate facilities.

"Non-ambulance" means a carrier that is not an ambulance.

"Non-emergency" means all reasons for transportation that are not an emergency as defined above.

"SoonerRide Non-Emergency Transportation (NET)" means non-emergency non-ambulance transportation provided statewide within the geographical boundaries of the State of Oklahoma.

317:30-5-327. Eligibility for SoonerRide NET ~~non-emergency non-ambulance transportation eligibility~~

Transportation is provided when medically necessary in connection with examination and treatment to the nearest appropriate facility ~~must be for medically necessary treatment~~ in accordance with 42 CFR 441.170. As the Medicaid Agency, OHCA is the payer of last resort, with few exceptions. When other resources are available, those resources must first be utilized. Exceptions to this policy are those receiving medical treatment through Indian Health Services and those eligible for the Crime Victims Compensation Act. Individuals considered fully dual eligible qualify for SoonerRide. However, SoonerRide excludes those individuals who are categorized as:

(1) Qualified Medicare Beneficiaries ~~Plus~~ ~~(QMBP)~~ (QMB) when SoonerCare pays only the Medicare premium, deductible and co-payment;

(2) Specified Low Income Medicare Beneficiaries (SLMB);

(3) Qualifying Individuals-1 and individuals who are in an institution for mental disease (IMD);

(4) inpatient;

(5) institutionalized (i.e. long-term care facility);

(6) Home and Community Based Waiver members, with the exception of the In-home Supports Waiver for Children and the Advantage Waiver.

317:30-5-327.1. SoonerRide NET Coverage ~~Access to non-emergency non-ambulance transportation through SoonerRide~~

(a) SoonerRide NET is available for SoonerCare covered admission and discharge into inpatient hospital care, outpatient hospital care, services from physicians, diagnostic

devices, clinic services, pharmacy services, eye care and dental care under the following conditions:

(1) Transportation is to the nearest appropriate facility or medical provider capable of providing the necessary services;

(A) The nearest appropriate facility or provider is not considered appropriate if the member's condition requires a higher level of care or specialized services available at the more distant facility. However, a legal impediment barring a member's admission would mean that the institution did not have "appropriate facilities". For example, the nearest transplant center may be in another state and that state's law precludes admission of nonresidents.

(B) The nearest appropriate facility is not considered appropriate if no bed, or provider is available. However, the medical records must be properly documented.

(C) Services should be available within 45 miles of the members' residence with exceptions. The OHCA has discretion and the final authority to approve or deny travel greater than 45 miles to access services.

(i) Members seeking self-referred services are limited to the 45 miles radius.

(ii) Native Americans seeking services at a tribal or I.H.S facility may be transported to any facility within a 45 miles radius equipped for their medical needs with exceptions. Trips to out-of-state facilities require prior approval.

(iii) Duals may be transported to the nearest Veterans Affairs (VA) facility equipped for their medical needs. Trips to out-of-state VA facilities require prior approval.

(2) The service provided must be a SoonerCare covered service provided by a medical provider who is enrolled in the SoonerCare program; and

(3) Services requiring prior authorization must have been authorized. (e.g. travel that exceeds the 45 mile radius, out-of-state travel, meals and lodging services)

~~(a)~~ (b) ~~Non-emergency, non-ambulance transportation services are available through the state's SoonerRide Non-Emergency Transportation (NET) program.~~ SoonerRide NET is available on a statewide basis to all eligible members.

~~(b)~~ (c) ~~SoonerRide NET includes non-emergency, non-ambulance transportation for members to and from SoonerCare providers of health care services. Eligible providers are providers who have valid OHCA contracts. The NET~~ non-emergency transportation ~~must be to access medically necessary covered~~

~~services for which a member has available benefits. Additionally,~~ SoonerRide NET may also be provided for eligible members to providers other than SoonerCare providers if the transportation is to access medically necessary services covered by SoonerCare.

~~(c)~~ (d) ~~The use of SoonerCare funded transportation for any other purpose is fraudulent activity and subject to criminal prosecution and civil and administrative sanctions.~~ SoonerRide NET is available if a member is being discharged from a facility to their home. The facility is responsible for scheduling the transportation.

~~(d) The SoonerRide broker assures that NET transportation services are provided:~~

~~(1) in a manner consistent with the best interest of the member;~~

~~(2) similar in scope and duration state-wide, although there will be some variation based on available resources in a particular geographical area of the state;~~

~~(3) appropriate to available services; and~~

~~(4) appropriate for the limitations of the member.~~

(e) In documented medically necessary instances, a medical escort may accompany the member.

(1) SoonerRide NET is not required to transport any additional individuals other than the one approved individual providing the escort services. In the event that additional individuals request transportation, the SoonerRide broker may charge those family members according to the SoonerRide broker's policies which have been approved by the OHCA.

(2) A medical escort is not eligible for direct compensation by the SoonerRide broker or SoonerCare.

317:30-5-327.2. Service availability [Revoked]

~~(a) SoonerRide NET is available for SoonerCare covered admission and discharge into inpatient hospital care, outpatient hospital care, services from physicians, diagnostic devices, clinic services, pharmacy services, eye care and dental care.~~

~~(b) SoonerRide NET is available if a member is being discharged from a facility to home. The facility is responsible for scheduling the transportation.~~

~~(c) In documented medically necessary instances, may wish to accompany the member for health care services. In such instances, the family member or legal guardian may accompany the member.~~

~~(1) SoonerRide is not required to transport any additional family members other than the one family member providing~~

~~escort services. In the event that additional family members request transportation, the SoonerRide broker may charge those family members according to the SoonerRide broker's policies which have been approved by the OHCA.~~
~~(2) A escort is not eligible for direct compensation by the SoonerRide broker or SoonerCare.~~

317:30-5-328. Subsistence (sleeping accommodations and meals)

The cost of meals and lodging are provided only when medically necessary in connection with transportation to and from medical care. Lodging and meals are reimbursable with prior authorization when the provider is up to a 100 miles from the members' city of residence and travel is to obtain specialty care or treatment that result in an overnight stay. When a member is not required to have a PCP or when as PCP referral is not required to obtain a SoonerCare covered service, a member may go to any provider they choose but SoonerCare will not reimburse for transportation, lodging, or meals if the distance is beyond what is considered the nearest appropriate facility. Reimbursement will be provided for NET services to and from the nearest qualified provider. Meals will be reimbursed only if an overnight stay is medically necessary and the overnight stay meets the lodging requirement criteria. Payment for meals is only provided for overnight stays based on a daily per diem and may be used for breakfast, lunch or dinner, or all three meals, whichever is required. During inpatient or outpatient medical stays, meals and lodging are limited to 14 days for each medical stay unless the OHCA prior authorizes additional days. All efforts to secure a temporary place to stay either by the hospital or a nonprofit organization must be exhausted prior to seeking SoonerCare reimbursement for lodging. A member may not receive reimbursement for lodging and meals for days the member is an inpatient in a hospital or medical facility. If the individual needs assistance with necessary expenses for lodging and meals, the member may pay for the lodging and meals and then submit a travel reimbursement form for reimbursement; if the member does not have the funds for the necessary subsistence; authorization is made by the Care Management Operations and Benefits division on the Room and Board Order form. The travel reimbursement form may be obtained by contacting OHCA. Any subsistence expense claimed on the travel reimbursement form must be documented with receipts, and reimbursement cannot state per diem amounts. The OHCA has discretion and the final authority to approve or deny meals and lodging reimbursement.

Oklahoma Health Care Authority

It is very important that you provide your comments regarding the proposed rule change by the comment due date. Comments are directed to Oklahoma Health Care Authority (OHCA) Health Policy Unit http://www.okhca.org/proposed-rule-changes.aspx

OHCA COMMENT DUE DATE: January 14, 2012

The proposed policy is a Permanent Rule. This proposal is scheduled to be presented to the Medical Advisory Committee (MAC) on January 19, 2012 and the (OHCA) Board of Directors on March 8, 2012.
Reference: APA WF 11-25B

SUMMARY:
SoonerRide Clarification— SoonerCare non-emergency transportation rules are revised to clarify OHCA's current policy concerning meals and lodging, travel distance, and eligibility. This rule will assist with future cost savings and prevent abuse of services. This rule will also ensure services for current and future SoonerCare members.

LEGAL AUTHORITY
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 and Section 5051.3 of Title 63 of Oklahoma Statutes

RULE IMPACT STATEMENT:
TO: Tywanda Cox
Health Policy

FROM: Demetria Morrison
Health Policy

SUBJECT: Rule Impact Statement
APA WF # 11-25B

A. Brief description of the purpose of the rule:

SoonerCare non-emergency transportation rules are revised to clarify OHCA's current policy concerning meals and lodging, travel distance, and eligibility. This rule will assist with future cost savings and prevent abuse of services. This rule will also ensure services for current and future SoonerCare members.

B. A description of the classes of persons who most likely will be affected by the proposed rule, including classes that will bear the cost of the proposed rule, and any information on cost impacts received by the agency from any private or public entities:

There are no classes of persons that will be affected by the proposed rule. Further, this revision will have no impact on existing cost.

C. A description of the classes of persons who will benefit from the proposed rule:

The classes of persons that will most likely be affected by the proposed rule are the SoonerCare members that are eligible for SoonerRide non-emergency transportation services.

D. A description of the probable economic impact of the proposed rule upon the affected classes of persons or political subdivisions, including a listing of all fee changes and, whenever possible, a separate justification for each fee change:

There is no economic impact and there are no fee changes associated with the proposed rule for any classes of persons or political subdivisions.

E. The probable costs and benefits to the agency and to any other agency of the implementation and enforcement of the proposed rule, the source of revenue to be used for implementation and enforcement of the proposed rule, and any anticipated affect on state revenues, including a projected net loss or gain in such revenues if it can be projected by the agency:

There is no probable budget impact for the proposed rule as it is to clarify policy.

F. A determination of whether implementation of the proposed rule will have an economic impact on any political subdivisions or require their cooperation in implementing or enforcing the rule:

The proposed rule will not have an economic impact on any political subdivisions or require their cooperation in implementing or enforcing the rule.

G. A determination of whether implementation of the proposed rule will have an adverse effect on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act:

The proposed rule will not have an adverse effect on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act.

H. An explanation of the measures the agency has taken to minimize compliance costs and a determination of whether there are less costly or non-regulatory methods or less intrusive methods for achieving the purpose of the proposed rule:

The agency has taken measures to determine that there is no less costly or non-regulatory method or less intrusive method for achieving the purpose of the proposed rule.

I. A determination of the effect of the proposed rule on the public health, safety and environment and, if the proposed rule is designed to reduce significant risks to the public health, safety and environment, an explanation of the nature of the risk and to what extent the proposed rule will reduce the risk:

The proposed rule should have no effect on the public health, safety, and environment.

J. A determination of any detrimental effect on the public health, safety and environment if the proposed rule is not implemented:

The agency does not anticipate any detrimental effect on the public health or safety and environment.

K. The date the rule impact statement was prepared and if modified, the date modified:

This rule impact statement was prepared on October 18, 2011.

RULE TEXT

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

SUBCHAPTER 3. COVERAGE AND EXCLUSIONS

317:35-3-2. SoonerCare transportation and subsistence

(a) The Oklahoma Health Care Authority (OHCA) is responsible for assuring that necessary transportation is available to all eligible SoonerCare members who are in need of SoonerCare medical services in accordance with 42 CFR 431.53. The agency contracts with a broker to provide statewide curb to curb coverage for non-emergency transportation under the SoonerRide program. The broker provides the most appropriate and least costly mode of transportation necessary to meet the individual needs of SoonerCare members. As the Medicaid Agency, OHCA is the payer of last resort, with few exceptions. When other resources are available, those resources must first be utilized. Exceptions to this policy are those receiving medical treatment through Indian Health Services and those eligible for the Crime Victims Compensation Act. Payment for covered services to the broker is reimbursed under a capitated methodology based on per member per month. The agency contracts directly with ambulance and air providers for all other transportation needs for eligible members not provided by SoonerRide. SoonerRide excludes those individuals who are categorized as:

(1) Qualified Medicare Beneficiaries ~~Plus~~ ~~(QMBP)~~ (QMB) when SoonerCare pays only the Medicare premium, deductible, and co-pay;

(2) Specified Low Income Medicare Beneficiaries (SLMB);

(3) Qualifying Individuals-1;

(4) individuals who are in an institution for mental disease (IMD), ~~inpatient;~~

(5) inpatient;

~~(5)~~ (6) institutionalized (i.e. long-term care facility);

~~(6)~~ (7) Home and Community Based Waiver members with the exception of the In-home Supports Waiver for Children and the ADvantage Waiver.

(b) Members seeking medically necessary non-emergency transportation will be required to contact the SoonerRide reservation center. Contact will be made via a toll-free phone number which is answered Monday through Saturday, 8 a.m. to 6 p.m. Whenever possible, the member is required to notify SoonerRide at least 72 hours prior to the appointment. The member is asked to furnish the SoonerRide reservation center

their SoonerCare member number, home address, the time and date of the medical appointment, the address and phone number of the medical provider, and any physical/mental limitations which will impact the type of transportation needed. SoonerRide makes arrangements for the most appropriate, least costly transportation. SoonerRide verifies appointments when appropriate. If the member disagrees with the transportation arranged or denied by SoonerRide, an appeal must be filed with OHCA according to OAC 317:2-1-2. The appropriateness of transportation may be appealed only to the extent that the transportation does not meet the medical needs of the member. Dissatisfaction with the use of public transportation, shared rides, type of vehicle, etc., is not appropriate grounds for appeal. The Oklahoma Health Care Authority's decision is final.

(1) **Authorization for transportation by private vehicle or bus.** Transportation by private vehicle or bus is administered through the broker when it is necessary for an eligible member to receive medical services.

(2) **Authorization for transportation by taxi.** Taxi service may be authorized at the discretion of the broker.

(3) **Transportation by ambulance (ground, air ambulance or helicopter).** Transportation by ambulance is compensable for individuals eligible for SoonerCare benefits when other available transportation does not meet the medical needs of the individual. Payment is made for ambulance transportation to and/or from a medical facility for medical care compensable under SoonerCare.

(4) **Transportation by airplane.** When an individual's medical condition is such that transportation out-of-state by a commercial airline is required, approval for airfare must be secured by telephoning the OHCA who will make the necessary flight arrangements.

(5) **Subsistence (sleeping accommodations and meals).** ~~An individual who is eligible for transportation to or from a medical facility to obtain medical services may receive assistance with the necessary expenses of lodging and meals from SoonerCare funds.~~ The cost of meals and lodging are provided only when medically necessary in connection with transportation to and from medical care. Lodging and meals are reimbursable with prior authorization when the provider is up to a 100 miles from the members' city of residence and travel is to obtain specialty care or treatment that result in an overnight stay. When a member is not required to have a PCP or when as PCP referral is not required to obtain a SoonerCare covered service, a member may go to any provider they choose but SoonerCare will not reimburse for

transportation, lodging, or meals if the distance is beyond what is considered the nearest appropriate facility. Reimbursement will be provided for NET services to and from the nearest qualified provider. Meals will be reimbursed only if an overnight stay is medically necessary and the overnight stay meets the lodging requirement criteria. Payment for meals is only provided for overnight stays based on a daily per diem and may be used for breakfast, lunch or dinner, or all three meals, whichever is required. During inpatient or outpatient medical stays, meals and lodging are limited to 14 days for each medical stay unless the OHCA prior authorizes additional days. All efforts to secure a temporary place to stay either by the hospital or a nonprofit organization must be exhausted prior to seeking SoonerCare reimbursement for lodging. A member may not receive reimbursement for lodging and meals for days the member is an inpatient in a hospital or medical facility. If the individual needs assistance with necessary expenses of lodging and meals, the member may pay for the lodging and meals and then submit a travel reimbursement form for reimbursement; if the member does not have the funds for the necessary subsistence, authorization is made by the ~~local office~~ Care Management Operations and Benefits division on the Room and Board Order form. The travel reimbursement form may be obtained by contacting OHCA ~~or the local OKDHS office~~. Any subsistence expense claimed on the travel reimbursement form must be documented with receipts, and reimbursement cannot state per diem amounts. The OHCA has discretion and the final authority to approve or deny meals and lodging reimbursement. ~~Payment for meals is only provided for overnight stays that are more than 50 miles from the home and are based on a daily per diem and may be used for breakfast, lunch or dinner, or all three meals, whichever is required.~~

(6) **Escort assistance required.** Payment for transportation and subsistence of one escort may be authorized if the service is required. Only one escort may be authorized. It is the responsibility of the OHCA to determine this necessity. The decision should be based on the following circumstances:

(A) when the individual's health does not permit traveling alone; and

(B) when the individual seeking medical services is a minor child.

Oklahoma Health Care Authority

It is very important that you provide your comments regarding the proposed rule change by the comment due date. Comments are directed to Oklahoma Health Care Authority (OHCA) Health Policy Unit http://www.okhca.org/proposed-rule-changes.aspx

OHCA COMMENT DUE DATE: December 28, 2011

The proposed policy is a Permanent Rule. This proposal is scheduled to be presented to the Medical Advisory Committee (MAC) on January 19, 2012 and the (OHCA) Board of Directors on February 9, 2012.
Reference: APA WF 11-26

SUMMARY:
Revocation of Enrollment and Billing Privileges. OHCA's provider agreements policy is expanded to explain situations in which a provider agreement and billing privileges may be revoked for improper actions. These situations include noncompliance with enrollment requirements, provider misconduct, and felony convictions, among others. These rules will assist the agency in provider integrity determinations and will align agency policy with CMS's Medicare regulations on provider agreements.

LEGAL AUTHORITY
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 U.S.C § 1396a; 42 CFR 424.535

RULE IMPACT STATEMENT:

TO: Tywanda Cox
Health Policy

From: Joseph Fairbanks
Health Policy

SUBJECT: Rule Impact Statement
APA WF # 11-26

A. Brief description of the purpose of the rule:

OHCA’s provider agreements policy is expanded to explain situations in which a provider agreement and billing privileges may be revoked for improper actions. These situations include noncompliance with enrollment requirements, provider misconduct, and felony convictions, among others. These rules will assist the agency in provider integrity determinations and will align agency policy with CMS’s Medicare regulations on provider agreements.

B. A description of the classes of persons who most likely will be affected by the proposed rule, including classes that will bear the cost of the proposed rule, and any information on cost impacts received by the agency from any private or public entities:

SoonerCare providers will be affected by this rule if they meet any of the conditions for revocation of enrollment and billing privileges. There is no cost associated with the proposed rule.

C. A description of the classes of persons who will benefit from the proposed rule:

There are no specific classes of persons who will benefit from the proposed rule.

D. A description of the probable economic impact of the proposed rule upon the affected classes of persons or political subdivisions, including a listing of all fee changes and, whenever possible, a separate justification for each fee change:

The proposed rule change will have no economic impact on any political subdivision. Only providers who are in violation of their provider agreements or meet criteria for revocation of their provider agreement or billing privileges will suffer an impact.

E. The probable costs and benefits to the agency and to any other agency of the implementation and enforcement of the proposed rule, the source of revenue to be used for implementation and enforcement of the proposed rule, and any anticipated affect on state revenues,

including a projected net loss or gain in such revenues if it can be projected by the agency:

There is no cost associated with this rule. The primary benefit to the agency is through enhanced provider integrity policies, which may help prevent improper payments.

F. A determination of whether implementation of the proposed rule will have an economic impact on any political subdivisions or require their cooperation in implementing or enforcing the rule:

The proposed rule will not have an economic impact to any political subdivision.

G. An explanation of the measures the agency has taken to minimize compliance costs and a determination of whether there are less costly or nonregulatory methods or less intrusive methods for achieving the purpose of the proposed rule:

The agency has determined there is no less costly or non-regulatory method or less intrusive method for achieving the purpose of the proposed rule.

H. A determination of the effect of the proposed rule on the public health, safety and environment and, if the proposed rule is designed to reduce significant risks to the public health, safety and environment, an explanation of the nature of the risk and to what extent the proposed rule will reduce the risk:

The proposed rule should have no adverse effect on the public health, safety, and environment.

I. A determination of any detrimental effect on the public health, safety and environment if the proposed rule is not implemented:

OHCA does not believe there is a detrimental effect on the public health and safety if the rule is not implemented.

J. The date the rule impact statement was prepared and if modified, the date modified:

This impact statement was prepared on December 1, 2011.

RULE TEXT

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 3. GENERAL PROVIDER POLICIES
PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-19.1. Revocation of enrollment and billing privileges in the Medicaid Program.

OHCA and providers have the right to terminate or suspend contracts with each other. Remedies are provided in this Section that may be used by the agency in addition to a formal contract action against the provider. When the use of these remedies results in a contract action, appropriate due process protections will be afforded to the provider for that contract action. Subsections (1) through (10) are additional remedies under which OHCA may revoke a currently enrolled provider or supplier's SoonerCare billing privileges and any corresponding provider agreement or supplier agreement.

(1) **Noncompliance**. The provider or supplier is determined not to be in compliance with the enrollment requirements described in OAC 317:30-3-2, or in the enrollment application applicable for its provider or supplier type. All providers and suppliers are granted an opportunity to correct the deficient compliance requirement before a final determination to revoke billing privileges, except for those imposed under subsections (2), (3), (5), or (7) of this Section.

(A) OHCA may request additional documentation from the provider or supplier to determine compliance if adverse information is received or otherwise found concerning the provider or supplier.

(B) Requested additional documentation must be submitted within 60 calendar days of request.

(2) **Provider or supplier conduct**. The provider or supplier, or any owner, managing employee, authorized or delegated official, medical director, supervising physician, or other health care personnel of the provider or supplier is:

(A) Excluded from the Medicare, Medicaid, or any other Federal health care program, as defined in 42 CFR 1001.2; or

(B) Is debarred, suspended, or otherwise excluded from participating in any other Federal procurement or nonprocurement program or activity.

(3) **Felonies**. The provider, supplier, or any owner of the provider or supplier, within the 10 years preceding enrollment or revalidation of enrollment, was convicted of a Federal or State felony offense that OHCA has determined to be detrimental to the best interests of the program and its beneficiaries. Denials based on felony convictions are for a period to be determined by the OHCA, but not less than 10 years from the date of conviction if the individual has been convicted on one previous occasion for one or more offenses. Offenses include but are not limited to:

(A) Felony crimes against persons, such as murder, rape, assault, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions;

(B) Financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions;

(C) Any felony that placed the Medicaid program or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct; and

(D) Any felonies that would result in mandatory exclusion under 42 U.S.C. § 1320a-7a of the Social Security Act.

(4) **False or misleading information**. The provider or supplier certified as "true" misleading or false information on the enrollment application to be enrolled or maintain enrollment in the SoonerCare program. Offenders may be subject to either fines or imprisonment, or both, in accordance with current law and regulations.

(5) **On-site review**. OHCA determines, upon on-site review, that the provider or supplier is no longer operational to furnish SoonerCare covered items or services, or is not meeting SoonerCare enrollment requirements under statute or regulation to supervise treatment of, or to provide SoonerCare covered items or services for, SoonerCare members.

(6) **Provider and supplier screening requirements.**

(A) A provider does not submit an application fee that meets the requirements set forth in 42 CFR 455.460.

(B) Either of the following occurs:

(i) OHCA is not able to deposit the full application amount.

(ii) The funds are not able to be credited to the State of Oklahoma.

(C) The provider or supplier lacks sufficient funds in the account at the banking institution whose name is imprinted on the check or other banking instrument to pay the application fee; or

(D) There is any other reason why OHCA is unable to deposit the application fee.

(7) **Misuse of billing number**. The provider or supplier knowingly sells to or allows another individual or entity to use its billing number. This does not include those providers or suppliers who enter into a valid reassignment of benefits as specified in 42 U.S.C. § 1396a (a)(32) or a change of ownership as outlined in 42 CFR 455.104(c) (within 35 days of a change in ownership).

(8) **Abuse of billing privileges**. The provider or supplier submits a claim or claims for services that could not have been furnished to a specific individual on the date of service. These instances include but are not limited to situations where the beneficiary is deceased, the directing physician or beneficiary is not in the State or country when services were furnished, or when the equipment necessary for testing is not present where the testing is said to have occurred.

(9) **Failure to report**. The provider or supplier did not comply with the reporting requirements specified in the SoonerCare provider agreement or regulations.

(10) **Failure to document or provide OHCA access to documentation.**

(A) The provider or supplier did not comply with the documentation or OHCA access requirements specified in the SoonerCare Provider Agreement.

(B) A provider or supplier that meets the revocation criteria specified in (10)(A) of this subsection is subject to revocation for a period of not more than 1 year for each act of noncompliance.

Oklahoma Health Care Authority

It is very important that you provide your comments regarding the proposed rule change by the comment due date. Comments are directed to Oklahoma Health Care Authority (OHCA) Health Policy Unit http://www.okhca.org/proposed-rule-changes.aspx

OHCA COMMENT DUE DATE: January 7, 2012

The proposed policy is a Permanent Rule. This proposal is scheduled to be presented to the Medical Advisory Committee (MAC) on January 19, 2012 and the (OHCA) Board of Directors on March 8, 2012.
Reference: APA WF 11-30

SUMMARY:
School Based Services — Rules are revised to align policy with changes to Current Procedural Terminology (CPT) coding and guidelines.

LEGAL AUTHORITY
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 and Section 5051.3 of Title 63 of Oklahoma Statutes

RULE IMPACT STATEMENT:
TO: Tywanda Cox
Health Policy

FROM: Demetria Morrison
Health Policy

SUBJECT: Rule Impact Statement
APA WF # 11-30

A. Brief description of the purpose of the rule:

OHCA rules for School Based services are being revised to align policy with Current Procedural Terminology (CPT) coding and guidelines. Proposed changes will correct references to units of service and include guidelines associated with the school based services. Additionally, rules are revised to remove Dental Screenings and Psychological Services to clarify that these services are covered in the child health encounter and psychotherapy services. Rules will remove references to IEP School Based

and School Based billing, the billing code/rate is the same for both IEP and non-IEP services.

B. A description of the classes of persons who most likely will be affected by the proposed rule, including classes that will bear the cost of the proposed rule, and any information on cost impacts received by the agency from any private or public entities:

There are no classes of persons that will be affected by the proposed rule. Further, this revision will have no impact on existing cost.

C. A description of the classes of persons who will benefit from the proposed rule:

No classes of person will benefit from the proposed rule as it revises rules to align with CPT guidelines and OHCA systematic procedures.

D. A description of the probable economic impact of the proposed rule upon the affected classes of persons or political subdivisions, including a listing of all fee changes and, whenever possible, a separate justification for each fee change:

There is no economic impact and there are no fee changes associated with the proposed rule for any classes of persons or political subdivisions.

E. The probable costs and benefits to the agency and to any other agency of the implementation and enforcement of the proposed rule, the source of revenue to be used for implementation and enforcement of the proposed rule, and any anticipated affect on state revenues, including a projected net loss or gain in such revenues if it can be projected by the agency:

There is no probable budget impact for the proposed rule as it is to clean up policy.

F. A determination of whether implementation of the proposed rule will have an economic impact on any political subdivisions or require their cooperation in implementing or enforcing the rule:

The proposed rule will not have an economic impact on any political subdivisions or require their cooperation in implementing or enforcing the rule.

G. A determination of whether implementation of the proposed rule will have an adverse effect on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act:

The proposed rule will not have an adverse effect on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act.

H. An explanation of the measures the agency has taken to minimize compliance costs and a determination of whether there are less costly or non-regulatory methods or less intrusive methods for achieving the purpose of the proposed rule:

The agency has taken measures to determine that there is no less costly or non-regulatory method or less intrusive method for achieving the purpose of the proposed rule.

I. A determination of the effect of the proposed rule on the public health, safety and environment and, if the proposed rule is designed to reduce significant risks to the public health, safety and environment, an explanation of the nature of the risk and to what extent the proposed rule will reduce the risk:

The proposed rule should have no effect on the public health, safety, and environment.

J. A determination of any detrimental effect on the public health, safety and environment if the proposed rule is not implemented:

The agency does not anticipate any detrimental effect on the public health or safety and environment.

K. The date the rule impact statement was prepared and if modified, the date modified:

This rule impact statement was prepared on December 2, 2011.

RULE TEXT

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 103. QUALIFIED SCHOOLS AS PROVIDERS OF HEALTH RELATED SERVICES

317:30-5-1023. Coverage by category

(a) **Adults.** There is no coverage for services rendered to adults.

(b) **Children.** Payment is made for compensable services rendered by local, regional, and state educational services agencies as defined by IDEA:

(1) **Child health screening ~~examination~~.** An initial screening may be requested by an eligible individual at any time and must be provided without regard to whether the individual'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.

(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: vision, hearing, dental, a child health history, physical examination, developmental assessment, nutrition assessment and counseling, social assessment and counseling, genetic evaluation and counseling, indicated laboratory and screening tests, screening for appropriate immunizations, health counseling and treatment of childhood illness and conditions.

(3) **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:

~~(3)~~ (A) **Hearing and Hearing Aid evaluation.** Hearing evaluation includes pure tone air, bone and speech audiometry provided by a state licensed audiologist who:

~~(A)~~ (i) holds a certificate of clinical competence from the American Speech and Hearing Association; or

~~(B)~~ (ii) has completed the equivalent educational requirements and work experience necessary for the certificate; or

~~(C)~~ (iii) has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

~~(4)~~ (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:

~~(A)~~ (i) holds a certificate of clinical competence from the American Speech and Hearing Association; or

~~(B)~~ (ii) has completed the equivalent educational requirements and work experience necessary for the certificate; or

~~(C)~~ (iii) has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

~~(5)~~ (C) **Ear impression (for earmold).** Ear impression (for earmold) includes taking impression of a member's ear and providing a finished earmold which is used with the member's hearing aid provided by a state licensed audiologist who:

~~(A)~~ (i) holds a certificate of clinical competence from the American Speech and Hearing Association; or

~~(B)~~ (ii) has completed the equivalent educational requirements and work experience necessary for the certificate; or

~~(C)~~ (iii) has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

~~(6)~~ (D) **Vision Screening.** Vision screening ~~examination~~ in school children includes application of tests and examinations to identify visual defects or vision disorders and must be provided by a state licensed Doctor of Optometry (O.D.) or licensed physician specializing in ophthalmology (M.D. or D.O.). At a minimum, vision services include diagnosis and treatment for defects in vision.

~~(7)~~ (E) **Speech Language evaluation.** Speech Language evaluation is for the purpose of identification of children with speech or language disorders and the diagnosis and appraisal of specific speech and language services and must be provided by state licensed speech language pathologist who:

~~(A)~~ (i) holds a certificate of clinical competence from the American Speech and Hearing Association; or

~~(B)~~ (ii) has completed the equivalent educational requirements and work experience necessary for the certificate; or

~~(C)~~ (iii) has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

~~(8)~~ (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.

~~(9)~~ (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.

~~(10)~~ (H) **Psychological Evaluation and Testing.** Psychological Evaluation and Testing are for the purpose of diagnosing and determining if emotional, behavioral, neurological, 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 State Department of Education (SDE).

~~(11) **Dental Screening Examination.** Screening for dental disease by a state licensed dentist. The child may be referred directly to a dentist for further screening and/or treatment.~~

~~(12)~~ (4) **Child guidance treatment encounter.** A child guidance treatment encounter may occur through the provision of individual, family, or group treatment services to children 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 IEP or IFSP 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, counseling for vision and hearing losses and disorders. Services must be provided by:

(i) state licensed, Master's Degree Audiologist who:

(I) holds a certificate of clinical competence from the American Speech and Hearing Association; or

(II) has completed the equivalent educational requirements and work experience necessary for the certificate; or

(III) has completed the academic program and is acquiring supervised work experience to qualify for the certificate;

(ii) state licensed, Master's Degree Speech Language Pathologist who:

(I) holds a certificate of clinical competence from the American Speech and Hearing Association; or

(II) has completed the equivalent educational requirements and work experience necessary for the certificate; or

(III) has completed the academic program and is acquiring supervised work experience to qualify for the certificate;

(iii) state certified Speech Therapist working under the direction of a state licensed Speech Language Pathologist;

(iv) state certified deaf education teacher;

(v) certified orientation and mobility specialists; and

(vi) 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 and must be provided by a state licensed Speech Language Pathologist who:

(i) holds a certificate of clinical competence from the American Speech and Hearing Association; or

(ii) has completed the equivalent educational requirements and work experience necessary for the certificate; or

(iii) has completed the academic program and is acquiring supervised work experience to qualify for the certificate; or

(iv) a Speech Therapy Assistant who has been authorized by the Board of Examiners, working under the direction of a state licensed speech language

pathologist. The licensed Speech Language Pathologist may not supervise more that two Speech Therapy assistants, and must be on site.

(C) **Physical Therapy Services.** Physical Therapy Services are provided for the purpose of preventing or alleviating movement dysfunction and related functional problems that adversely affects the child's education and must be provided by state licensed physical therapist or a Physical Therapy Assistant who has been authorized by the Board of Examiners working under the supervision of a licensed Physical Therapist. The licensed Physical Therapist may not supervise more than three Physical Therapy Assistants.

(D) **Occupational Therapy Services.** Occupational therapy may include provision of services to improve, develop or restore impaired ability to function independently and must be provided by a state licensed Occupational Therapist or an Occupational Therapy Assistant who has been authorized by the Board of Examiners, working under the supervision of a licensed Occupational Therapist.

(E) **Nursing Services.** Nursing Services may include provision of services to protect the health status of children, correct health problems and assist in removing or modifying health related barriers and must be provided by a registered nurse or licensed practical nurse under supervision of a registered nurse. Services include medically necessary procedures rendered at the school site, such as catheterization, suctioning, administration and monitoring of medication.

~~(F) **Psychological Services.** Psychological services are planning and managing a program of psychological services, including the provision of counseling for children and parents, consulting on management of severe behavioral and emotional concerns in school and home. All services must be for the direct benefit of the child. Psychological services must be provided by a state licensed Psychologist, or School Psychologist certified by SDE.~~

~~(G)~~ (F) **Psychotherapy Counseling Services.** Psychotherapy counseling services are the provision of counseling for children and parents. All services must be for the direct benefit of the child. Psychotherapy counseling services must be provided by a state licensed Social Worker, a state Licensed Professional Counselor, a State licensed Psychologist or School Psychologist certified by the SDE, a State licensed Marriage and Family Therapist or a State licensed Behavioral Practitioner, or under

Board supervision to be licensed in one of the above stated areas.

~~(H)~~ (G) **Assistive Technology.** Assistive technology are 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 child and caregiver. Services must be provided by a:

(i) state licensed, Speech Language Pathologist who:

(I) holds a certificate of clinical competence from the American Speech and Hearing Association; or

(II) has completed the equivalent educational requirements and work experience necessary for the certificate; or

(III) has completed the academic program and is acquiring supervised work experience to qualify for the certificate;

(ii) state licensed Physical Therapist; or

(iii) state licensed Occupational Therapist.

~~(13)~~ (H) **Personal Care.** Provision of personal care services allow students with disabilities to safely attend school; includes, but is not limited to assistance with toileting, feeding, positioning, hygiene, and riding school bus to handle medical or physical emergencies. Services must be provided by registered paraprofessionals/assistants who have completed training approved or provided by SDE, or Personal Care Assistants, including Licensed Practical Nurses, who have completed on-the-job training specific to their duties.

~~(14)~~ (I) **Therapeutic Behavioral Services**. Therapeutic behavioral services is an intervention 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 evaluation. Services encompass behavioral management, redirection, and assistance in acquiring, retaining, improving, and generalizing socialization, communication and adaptive skills. This service must be provided by a Behavioral Health School Aide (BHSA) who has a high school diploma or equivalent and has successfully completed the paraprofessional training approved by the State Department of Education and a training curriculum in behavioral interventions for Pervasive Developmental Disorders as recognized by OHCA. BHSA must be supervised by a bachelors level individual with a special education certification. BHSA must have CPR and First Aid

certification. Six additional hours of related continuing education are required per year.

~~(15)~~ (J) **Immunization.** Immunizations must be coordinated with the Primary Care Physician for those Medicaid eligible children enrolled in SoonerCare. An administration fee, only, can be paid for immunizations provided by the schools.

(c) **Individuals eligible for Part B of Medicare.** EPSDT school health related services provided to Medicare eligible recipients are billed directly to the fiscal agent.

317:30-5-1027. Billing

(a) Unit of Service (Unit): Each service has a specified unit for billing purposes. This is time spent in a direct service. Direct service must be face-to face with the child (exceptions may be completing a child health history; or providing health education to the parent/guardian; but at all times service must be individualized to the child's needs). 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 Evaluation, 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: 5-10 minutes equals 1 unit; 11-20 minutes equals 2 units; over 21 minutes equals 3 units;~~ Unit: per encounter; limited to 3 encounters per day, ~~30 units per year, additional units must be prior authorized~~.

(4) Service: Individual Treatment Encounter ~~for IEP School Based and School Based~~; Unit: 15 minutes, unless otherwise specified.

(A) Hearing and Vision Services~~, IEP School Based~~.

~~(B) Hearing and Vision Services, School Based.~~

~~(C)~~ (B) Speech Language Therapy~~, IEP School Based~~; Unit: per session, limited to one per day.

~~(D) Speech Language Therapy, School Based~~

~~(E)~~ (C) Physical Therapy~~, IEP School Based~~.

~~(F) Physical Therapy, School Based.~~

~~(G)~~ (D) Occupational Therapy~~, IEP School Based~~.

~~(H) Occupational Therapy, School Based.~~

~~(I)~~ (E) Nursing Services~~, IEP School Based~~; ~~Unit: 5 minutes equals 1 unit; limited to 24 per day~~ Unit: up to 15 minutes; maximum 32 units per day.

~~(J) Nursing Services, School Based; Unit: 5 minutes equals 1 unit; limited to 24 per day~~

~~(K) Psychological Services, IEP School Based~~.

~~(L) Psychological Services, School Based.~~

~~(M)~~ (F) Psychotherapy ~~Counseling~~ Services~~, IEP School Based~~.

~~(N) Psychotherapy Counseling Services, School Based.~~

~~(O)~~ (G) Assistive Technology~~, IEP School Based~~.

~~(P) Assistive Technology, School Based.~~

~~(Q) Dental Screening, IEP School Based.~~

~~(R) Dental Screening, School Based.~~

~~(S)~~ (H) Therapeutic Behavioral Services~~, IEP School Based; limited to 12 units per day~~.

(5) Service: Group Treatment Encounter ~~for IEP School Based and School Based~~; No more than 5 recipients per group, Unit: 15 minutes, unless otherwise specified.

(A) Hearing and Vision Services~~, IEP School Based~~.

~~(B) Hearing and Vision Services, School Based.~~

~~(C)~~ (B) Speech Language Therapy; Unit: per session, limited to one per day.~~, IEP School Based~~.

~~(D) Speech Language Therapy, School Based.~~

~~(E)~~ (C) Physical Therapy~~, IEP School Based~~.

~~(F) Physical Therapy, School Based.~~

~~(G)~~ (D) Occupational Therapy~~, IEP School Based~~.

~~(H) Occupational Therapy, School Based.~~

~~(I) Psychological Services, IEP School Based.~~

~~(J) Psychological Services, School Based.~~

~~(K)~~ (E) Psychotherapy ~~Counseling~~ Services~~, IEP School Based~~.

~~(L) Psychotherapy Counseling Services, School Based.~~

(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 ~~(with written report)~~.
(17) Service: Personal Care Services; Unit: 10 minutes.
(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.

Oklahoma Health Care Authority

It is very important that you provide your comments regarding the proposed rule change by the comment due date. Comments are directed to Oklahoma Health Care Authority (OHCA) Health Policy Unit http://www.okhca.org/proposed-rule-changes.aspx

OHCA COMMENT DUE DATE: January 1, 2012

The proposed policy is a Permanent Rule. This proposal is scheduled to be presented to the Medical Advisory Committee (MAC) on January 19, 2012 and the (OHCA) Board of Directors on March 8, 2012.
Reference: APA WF 11-31

SUMMARY:
Purchasing — Purchasing rules are revised to align policy with Department of Central Services (DCS) rules. Rules refer to sections that are not valid; therefore rules need to be revised to reflect new numbering for DCS policy.

LEGAL AUTHORITY
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 and Section 5051.3 of Title 63 of Oklahoma Statutes

RULE IMPACT STATEMENT:
TO: Tywanda Cox
Health Policy

FROM: Demetria Morrison
Health Policy

SUBJECT: Rule Impact Statement
APA WF # 11-31

A. Brief description of the purpose of the rule:

The Department of Central Services (DCS) policy was revised July 1, 2011 as a result Chapter 15 Central Purchasing was revoked and Chapter 16 Central Purchasing was added. OHCA purchasing rules reference DCS Chapter 15 rules and need to be revised to reflect the new corresponding Chapter 16 rules. Rules are being revised to ensure policy references the correct DCS rule citations.

B. A description of the classes of persons who most likely will be affected by the proposed rule, including classes that will bear the cost of the proposed rule, and any information on cost impacts received by the agency from any private or public entities:

There are no classes of persons that will be affected by the proposed rule. Further, this revision will have no impact on existing cost.

C. A description of the classes of persons who will benefit from the proposed rule:

No classes of person will benefit from the proposed rule as it is simply clean up to reference the new numbering associated with DCS rules.

D. A description of the probable economic impact of the proposed rule upon the affected classes of persons or political subdivisions, including a listing of all fee changes and, whenever possible, a separate justification for each fee change:

There is no economic impact and there are no fee changes associated with the proposed rule for any classes of persons or political subdivisions.

E. The probable costs and benefits to the agency and to any other agency of the implementation and enforcement of the proposed rule, the source of revenue to be used for implementation and enforcement of the proposed rule, and any anticipated affect on state revenues, including a projected net loss or gain in such revenues if it can be projected by the agency:

There is no probable budget impact for the proposed rule as it is to clean up policy.

F. A determination of whether implementation of the proposed rule will have an economic impact on any political subdivisions or require their cooperation in implementing or enforcing the rule:

The proposed rule will not have an economic impact on any political subdivisions or require their cooperation in implementing or enforcing the rule.

G. A determination of whether implementation of the proposed rule will have an adverse effect on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act:

The proposed rule will not have an adverse effect on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act.

H. An explanation of the measures the agency has taken to minimize compliance costs and a determination of whether there are less costly or non-regulatory methods or less intrusive methods for achieving the purpose of the proposed rule:

The agency has taken measures to determine that there is no less costly or non-regulatory method or less intrusive method for achieving the purpose of the proposed rule.

I. A determination of the effect of the proposed rule on the public health, safety and environment and, if the proposed rule is designed to reduce significant risks to the public health, safety and environment, an explanation of the nature of the risk and to what extent the proposed rule will reduce the risk:

The proposed rule should have no effect on the public health, safety, and environment.

J. A determination of any detrimental effect on the public health, safety and environment if the proposed rule is not implemented:

The agency does not anticipate any detrimental effect on the public health or safety and environment.

K. The date the rule impact statement was prepared and if modified, the date modified:

This rule impact statement was prepared on November 17, 2011.

RULE TEXT

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 10. PURCHASING

317:10-1-1. Purpose

(a) The purpose of this Chapter is to describe the rules governing the contracting and purchasing requirements of the Oklahoma Health Care Authority (OHCA). The Contracts and Purchasing Divisions are internal divisions of the OHCA. These divisions provide the mechanism for the acquisition of goods, equipment, non-professional and professional services for the operation of the OHCA. These rules are superseded by the Oklahoma Department of Central Services (DCS) Purchasing rules ~~(OAC 580:15)~~ (OAC 580:16) whenever DCS has final authority on an acquisition.

(b) Different rules apply depending on which of the above three entities is making the acquisition and whether the purchase is for professional services or non-professional services and products. When an acquisition is made by DCS, the DCS Purchasing rules at OAC ~~580:15~~ 580:16 apply. When an acquisition is made by OHCA, these rules must be read in conjunction with the DCS rules.

317:10-1-12. Protest of award

(a) Protests of awards made by the Authority under 74 Okla. Stat. ' 85.5T are addressed at OAC 317:2-1-1 et seq.

(b) Bidders who wish to protest any other award shall follow the process outlined in the Oklahoma Department of Central Services rules at OAC ~~580:15-4-13~~ 580:16-3-21.

Oklahoma Health Care Authority

It is very important that you provide your comments regarding the proposed rule change by the comment due date. Comments are directed to Oklahoma Health Care Authority (OHCA) Health Policy Unit http://www.okhca.org/proposed-rule-changes.aspx

OHCA COMMENT DUE DATE: Monday, January 2, 2012.

The proposed policy is a Permanent rule. This proposal is scheduled to be presented to the Medical Advisory Committee (MAC) on January 19th, 2012 and the (OHCA) Board of Directors on March 8th, 2012.
Reference: APA WF 11-32

SUMMARY:
Permanent rule revisions are proposed by the OKDHS Developmental Disability Services Division (DDSD) pertaining to clarification of policy for the termination of Agency Companion providers based on certain background check information and to provide clarification on the limits of background search information for Specialized Foster Care providers regarding involvement in a court action. Additionally policy is revised to require architectural modification contractors to provide evidence of a lead based paint safety certificate; the addition of Adult Day Services for members in the Homeward Bound Waiver; Targeted Case Management to be billed weekly rather than monthly; removal of the Physical Status Review score as one of criteria for determining the enhanced rate for Community Based Group services and Job Coaching Services, and removal of Adult Day Services as an option to the member's required employment hours. Other minor policy revisions are also included.

LEGAL AUTHORITY:
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; Section 1915 (c) of the Social Security Act

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

TO: Tywanda Cox
Policy Development

From: Samantha Galloway

SUBJECT: Rule Impact Statement
(Reference APA WF # 11-32)

A. Brief description of the purpose of the rule:

SoonerCare waiver policy for individuals with intellectual disabilities is revised to provide clarification of policy for the termination of Agency Companion providers based on certain background check information and to provide clarification on the limits of background search information for Specialized Foster Care providers regarding involvement in a court action. Additionally policy is revised to require architectural modification contractors to provide evidence of a lead based paint safety certificate; the addition of Adult Day Services for members in the Homeward Bound Waiver; Targeted Case Management to be billed weekly rather than monthly; removal of the Physical Status Review score as one of criteria for determining the enhanced rate for Community Based Group services and Job Coaching Services, and removal of Adult Day Services as an option to the member's required employment hours. Other minor policy revisions are also included.

B. A description of the classes of persons who most likely will be affected by the proposed rule, including classes that will bear the cost of the proposed rule, and any information on cost impacts received by the agency from any private or public entities:

The classes of persons most likely to be affected by the proposed rules are Oklahomans receiving community supports or residential services through the Oklahoma Department of Human Services, Developmental Disabilities Services Division (DDSD), placement providers, community contractors, and DDSD staff. The affected classes of persons will bear no costs associated with implementation of the rules.

C. A description of the classes of persons who will benefit from the proposed rule:

The classes of persons who will benefit are children, youth, adults, and families served by DDSD, DDSD staff, contract agencies, and service and placement providers with OKDHS, OHCA, or both, contractual agreements.

D. A description of the probable economic impact of the proposed rule upon the affected classes of persons or political subdivisions, including a listing of all fee changes and, whenever possible, a separate justification for each fee change:

The revised rules do not have a known economic impact on the affected entities. There are no fee changes associated with the revised rules.

E. The probable costs and benefits to the agency and to any other agency of the implementation and enforcement of the proposed rule, the source of revenue to be used for implementation and enforcement of the proposed rule, and any anticipated affect on state revenues, including a projected net loss or gain in such revenues if it can be projected by the agency:

There is no anticipated cost or monetary benefit to this or any other agency as a result of implementation of the rule changes.

F. A determination of whether implementation of the proposed rule will have an economic impact on any political subdivisions or require their cooperation in implementing or enforcing the rule:

The proposed rule will not have an economic impact on any political subdivision or require their cooperation in implementing or enforcing the rule.

G. A determination of whether implementation of the proposed rule will have an adverse effect on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act:

The proposed rule will not have an adverse effect on small businesses as provided by the Oklahoma Small Business Regulatory Flexibility Act.

H. An explanation of the measures the agency has taken to minimize compliance costs and a determination of whether there are less costly or non-regulatory methods or less intrusive methods for achieving the purpose of the proposed rule:

There are no less costly or non-regulatory methods or less intrusive methods for complying with state or federal mandates. DDSD solicited and incorporated suggestions from family members of service recipients, advisory groups, contractors, and DDSD staff regarding service provisions and other supportive activities in the proposed revisions.

I. A determination of the effect of the proposed rule on the public health, safety and environment and, if the proposed rule is designed to reduce significant risks to the public health, safety and environment, an explanation of the nature of the risk and to what extent the proposed rule will reduce the risk:

Implementation of the proposed rules will improve the means in which supportive services are rendered at the community and statewide level.

J. A determination of any detrimental effect on the public health, safety and environment if the proposed rule is not implemented:

The agency does not anticipate any detrimental effects on the public health, safety, or environment.

K. The date the rule impact statement was prepared and if modified, the date modified:

This rule impact statement was prepared on September 16, 2011.

RULE TEXT

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

PART 9. LONG TERM CARE FACILIIES

317:30-5-123. Patient certification for long term care

(a) **Medical eligibility.** Initial approval of medical eligibility for long-term care is determined by the Oklahoma Department of Human Services (OKDHS) area nurse, or nurse designee. The certification is obtained by the facility at the time of admission.

(1) **Pre-admission screening.** Federal Regulations govern the State's responsibility for Preadmission Screening and Resident Review (PASRR) for individuals with mental illness and ~~mental retardation~~ intellectual disability. PASRR applies to the screening or reviewing of all individuals for mental illness or ~~mental retardation~~ intellectual disability or related conditions who apply to or reside in Title XIX certified nursing facilities regardless of the source of payment for the nursing facility services and regardless of the individual's or resident's known diagnoses. The nursing facility (NF) must independently evaluate the Level I PASRR Screen regardless of who completes the form and determine whether or not to admit an individual to the facility. Nursing facilities which inappropriately admit a person without a PASRR Screen are subject to recoupment of funds. PASRR is a requirement for nursing facilities with dually certified (both Medicare and Medicaid) beds. There are no PASRR requirements for Medicare skilled beds that are not dually certified, nor is PASRR required for individuals seeking residency in an intermediate care facility for the mentally retarded (ICF/MR).

(2) **PASRR Level I screen.**

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

(i) The nursing facility administrator or co-administrator;

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

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

(B) Prior to admission, the authorized NF official must evaluate the properly completed OHCA Form ~~LTC-300R~~ LTC-300 and the Minimum Data Set (MDS), if available. Any other readily available medical and social information is also used to determine if there currently exists any indication

of mental illness (MI), ~~mental retardation (MR)~~, intellectual disability or other related condition, or if such condition existed in the applicant's past history. Form ~~LTC-300R~~ LTC-300 constitutes the Level I PASRR Screen and is utilized in determining whether or not a Level II Assessment is necessary prior to allowing the patient to be admitted. The NF is also responsible for consulting with the Level of Care Evaluation Unit (LOCEU) regarding any ~~MI/MR~~ mental illness/intellectual disability related condition information that becomes known either from completion of the MDS or throughout the resident's stay.

(C) The nursing facility is responsible for determining from the evaluation whether or not the patient can be admitted to the facility. A "yes" response to any question from Form ~~LTC-300R~~ LTC-300, Section E, will require the nursing facility to contact the LOCEU for a consultation to determine if a Level II Assessment is needed. If there is any question as to whether or not there is evidence of ~~MI, MR,~~ mental illness, intellectual disability or related condition, LOCEU should be contacted prior to admission. The original Form ~~LTC-300R~~ LTC-300 must be submitted by mail to the LOCEU within 10 days of the resident admission. SoonerCare payment may not be made for a resident whose ~~LTC-300R~~ LTC-300 requirements have not been satisfied in a timely manner.

(D) Upon receipt and review of the Form ~~LTC-300R~~ LTC-300, the LOCEU may, in coordination with the OKDHS area nurse, re-evaluate whether a Level II PASRR assessment may be required. If a Level II Assessment is not required, the process of determining medical eligibility continues. If a Level II is required, a medical decision is not made until the results of the Level II Assessment are known.

(3) **Level II Assessment for PASRR.**

(A) Any one of the following three circumstances will allow a patient to enter the nursing facility without being subjected to a Level II PASRR Assessment.

(i) The patient has no current indication of mental illness or ~~mental retardation~~ intellectual disability or other related condition and there is no history of such condition in the patient's past.

(ii) The patient does not have a diagnosis of ~~mental retardation~~ intellectual disability or related condition.

(iii) An individual may be admitted to an NF if he/she has indications of mental illness or ~~mental retardation~~

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

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

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

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

(B) If the patient has current indications of mental illness or ~~mental retardation~~ intellectual disability or other related condition, or if there is a history of such condition in the patient's past, the patient cannot be admitted to the nursing facility until the LOCEU is contacted for consultation to determine if a Level II PASRR Assessment must be performed. Results of any Level II PASRR Assessment ordered must indicate that nursing facility care is appropriate prior to allowing the patient to be admitted.

(C) The OHCA, LOCEU, authorizes Advance Group Determinations for the ~~MI and MR~~ mental illness and intellectual disability Authorities in the following categories listed in (i) through (iii) of this subparagraph. Preliminary screening by the LOCEU may indicate eligibility for nursing facility level of care prior to consideration of the provisional admission.

(i) **Provisional admission in cases of delirium.** Any person with mental illness, ~~mental retardation~~ intellectual disability or related condition that is not a danger to self and or others, may be admitted to a Title XIX certified NF if the individual is

experiencing a condition that precludes screening, i.e., effects of anesthesia, medication, unfamiliar environment, severity of illness, or electrolyte imbalance.

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

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

(ii) **Provisional admission in emergency situations.** Any person with a mental illness, ~~mental retardation~~ intellectual disability or related condition, who is not a danger to self and/or others, may be admitted to a Title XIX certified nursing facility for a period not to exceed seven days pending further assessment in emergency situations requiring protective services. The request for Level II evaluation must be made immediately upon admission to the NF if a longer stay is anticipated. The LOCEU must be provided with written documentation from OKDHS Adult Protective Services which supports the individual's emergency admission. Payment for NF services will not be made beyond the emergency admission ending date.

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

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

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

(4) **Resident Review.**

(A) The nursing facility's routine resident assessment will identify those individuals previously undiagnosed as ~~MR or MI~~ intellectually disabled or mentally ill. A new condition of ~~MR or MI~~ intellectual disability or mental illness must be referred to LOCEU by the NF for determination of the need for the Level II Assessment. The facility's failure to refer such individuals for a Level II Assessment may result in recoupment of funds.

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

(C) A significant change in a resident's mental condition could trigger a Level II Resident Review. If such a change should occur in a resident's condition, it is the responsibility of the nursing facility to notify the LOCEU of the need to conduct a resident review.

(5) **Results of Level II Pre-Admission Assessment and Resident Review.** Through contractual arrangements between the OHCA and the ~~MI/MR~~ mental illness/intellectual disability authorities, individualized assessments are conducted and findings presented in written evaluations. The evaluations determine if nursing facility services are needed, if specialized services or less than specialized services are needed, and if the individual meets the federal PASRR definition of mental illness or ~~mental retardation~~ intellectual disability or related conditions. Evaluations are delivered to the LOCEU to process formal, written notification to patient, guardian, NF and interested parties.

(6) **Readmissions, and interfacility transfers.** The Preadmission Screening process does not apply to readmission

of an individual to an NF after transfer for a continuous hospital stay, and then back to the NF. There is no specific time limit on the length of absence from the nursing facility for the hospitalization. Inter-facility transfers are also subject to preadmission screening. In the case of transfer of a resident from an NF to a hospital or to another NF, the transferring NF is responsible for ensuring that copies of the resident's most recent ~~LTC-300R~~ LTC-300 and any PASRR evaluations accompany the transferring resident. The receiving NF must submit an updated ~~LTC-300R~~ LTC-300 that reflects the resident's current status to LOCEU within 10 days of the transfer. Failure to do so could result in possible recoupment of funds. LOCEU should also be contacted prior to admitting out-of-state NF applicants with mental illness or ~~mental retardation~~ intellectual disability or related condition, so that PASRR needs can be ascertained. Any PASRR evaluations previously completed by the referring state should be forwarded to LOCEU as part of this PASRR consultation.

(7) **PASRR appeals process.**

(A) Any individual who has been adversely affected by any PASRR determination made by the State in the context of either a preadmission screening or an annual resident review may appeal that determination by requesting a fair hearing. If the individual does not consider the PASRR decision a proper one, the individual or their authorized representative must contact the local county OKDHS office to discuss a hearing. Forms for requesting a fair hearing (OKDHS Form 13MP001E, Request for a Fair Hearing), as well as assistance in completing the forms, can be obtained at the local county OKDHS office. Any request for a hearing must be made no later than 20 days following the date of written notice. Appeals of these decisions are available under OAC 317:2-1-2. All individuals seeking an appeal have the same rights, regardless of source of payment. Level I determinations are not subject to appeal.

(B) When the individual is found to experience ~~MI, MR,~~ mental illness, intellectual disability or related condition through the Level II Assessment, the PASRR determination made by the ~~MR/MI~~ intellectual disability/mental illness authorities cannot be countermanded by the Oklahoma Health Care Authority, either in the claims process or through other utilization control/review processes, or by the Oklahoma State Department of Health. Only appeals determinations made

through the fair hearing process may overturn a PASRR determination made by the ~~MR/MI~~ intellectual disability /mental illness authorities.

(b) **Determination of Title XIX medical eligibility for long term care.** The determination of medical eligibility for care in a nursing facility is made by the OKDHS area nurse, or nurse designee. The procedures for determining Nursing Facility (NF) program medical eligibility are found in OAC 317:35-19. Determination of ICF/MR medical eligibility is made by LOCEU. The procedures for obtaining and submitting information required for a decision are outlined below.

(1) **Pre-approval of medical eligibility.** Pre-approval of medical eligibility for private ICF/MR care is based on results of a current comprehensive psychological evaluation by a licensed psychologist or state staff psychologist, documentation of ~~MR~~ intellectual disability or related condition prior to age 22, and the need for active treatment according to federal standards. Pre-approval is made by LOCEU analysts.

(2) **Medical eligibility for ICF/MR services.** Within ~~10~~ 30 calendar days after services begin, the facility must submit the original of the Nursing Facility Level of Care Assessment ~~(Form LTC-300R)~~ (Form LTC-300) to LOCEU. Required attachments include current (within 90 days of requested approval date) medical information signed by a physician, a current (within 12 months of requested approval date) psychological evaluation, a copy of the pertinent section of the Individual Developmental Plan or other appropriate documentation relative to discharge planning and the need for ICF/MR level of care, and a statement that the member is not an imminent threat of harm to self or others (i.e., suicidal or homicidal). If pre-approval was determined by LOCEU and the above information is received, medical approval will be entered on MEDATS.

(3) **Categorical relationship.** Categorical relationship must be established for determination of eligibility for long-term medical care. If categorical relationship to disability has not already been established, the proper forms and medical information are submitted to LOCEU. (Refer to OAC 317:35-5-4). In such instances, LOCEU will render a decision on categorical relationship using the same definition as used by the Social Security Administration (SSA). A follow-up is required by the OKDHS worker with SSA to be sure that their disability decision agrees with the decision of LOCEU.

PART 51. HABILITATION SERVICES

317:30-5-482. Description of services

Habilitation services include the services identified in (1) through (15). Providers of any habilitation service must have an applicable agreement with the Oklahoma Health Care Authority (OHCA) to provide Developmental Disabilities Services Division (DDSD) Home and Community Based Services (HCBS).

(1) **Dental services.** Dental services are provided per OAC 317:40-5-112.

(A) **Minimum qualifications.** Providers of dental services must have non-restrictive licensure to practice dentistry in Oklahoma by the Board of Governors of Registered Dentists of Oklahoma.

(B) **Description of services.** Dental services include services for maintenance or improvement of dental health as well as relief of pain and infection. These services may include:

(i) oral examination;
(ii) bite-wing x-rays;
(iii) prophylaxis;
(iv) topical fluoride treatment;
(v) development of a sequenced treatment plan that prioritizes:
(I) elimination of pain;
(II) adequate oral hygiene; and
(III) restoration or improved ability to chew;
(vi) routine training of member or primary caregiver regarding oral hygiene; and
(vii) preventive, restorative, replacement and repair services to achieve or restore functionality are provided after appropriate review if applicable per OAC 317:40-5-112.

(C) **Coverage limitations.** Coverage of dental services is specified in the member's Individual Plan (IP), in accordance with applicable Waiver limits. Dental services are not authorized when recommended for cosmetic purposes.

(2) **Nutrition services.** Nutrition Services are provided per OAC 317:40-5-102.

(3) **Occupational therapy services.**

(A) **Minimum qualifications.** Occupational therapists and occupational therapy assistants must have current non-restrictive licensure by the Oklahoma State Board of Medical Licensure and Supervision. Occupational therapy assistants must be employed by the occupational therapist.

(B) **Description of services.** Occupational therapy services include evaluation, treatment, and consultation in leisure management, daily living skills, sensory motor, perceptual motor, and mealtime assistance. Occupational therapy services may include the use of occupational therapy assistants, within the limits of their practice.

(i) Services are:

(I) intended to help the member achieve greater independence to reside and participate in the community; and

(II) rendered in any community setting as specified in the member's IP. The IP must include a ~~physician's~~ practitioner's prescription.

(ii) ~~For purposes of this Section, a physician is defined as all licensed medical and osteopathic physicians, and physician assistants in accordance with the rules and regulations covering the OHCA's SoonerCare program~~ For purposes of this Section, a practitioner is defined as all medical and osteopathic physicians, physician assistants and other licensed professionals with prescriptive authority to order occupational therapy services in accordance with the rules and regulations governing the SoonerCare program.

(iii) The provision of services includes written report or record documentation in the member's record, as required.

(C) **Coverage limitations.** Payment is made for compensable services to the individual occupational therapist for direct services or for services provided by a qualified occupational ~~therapy~~ therapist assistant within their employment. Payment is made in 15-minute units, with a limit of 480 units per Plan of Care year. Payment is not allowed solely for written reports or record documentation.

(4) **Physical therapy services.**

(A) **Minimum qualifications.** Physical therapists and physical ~~therapy~~ therapist assistants must have a current non-restrictive licensure with the Oklahoma State Board of Medical Licensure and Supervision. The physical ~~therapy~~ therapist assistant must be employed by the physical therapist.

(B) **Description of services.** Physical therapy services include evaluation, treatment, and consultation in locomotion or mobility and skeletal and muscular conditioning to maximize the member's mobility and

skeletal/muscular well-being. Physical therapy services may include the use of physical ~~therapy~~ therapist assistants, within the limits of their practice.

(i) Services are intended to help the member achieve greater independence to reside and participate in the community. Services are provided in any community setting as specified in the member's IP. The IP must include a ~~physician's~~ practitioner's prescription.

(ii) For purposes of this Section, a ~~physician~~ practitioner is defined as all licensed medical and osteopathic physicians, and physician assistants in accordance with the rules and regulations covering the OHCA's SoonerCare program.

(iii) The provision of services includes written report or record documentation in the member's record, as required.

(C) **Coverage limitations.** Payment is made for compensable services to individual physical therapists for direct services or for services provided by a qualified physical ~~therapy~~ therapist assistant within their employment. Payment is made in 15-minute units with a limit of 480 units per Plan of Care year. Payment is not allowed solely for written reports or record documentation.

(5) **Psychological services.**

(A) **Minimum qualifications.** Qualification as a provider of psychological services requires non-restrictive licensure as a psychologist by the Oklahoma Psychologist Board of Examiners, or licensing board in the state in which service is provided.

(B) **Description of services.** Psychological services include evaluation, psychotherapy, consultation, and behavioral treatment. Service is provided in any community setting as specified in the member's IP.

(i) Services are:

(I) intended to maximize a member's psychological and behavioral well-being; and

(II) provided in individual and group, six person maximum, formats.

(ii) A minimum of 15 minutes for each individual encounter and 15 minutes for each group encounter and record documentation of each treatment session is included and required.

(C) **Coverage limitations.**

(i) Limitations for psychological services are:

(I) Description: Psychotherapy services and behavior treatment services (individual): Unit: 15 minutes; and

(II) Description: Cognitive/behavioral treatment (group): Unit: 15 minutes.

(ii) Psychological services are authorized for a period not to exceed six months.

(I) Initial authorization is through the Developmental Disabilities Services Division (DDSD) case manager, with review and approval by the DDSD case management supervisor.

(II) Initial authorization must not exceed 192 units (48 hours of service).

(III) Monthly progress notes must include a statement of hours and type of service provided, and an empirical measure of member status as it relates to each objective in the member's IP.

(IV) If progress notes are not submitted to the DDSD case manager for each month of service provision, authorization for payment must be withdrawn until such time as progress notes are completed.

(iii) Treatment extensions may be authorized by the DDSD area manager based upon evidence of continued need and effectiveness of treatment.

(I) Evidence of continued need of treatment, treatment effectiveness, or both, is submitted by the provider to the DDSD case manager and must include, at a minimum, completion of the Service Utilization and Evaluation protocol.

(II) When revising a protective intervention plan (PIP) to accommodate recommendations of a required committee review or an Oklahoma Department of Human Services (OKDHS) audit, the provider may bill for only one revision. The time for preparing the revision must be clearly documented and must not exceed four hours.

(III) Treatment extensions must not exceed 24 hours (96 units) of service per request.

(iv) The provider must develop, implement, evaluate, and revise the PIP corresponding to the relevant goals and objectives identified in the member's IP.

(v) No more than 12 hours (48 units) may be billed for the preparation of a PIP. Any clinical document must be prepared within 45 days of the request. Further, if

the document is not prepared, payments are suspended until the requested document is provided.

(vi) Psychological technicians may provide up to 140 billable hours (560 units) of service per month to members.

(vii) The psychologist must maintain a record of all billable services provided by a psychological technician.

(6) **Psychiatric services.**

(A) **Minimum qualifications.** Qualification as a provider of psychiatric services requires a non-restrictive license to practice medicine in Oklahoma. Certification by the Board of Psychiatry and Neurology or satisfactory completion of an approved residency program in psychiatry is required.

(B) **Description of services.** Psychiatric services include outpatient evaluation, psychotherapy, and medication and prescription management and consultation provided to members who are eligible. Services are provided in any community setting as specified in the member's IP.

(i) Services are intended to contribute to the member's psychological well-being.

(ii) A minimum of 30 minutes for encounter and record documentation is required.

(C) **Coverage limitations.** A unit is 30 minutes, with a limit of 200 units per Plan of Care year.

(7) **Speech/language services.**

(A) **Minimum qualifications.** Qualification as a provider of speech/language services requires non-restrictive licensure as a speech/language pathologist by the State Board of Examiners for Speech Pathology and Audiology.

(B) **Description of services.** Speech therapy includes evaluation, treatment, and consultation in communication and oral motor/feeding activities provided to members who are eligible. Services are intended to maximize the member's community living skills and may be provided in any community setting as specified in the member's IP. The IP must include a ~~physician's~~ practitioner's prescription.

(i) For purposes of this Section, a ~~physician~~ practitioner is defined as all licensed medical and osteopathic physicians, and physician assistants and other licensed professionals with prescriptive authority to order speech/language services in

accordance with rules and regulations covering the OHCA's SoonerCare program.

(ii) A minimum of 15 minutes for encounter and record documentation is required.

(C) **Coverage limitations.** A unit is 15 minutes, with a limit of 288 units per Plan of Care year.

(8) **Habilitation training specialist (HTS) services.**

(A) **Minimum qualifications.** Providers must complete the OKDHS DDSD sanctioned training curriculum. Residential habilitation providers:

(i) are at least 18 years of age;

(ii) are specifically trained to meet the unique needs of members;

(iii) have not been convicted of, pled guilty, or pled nolo contendere to misdemeanor assault and battery or a felony per Section 1025.2 of Title 56 of the Oklahoma Statutes (56 O.S. § 1025.2), unless a waiver is granted per 56 O.S. § 1025.2; and

(iv) receive supervision and oversight from a contracted agency staff with a minimum of four years of any combination of college level education or full-time equivalent experience in serving persons with disabilities.

(B) **Description of services.** HTS services include services to support the member's self-care, daily living, and adaptive and leisure skills needed to reside successfully in the community. Services are provided in community-based settings in a manner that contributes to the member's independence, self-sufficiency, community inclusion, and well-being.

(i) Payment will not be made for:

(I) routine care and supervision that is normally provided by family; or

(II) services furnished to a member by a person who is legally responsible per OAC 340:100-3-33.2.

(ii) Family members who provide HTS services must meet the same standards as providers who are unrelated to the member. HTS staff residing in the same household as the member may not provide services in excess of 40 hours per week. Members who require more than 40 hours per week of HTS must use staff members who do not reside in the household and are employed by the member's chosen provider agency to deliver the balance of any necessary support staff hours.

(iii) Payment does not include room and board or maintenance, upkeep, and improvement of the member's or family's residence.

(iv) For members who also receive intensive personal supports (IPS), the member's IP must clearly specify the role of the HTS and person providing IPS to ensure there is no duplication of services.

(v) DDSD case management supervisor review and approval is required.

(vi) Pre-authorized HTS services accomplish the same objectives as other HTS services, but are limited to situations where the HTS provider is unable to obtain required professional and administrative oversight from an oversight agency approved by the OHCA. For pre-authorized HTS services, the service:

(I) provider will receive oversight from DDSD area staff; and

(II) must be pre-approved by the DDSD director or designee.

(C) **Coverage limitations.** HTS services are authorized as specified in OAC 317:40-5-110, 317:40-5-111, and 317:40-7-13, and OAC 340:100-3-33.1.

(i) A unit is 15 minutes.

(ii) Individual HTS services providers will be limited to a maximum of 40 hours per week regardless of the number of members served.

(iii) More than one HTS may provide care to a member on the same day.

(iv) Payment cannot be made for services provided by two or more HTSs to the same member during the same hours of a day.

(v) A HTS may receive reimbursement for providing services to only one 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.

(vi) HTS providers may not perform any job duties associated with other employment including on call duties, at the same time they are providing HTS services.

(9) **Self Directed HTS (SD HTS).**

SD HTS are provided per 317:40-9-1.

(10) **Self Directed Goods and Services (SD GS).**

SD GS are provided per 317:40-9-1.

(11) **Audiology services.**

(A) **Minimum qualifications.** Audiologists must have licensure as an audiologist by the State Board of Examiners for Speech Pathology and Audiology.

(B) **Description of services.** Audiology services include individual evaluation, treatment, and consultation in hearing to members who are eligible. Services are intended to maximize the member's auditory receptive abilities. The member's IP must include a ~~physician's~~ practitioner's prescription.

(i) For purposes of this Section, a ~~physician~~ practitioner is defined as all licensed medical and osteopathic physicians, and physician assistants in accordance with rules and regulations covering the OHCA's SoonerCare program.

(ii) A minimum of 15 minutes for encounter and record documentation is required.

(C) **Coverage limitations.** Audiology services are provided in accordance with the member's IP.

(12) **Prevocational services.**

(A) **Minimum qualifications.** Prevocational services providers:

(i) are at least 18 years of age;

(ii) complete the OKDHS DDSD sanctioned training curriculum;

(iii) have not been convicted of, pled guilty, or pled nolo contendere to misdemeanor assault and battery or a felony per 56 O.S. § 1025.2, unless a waiver is granted per 56 O.S. § 1025.2; and

(iv) receive supervision and oversight by a person with a minimum of four years of any combination of college level education or full-time equivalent experience in serving persons with disabilities.

(B) **Description of services.** Prevocational services are not available to persons who can be served under a program funded per Section 110 of the Rehabilitation Act of 1973 or Section 602(16) and (17) of the Individuals with Disabilities Education Act (IDEA). Services are aimed at preparing a member for employment, but are not job-task oriented. Services include teaching concepts, such as compliance, attendance, task completion, problem solving, and safety.

(i) Prevocational services are provided to members who are not expected to:

(I) join the general work force; or

(II) participate in a transitional sheltered workshop within one year, excluding supported employment programs.

(ii) When compensated, members are paid at less than 50 percent of the minimum wage. Activities included in this service are not primarily directed at teaching specific job skills, but at underlying habilitative goals, such as attention span and motor skills.

(iii) All prevocational services will be reflected in the member's IP as habilitative, rather than explicit employment objectives.

(iv) Documentation must be maintained in the record of each member receiving this service noting that the service is not otherwise available through a program funded under the Rehabilitation Act of 1973 or IDEA.

(v) Services include:

(I) center-based prevocational services as specified in OAC 317:40-7-6;

(II) community-based prevocational services as specified in OAC 317:40-7-5;

(III) enhanced community-based prevocational services as specified in OAC 317:40-7-12; and

(IV) supplemental supports as specified in OAC 317:40-7-13.

(C) **Coverage limitations.** A unit of center-based or community-based prevocational services is one hour and payment is based upon the number of hours the member participates in the service. All prevocational services and supported employment services combined may not exceed $25,000 per Plan of Care year. The following services may not be provided to the same member at the same time as prevocational services:

(i) HTS;

(ii) Intensive Personal Supports;

(iii) Adult Day Services;

(iv) Daily Living Supports;

(v) Homemaker; or

(vi) therapy services such as occupational therapy, physical therapy, nutrition, speech, psychological services, family counseling, or family training except to allow the therapist to assess the individual's needs at the workplace or to provide staff training and as allowed per 317:40-7-6.

(13) **Supported employment.**

(A) **Minimum qualifications.** Supported employment providers:

(i) are at least 18 years of age;

(ii) complete the OKDHS DDSD sanctioned training curriculum;

(iii) have not been convicted of, pled guilty, or pled nolo contendere to misdemeanor assault and battery or a felony per 56 O.S. § 1025.2, unless a waiver is granted per 56 O.S. § 1025.2; and

(iv) receive supervision and oversight by a person with a minimum of four years of any combination of college level education or full-time equivalent experience in serving persons with disabilities.

(B) **Description of services.** Supported employment is conducted in a variety of settings, particularly work sites in which persons without disabilities are employed, and includes activities that are outcome based and needed to sustain paid work by members receiving services through HCBS Waiver, including supervision and training.

(i) When supported employment services are provided at a work site in which persons without disabilities are employed, payment:

(I) is made for the adaptations, supervision, and training required by members as a result of their disabilities; and

(II) does not include payment for the supervisory activities rendered as a normal part of the business setting.

(ii) Services include:

(I) job coaching as specified in OAC 317:40-7-7;

(II) enhanced job coaching as specified in OAC 317:40-7-12;

(III) employment training specialist services as specified in OAC 317:40-7-8; and

(IV) stabilization as specified in OAC 317:40-7-11.

(iii) Supported employment services furnished under HCBS Waiver are not available under a program funded by the Rehabilitation Act of 1973 or IDEA.

(iv) Documentation that the service is not otherwise available under a program funded by the Rehabilitation Act of 1973 or IDEA must be maintained in the record of each member receiving this service.

(v) Federal financial participation (FFP) may not be claimed for incentive payment subsidies or unrelated vocational training expenses, such as:

(I) incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
(II) payments that are passed through to users of supported employment programs; or
(III) payments for vocational training that are not directly related to a member's supported employment program.

(C) **Coverage limitations.** A unit is 15 minutes and payment is made in accordance with OAC 317:40-7-1 through 317:40-7-21. All prevocational services and supported employment services combined cannot exceed $25,000 per Plan of Care year. The DDSD case manager assists the member to identify other alternatives to meet identified needs above the limit. The following services may not be provided to the same member at the same time as supported employment services:

(i) HTS;
(ii) Intensive Personal Supports;
(iii) Adult Day Services;
(iv) Daily Living Supports;
(v) Homemaker; or
(vi) Therapy services such as occupational therapy, physical therapy, nutrition, speech, psychological services, family counseling, or family training except to allow the therapist to assess the individual's needs at the workplace or to provide staff training.

(14) **Intensive personal supports (IPS).**

(A) **Minimum qualifications.** IPS provider agencies must have a current provider agreement with OHCA and OKDHS DDSD. Providers:

(i) are at least 18 years of age;
(ii) complete the OKDHS DDSD sanctioned training curriculum;
(iii) have not been convicted of, pled guilty, or pled nolo contendere to misdemeanor assault and battery or a felony per 56 O.S. § 1025.2, unless a waiver is granted per 56 O.S. § 1025.2;
(iv) receive supervision and oversight by a person with a minimum of four years of any combination of college level education or full-time equivalent experience in serving persons with disabilities; and
(v) receive oversight regarding specific methods to be used with the member to meet the member's complex behavioral or health support needs.

(B) **Description of services.**

(i) IPS:

(I) are support services provided to members who need an enhanced level of direct support in order to successfully reside in a community-based setting; and

(II) build upon the level of support provided by a HTS or daily living supports (DLS) staff by utilizing a second staff person on duty to provide assistance and training in self-care, daily living, recreational, and habilitation activities.

(ii) The member's IP must clearly specify the role of HTS and the person providing IPS to ensure there is no duplication of services.

(iii) DDSD case management supervisor review and approval is required.

(C) **Coverage limitations.** IPS are limited to 24 hours per day and must be included in the member's IP per OAC 317:40-5-151 and 317:40-5-153.

(15) **Adult day services.**

(A) **Minimum qualifications.** Adult day services provider agencies must:

(i) meet the licensing requirements set forth in 63 O.S. ~~1~~ § 1-873 *et seq.* and comply with OAC 310:605; and

(ii) be approved by the OKDHS DDSD and have a valid OHCA contract for adult day services.

(B) **Description of services.** Adult day services provide assistance with the retention or improvement of self-help, adaptive, and socialization skills, including the opportunity to interact with peers in order to promote maximum level of independence and function. Services are provided in a non-residential setting separate from the home or facility where the member resides.

(C) **Coverage limitations.** Adult day services are typically furnished four or more hours per day on a regularly scheduled basis, for one or more days per week. A unit is 15 minutes for up to a maximum of six hours daily, at which point a unit is one day. All services must be authorized in the member's IP.

PART 101. TARGETED CASE MANAGEMENT SERVICES FOR PERSONS WITH ~~MENTAL RETARDATION~~ INTELLECTUAL DISABILITY AND/OR RELATED CONDITIONS

317:30-5-1012. Reimbursement

(a) Reimbursement for DDSDTCM services is a unit rate based on the ~~monthly~~ weekly cost per case for documented DDSDTCM services. The cost base consists of the annualized cost of case management staff including all applicable overhead and indirect service cost in accordance with the approved DHS cost allocation plan. A first year interim rate is computed by dividing the annual cost base by the projected number of units. Subsequent annual rates will include an adjustment based on previous years cost versus total billable amount. A unit of service is defined as one calendar ~~month~~ week of targeted case management, provided that a minimum of one contact which meets the description of a targeted case management activity with or on behalf of the ~~recipient~~ member has been documented during the ~~month~~ week claimed. Payment is made on the basis of claims submitted for payment. The provider bills at the ~~monthly~~ weekly unit rate for a documented unit of ~~Medicaid~~ SoonerCare DDSDTCM services provided to each ~~Medicaid~~ SoonerCare eligible ~~recipient~~ member during the calendar ~~month~~ week.
(b) Only one unit of DDSDTCM services may be billed for each ~~Medicaid~~ SoonerCare eligible ~~recipient~~ member per ~~month~~ week while the ~~recipient~~ member is receiving services under a DHS/DDSD HCBS Waiver or is in the transition process to receive those services. No more than twenty-six units of DDSDTCM may be provided and billed for each eligible ~~Medicaid~~ SoonerCare ~~recipient~~ member during their transition period from the institution. DHS/DDSD must provide documentation of all such transitional DDSDTCM services provided, indicating the date performed for each unit billed. In no case may DHS/DDSD bill for transitional and regular DDSDTCM services provided during the same ~~month~~ week (i.e., if DDSD bills transitional DDSDTCM for the third week in June and the ~~recipient~~ member is deinstitutionalized into the particular Waiver during the third week in June, DDSD cannot also bill for regular DDSDTCM for the third week in June). If DDSDTCM has been provided to an individual during such a transitional period but that individual dies before the placement into the community is made, decides to refuse the placement or the placement falls through, reimbursement is available.
(c) the billing week for DDSDTCM is Monday through Sunday.

317:30-5-1014. Documentation of records

All case management services rendered must be reflected by documentation in the records. All units of ~~Medicaid~~ SoonerCare DDSDTCM services provided are documented by the case manager ~~on the monthly Record of Contact form~~ weekly in Client Contact

Manager. The following conditions must be met in order for case management services to reimbursed under ~~Medicaid~~ SoonerCare.

(1) The case manager must conduct a face-to-face interview with the ~~client~~ member in order to determine ~~client~~ member needs and develop approaches to meet these needs.

(2) The case manager with a team including the ~~client~~ member or ~~client's~~ member's representative, must develop a plan of care which is documented in the case record.

(3) The case manager must reassess the plan of care when necessary but at a minimum annually.

(4) The case manager must provide documentation to supplement the plan of care which includes:

(A) information supporting the selection of outcomes;

(B) information supporting the approaches selected;

(C) information supporting case management decisions and actions;

(D) documentation of communication with the ~~client~~ member and, as appropriate, his/her representative;

(E) documentation of linkages with resources;

(F) documentation of follow-up and monitoring of the plan; and

(G) other factual information relevant to the case.

CHAPTER 40. DEVELOPMENTAL DISABILITIES SERVICES
PART 1. AGENCY COMPANION SERVICES

317:40-5-3. Agency companion services

(a) Agency companion services (ACS):

(1) are provided by agencies that have a provider agreement with the Oklahoma Health Care Authority (OHCA);

(2) provide a living arrangement developed to meet the specific needs of the member that includes a live-in companion providing supervision, supportive assistance, and training in daily living skills provided in a shared home owned or rented by the member, companion, or in a mutually rented or owned home;

(3) are available to members 18 years of age or older who are eligible for services through Community or Homeward Bound Waivers. Persons under the age of 18 years may be served with approval from the DDSD director or designee;

(4) are based on the member's need for residential services per OAC 340:100-5-22 and support as described in the member's Individual Plan ~~(IP)~~ (Plan), per OAC 340:100-5-50 through 340:100-5-58.

(b) An agency companion:

(1) must be employed by or contract with a provider agency approved by the Oklahoma Department of Human Services Developmental Disabilities Services Division (DDSD);
(2) may provide companion services for one member. Exceptions to serve as companion for two members may be ~~granted only upon~~ approved by the DDSD director or designee. Exceptions may be approved when members have an existing relationship and to separate them would be detrimental to their well being and the companion demonstrates the skill and ability required to serve as companion for two members;
(3) household is limited to one individual companion provider. Exceptions for two individual companion providers in a household who each provide companion services to different members may be approved by the DDSD director or designee;
(4) may not provide companion services to more than two members at any time;
(5) household may not serve more than three members through any combination of companion or respite services;
(6) may not have employment, volunteer activities, or personal commitments that prevent the companion from fulfilling his or her responsibilities to the member per OAC 317:40-5.

(A) Employment as an agency companion is the companion's primary employment.

(B) The companion may not have other employment when approved to serve two members regardless of the levels of support required by the members.

(C) The companion may have other employment when:

(i) the ~~personal support~~ Team documents and addresses all related concerns in the member's ~~IP~~ Plan;

(ii) the other employment is approved in advance by the DDSD area manager or designee; and

(iii) the companion's employment does not require on-call duties and occurs during time the member is engaged in outside activities such as school, employment or other routine scheduled meaningful activities; and

(iv) the companion provides assurance the employment is such that the member's needs will be met by the companion should the member's outside activities be disrupted.

(D) If, after receiving approval for other employment, authorized DDSD staff determines the other employment interferes with the care, training, or supervision needed

by the member, the companion must terminate, within 30 days:

(i) the other employment; or

(ii) his or her employment as an agency companion.

(E) Homemaker, habilitation training specialist, and respite services are not provided ~~in order~~ for the companion to ~~perform~~ maintain other employment.

(c) Each member may receive up to 60 days per year of therapeutic leave without reduction in the agency companion's salary.

(1) Therapeutic leave:

(A) is a SoonerCare payment made to the contract provider to enable the member to retain services; and

(B) is claimed when:

(i) the member does not receive ACS for 24 consecutive hours due to:

(I) a visit with family or friends without the companion;

(II) vacation without the companion; or

(III) hospitalization, regardless of whether the companion is present; or

(ii) the companion uses authorized respite time;

(C) is limited to no more than 14 consecutive days per event, not to exceed 60 days per Plan of Care (POC) year; and

(D) cannot be accrued from one Plan of Care (POC) year to the next.

(2) The therapeutic leave daily rate is the same amount as the ACS per diem rate except for the pervasive rate which is paid at the enhanced agency companion per diem rate.

(3) The provider agency pays the agency companion the salary that he or she would earn if the member were not on therapeutic leave.

(d) The companion may receive a combination of hourly or daily respite per POC year equal to 660 hours for respite for the companion.

(e) Habilitation Training Specialist (HTS) services:

(1) may be approved by the DDSD director or designee when providing ACS with additional support represents the most cost-effective placement for the member when there is an ongoing pattern of not:

(A) sleeping at night; or

(B) working or attending employment, educational, or day services with documented and continuing efforts by the Team;

(2) may be approved when a time-limited situation exists in which the ACS provider is unable to provide ACS, and the provision of HTS will maintain the placement or provide needed stability for the member, and must be reduced when the situation changes;

(3) must be reviewed annually or more frequently as needed, which includes a change in agencies or individual companion providers.

(f) The agency receives a provider rate based on the agency's service model. The AC rate for the:

(1) employer model includes funding for the provider agency for the provision of benefits to the companion; or

(2) contractor model does not include funding for the provider agency for the provision of benefits to the companion.

~~(d)~~ (g) The agency receives a provider rate based on the member's level of support. Levels of support for the member and corresponding payment are:

(1) determined by authorized DDSD staff in accordance with levels described in (A) through(D); and

(2) re-evaluated when the member has a change in agency companion providers which includes a change in agencies or individual companion providers.

(A) **Intermittent level of support.** Intermittent level of support is authorized when the member:

(i) requires minimal physical assistance with basic daily living skills, such as bathing, dressing, and eating;

(ii) may be able to spend short periods of time unsupervised inside and outside the home; and

(iii) requires assistance with medication administration, money management, shopping, housekeeping, meal preparation, scheduling appointments, arranging transportation or other activities.

(B) **Close level of support.** Close level of support is authorized when the member:

(i) requires regular, frequent and sometimes constant physical assistance and support to complete daily living skills, such as bathing, dressing, eating, and toileting;

(ii) requires extensive assistance with medication administration, money management, shopping, housekeeping, meal preparation, scheduling

appointments, arranging transportation or other activities; and

(iii) requires assistance with health, medication, or behavior interventions that may include the need for specialized training, equipment, and diet.

(C) **Enhanced level of support.** Enhanced level of support is authorized when the member:

(i) is totally dependent on others for:

(I) completion of daily living skills, such as bathing, dressing, eating, and toileting; and

(II) medication administration, money management, shopping, housekeeping, meal preparation, scheduling appointments, and arranging transportation or other activities;

(ii) demonstrates ongoing complex medical issues requiring specialized training courses per OAC 340:100-5-26; or

(iii) has behavioral issues that requires a protective intervention plan (PIP) with a restrictive or intrusive procedure as defined in OAC 340:100-1-2. The PIP must:

(I) be approved by the Statewide Behavior Review Committee (SBRC), per OAC 340:100-3-14;

(II) be reviewed by the Human Rights Committee (HRC), per OAC 340:100-3-6, or

(III) have received expedited approval per OAC 340:100-5-57.

(D) **Pervasive level of support.** Pervasive level of support is authorized when the member:

(i) requires additional professional level support to remain in an agency companion setting due to pervasive behavioral or emotional challenges. The support must be provided:

(I) by a licensed professional counselor (LPC) or professional with a minimum of Masters of Social Work (MSW) degree; and

(II) as ongoing support and training to the companion, offering best practice approaches in dealing with specific members; and

(ii) does not have an available personal support system. The need for this service level:

(I) must be identified by the grand staffing committee, per OAC 340:75-8-40; and

(II) requires the provider to market, recruit, screen, and train potential companions for the member identified.

(h) The Plan reflects the amount of room and board the member pays to the companion. If the amount exceeds $450, the additional amount must be:

(1) agreed upon by the member and, if applicable, legal guardian;

(2) recommended by the Team; and

(3) approved by the DDSD area manager or designee.

317:40-5-5. Agency Companion Services provider responsibilities

(a) Providers of Agency Companion Services (ACS) are required to meet all applicable standards outlined in this subchapter and competency-based training described in OAC 340:100-3-38. The provider agency ensures that all companions meet the criteria in this Section.

(b) Failure to follow any rules or standards, failure to promote the independence of the member, or failure to follow recommendation(s) of the personal support team (Team) results in problem resolution, ~~as described in subsection (b) of~~ per OAC 340:100-3-27, for the companion, and if warranted, revocation of approval of the companion.

(c) In addition to the criteria given in OAC 317:40-5-4, the companion:

(1) ensures no other adult or child is cared for in the home on a regular or part-time basis including other Oklahoma Department of Human Services (OKDHS) placements, family members, ~~and~~ or friends without prior written authorization from the OKDHS Developmental Disabilities Services Division (DDSD) area manager or designee;

(2) meets the requirements of OAC 317:40-5-103, Transportation. Neither the companion nor the provider agency may claim transportation reimbursement for vacation travel;

(3) transports or arranges transportation for the member to and from school, employment programs, recreational activities, medical appointments, and therapy appointments;

(4) delivers services in a manner that contributes to the member's enhanced independence, self sufficiency, community inclusion, and well-being;

(5) participates as a member of the member's Team and assists in the development of the member's Individual Plan (Plan) for service provision;

(6) with assistance from the DDSD case manager and the provider agency program coordination staff, develops, implements, evaluates, and revises the training strategies corresponding to the relevant outcomes for which the

companion is responsible, as identified in the ~~Individual~~ Plan;

(A) The companion documents and provides monthly data and health care summaries to the provider agency program coordination staff.

(B) The agency staff provides monthly reports to the DDSD case manager or nurse.

(7) delivers services at appropriate times as directed in the ~~Individual~~ Plan;

(8) does not deliver services that duplicate the services mandated to be provided by the public school district pursuant to the Individuals with Disabilities Education Act (IDEA);

(9) is sensitive to and assists the member in participating in the member's chosen religious faith. No member is expected to attend any religious service against his or her wishes;

(10) participates in and supports visitation and contact with the member's natural family, guardian, and friends, provided this visitation is desired by the member;

(11) obtains permission from the member's legal guardian, if a guardian is assigned, and notifies the family, the provider agency program coordination staff, and the case manager prior to:

(A) traveling out of state;

(B) overnight visits; or

(C) involvement of the member in any publicity;

(12) serves as the member's health care coordinator ~~in accordance with~~ per OAC 340:100-5-26;

(13) ensures the monthly room and board contribution received from the member ~~as reflected on OKDHS Form 06AC074E, Service Authorization Budget (SAB),~~ is used toward the cost of operating the household;

(14) assists the member in accessing entitlement programs for which the member may be eligible and maintains records required for the member's ongoing eligibility;

(15) works closely with the provider agency program coordination staff and the DDSD case manager to ensure all aspects of the member's program are implemented to the satisfaction of the member, the member's family or legal guardian, when appropriate, and the member's Team;

(16) assists the member in achieving the member's maximum level of independence;

(17) submits, in a timely manner, to the provider agency program coordination staff all necessary information regarding the member;
(18) ensures that the member's confidentiality is maintained ~~in accordance with~~ per OAC 340:100-3-2;
(19) supports the member in forming and maintaining friendships with neighbors, co-workers, and peers, including people who do not have disabilities;
(20) implements training and provides supports that enable the member to actively join in community life;
(21) does not serve as representative payee for the member without a written exception ~~approval~~ from the DDSD area manager or designee;
(A) The written ~~approval~~ exception is retained in the member's home record.
(B) When serving as payee, the companion complies with the requirements of OAC 340:100-3-4.
(22) ensures the member's funds are properly safeguarded.
(23) ~~must obtain~~ obtains prior approval from the provider agency when making a purchase of over $50.00 with the member's funds;
(24) allows the provider agency staff and DDSD staff to make announced and unannounced visits to the home;
(25) develops an Evacuation Plan, using OKDHS Form 06AC020E, for the home and conducts training with the member;
(26) conducts fire and weather drills at least quarterly and ~~maintains~~ documents the ~~Fire and Weather Drill Record, OKDHS~~ fire and weather drills using Form 06AC021E~~, available for review:~~ ;
(27) develops and maintains a ~~Personal Possession Inventory~~ personal possession inventory for personal possessions and adaptive equipment, ~~OKDHS~~ using Form 06AC022E~~, documenting the member's possessions and adaptive equipment~~;
(28) supports the member's employment program by:
(A) assisting the member to wear appropriate work attire; and
(B) contacting the member's employer ~~only~~ as outlined by the Team and in the ~~Individual~~ Plan; and
(29) is responsible for the cost of their meals and entertainment during recreational and leisure activities. Activities must be affordable to the member. Concerns about affordability are presented to the Team for resolution.
~~(29)~~ (30) follows all applicable rules promulgated by the Oklahoma Health Care Authority ~~or~~ and DDSD, including:
(A) OAC 340:100-3-40;

(B) OAC 340:100-5-50 through 100-5-58;
(C) OAC 340:100-5-26;
(D) OAC 340:100-3-34;
(E) OAC 340:100-5-32;
(F) OAC 340:100-5-22.1;
(G) OAC 340:100-3-27; and
(H) OAC 340:100-3-38.

317:40-5-8. Agency companion services service authorization budget [REVOKED]

~~Upon approval of the home profile per OAC 317:40-5-40, the companion, provider agency, the Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDSD) case manager, agency companion services (ACS) staff, and others as appropriate meet to develop a service authorization budget. The service authorization budget form is used to develop the individual service budget for the member's program and is updated annually by the member's Personal Support Team (Team).~~

~~(1) The companion receives:~~

~~(A) a salary based on the level of support needed by the member. The level of support is determined by authorized DDSD staff per OAC 317:40-5-3. The ACS rate for the:~~

~~(i) employer model includes funding for the provider agency for the provision of benefits to the companion; and~~

~~(ii) contractor model does not include funding for the provider agency for the provision of benefits to the companion.~~

~~(B) any combination of hourly or daily respite per Plan of Care year to equal 660 hours in order to provide respite to the companion as reflected on the service authorization budget form.~~

~~(C) Habilitation training specialist (HTS) services:~~

~~(i) may be approved by the DDSD director or designee when providing ACS with additional support represents the most cost-effective placement for the member and the member has an ongoing pattern of not:~~

~~(I) sleeping at night; or~~

~~(II) working or attending employment services, with documented and continuing efforts by the Team.~~

~~(ii) may be approved when a time limited situation exists in which the ACS provider is unable to provide ACS and the provision of HTS will maintain the~~

placement or provide needed stability to the member; and must be reduced when the situation changes.

(iii) must be reviewed annually or more often if needed, which includes a change in agencies or individual companion providers.

(2) The service authorization budget form reflects the amount of room and board the member pays to the companion. If the amount exceeds $450, the increase must be:

(A) agreed to by the member and, if applicable, legal guardian;

(B) recommended by the Team; and

(C) submitted with written justification attached to the service authorization budget form to the DDSD area manager or designee for approval.

(3) A back-up plan identifying respite staff is developed by the provider agency program coordination staff and companion, prior to the meeting to discuss the service authorization budget.

(A) The back-up plan:

(i) is submitted to the DDSD case manager for review and approval;

(ii) describes expected and emergency back-up support and program monitoring for the home; and

(iii) is reviewed initially and annually by the SFC specialist.

(B) The companion and provider agency program coordination staff equally share the responsibility to identify approved respite providers who are:

(i) knowledgeable about the member;

(ii) trained to implement the member's Individual Plan (Plan);

(iii) trained per OAC 340:100-3-38; and

(iv) when possible, involved in the member's daily life.

(C) The spouse or other adult residing in the home may provide ACS in the absence of the companion, when trained per OAC 340:100-3-38.

(D) The spouse or other adult residing in the home cannot serve as paid respite staff.

(4) The companion and respite staff are responsible for the cost of their meals and entertainment during recreation and leisure activities. Activities selected must be affordable to the member and respite staff. Concerns about affordability are presented to the Team for resolution.

~~(5) The member is allowed therapeutic leave per OAC 317:40-5-3.~~

317:40-5-9. Payment authorization for Agency Companion Services

Authorization for payment of Agency Companion Services (ACS) is ~~made~~ contingent upon ~~the completion~~ receipt of:

(1) ~~the letter that approves~~ the ~~applicant~~ applicant's approval letter authorizing ~~to provide~~ ACS for the identified ~~service recipient~~ member;

~~(2) an approved service authorization budget (SAB) in accordance with OAC 317:40-5-8;~~

~~(3)~~ (2) ~~an~~ approved relief and emergency back-up plan;

~~(4)~~ (3) ~~revision of the~~ revised Individual Plan;

~~(5)~~ (4) ~~revision of the service recipient's~~ revised Plan of Care; and

~~(6)~~ (5) ~~the~~ placement of the ~~service recipient~~ member in the ACS home.

317:40-5-13. Agency Companion Services provider agency responsibilities

(a) The agency providing Agency Companion Services (ACS) complies with Oklahoma Health Care Authority and Oklahoma Department of Human Services policies and procedures governing all aspects of service provision.

(b) The provider agency is responsible for all employee or contract provider related activities detailed in this Subchapter.

(c) In the event the provider agency wishes to discontinue services immediately due to an emergency, the provider agency cooperates with the Developmental Disabilities Services Division (DDSD) to secure alternative services in the least restrictive environment.

(d) The provider agency ensures that services provided meet requirements of OAC 340:100-5-22.1, unless different requirements are stated in this Section.

(e) If the agency serves as the ~~service recipient's~~ member's representative payee, the agency must adhere to the requirements of OAC 340:100-3-4.1.

(f) The provider agency acts immediately to remedy any situation posing a risk to the health, well-being, or provision of specified services to the ~~service recipient~~ member.

(1) In the event of such a risk, the provider agency immediately notifies DDSD of the nature of the situation and notifies DDSD upon the resolution of the threatening situation.

(2) The provider agency's program coordination staff contacts and informs the DDSD case manager within 24 hours of an incident or injury. The provider agency completes and submits incident and injury reports to DDSD in accordance with OAC 340:100-3-34.

(3) A companion is immediately terminated when a provider agency becomes aware that a companion's name appears on the Community Services Worker Registry per OAC 340:100-3-39.

(g) The provider agency ensures that only one ~~service recipient~~ member is served in a provider home. Exceptions may be approved by the DDSD area manager or designee.

(h) When the provider agency has knowledge of problems occurring in the placement, the provider agency's program coordination staff immediately schedules a meeting with the companion, the ~~service recipient~~ member, the ~~service recipient's~~ member's legal guardian or advocate, the DDSD case manager and other appropriate DDSD staff to resolve the issues involved. If resolution of the issues does not occur at the meeting, any participant is to contact the DDSD area manager or designee and the provider agency for resolution.

(i) When a change in the provider agency is requested by the ~~service recipient~~ member or the companion, all participants attempt to resolve the issues. No change in the provider agency occurs unless the DDSD area manager or designee agrees that all issues have been discussed.

(j) The decision to remain or terminate services with the provider agency is the choice of the ~~service recipient~~ member or his or her legal guardian.

(k) When a ~~service recipient~~ member transfers from a provider agency, the provider agency ensures that the ~~service recipient~~ member has a 30-day supply of medication and a seven-day supply of food, household supplies, and personal supplies.

(l) The responsibilities of the provider agency's program coordination staff are:

(1) to visit the provider home daily during the first week of placement;

(2) to visit the home a minimum of three times per month ~~in accordance with~~ per OAC 340:100-5-22.1;

(3) to allow the needs of the ~~service recipient~~ member to determine the frequency of all other visits;

(4) to coordinate and submit ~~monthly~~ quarterly reports to the provider agency for submission to the DDSD area office; and

(5) to communicate regularly with the DDSD case manager regarding any changes in the household or any other program issues or concerns.

(m) The provider agency works with the companion, member, and guardian to develop a back-up plan identifying respite staff.

(1) The back-up plan:

(i) is submitted to the DDSD case manager for approval;

(ii) describes expected and emergency back-up support and program monitoring for the home; and

(iii) is incorporated into the member's Individual Plan (Plan).

(n) The respite provider is:

(1) knowledgeable about the member;

(2) trained to implement the member's Plan;

(3) trained per OAC 340:100-3-38;

(4) responsible for the cost of their meals and entertainment during recreation and leisure activities. Activities selected must be affordable to the member and respite staff. Concerns about affordability are presented to the Team for resolution.

(o) The spouse or other adult residing in the home is considered a natural support and may provide ACS in the absence of the companion, when trained per OAC 340:100-3-38.12.

(p) The spouse or other adult residing in the home cannot serve as paid respite staff.

PART 5. SPECIALIZED FOSTER CARE

317:40-5-59. Back-up Plan for persons receiving Specialized Foster Care

Prior to a member moving into Specialized Foster Care (SFC), the SFC provider and the SFC specialist develop a Back-up Plan. The SFC specialist communicates the Back-Up Plan in writing to the DDSD case manager for incorporation into the Individual Plan.

(1) The Back-up Plan identifies the person(s) who provides emergency back-up supports.

(2) The member's natural family is considered as the first resource for the Back-up Plan at no cost to OKDHS, unless the member is in the custody of the Oklahoma Department of Human Services.

(3) The Back-up Plan contains the name(s) and current telephone number(s) of the person(s) providing back-up service.

(4) When paid providers are necessary, the Back-up Plan explains specifically where the service is to be provided.

(A) If back-up service is to be provided outside the SFC home, a Home Profile must be completed for the back-up staff per OAC 317:40-5-40.

(B) If back-up service is to be provided in the SFC home, the person providing this service must have completed all necessary requirements to become a paid provider, including:

(i)an Oklahoma State Bureau of Investigation (OSBI) name and criminal records history search , including the Department of Public Safety (DPS), Sex Offender, and Mary Rippy Violent Offender Registries;

(ii) a Federal Bureau of Investigation (FBI) national criminal history search, based on the fingerprints of the applicant;

(iii) a search of any involvement as a party in a court action~~;~~ that may impact the safety or stability of the member that includes:

(I) victims protective order; or

(II) bankruptcy;

(iv) a search of all Oklahoma Department of Human Services (OKDHS) records, including child welfare (CW) records;

(v) a search of all applicable out-of-state child abuse and neglect registries for any applicant who has not lived continuously in Oklahoma for the past five years. The applicant is not approved without the results of the out-of-state maintained child abuse and neglect registry checks, if a registry is maintained in the applicable state;

(vi) Community Services Worker registry check;

(vii) Oklahoma statutorily mandated liability insurance coverage, and a valid driver license; and

(viii) completion of required DDSD training per OAC 340:100-3-38.4.

(C) The Back-up Plan details where the member and provider will stay if the provider's home is not habitable. If there is a fee to stay in the alternate location, the fee is paid by the provider and not reimbursed by DDSD.

(5) The Back-up Plan is jointly reviewed at least monthly by the SFC specialist and the SFC provider to ensure the Back-up Plan continues to be appropriate and current.

(6) The SFC provider is responsible to report any needed changes in the Back-up Plan to the SFC specialist.

(7) The SFC specialist will report any changes in the Back-up Plan to the case manager.

PART 9. SERVICE PROVISIONS

317:40-5-101. Architectural modifications

(a) **Applicability.** The rules in this Section apply to architectural modification (AM) services authorized by the Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDSD) through Home and Community Based Services (HCBS) Waivers.

(b) **General information.** Architectural Modification services:

(1) are provided by building contractors who have contractual agreements with the Oklahoma Health Care Authority to provide Home and community Based Services. Providers must meet requirements of the International Code Council (ICC), formerly the Building Official and Code Administrators (BOCA), for building, electrical, plumbing and mechanical inspections;

(2) include the installation of ramps, grab-bars, widening of doorways, modification of a bathroom or kitchen facilities, specialized safety adaptations such as scald protection devices, stove guards, and modifications required for the installation of specialized equipment, which are necessary to ensure the health, welfare and safety of the member or that enable the member to function with greater independence in the home;

(3) must be recommended by the member's Team and included in the member's IP. Arrangements for this service must be made through the member's case manager;

(4) are performed on homes of eligible members who have disabilities that limit accessibility or require modifications to ensure health and safety;

(5) are provided based on the:

(A) assessment and Personal Support Team (Team) consideration of the member's unique needs per OAC 317:40-5-101(b);

(B) scope of architectural modifications per OAC 317:40-5-101;

(C) most appropriate and cost effective bid, if applicable, ensuring the quality of materials and workmanship;

(D) lack of a less expensive equivalent, such as assistive technology, that meets the member's needs; and

(E) safety and suitability of the home.

(6) are limited to modifications of two different residences within any seven year period beginning with the member's first request for an approved architectural modification service;

(7) are provided with assurance of plans for the member to remain in the residence for at least five years;
(8) may be denied when DDSD determines the home is unsafe or otherwise unsuitable for architectural modifications.
(A) DDSD area office resource development staff with architectural modification experience screens a home for safety and suitability for architectural modifications prior to home acquisition.
(B) Members needing home modification services and provider agencies assisting members to locate rental property identify several homes, when possible, for screening in order to select a home with the fewest or most cost effective modifications;
(9) are provided to eligible members with the homeowner's signed permission;
(10) are not authorized to modify homes solely for family or staff convenience or for cosmetic preference;
(11) are provided on finished rooms complete with wiring and plumbing;
(12) services that do not meet the requirements of OAC 317:40-5-101 may be approved by the DDSD division administrator or designee in exceptional circumstances; and
(13) are authorized in accordance with requirements of The Oklahoma Central Purchasing Act 74 O.S., § 85.1 et. Seq., Chapter 15 of Title 580 of the Department of Central Services, and other applicable statutory provisions.

(c) **Assessment and Team process.**
(1) Architectural modification assessments are performed by:
(A) DDSD area office resource development staff with architectural modification experience, when the requested architectural modification complies with minimum applicable national standards for persons with physical disabilities as applicable to private homes; or
(B) a licensed occupational therapist or physical therapist, at the request of designated DDSD area office resource development staff or area program supervisory staff, when the requested architectural modification exceeds or requires a variance to applicable national standards for persons with physical disabilities, or when such expertise is deemed necessary by DDSD area office resource development staff or area program supervisory staff.
(2) The Team considers the most appropriate architectural modifications based on the:
(A) member's needs;

(B) member's ability to access his or her environment; and

(C) possible use of assistive technology instead of architectural modification.

(3) The Team considers architectural modifications that:

(A) are necessary to ensure the health, welfare, and safety of the member; and

(B) provide the member increased access to the home to reduce dependence on others for assistance in daily living activities.

(d) **Requirements and standards for architectural modification contractors and construction.** All contractors must meet applicable federal, state and local requirements.

(1) Contractors are responsible for:

(A) obtaining all permits required by the municipality where construction is performed;

(B) following all applicable building codes; and

(C) taking and providing pictures to area office resource development staff of each completed architectural modification project within five working days of project completion and prior to payment of the architectural modification claim. Area office resource development staff may take pictures of the completed architectural modification projects when requested by the contractor.

(2) Any penalties assessed for failure to comply with requirements of the municipality are the sole responsibility of the contractor.

(3) New contractors must provide three references of previous work completed.

(4) Contractors must provide evidence of:

(A) liability insurance;

(B) vehicle insurance; ~~and~~

(C) worker's compensation insurance or affidavit of exemption~~.~~ ; and

(D) lead paint safety certificate.

(5) All modifications meet national standards for persons with physical disabilities as applicable to private homes unless a variance is required by the assessment.

(6) Contractors complete construction in compliance with written assessment recommendations from the:

(A) DDSD area office resource development staff with architectural modification experience; or

(B) a licensed professional.

(7) All architectural modifications must be completed by using high standard materials and workmanship, in accordance with industry standard.

(8) Ramps are constructed using the standards in (A) through (G) of this paragraph.

(A) All exterior wooden ramps are constructed of number two pressure treated wood.

(B) Surface of the ramp has a rough, non-skid texture.

(C) Ramps are assembled by the use of deck screws.

(D) Hand rails on ramps, if required, are sanded and smooth.

(E) Ramps can be constructed of stamped steel.

(F) Support legs on ramps are no more than six feet apart.

(G) Posts on ramps must be set or anchored in concrete.

(9) Roll-in showers are constructed to meet standards in (A) through (E) of this paragraph.

(A) The roll-in shower includes a new floor that slopes uniformly to the drain at not less than one-fourth nor more than one-half inch per foot.

(B) The material around the drain is flush, without an edge on which water can catch before going into the drain.

(C) Duro-rock, rather than sheet rock, is installed around the shower area, at least 24 inches up from the floor, with green board above the duro-rock.

(D) Tile, shower insert, or other appropriate water resistant material is installed to cover the duro-rock and green board.

(E) The roll-in shower includes a shower pan, or liner if applicable.

(F) Roll in showers may also be constructed with a one piece pre-formed material.

(10) DDSD area office resource development staff inspect any or all architectural modification work, prior to payment of an architectural modifications claim, to ensure:

(A) architectural modifications are completed in accordance with assessments; and

(B) quality of workmanship and materials used comply with requirements of OAC 317:40-5-101.

(e) **Architectural modifications when members change residences.**

(1) When two or more members share a home that has been modified and the member will no longer be sharing the home, the member whose Plan of Care authorized the modifications is given the first option of remaining in the residence.

(2) Restoration of architectural modifications is performed only for members of the Homeward Bound class when a written agreement between the homeowner and DDSD director, negotiated before any architectural modifications begin, describes in full the extent of the restoration. If no written agreement

exists between the DDSD director and homeowner, OKDHS is not responsible to provide, pay for, or authorize any restorative services.

(f) **Services not covered under architectural modifications.** Architectural modifications do not include adaptations or improvements to the home which are of general utility and are not of direct medical or remedial benefit to the member, construction, reconstruction, or remodeling of any existing construction in the home, such as floors, sub-floors, foundation work, roof, or major plumbing.

(1) Square footage is not added to the home as part of an architectural modification.

(2) Architectural modifications are not performed during construction or remodeling of a home.

(3) Modifications not authorized by the OKDHS include, but are not limited to:

(A) roofs;
(B) installation of heating or air conditioning units;
(C) humidifiers;
(D) water softener units;
(E) fences;
(F) sun rooms;
(G) porches;
(H) decks;
(I) canopies;
(J) covered walkways;
(K) driveways;
(L) sewer lateral lines or septic tanks;
(M) foundation work;
(N) room additions;
(O) carports;
(P) concrete for any type of ramp, deck, or surface other than a five by five landing pad at the end of a ramp, as described in applicable national standards for persons with physical disabilities as applicable to private homes;
(Q) non-adapted home appliances;
(R) carpet or floor covering that is not part of an approved architectural modification that requires and includes a portion of the floor to be re-covered such as a roll in shower, a door widening; or
(S) a second ramp or roll in shower in a home.

(4) A sidewalk is not authorized unless needed by the member to move between the house and vehicle.

(g) **Approval or denial of architectural modification services.** DDSD approval or denial of an architectural modification service

is determined in accordance with (1) through (3) of this subsection.

(1) The architectural modification request provided by the DDSD case manager to DDSD area office resource development staff includes:

(A) documentation from the member's Team confirming the need and basis for architectural modification, including the architectural modification assessment;

(B) documentation of current Team consensus, including consideration of issues per OAC 317:40-5-101;

(C) lease, proof of home ownership, or other evidence that the member is able to live in the modified residence for at least 12 months; and

(D) an assurance by the member or legal guardian, if applicable, that the member plans to reside in the residence for five years.

(2) The DDSD area office:

(A) authorizes architectural modification services less than $2500 when the plan of care is less than the state office reviewer limit; and

(B) provides all required information to the DDSD State Office architectural modification programs manager for authorization of services when the plan of care is more than the area office limit or is $2500 or more.

(3) Architectural modifications may be denied when the requirements of OAC 317:40-5-101 are not met.

(h) **Appeals.** The denial of acquisition of an architectural modification request may be appealed per OAC 340:2-5.

(i) **Resolving problems with services.** If the member, family member, or legal guardian, or Team is dissatisfied with the architectural modification, the problem resolution process per OAC 340:100-3-27 is initiated.

317:40-5-113. Adult Day Services

(a) **Introduction.** Adult Day Services are provided by agencies approved by the Developmental Disabilities Services Division (DDSD) of the Oklahoma Department of Human Services (OKDHS) that have a valid Oklahoma Health Care Authority contract for providing Adult Day Services. This service is available through the Community Waiver, Homeward Bound Waiver and through the In-Home Supports Waiver for Adults. Adult Day Services is a structured, comprehensive program that provides a variety of health, social, and related support services in a protective environment for some portion of a day. Individuals who participate in adult day services receive these services on a

planned basis during specified hours. Adult day services are designed to work toward the goals of:

(1) promoting the member's maximum level of independence;

(2) maintaining the member's present level of functioning as long as possible, preventing or delaying further deterioration;

(3) assisting the member in achieving the highest level of functioning possible;

(4) providing support, respite, and education for families and other caregivers; and

(5) fostering socialization and peer interaction.

(b) **Eligibility requirements.** Adult Day Services are provided to eligible members whose teams have determined the service is appropriate to meet their needs. Members must:

(1) require ongoing support and supervision in a safe environment when away from their own residence;

(2) be 18 years of age or older; and

(3) not pose a threat to others.

(c) **Provider requirements.** Provider agencies must:

(1) meet the licensing requirements set forth by Section 1-873 et seq of Title 63 of the Oklahoma Statutes;

(2) comply with OAC 310:605, Adult Day Care Centers;

(3) allow DDSD staff to make announced and unannounced visits to the facility during the hours of operation;

(4) provide the DDSD case manager a copy of the individualized plan of care;

(5) submit incident reports per OAC 340:100-3-34;

(6) maintain a copy of the member's Individual Plan (Plan);

(7) submit Oklahoma Department of Human Services (OKDHS) Adult Day Services Progress Report Form 06WP046E to the DDSD case manager ~~by the tenth of each month for the previous month's services~~ per OAC 340:100-5-52, for each member receiving services; and

(8) serve as a member of the Personal Support Team and meet the Personal Support Team requirements per OAC 340:100-5-52.

(d) **Coverage.** The member's Plan contains detailed descriptions of services to be provided and documentation of hours of services. All services must be authorized in the Plan and reflected in the approved plan of care. Arrangements for care must be made with the member's case manager.

SUBCHAPTER 7. EMPLOYMENT SERVICES THROUGH HOME AND COMMUNITY-BASED SERVICES WAIVERS

317:40-7-12. Enhanced rates

An Enhanced Rate is available for both Community-Based Group Services and Group Job Coaching Services when necessary to meet a member's intensive personal needs in the employment setting(s). The need for the enhanced rate is identified through the Team process and is supported by documentation in the Individual Plan (Plan) with consideration of risk assessment per OAC 340:100-5-56 and assessment of medical, nutritional, and mobility needs and:

(1) Team assessment per OAC 340:100-5-51, OAC 340:100-5-56, OAC 340:100-5-57, and OAC 340:100-5-26 of the member's needs.

(2) the member must:

(A) have a protective intervention plan that:

(i) contains a restrictive or intrusive procedure as defined in OAC 340:100-1-2 implemented in the employment setting;

(ii) has been approved by the State Behavior Review Committee (SBRC) in accordance with OAC 340:100-3-14 or by the Developmental Disabilities Services Division (DDSD) staff per OAC 340:100-5-57; and

(iii) has been reviewed by the Human Rights Committee (HRC) per OAC 340:100-3-6;

(B) have procedures included in the Individual Plan which address dangerous behavior that places the member or others at risk of serious physical harm but are neither restrictive or intrusive procedures as defined in OAC 340:100-1-2. The Team submits documentation of this risk and the procedures to the positive support field specialist to assure that positive approaches are being used to manage dangerous behavior;

(C) have a visual impairment that requires assistance for mobility or safety;

~~(D) have two or more of the circumstances given in this subparagraph.~~

~~(i) The member has medical support needs which are rated at Level 4, Level 5, or Level 6 on the Physical Status Review (PSR), explained in OAC 340:100-5-26 or a comparable level of high medical needs as documented in the Plan.~~

~~(ii)~~ (D) ~~The member has~~ have nutritional needs requiring tube feeding or other dependency for food intake which must occur in the employment setting.

~~(iii)~~ (E) ~~The member has~~ have mobility needs, such that he or she requires two or more people for lifts, transfers, and personal care. Use of a mechanical lift or other assistive technology has been evaluated for

the current employment program and determined not feasible by the DDSD division director or designee; or

~~(E)~~ (F) reside in alternative group home as described in OAC 317:40-5-152.

(3) The enhanced rate can be claimed only if the person providing services fulfills all applicable training criteria specified in OAC 340:100-3-38.

(4) There are no exceptions for the enhanced rate other than as allowed in this Section.

317:40-7-15. Service requirements for employment services through Home and Community-Based Services Waivers

(a) The Developmental Disabilities Services Division (DDSD) case manager, member, a member's family or, if applicable, legal guardian, and provider develop a preliminary plan of services including:

(1) site and amount of the services to be offered;

(2) types of services to be delivered; and

(3) expected outcomes.

(b) To promote community integration and inclusion, employment services are only delivered in non-residential sites.

(1) Employment services through Home and Community-Based Services (HCBS) Waivers cannot be reimbursed if those services occur in the residence or property of the member or provider-paid staff, including garages and sheds, whether or not the garage or shed is attached to the home.

(2) No exceptions to OAC 317:40-7-15(b) are authorized.

~~(c) Providers of HCBS employment services comply with OAC 340:100-17.~~

~~(d)~~ (c) The service provider is required to notify the DDSD case manager in writing when the member:

(1) is placed in a new job;

(2) loses his or her job. A Personal Support Team (Team) meeting must be held if the member loses the job;

(3) experiences significant changes in the community-based schedule or employment schedule; or

(4) experiences other circumstances, per OAC 340:100-3-34.

~~(e)~~ (d) The provider submits Oklahoma Department of Human Services (OKDHS) Provider Progress Report per OAC 340:100-5-52, for each member receiving services.

~~(f)~~ (e) The cost of a member's employment services, excluding transportation and state-funded services per OAC 340:100-17-30, cannot exceed $25,000 per Plan of Care year.

~~(g)~~ (f) Each member receiving residential supports per OAC 340:100-5-22.1 or group home services is employed for 30 hours

per week or receives a minimum of 30 hours of employment services, ~~adult day services per OAC 317:40-5-113, or a combination of both,~~ each week, excluding transportation to and from the member's residence.

(1) Thirty hours of employment service each week can be a combination of community-based services, center-based services, employment training specialist (ETS) intensive training services, stabilization services, and job coaching services. Center-based services cannot exceed 15 hours per week for members receiving services through the Homeward Bound Waiver.

(2) Less than 30 hours of employment activities per week requires approval per OAC 317:40-7-21.

317:40-7-21. Exception process for employment services through Home and Community-Based Services Waivers

(a) All exceptions to rules in OAC 317:40-7 are:

(1) approved per OAC 317:40-7-21 prior to service implementation;

(2) intended to result in the Personal Support Team (Team) development of an employment plan tailored to meet the member's needs;

(3) identified in the Individual Plan (Plan) process per OAC 340:100-5-50 through 340:100-5-58; and

(4) documented and recorded in the Individual Plan by the Developmental Disabilities Services Division (DDSD) case manager after Team approval.

(b) A request for an exception to the minimum of 30 hours per week of employment services, ~~adult day services per OAC 317:40-5-113, or a combination of both,~~ per OAC 317:40-7-15, includes documentation of the Team's:

(1) discussion of:

(A) current specific situation that requires an exception;

(B) all employment efforts, successful and unsuccessful, made by the member and Team in the past year; and

(C) progress toward previous exception strategies or plans;

(2) plan with specific steps and target dates to address the situation throughout the Plan of Care year so the exception may be lessened or no longer necessary at the end of the Plan of Care year; and

(3) specific residential schedule to provide integrated activities outside the home while the plan to increase to 30 hours is implemented.

(c) A request for an exception to the maximum limit of 15 hours per week for center-based services, per OAC 317:40-7-6, or continuous supplemental supports, per OAC 317:40-7-13, for a member receiving services through the Homeward Bound Waiver includes documentation of the Team's:

(1) discussion of:

(A) current specific situation that requires an exception;

(B) all employment efforts, successful and unsuccessful, made by the member and Team in the past year; and

(C) progress toward previous exception strategies or plans; and

(2) plan with specific steps and target dates to address the situation throughout the Plan of Care year so the exception may be lessened or no longer necessary at the end of the Plan of Care year.

(d) A request for an alternative to required community-based activities per OAC 317:40-7-5 includes documentation of the Team's:

(1) discussion of:

(A) current specific situation that requires an exception;

(B) all employment efforts, successful and unsuccessful, made by the member and Team in the past year; and

(C) progress toward previous exception strategies or plans; and

(2) plan with specific steps and target dates to address the situation throughout the Plan of Care year so the exception may be lessened or no longer necessary at the end of the Plan of Care year.

(e) Exception requests per OAC 340:40-7-21(f) are documented by the DDSD case manager after Team consensus and submitted to the DDSD area manager or designee within ten working days after the annual IP or interim Team meeting. The area manager approves or denies the request with a copy to the DDSD area office claims staff and case manager based on the thoroughness of the Team's discussion of possible alternatives and reasons for rejection of the other possible alternatives.

(1) State dollar reimbursement for absences of a member receiving services through the Community Waiver in excess of 10% of authorized units up to 150 units is approved for medical reasons only. The request includes:

(A) Team's discussion of current specific situation that requires an exception;

(B) specific medical issues necessitating the exception request; and

(C) a projection of units needed to complete the State fiscal year.

(2) A request for any other exception to rules in OAC 317:40-7-21 requires documentation of the Team's discussion of:

(A) current specific situation that requires an exception;

(B) all employment efforts, successful and unsuccessful, made by the member and Team in the past year; and

(C) progress toward previous exception strategies or plans.

(f) The DDSD director or designee may review exceptions granted per OAC 317:40-7-21, directing the Team to provide additional information, if necessary, to comply with OAC 340:100-3-33.1 and other applicable rules.

Oklahoma Health Care Authority

It is very important that you provide your comments regarding the proposed rule change by the comment due date. Comments are directed to Oklahoma Health Care Authority (OHCA) Health Policy Unit http://www.okhca.org/proposed-rule-changes.aspx

OHCA COMMENT DUE DATE: January 12, 2012

The proposed policy is a Permanent Rule. This proposal is scheduled to be presented to the Medical Advisory Committee (MAC) on January 19, 2012 and the (OHCA) Board of Directors in March 2012.
Reference: APA WF 11-34

SUMMARY:
Catheter Type Limitations— Rules are revised to limit the number and type of catheters covered per member per month and bring policy in line with CMS regulations on catheter utilization. The change will allow a combined maximum of 200 intermittent catheters per member per month. Of the 200 catheters, 60 may be the intermittent catheter with insertion supplies kit. Finally, prior authorization for these catheters will no longer be required.

LEGAL AUTHORITY
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes

RULE IMPACT STATEMENT:
TO: Tywanda Cox
Health Policy

FROM: Joseph Fairbanks
Health Policy

SUBJECT: Rule Impact Statement
APA WF # 11-34

A. Brief description of the purpose of the rule:

Rules are revised to limit the number and type of catheters covered per member per month and bring policy in line with CMS regulations on catheter utilization. The change will allow a combined maximum of 200 intermittent catheters per

member per month. Of the 200 catheters, 60 may be the intermittent catheter with insertion supplies kit. Finally, prior authorization for these catheters will no longer be required.

B. A description of the classes of persons who most likely will be affected by the proposed rule, including classes that will bear the cost of the proposed rule, and any information on cost impacts received by the agency from any private or public entities:

Certain durable medical equipment suppliers and SoonerCare members who require intermittent catheters will be affected by the rule, but there will be no added cost to either. Current policy covers 240 intermittent catheters, but research has shown this number is excessively high and unnecessary. The coverage will be brought in line with the Centers of Medicare and Medicaid Services regulations that allow 200 intermittent catheters per month.

C. A description of the classes of persons who will benefit from the proposed rule:

Durable medical equipment suppliers and their SoonerCare customers will benefit as prior authorization requirements are removed to allow for swifter access to these supplies.

D. A description of the probable economic impact of the proposed rule upon the affected classes of persons or political subdivisions, including a listing of all fee changes and, whenever possible, a separate justification for each fee change:

There is no economic impact and there are no fee changes associated with the rule change for the above classes of persons or any political subdivision.

E. The probable costs and benefits to the agency and to any other agency of the implementation and enforcement of the proposed rule, the source of revenue to be used for implementation and enforcement of the proposed rule, and any anticipated affect on state revenues, including a projected net loss or gain in such revenues if it can be projected by the agency:

The rule change will result in a budget savings of approximately $548,500.

F. A determination of whether implementation of the proposed rule will have an economic impact on any political subdivisions or require their cooperation in implementing or enforcing the rule:

There is no economic impact on political subdivisions.

G. A determination of whether implementation of the proposed rule will have an adverse effect on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act:

There should be no adverse economic impact on small businesses as a result of this rule.

H. An explanation of the measures the agency has taken to minimize compliance costs and a determination of whether there are less costly or non-regulatory methods or less intrusive methods for achieving the purpose of the proposed rule:

The agency has taken measures to determine that there is no less costly or non-regulatory method or less intrusive method for achieving the purpose of the proposed rule. The agency discussed the idea with DME provider community and underwent thorough examination of the issue with medical consultants.

I. A determination of the effect of the proposed rule on the public health, safety and environment and, if the proposed rule is designed to reduce significant risks to the public health, safety and environment, an explanation of the nature of the risk and to what extent the proposed rule will reduce the risk:

The proposed rule should have no effect on the public health, safety, and environment.

J. A determination of any detrimental effect on the public health, safety and environment if the proposed rule is not implemented:

OHCA does not believe there is a detrimental effect on the public health and safety if the rule is not passed.

K. The date the rule impact statement was prepared and if modified, the date modified:

The rule impact statement was prepared December 6, 2011.

RULE TEXT

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 17. MEDICAL SUPPLIERS

317:30-5-211.15. Supplies

(a) The OHCA provides coverage for supplies that are prescribed by the appropriate medical provider, medically necessary and meet the special requirements below.

(b) Special requirements:

(1) **Intravenous therapy.** Supplies for intravenous therapy are covered items. Drugs for IV therapy are covered items only as specified by the Vendor Drug program.

(2) **Diabetic supplies.** A maximum of 100 glucose test strips and 100 lancets per month when medically necessary and prescribed by a physician are covered items. Diabetic supplies in excess of these parameters must be prior authorized.

(3) **Catheters.** Permanent indwelling catheters, male external catheters, drain bags and irrigation trays are covered items. ~~Single use self catheters when the member has a history of urinary tract infections is a covered item. The prescription from the attending physician must indicate such documentation is available in the member's medical record.~~ Coverage for intermittent catheters is limited to a maximum of 200 catheters per month when medically necessary and prescribed by a physician. Of the 200 catheters, 60 may be the intermittent catheter with insertion supplies kit (procedure code A4353).

(4) **Colostomy and urostomy supplies**. Colostomy and urostomy bags and accessories are covered items.

Oklahoma Health Care Authority

It is very important that you provide your comments regarding the proposed rule change by the comment due date. Comments are directed to Oklahoma Health Care Authority (OHCA) Health Policy Unit http://www.okhca.org/proposed-rule-changes.aspx

OHCA COMMENT DUE DATE: January 5, 2012

The proposed policy is a Permanent Rule. This proposal is scheduled to be presented to the Medical Advisory Committee (MAC) on January 19, 2012 and the (OHCA) Board of Directors on March 8, 2012.
Reference: APA WF 11-35

SUMMARY:
11-35 Program of All-Inclusive Care for Elderly (PACE) – PACE rules are revised to remove pilot specific requirements. Current language references Cherokee Nation as the PACE provider; revisions will replace specifics with general language that is applicable to any PACE provider. Additional revisions include revising the Nursing Facility Level of Care criteria to be more specific to PACE eligibility criteria and cleaning up rules for clarity.

LEGAL AUTHORITY
The Oklahoma Health Care Authority Board; Then Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes;42 CFR Part 460

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

TO: Tywanda Cox
Policy Development

From: LeKenya Samilton

SUBJECT: Rule Impact Statement
APA WF # 11-35

A. Brief description of the purpose of the rule:

Program of All-Inclusive Care for the Elderly (PACE) rules are revised to remove pilot specific requirements and replace with language that is applicable to all PACE providers. Additional revisions include revising the Nursing Facility Level of Care criteria to be more specific to PACE eligibility criteria and cleaning up rules for clarity.

B. A description of the classes of persons who most likely will be affected by the proposed rule, including classes that will bear the cost of the proposed rule, and any information on cost impacts received by the agency from any private or public entities:

The classes of persons most affected by this rule will be elderly individuals who are potentially eligible for PACE.

C. A description of the classes of persons who will benefit from the proposed rule:

The persons who will most likely benefit from the proposed rule are both PACE providers and participants. Revising the Nursing Facility Level of Care criteria increases flexibility for eligibility for the PACE program. As a results PACE providers will see an increase in the numbers of individuals eligible for PACE.

D. A description of the probable economic impact of the proposed rule upon the affected classes of persons or political subdivisions, including a listing of all fee changes and, whenever possible, a separate justification for each fee changes:

There is no probable economic impact of the proposed rule upon any classes of persons or political subdivisions.

E. The probable costs and benefits to the agency and to any other agency of the implementation and enforcement of the proposed rule, the source of revenue to be used for implementation and enforcement of the proposed rule, and any anticipated affect on state revenues, including a projected net loss or gain in such

revenues if it can be projected by the agency:

There is no budgetary impact as a result of this rule.

F. A determination of whether implementation of the proposed rule will have an economic impact on any political subdivisions or require their cooperation in implementing or enforcing the rule:

The proposed rule will not have an economic impact on any political subdivision or require their cooperation in implementing or enforcing the rule.

G. A determination of whether implementation of the proposed rule will have an adverse effect on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act:

The proposed rule will not have an adverse effect on small businesses as provided by the Oklahoma Small Business Regulatory Flexibility Act.

H. An explanation of the measures the agency has taken to minimize compliance costs and a determination of whether there are less costly or non-regulatory methods or less intrusive methods for achieving the purpose of the proposed rule:

There agency has taken measures to determine that there is no less costly or non-regulatory method or less intrusive method for achieving the purpose of the proposed rule.

I. A determination of the effect of the proposed rule on the public health, safety and environment and, if the proposed rule is designed to reduce significant risks to the public health, safety and environment, an explanation of the nature of the risk and to what extent the proposed rule will reduce the risk:

The proposed rule should have no effect on the public health, safety, or environment.

J. A determination of any detrimental effect on the public health, safety and environment if the proposed rule is not implemented:

The agency does not anticipate any detrimental effects on the public health, safety, or environment.

K. The date the rule impact statement was prepared and if modified, the date modified:

This rule impact statement was prepared on December 7, 2011.

RULE TEXT

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
SUBCHAPTER 18. PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY

317:35-18-1. Programs of All-Inclusive Care for the Elderly (PACE)

This chapter establishes the requirements for ~~the Cherokee Nation Pilot Program~~ approved SoonerCare contracted Program of All-Inclusive Care for the Elderly (PACE) providers to provide services to eligible elderly ~~clients~~ individuals through the Oklahoma Health Care Authority's (OHCA) ~~Programs of All-Inclusive Care for the Elderly (PACE)~~ PACE program.

317:35-18-2. Introduction

(a) Programs of All-Inclusive Care for the Elderly (PACE) provide home and community-based acute and long-term care services to eligible individuals who meet the medical requirements for nursing facility care and can be served safely and appropriately in the community. PACE is optional in a State Medicaid program. PACE is jointly funded and administered by the Centers for Medicare and Medicaid Services and the state of Oklahoma. The PACE provider receives a monthly capitation payment and is at full risk for the delivery of all medically necessary services for the ~~recipient~~ individual. For eligible individuals who elect to participate in the PACE program, the OHCA will make capitation payments for individuals who are only eligible for Medicaid or who are dually eligible for Medicaid and Medicare. OHCA will contract with ~~the Cherokee Nation~~ providers for ~~a~~ the PACE ~~pilot~~ program in the geographic areas as specified and approved in the ~~Cherokee Nation~~ provider PACE application. ~~The Cherokee Nation PACE pilot~~ The PACE program will provide medically necessary services to both American Indian/Alaska Native (AI/AN) and non-Indian Medicaid eligible ~~recipients~~ individuals.

(b) Rules applicable to the operation of the PACE program are contained in 42 Code of Federal Regulations (CFR), Part 460. These regulations, as currently written or amended in the future, are incorporated by reference as the rule base for operating the PACE program in Oklahoma.

317:35-18-3. Definitions

The words and terms used in this Subchapter have the following meanings, unless the context clearly indicates otherwise:

(1) **"American Indian/Alaska Native (AI/AN)"** means an individual of Native American descent who has or is eligible for a Certificate of Degree of Indian Blood (CDIB) card;

(2) **"Capitation"** means the per member per month (pmpm) amount that the Oklahoma Health Care Authority pays ~~to the~~ PACE ~~provider~~ providers for PACE compensable services.

(3) **"Interdisciplinary Team (IDT)"** means the team of persons who interact and collaborate to assess PACE ~~clients~~ participants and plan for their care as set forth in 42 CFR ~~460:102~~ 460.102. The IDT may also include the PACE ~~client's~~ participant's personal representative or advocate.

(4) **"Participant"** means an individual enrolled in a PACE program.

(5) **"Program agreement"** means the three-party agreement between the PACE provider, ~~CMS~~ Centers for Medicare & Medicaid Services (CMS), and OHCA.

(6) **"Provider"** means the non-profit entity ~~established by the Cherokee Nation~~ that delivers required PACE services under an agreement with OHCA and CMS.

(7) **"Service area"** means the geographic area served by the provider agency, according to the program agreement.

(8) **"State Administering Agency (SAA)"** means the Oklahoma Health Care Authority.

317:35-18-4. Provider regulations

(a) The provider must comply with provisions of this Subchapter, and the regulations in 42 CFR, Part 460.

(b) The provider agency must be licensed by the State of Oklahoma as an adult day care center.

(c) The provider must meet all applicable local, state, and federal regulations.

(d) The provider must maintain an inquiry log of all individuals requesting Programs of All-Inclusive Care for the Elderly (PACE) services. This log will be available to the OHCA at all times. The log must include:

(1) type of contact;

(2) date of contact;

(3) name and phone number of the individual requesting services;
(4) name and address of the potential ~~client~~ participant; and
(5) date of enrollment, or reason for denial if the individual is not enrolled.

317:35-18-5. Eligibility criteria

(a) To be eligible for participation in PACE, the applicant must:

(1) meet categorical relationship to disability (reference OAC 317:35-5-4);
(2) meet ~~medical and~~ financial criteria for the ADvantage program (reference OAC ~~317:35-17-2,~~ 317:35-17-10, and 317:35-17-11);
(3) ~~be age 55 years or older~~ meet medical criteria for the ADvantage program (reference OAC 317:35-17-2)with the exception of the Uniform Comprehensive Assessment Tool (UCAT) Client Support score criteria. Individuals whose Client Support score is below the minimum criteria (15 moderate) for ADvantage; with the exception of those individuals whose scores are low or very low (0-5), will be eligible for PACE if all other eligibility requirements of this section are met;
(4) be age 55 years or older;
~~(4)~~ (5) live in a PACE service area;
~~(5)~~ (6) be determined by the PACE Interdisciplinary team as able to be safely served in the community. If the PACE provider denies enrollment because the IDT determines that the applicant cannot be served safely in the community, the PACE provider must:

(A) notify the applicant in writing of the reason for the denial;
(B) refer the ~~individual~~ applicant to alternative services as appropriate;
(C) maintain supporting documentation for the denial and notify CMS and OHCA of the denial and make the supporting documentation available for review; and
(D) advise the ~~client~~ applicant orally and in writing of the grievance and appeals process.

(b) To be eligible for ~~Medicaid~~ SoonerCare capitated payments, the ~~participant~~ individual must:

(1) be eligible for Title XIX services if institutionalized as determined by the Oklahoma Department of Human Services;
(2) be eligible for ~~Medicaid~~ SoonerCare State Plan services;
(3) be eligible for the ~~Medicaid~~ SoonerCare ADvantage program per OAC 317:35-17-3 and 317:35-17-5.

(c) To obtain and maintain eligibility, the ~~participant~~ individual must agree to accept the PACE providers and its contractors as the ~~participant's~~ individual's only service provider. The ~~participant~~ individual may be held financially liable for services received without prior authorization except for emergency medical care.

317:35-18-6. Program benefits

(a) A provider agency must provide a participant all the services listed in 42 CFR 460.92 that are approved by the IDT. The PACE benefit package for all participants, regardless of the source of payment, must include but is not limited to the following:

(1) All ~~Medicaid-covered~~ SoonerCare-covered services, as specified in the State's approved ~~Medicaid~~ SoonerCare plan.

(2) Interdisciplinary assessment and treatment planning.

(3) Primary care, including physician and nursing services.

(4) Social work services.

(5) Restorative therapies, including physical therapy, occupational therapy, and speech-language pathology services.

(6) Personal care and supportive services.

(7) Nutritional counseling.

(8) Recreational therapy.

(9) Transportation.

(10) Meals.

(11) Medical specialty services including, but not limited to the following:

(A) Anesthesiology.

(B) Audiology.

(C) Cardiology.

(D) Dentistry.

(E) Dermatology.

(F) Gastroenterology.

(G) Gynecology.

(H) Internal medicine.

(I) Nephrology.

(J) Neurosurgery.

(K) Oncology.

(L) Ophthalmology.

(M) Oral surgery.

(N) Orthopedic surgery.

(O) Otorhinolaryngology.

(P) Plastic surgery.

(Q) Pharmacy consulting services.

(R) Podiatry.

(S) Psychiatry.

(T) Pulmonary disease.
(U) Radiology.
(V) Rheumatology.
(W) General surgery.
(X) Thoracic and vascular surgery.
(Y) Urology.

(12) Laboratory tests, x-rays and other diagnostic procedures.

(13) Drugs and biologicals.

(14) Prosthetics, orthotics, durable medical equipment, corrective vision devices, such as eyeglasses and lenses, hearing aids, dentures, and repair and maintenance of these items.

(15) Acute inpatient care, including the following:
(A) Ambulance.
(B) Emergency room care and treatment room services.
(C) Semi-private room and board.
(D) General medical and nursing services.
(E) Medical surgical/intensive care/coronary care unit.
(F) Laboratory tests, x-rays and other diagnostic procedures.
(G) Drugs and biologicals.
(H) Blood and blood derivatives.
(I) Surgical care, including the use of anesthesia.
(J) Use of oxygen.
(K) Physical, occupational, respiratory therapies, and speech-language pathology services.
(L) Social services.

(16) Nursing facility care including:
(A) Semi-private room and board;
(B) Physician and skilled nursing services;
(C) Custodial care;
(D) Personal care and assistance;
(E) Drugs and biologicals;
(F) Physical, occupational, recreational therapies, and speech-language pathology, if necessary;
(G) Social services; and
(H) Medical supplies and appliances.

(17) Other services determined necessary by the interdisciplinary team to improve and maintain the participant's overall health status.

(b) The following services are excluded from coverage under PACE:

(1) Any service that is not authorized by the interdisciplinary team, even if it is a required service, unless it is an emergency service.

(2) In an inpatient facility, private room and private duty nursing services (unless medically necessary), and non-medical items for personal convenience such as telephone charges and radio or television rental (unless specifically authorized by the interdisciplinary team as part of the participant's plan of care).
(3) Cosmetic surgery, which does not include surgery that is required for improved functioning of a malformed part of the body resulting ~~fran~~ from an accidental injury or for reconstruction following mastectomy.
(4) Experimental medical, surgical, or other health procedures.
(5) Services furnished outside of the United States, except as follows:
(A) in accordance with 42 CFR 424.122 through 42 CFR 424.124, and
(B) as permitted under the State's approved Medicaid plan.

317:35-18-7. Appeals process

(a) Internal appeals
(1) Any ~~client~~ individual who is denied program services is entitled to an appeal through the provider.
(2) If the ~~client~~ individual also chooses to file an external appeal, the provider must assist the ~~client~~ individual in filing an external appeal.

(b) External appeals may be filed by any ~~client~~ individual covered by:
(1) ~~Medicaid~~ SoonerCare through the OHCA legal division.
(2) Medicare but not ~~Medicaid~~ SoonerCare through the Centers for Medicare and Medicaid Services hearing process.

317:35-18-9. Continuation of enrollment

(a) At least annually, OHCA must reevaluate whether a participant needs the level of care for nursing facility services.
(b) At least annually, OKDHS will reevaluate the participant's financial eligibility for ~~Medicaid~~ SoonerCare.
(c) If the individual meets the state's medical eligibility criteria and the individual has an irreversible or progressive diagnosis or a terminal illness that could ~~reasonable~~ reasonably be expected to result in death in the next six months, and OHCA determines that there is no reasonable expectation of improvement or significant change in the condition because of severity of a chronic condition or the degree of impairment of functional capacity, OHCA will permanently waive the annual recertification requirement and

the ~~client~~ participant ~~may~~ will be deemed to be continually eligible for PACE. The assessment form must have sufficient documentation to substantiate the participant's prognosis and functional capacity.
(d) If OHCA determines that a PACE participant no longer meets the medical criteria for nursing facility level of care, the participant ~~may~~ will be deemed to continue to be eligible for PACE until the next annual reassessment, if, in the absence of PACE services, it is reasonable to expect that the ~~client~~ participant would meet the nursing facility level of care criteria within the next six months.
(e) Participant enrollment continues when OHCA in consultation with the PACE organization, makes a determination of continued eligibility based on a review of the participant's medical record and plan of care. The participant's medical record and plan of care must support deemed continued eligibility.

317:35-18-10. Disenrollment (voluntary and involuntary)
(a) ~~The member~~ A participant may voluntarily disenroll from PACE at any time without cause ~~but~~ however, the effective date of disenrollment must be the last day of the month that the participant elects to disenroll.
(b) A participant may be involuntarily disenrolled for any of the following reasons:
(1) The participant/caregiver or guardian fails to pay, or to make satisfactory arrangements to pay, any premium due the PACE organization after a 30-day grace period.
(2) The participant/caregiver or guardian engages in disruptive or threatening behavior, as described in subsection (c) of this section.
(3) The participant moves out of the PACE program service area or is out of the service area for more than 30 consecutive days, unless the PACE organization agrees to a longer absence due to extenuating circumstances.
(4) The participant is determined to no longer meet the ~~State Medicaid~~ SoonerCare nursing facility level of care requirements and is not deemed eligible.
(5) The PACE program agreement with CMS and ~~the State administering agency~~ OHCA is not renewed or is terminated.
(6) The PACE organization is unable to offer health care services due to the loss of State licenses or contracts with outside providers.
(c) A participant may be involuntarily disenrolled for disruptive or threatening behavior. For purposes of this section, a participant who engages in disruptive or threatening behavior refers to a participant who exhibits either of the following:

(1) A participant whose behavior jeopardizes his or her health or safety, or the safety of others; or

(2) A participant with decision-making capacity who consistently refuses to comply with his or her individual plan of care or the terms of the PACE enrollment agreement.

(d) If a PACE organization proposes to disenroll a participant who is disruptive or threatening, the organization must document the following information in the participant's medical record:

(1) The reasons for proposing to disenroll the participant.

(2) All efforts to remedy the situation.

(e) A participant may be disenrolled involuntarily for noncompliant behavior.

(1) PACE organization may not disenroll a PACE participant on the grounds that the participant has engaged in noncompliant behavior if the behavior is related to a mental or physical condition of the participant, unless the participant's behavior jeopardizes his or her health or safety, or the safety of others.

(2) For purposes of this section, noncompliant behavior includes repeated noncompliance with medical advice and repeated failure to keep appointments.

(f) Before an involuntary disenrollment is effective, ~~the State administering agency must~~ OHCA will review ~~it~~ the participant's medical record and determine in a timely manner that the PACE organization has adequately documented acceptable grounds for disenrollment.

317:35-18-11. Data collection and reporting

The PACE provider must:

(1) collect ~~and enter~~ data to comply with reporting requirements in provider application ~~into the DATA PACE system.~~;

(2) generate and maintain monthly reports from ~~the DATA PACE system.~~ collected data;

(3) make the reports available to the OHCA~~.~~; and

(4) comply with all data requests as specified by the OHCA within 30 days of such requests.

Oklahoma Health Care Authority

It is very important that you provide your comments regarding the proposed rule change by the comment due date. Comments are directed to Oklahoma Health Care Authority (OHCA) Health Policy Unit http://www.okhca.org/proposed-rule-changes.aspx

OHCA COMMENT DUE DATE: January 16, 2012

The proposed policy is a Permanent Rule. This proposal is scheduled to be presented to the Medical Advisory Committee (MAC) on January 19, 2012 and the (OHCA) Board of Directors on March 8, 2012.
Reference: APA WF 11-36

SUMMARY:
Cvek Pulpotomy and Crown Equalization— Agency dental policy is revised to allow for permanent restoration of a tooth when done as part of a Cvek Pulpotomy. The Cvek Pulpotomy is a procedure that better maintains the vitality of exposed pulps, especially in young patients. Allowing permanent restoration with the Cvek Pulpotomy will reduce the need for root canals. Finally, rules are revised to allow dentists to choose the proper type of crown that best serves the member's oral environment.

LEGAL AUTHORITY
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes

RULE IMPACT STATEMENT:
TO: Tywanda Cox
Health Policy

FROM: Joseph Fairbanks
Health Policy

SUBJECT: Rule Impact Statement
APA WF # 11-36

A. Brief description of the purpose of the rule:

Agency dental policy is revised to allow for permanent restoration of a tooth when done as part of a Cvek Pulpotomy. The Cvek Pulpotomy is a procedure that better maintains the vitality of exposed pulps, especially in young

patients. Allowing permanent restoration with the Cvek Pulpotomy will reduce the need for root canals. Finally, rules are revised to allow dentists to choose the proper type of crown that best serves the member's oral environment.

B. A description of the classes of persons who most likely will be affected by the proposed rule, including classes that will bear the cost of the proposed rule, and any information on cost impacts received by the agency from any private or public entities:

SoonerCare members and their dentists will be affected. The rule will allow dentists to perform a relatively new procedure on their patients that helps maintain exposed pulps and reduces the need for root canals.

C. A description of the classes of persons who will benefit from the proposed rule:

SoonerCare members and their dentists will be benefit. The rule will allow dentists to be reimbursed when they perform the Cvek Pulpotomy and a permanent restoration on their patients. Members benefit from a comparatively advanced procedure that better maintains the vitality of the pulp. Further, dentists will be able to utilize new technology when putting a crown on a tooth that requires it and determine the proper type of crown.

D. A description of the probable economic impact of the proposed rule upon the affected classes of persons or political subdivisions, including a listing of all fee changes and, whenever possible, a separate justification for each fee change:

There is no economic impact and there are no fee changes associated with the rule change for the above classes of persons or any political subdivision.

E. The probable costs and benefits to the agency and to any other agency of the implementation and enforcement of the proposed rule, the source of revenue to be used for implementation and enforcement of the proposed rule, and any anticipated affect on state revenues, including a projected net loss or gain in such revenues if it can be projected by the agency:

The rule change is budget neutral.

F. A determination of whether implementation of the proposed rule will have an economic impact on any political subdivisions or require their cooperation in implementing or enforcing the rule:

There is no economic impact on political subdivisions.

G. A determination of whether implementation of the proposed rule will have an adverse effect on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act:

There will be no adverse economic impact on small businesses as a result of this rule.

H. An explanation of the measures the agency has taken to minimize compliance costs and a determination of whether there are less costly or non-regulatory methods or less intrusive methods for achieving the purpose of the proposed rule:

The agency has taken measures to determine that there is no less costly or non-regulatory method or less intrusive method for achieving the purpose of the proposed rule.

I. A determination of the effect of the proposed rule on the public health, safety and environment and, if the proposed rule is designed to reduce significant risks to the public health, safety and environment, an explanation of the nature of the risk and to what extent the proposed rule will reduce the risk:

The proposed rule should have no effect on the public health, safety, and environment.

J. A determination of any detrimental effect on the public health, safety and environment if the proposed rule is not implemented:

OHCA does not believe there is a detrimental effect on the public health and safety if the rule is not passed.

K. The date the rule impact statement was prepared and if modified, the date modified:

The rule impact statement was prepared December 14, 2011.

RULE TEXT

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 79. DENTISTS

317:30-5-696. Coverage by category

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

(1) **Adults.**

(A) Dental coverage for adults is limited to:

(i) emergency extractions;

(ii) Smoking and Tobacco Use Cessation Counseling; and

(iii) medical and surgical services performed by a dentist, to the extent such services may be performed under State law either by a doctor of dental surgery or dental medicine, 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 the Mentally Retarded (ICF/MR) and who have been approved for ICF/MR level of care, similar to the scope of services available to individuals under age 21.

(C) Pregnant women are covered under a limited dental benefit plan (Refer to (a)(4)of this Section).

(2) **Home and community based waiver services (HCBWS) for the mentally retarded.** All providers participating in the HCBWS must have a separate contract with the OHCA to provide services under the HCBWS. 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 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 is performed for any member not seen by any dentist for more than 12 months.

(B) **Periodic oral evaluation.** This procedure may be provided for a member of record if she or he has not been seen for more than six months.

(C) **Emergency examination/limited oral evaluation.** This procedure is not compensable within two months of a periodic oral examination or if the member is involved in active treatment unless trauma or acute infection is the presenting complaint.

(D) **Radiographs (x-rays).** To be SoonerCare compensable, x-rays must be of diagnostic quality and medically necessary. A clinical examination must precede any radiographs, and chart documentation must include member history, prior radiographs, caries risk assessment and both dental and general health needs of the member. The referring dentist is responsible for providing properly identified x-rays of acceptable quality with a referral, if that provider chooses to expose and submit for reimbursement prior to referral. Panoramic films are allowable once in a three year period and must be of diagnostic quality. Panoramic films are only compensable when chart documentation clearly indicates the test is being performed to rule out or evaluate non-caries related pathology. Prior authorization and a detailed medical need narrative are required for additional panoramic films taken within three 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 18 years of age and is compensable only once per lifetime. Replacement of sealants is not a covered service under the SoonerCare program.

(F) **Dental prophylaxis.** This procedure is provided once every 184 days including topical application of fluoride.

(G) **Composite restorations.**

(i) This procedure is compensable for primary incisors as follows:

(I) tooth numbers O and P to age 4 years;

(II) tooth numbers E and F to age 6 years;

(III) tooth numbers N and Q to 5 years; and

(IV) tooth numbers D and G to 6 years.

(ii) The procedure is also allowed for use in all vital and successfully treated non-vital permanent anterior teeth.

(iii) Class I and II composite restorations are allowed in posterior teeth; however, the OHCA has certain restrictions for the use of this restorative material. (See OAC 317:30-5-699).

(H) **Amalgam.** Amalgam restorations are allowed in:

(i) posterior primary teeth when:

(I) 50 percent or more root structure is remaining;

(II) the teeth have no mobility; or

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

(ii) any permanent tooth, determined as medically necessary by the treating dentist.

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

(i) Stainless steel crowns are allowed if:

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

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

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

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

(I) primary teeth with pulpotomies or pulpectomies, if the above conditions exist;

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

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

(iii) Stainless steel crowns are the treatment of choice on posterior permanent teeth that have completed endodontic therapy, if more than three surfaces of extensive decay exist or where cuspal occlusion are lost due to decay prior to age 16 years.

(iv) Preoperative periapical x-rays and/or written documentation explaining the extent of decay must be available for review, if requested.

(v) Placement of a stainless steel crown includes all related follow up service for a period of two years. No other prosthetic procedure on that tooth is compensable during that period of time. A stainless steel crown is not a temporizing treatment to be used while a permanent crown is being fabricated.

(J) **Pulpotomies and pulpectomies.**

(i) Therapeutic pulpotomies are allowable for molars and teeth numbers listed below. Pre and post operative periapical x-rays must be available for review, if requested.

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

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

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

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

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

(ii) Pulpectomies are allowed for primary teeth if exfoliation of the teeth is not expected to occur for at least one year or if 70 percent or more of root structure is remaining.

(K) **Anterior root canals.** Payment is made for the services provided in accordance with the following:

(i) This procedure is done for permanent teeth when there are no other missing anterior teeth in the same arch requiring replacement.

(ii) Acceptable ADA filling materials must be used.

(iii) Preauthorization is required if the member's treatment plan involves more than four anterior root canals.

(iv) Teeth with less than 50 percent of clinical crown should not be treatment-planned for root canal therapy.

(v) Pre and post operative periapical x-rays must be available for review.

(vi) Pulpotomy may be performed for the relief of pain while waiting for the decision from the OHCA.

(vii) Providers are responsible for any follow-up treatment required due to a failed root canal therapy for 24 month post completion.

(viii) Endodontic 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.

(ix) If there are three or more missing teeth in the arch that requires replacement, root therapy will not be allowed.

(L) **Space maintainers.** Certain limitations apply with regard to this procedure. Providers are responsible for recementation of any maintainer placed by them for six 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 or where the successor tooth would not normally erupt in the next 12 months.

(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 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 x-rays must be available for review.

(VI) Bilateral band and loop space maintainer is allowed if member does not have eruption of the four 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 multiple missing teeth exist in the same arch.

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

(III) Multiple missing upper anterior primary incisors may be replaced with the appliance to age 6 years to prevent abnormal swallowing habits.

(IV) Pre and post operative x-rays must be available.

(iii) **Interim partial dentures.** This service is for anterior permanent tooth replacement or if the member is missing three or more posterior teeth to age 16 years.

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

(i) **Inhalation of nitrous oxide.** Use of nitrous oxide is compensable for four 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 need for this service must be documented in the member's record. This procedure is not covered when it is the dentist's usual practice to offer it to all patients.

(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.

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

(O) **Sedative restorations.** Sedative restorations include removal of decay, if present, and direct or indirect pulp cap, if needed. These services are reimbursable for the same tooth on the same date of service. Permanent restoration of the tooth is allowed after 30 days unless the tooth becomes symptomatic and requires pain relieving treatment.

(P) **History and physical.** Payment is made for services for the purpose of admitting a patient to a hospital for dental treatment.

(Q) **Local anesthesia.** This procedure is included in the fee for all services.

(R) **Smoking and Tobacco Use Cessation Counseling.** Smoking and Tobacco Use Cessation Counseling is covered when performed utilizing the five 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 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, nurse midwives, and Oklahoma State Health Department and FQHC nursing staff in addition to other appropriate services rendered. Chart documentation must include a separate note, separate signature, and the member specific information addressed in the five steps and the time spent by the practitioner performing the counseling. Anything under three minutes is considered part of a routine visit.

(4) **Pregnant Women.** Dental coverage for this special population is provided regardless of age.

(A) Proof of pregnancy is required (Refer to OAC 317:35-5-6).

(B) Coverage is limited to a time period beginning at the diagnosis of pregnancy and ending upon 60 days post partum.

(C) In addition to dental services for adults, other services available include:

(i) Comprehensive oral evaluation must be performed and recorded for each new member, or established member not seen for more than 24 months;

(ii) Periodic oral evaluation as defined in OAC 317:30-5-696(3)(B);

(iii) Emergency examinations/limited oral evaluation. This procedure is not allowed within two months of an oral examination by the same provider for the same member, or if the member is under active treatment;

(iv) Radiographs as defined in OAC 317:30-5-696(3)(D);

(v) Dental prophylaxis as defined in OAC 317:30-5-696(3)(F);

(vi) Composite restorations:

(I) Any permanent tooth that has an opened lesion that is a food trap will be deemed medically necessary for this program and will be allowed for all anterior teeth.

(II) Class I posterior composite resin restorations are allowed in posterior teeth that qualify;

(vii) Amalgam. Any permanent tooth that has an opened lesion that is a food trap will be deemed as medically necessary and will be allowed; and

(viii) Analgesia. Analgesia services are reimbursable in accordance with OAC 317:30-5-696(iii)(M).

(D) Services requiring prior authorization (Refer to OAC 317:30-5-698).

(E) Periodontal scaling and root planing. Required that 50% or more of six point measurements be 5 millimeters or greater. This procedure is designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins and microorganism and requires anesthesia and some soft tissue removal.

(5) **Individuals eligible for Part B of Medicare.**

(A) Payment is made based on the member's coinsurance and deductibles.

(B) Services which have been denied by Medicare as non-compensable should be filed directly with the OHCA with a

copy of the Medicare EOB indicating the reason for denial.

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 317:30-5-695(d)(2). Requests for dental services requiring prior authorization must be accompanied by sufficient documentation. X-rays, six point periodontal charting and comprehensive treatment plans are required. Study models and narratives may be requested by OHCA or representatives of OHCA. If the quality of the supporting material is such that a determination of authorization cannot be made, the material is returned to the provider. Any new documentation must be provided at the provider's expense. Submitted documentation used to base a decision will not be returned.

(b) Requests for prior authorization are filed on the currently approved 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 and eligible ICF/MR residents. Minimum required records to be submitted with each request are right and left mounted bitewing x-rays and periapical films of tooth/teeth involved or the edentulous areas if not visible in the bitewings. X-rays must be submitted with x-ray film mounts and each film or print must be of good readable quality. X-rays must be identified by left and right sides with the date, member name, member ID, provider name, and provider ID. All x-rays, regardless of the media, must be placed together in the same envelope with a completed comprehensive treatment plan and a completed current ADA form requesting all treatments requiring prior authorization. The film, digital media or printout 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.** Pulpotomy may be performed for the relief of pain while waiting for the decision from the OHCA on request for endodontics. ~~A permanent restoration is not billable to the OHCA when performing pulpotomy or pulpal debridement on a permanent tooth.~~

(A) **Anterior root canals.** This procedure is for members who have a treatment plan requiring more than four anterior and/or posterior root canals. Payment is made for services provided in accordance with the following:

(i) Permanent teeth numbered 6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26 and 27 are eligible for therapy if there are no other missing teeth in the same arch requiring replacement, unless numbers 6 , 11 , 22, or 27 are abutments for prosthesis.

(ii) Accepted ADA materials must be used.

(iii) Pre and post operative periapical x-rays must be available for review.

(iv) Providers are responsible for any follow-up treatment required by a failed endodontically treated tooth within 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.

(vi) An endodontic procedure may not be approved if the tooth requires a post and core to retain a crown.

(vii) If there are three or more missing teeth in the arch that requires replacement, root therapy will not be authorized.

(B) **Posterior endodontics.** The guidelines for this procedure are as follows:

(i) The provider documents that the member has improved oral hygiene and flossing ability in this member's records.

(ii) Teeth that would 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 x-rays must be available for review.

(iv) Providers are responsible for any follow-up treatment required by a failed endodontically treated tooth within 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 is limited to a maximum of five teeth. A request 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) there are missing teeth in the same arch requiring replacement;

(II) an opposing tooth has super erupted;

(III) loss of tooth space is one third or greater;

(IV) opposing second molars are involved unless prior authorized; or

(V) the member has multiple teeth failing due to previous inadequate root canal therapy or follow-up.

(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.

(x) a failing root canal is determined not medically necessary for re-treatment.

(2) ~~**Cast metal crowns or ceramic-based crowns.**~~ **Crowns for permanent teeth.** ~~These procedures~~ Crowns are compensable for restoration of natural teeth for members who are 16 years of age or older and adults residing in private Intermediate Care Facilities for the Mentally Retarded(ICF/MR) and who have been approved for (ICF/MR) level of care. Certain criteria and limitations apply.

(A) The following conditions must exist for approval of this procedure.

(i) The tooth must be ~~fractured or~~ decayed to such an extent to prevent proper cuspal or incisal function.

(ii) The clinical crown is fractured or destroyed ~~by the above elements~~ by one-half or more.

(iii) Endodontically treated teeth must have three or more surfaces restored or lost due to carious activity to be considered.

(B) The conditions listed in (A)(i) through (A)(iii) of this paragraph should be clearly visible on the submitted x-rays when a request is made for any type of crown.

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

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

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

~~(F) Ceramic-metal based crowns will be considered only for tooth numbers 4 through 13 and 21 through 28.~~

~~(G) Porcelain/Ceramic substrate crowns are allowed on maxillary and mandibular incisors only.~~

~~(H) Full cast metal crowns are treatment for all posterior teeth,~~

~~(I)~~ (F) Provider is responsible for replacement or repair of all ~~cast~~ crowns if ~~due to~~ failure is caused by poor laboratory processes or procedure by provider for 48 months post insertion.

(3) **Cast frame partial dentures.** This appliance is the treatment of choice for replacement of three or more missing permanent teeth in the same arch for members 16 through 20 years of age. Provider must indicate tooth number to be replaced and teeth to be clasped.

(4) **Acrylic partial.** This appliance is the treatment of choice for replacement of missing anterior permanent teeth or three or more missing teeth in the same arch for members 12 through 16 years of age and adults residing in private Intermediate Care Facilities for the Mentally Retarded (ICF/MR) and who have been approved for ICF/MR level of care. Provider must indicate tooth numbers to be replaced and teeth to be clasped. This appliance includes all necessary clasps and rests.

(5) **Occlusal guard.** Narrative of clinical findings must be sent with prior authorization request.

(6) **Fixed cast non-precious metal or porcelain/metal bridges.** Only members 17 through 20 years of age where the bite relationship precludes the use of removable partial dentures are considered. Members must have excellent oral hygiene documented in the requesting provider's records. Provider is responsible for any needed follow up for a period of five years post insertion.

(7) **Periodontal scaling and root planing.** This procedure requires that 50% or more of the six point measurements be five millimeters or greater and must involve two or more teeth per quadrant for consideration. This procedure is allowed on members 12 to 20 years of age and requires

anesthesia and some soft tissue removal. The procedure is not allowed in conjunction with any other periodontal surgery. Allowance may be made for submission of required authorization data post treatment if the member has a medical or emotional problem that requires sedation.

(8) **Additional prophylaxis.** The OHCA recognizes that certain physical conditions require more than two prophylaxes. The following conditions may qualify a member for one additional prophylaxis per year:

(A) dilantin hyperplasia;

(B) cerebral palsy;

(C) mental retardation;

(D) juvenile periodontitis.

Oklahoma Health Care Authority

It is very important that you provide your comments regarding the proposed rule change by the comment due date. Comments are directed to Oklahoma Health Care Authority (OHCA) Health Policy Unit http://www.okhca.org/proposed-rule-changes.aspx

OHCA COMMENT DUE DATE: January 12, 2011

The proposed policy is a Permanent Rule. This proposal is scheduled to be presented to the Medical Advisory Committee (MAC) on January 19, 2012 and the (OHCA) Board of Directors in March 2012.
Reference: APA WF 11-38

SUMMARY:
PAP Certificates of Medical Necessity— Policy is revised to remove the requirement for a certificate of medical necessity for positive airway pressure devices (BiPAP and CPAP) as such CMNs are no longer used for authorization decisions. The agency's Medical Authorization Unit and physicians rely on documentation from sleep studies and other medical records to prior authorize.

LEGAL AUTHORITY
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes

RULE IMPACT STATEMENT:
TO: Tywanda Cox
Health Policy

FROM: Joseph Fairbanks
Health Policy

SUBJECT: Rule Impact Statement
APA WF # 11-38

A. Brief description of the purpose of the rule:

Policy is revised to remove the requirement for a certificate of medical necessity for positive airway pressure devices (BiPAP and CPAP) as such CMNs are no longer used for authorization decisions. The agency's Medical

Authorization Unit and physicians rely on documentation from sleep studies and other medical records to prior authorize.

B. A description of the classes of persons who most likely will be affected by the proposed rule, including classes that will bear the cost of the proposed rule, and any information on cost impacts received by the agency from any private or public entities:

No classes of persons will be affected by the proposed rule.

C. A description of the classes of persons who will benefit from the proposed rule:

Durable medical equipment providers and their SoonerCare customers will benefit as unnecessary paperwork will no longer be required.

D. A description of the probable economic impact of the proposed rule upon the affected classes of persons or political subdivisions, including a listing of all fee changes and, whenever possible, a separate justification for each fee change:

There is no economic impact and there are no fee changes associated with the rule change for the above classes of persons or any political subdivision.

E. The probable costs and benefits to the agency and to any other agency of the implementation and enforcement of the proposed rule, the source of revenue to be used for implementation and enforcement of the proposed rule, and any anticipated affect on state revenues, including a projected net loss or gain in such revenues if it can be projected by the agency:

The rule change will have no budget impact.

F. A determination of whether implementation of the proposed rule will have an economic impact on any political subdivisions or require their cooperation in implementing or enforcing the rule:

There is no economic impact on political subdivisions.

G. A determination of whether implementation of the proposed rule will have an adverse effect on small business as

provided by the Oklahoma Small Business Regulatory Flexibility Act:

There should be no adverse economic impact on small businesses as a result of this rule.

H. An explanation of the measures the agency has taken to minimize compliance costs and a determination of whether there are less costly or non-regulatory methods or less intrusive methods for achieving the purpose of the proposed rule:

The agency has taken measures to determine that there is no less costly or non-regulatory method or less intrusive method for achieving the purpose of the proposed rule.

I. A determination of the effect of the proposed rule on the public health, safety and environment and, if the proposed rule is designed to reduce significant risks to the public health, safety and environment, an explanation of the nature of the risk and to what extent the proposed rule will reduce the risk:

The proposed rule should have no effect on the public health, safety, and environment.

J. A determination of any detrimental effect on the public health, safety and environment if the proposed rule is not implemented:

OHCA does not believe there is a detrimental effect on the public health and safety if the rule is not passed.

K. The date the rule impact statement was prepared and if modified, the date modified:

The rule impact statement was prepared December 8, 2011.

RULE TEXT

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 17. MEDICAL SUPPLIERS

317:30-5-211.10. Durable medical equipment (DME)

(a) **DME**. DME includes, but is not limited to: medical supplies, orthotics and prosthetics, custom braces, therapeutic lenses, respiratory equipment and other qualifying items when acquired from a contracted DME provider.

(b) **Certificate of medical necessity**. Certain items of DME require a CMN/OHCA CMN which should be submitted with the request for prior authorization. These items include but are not limited to:

(1) hospital beds;

(2) support surfaces;

~~(3) continuous positive airway pressure devices (BiPAP and CPAP);~~

~~(4)~~ (3) patient lift devices;

~~(5)~~ (4) external infusions pumps;

~~(6)~~ (5) enteral and parenteral nutrition;

~~(7)~~ (6) osteogenesis stimulators; and

~~(8)~~ (7) pneumatic compression devices.

(c) **Prior authorization.**

(1) **Rental.** Rental of hospital beds, support surfaces, continuous positive airway pressure devices (CPAP and BiPAP), pneumatic compression devices, and lifts require prior authorization and, except for CPAP and BiPAP devices, a completed CMN/OHCA CMN; medical necessity must be documented in the member's medical record and be signed by the physician.

(2) **Purchase.** Equipment will be purchased when a member requires the equipment for an extended period of time. During the prior authorization review the PA consultant may change the authorization from a rental to a purchase or a purchase to a rental based on the documentation submitted. The provider must indicate whether the DME item provided is new or used.

(d) **Backup equipment.** Backup equipment is considered part of the rental cost and not a covered service without prior authorization.

(e) **Home modification.** Equipment used for home modification is not a covered service.

Oklahoma Health Care Authority

It is very important that you provide your comments regarding the proposed rule change by the comment due date. Comments are directed to Oklahoma Health Care Authority (OHCA) Health Policy Unit http://www.okhca.org/proposed-rule-changes.aspx

OHCA COMMENT DUE DATE: January 18, 2011

The proposed policy is a Permanent Rule. This proposal is scheduled to be presented to the Medical Advisory Committee (MAC) on January 19, 2012 and the (OHCA) Board of Directors on March 8, 2012.
Reference: APA WF 11-40

SUMMARY:
Eligibility Clean-Up— Eligibility policy is revised for clarity and updates. All changes are minor and will not affect programs or budget. The revisions include changing a form number and altering punctuation to ensure the meaning and intention of the policy is clear.

LEGAL AUTHORITY
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes

RULE IMPACT STATEMENT:
TO: Tywanda Cox
Health Policy

FROM: Joseph Fairbanks
Health Policy

SUBJECT: Rule Impact Statement
APA WF # 11-40

A. Brief description of the purpose of the rule:

Eligibility policy is revised for clarity and updates. All changes are minor and will not affect programs or budget. The revisions include changing a form number and altering punctuation to ensure the meaning and intention of the policy is clear.

B. A description of the classes of persons who most likely will be affected by the proposed rule, including classes that will bear the cost of the proposed rule, and any information on cost impacts received by the agency from any private or public entities:

There is no class of persons who will be affected by this rule. Changes are minor and only for purposes of clarity.

C. A description of the classes of persons who will benefit from the proposed rule:

No classes of persons will benefit from the proposed rule. The proposed rule merely clarifies policy.

D. A description of the probable economic impact of the proposed rule upon the affected classes of persons or political subdivisions, including a listing of all fee changes and, whenever possible, a separate justification for each fee change:

There is no economic impact and there are no fee changes associated with the rule change.

E. The probable costs and benefits to the agency and to any other agency of the implementation and enforcement of the proposed rule, the source of revenue to be used for implementation and enforcement of the proposed rule, and any anticipated affect on state revenues, including a projected net loss or gain in such revenues if it can be projected by the agency:

The rule change will not result in any additional costs or revenue changes to the agency.

F. A determination of whether implementation of the proposed rule will have an economic impact on any political subdivisions or require their cooperation in implementing or enforcing the rule:

There is no economic impact on political subdivisions.

G. A determination of whether implementation of the proposed rule will have an adverse effect on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act:

There is no adverse economic impact on small businesses as a result of this rule.

H. An explanation of the measures the agency has taken to minimize compliance costs and a determination of whether there are less costly or non-regulatory methods or less intrusive methods for achieving the purpose of the proposed rule:

The agency has taken measures to determine that there is no less costly or non-regulatory method or less intrusive method for achieving the purpose of the proposed rule.

I. A determination of the effect of the proposed rule on the public health, safety and environment and, if the proposed rule is designed to reduce significant risks to the public health, safety and environment, an explanation of the nature of the risk and to what extent the proposed rule will reduce the risk:

The proposed rule should have no effect on the public health, safety, and environment.

J. A determination of any detrimental effect on the public health, safety and environment if the proposed rule is not implemented:

OHCA does not believe there is a detrimental effect on the public health and safety if the rule is not passed.

K. The date the rule impact statement was prepared and if modified, the date modified:

The rule impact statement was prepared December 15, 2011.

RULE TEXT

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME
PART 1. DETERMINATION OF QUALIFYING CATEGORICAL RELATIONSHIPS

317:35-5-4. Determining categorical relationship to the disabled

An individual is related to disability if he/she is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death, or which has lasted (or can be expected to last) for a continuous period of not less than 12 months.

(1) **Determination of categorical relationship to the disabled by SSA.** The procedures outlined in (A) through (G) of this paragraph are applicable when determining categorical relationship based on a SSA disability decision:

(A) **Already determined eligible for Social Security disability benefits.** If the applicant states he/she is already receiving Social Security benefits on the basis of disability, the information is verified by seeing the applicant's notice of award or the Social Security benefit check. If the applicant states an award letter approving Social Security disability benefits has been received but a check has not been received, this information is verified by seeing the award letter. Such award letter or check establishes categorical relationship. The details of the verification used are recorded in the case record.

(B) **Already determined eligible for SSI on disability.** If the applicant, under age 65, states he/she is already receiving SSI on the basis of his/her disability (or that a written notice of SSI eligibility on disability has been received but has not yet received a check) this information is verified by seeing the written notice or check. If neither are available, the county clears on the terminal system for the Supplemental Data Exchange (SDX) record. The SDX record shows, on the terminal, whether the individual has been approved or denied for SSI. If the individual has been approved for such benefits, the county uses this terminal clearance to establish disability for categorical relationship. The details of the verification used are recorded in the case record.

(C) **Pending SSI/SSA application or has never applied for SSI.** If the applicant says he/she has a pending SSI/SSA application, an SDX record may not appear on the terminal. Therefore, it is requested that the applicant bring the notice regarding the action taken on his/her SSI/SSA application to the county office as soon as it is received. The other conditions of eligibility are established while awaiting the SSI/SSA decision. When the SSI/SSA notice is presented, the details of the verification are recorded in the case record and the

indicated action is taken on the Title XIX application. If the applicant says he/she has never applied for SSI/SSA but appears potentially eligible from the standpoint of unearned income and has an alleged disability which would normally be expected to last for a period of 12 months, he/she is referred to the SSA office to make SSI/SSA application immediately following the filing of the Title XIX application.

(D) **Already determined ineligible for SSI.** If the applicant says he/she has been determined ineligible for SSI, the written notice of ineligibility from SSA is requested to determine if the denial was based on failure to meet the disability definition. If the SSI notice shows ineligibility was due to not meeting the disability definition, and the applicant says the medical condition has not worsened since the SSI denial, the Title XIX application is denied for the same reason. If written notice is not available, the SDX record on the terminal system is used. This record shows whether the individual has been determined eligible or ineligible for SSI. If he/she has been determined ineligible, the payment status code for ineligibility is shown. The definition of this code is found on OKDHS Appendix Q in order to determine the reason for SSI ineligibility. If the reason for SSI ineligibility was based on failure to meet the disability definition, the Title XIX application is denied for the same reason and the details of the verification are recorded in the case record. If the reason for SSI ineligibility was based on some reason other than failure to meet the disability definition (and therefore, a determination of disability was not made), the Level of Care Evaluation Unit (LOCEU) must determine categorical relationship. In any instance in which an applicant who was denied SSI on "disability" states the medical condition has worsened since the SSI denial, he/she is referred to the SSA office to reapply for SSI immediately following the filing of the Title XIX application.

(E) **Already determined ineligible for Social Security disability benefits.** If the applicant says he/she has been determined ineligible for Social Security disability benefits, he/she is requested to provide written notice of ineligibility to determine if the denial was based on failure to meet the disability definition. If the SSA notice shows ineligibility was due to not meeting the disability definition, and the applicant says the medical condition has not worsened since the denial, the Title XIX application is denied for the same reason. The

details of the verification used are recorded in the case record. If the written notice is not available, TPQY procedure is used to verify the denial and the reason for ineligibility. If the reason for ineligibility was based on failure to meet the disability definition, the Title XIX application is denied for the same reason and the details of the verification are recorded in the case record. If the reason for ineligibility was based on some reason other than failure to meet the disability definition (and a determination of disability was, thus, not made), the LOCEU must determine categorical relationship. In any instance in which an applicant who was denied Social Security benefits on disability states the medical condition has worsened since the denial, he/she is referred to the SSA office to reapply immediately following the filing of the Title XIX application.

(F) **Determined retroactively eligible for SSA/SSI due to appeal.** If an individual becomes retroactively eligible for SSA/SSI due to a decision on an appeal, categorical relationship is established as of the effective date of the retroactive disability decision. Payment will be made for medical services only if the claim is received within 12 months from the date of medical services. If the effective date of the retroactive disability decision does not cover the period of the medical service because the SSA/SSI application was made subsequent to the service, a medical social summary with pertinent medical information is sent to the LOCEU for a categorical relationship decision for the time period of the medical service.

(G) **SSA/SSI appeal with benefits continued.** A Title XIX recipient who has filed an appeal due to SSA's determination that he/she is no longer disabled may continue to receive SSA benefits. The recipient has the option to have Title XIX benefits continued until the appeal decision has been reached. After the decision has been reached, the appropriate case action is taken. If SSA's decision is upheld, an overpayment referral is submitted for any Title XIX benefits the recipient received beginning with the month that SSA/SSI determined the recipient did not meet disability requirements.

(H) **Applicant deceased.** Categorical relationship to the disabled is automatically established if an individual dies while receiving a medical service or dies as a result of an illness for which he/she was hospitalized if death occurs within two months after hospital release.

The details of the verification used are recorded in the case record.

(2) **Determination of categorical relationship to the disabled by the LOCEU.**

(A) A disability decision from the LOCEU to determine categorical relationship to the disabled is required only when SSA makes a disability decision effective after medical services were received or when the SSA will not make a disability decision. The LOCEU is advised of the basis for the referral. SSA does not make disability decisions on individuals who:

(i) have been determined ineligible by SSA on some condition of eligibility other than disability,

(ii) have unearned income in excess of the SSI standard and, therefore, are not referred to SSA, or

(iii) do not have a disability which would normally be expected to last 12 months but the applicant disagrees.

(B) A disability decision from the LOCEU is not required if the disability obviously will not last 12 months and the individual agrees with the short term duration. The case record is documented to show the individual agrees with the short term duration.

(C) The local OKDHS office is responsible for submitting a medical social summary on OKDHS form ~~ABCDM-80-B~~ ABCDM-80-D 08MA022E with pertinent medical information substantiating or explaining the individual's physical and mental condition. The medical social summary should include relevant social information such as the worker's personal observations, details of the individual's situation including date of onset of the disability, and the reason for the medical decision request. The worker indicates the beginning date for the categorical relationship to disability. Medical information submitted might include physical exam results, psychiatric, lab, and x-ray reports, hospital admission and discharge summaries, and/or doctors' notes and statements. Copies of medical and hospital bill and OKDHS Form ~~MS-MA-5~~ 08MA005E are not normally considered pertinent medical information by themselves. Current (less than 90 days old) medical information is required for the LOCEU to make a decision on the client's current disability status. If existing medical information cannot be obtained without cost to the client, the county administrator authorizes either payment for existing medical information or one general physical examination by a medical or osteopathic physician of the client's

choice. The physician cannot be in an intern, residency or fellowship program of a medical facility, or in the full-time employment of Veterans Administration, Public Health Service or other Agency. Such examination is authorized by use of OKDHS form ~~ABCDM-16~~ 08MA016E, Authorization for Examination and Billing. The OKDHS worker sends the ~~ABCDM-16~~ 08MA016E and OKDHS form ~~ABCDM-80~~ 08MA080E, Report of Physician's Examination, to the physician who will be completing the exam.

(i) **Responsibility of Medical Review Team in the LOCEU.** The responsibilities of the Medical Review Team in the LOCEU include:

(I) The decision as to whether the applicant is related to Aid to the Disabled.

(II) The effective date (month and year) of eligibility from the standpoint of disability. (This date may be retroactive for any medical service provided on or after the first day of the third month prior to the month in which the application was made.)

(III) A request for additional medical and/or social information when additional information is necessary for a decision.

(IV) Authorizing specialists' examinations as needed.

(V) Setting a date for re-examination, if needed.

(ii) **Specialist's examination.** If, on receipt of the medical information from the county office, the LOCEU needs additional medical information, the LOCEU may, at their discretion, make an appointment for a specialist's examination by a physician selected by the medical member of the team and authorize it on Form M-S-32, Request to Physician for Examination and Authorization for Billing, routing the original of the form to the examining physician and a copy to the county office. As soon as the county receives a copy of Form M-S-32, the worker immediately notifies the individual of the appointment and explains that failure to keep the appointment with the specialist without good cause will result in denial of the application (or closure of the case in instances of determination of continuing disability). The worker assists the individual in keeping the appointment, if necessary.

(I) If the specialist requires additional laboratory work or X-rays, he/she should call the LOCEU for authorization. The LOCEU is responsible

for making the decision regarding the request. If additional medical services are authorized, another Form M-S-32 will be completed.

(II) If the individual notifies the worker at least 24 hours prior to the date of the examination that he/she cannot keep the appointment, this constitutes good cause. In such an instance, the worker cancels the appointment, makes a new appointment, and submits information regarding the cancellation and the date of a new appointment to the LOCEU.

(III) When the individual fails to keep the appointment without advance notice, good cause must be determined. The worker determines the reasons and submits a memorandum to the LOCEU for a decision on good cause.

(IV) If the appointment was missed due to illness, the illness must be supported by a written statement from a physician. If missed for some reason other than illness, the reason must be supported by an affidavit signed by someone other than the individual or his/her representative and sworn to before a notary public or other person authorized to administer oaths. If, in the opinion of the LOCEU, good cause is established, the LOCEU and the county follow the same procedures as outlined in (2)(C)(ii) of this Section for any other specialist's examination. If, in the opinion of the LOCEU, good cause is not established, the LOCEU notifies the local office. The local office is responsible for denying the application or closing the case with notification to individual in accordance with OHCA and Department policy.

(D) When the LOCEU has made a determination of categorical relationship to disability and SSA later renders a different decision, the county uses the effective date of the SSA approval or denial as their date of disability approval or denial. No overpayment will occur based solely on the SSA denial superseding the LOCEU approval.

(E) Public Law 97-248, the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982, provides coverage to certain disabled children living in the home if they would qualify for Medicaid as residents of nursing facilities, ICF/MRs, or inpatient acute care hospital stays expected to last not less than 60 days. In

addition to disability LOCEU determines the appropriate level of care and cost effectiveness.

(3) **Determination of categorical relationship to the disabled based on TB infection.** Categorical relationship to disability is established for individuals with a diagnosis of tuberculosis (TB). An individual is related to disability for TB related services if he/she has verification of an active TB infection established by a medical practitioner.

(4) **Determination of categorical relationship to the disabled for TEFRA.** Section 134 of TEFRA allows states, at their option, to make Medicaid benefits available to children, under 19 years of age, living at home who are disabled as defined by the Social Security Administration, even though these children would not ordinarily be eligible for SSI benefits because of the deeming of parental income or resources. Under TEFRA, a child living at home who requires the level of care provided in an acute care hospital (for a minimum of 60 days), nursing facility or intermediate care facility for the mentally retarded, is determined eligible using only his/her income and resources as though he/she were institutionalized.

SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME
PART 5. COUNTABLE INCOME AND RESOURCES

317:35-5-43. Third party resources; insurance, workers' compensation and Medicare

Federal Regulations require that all reasonable measures to ascertain legal liability of third parties to pay for care and services be taken. In instances where such liability is found to exist after SoonerCare has been made available, reimbursement to the extent of such legal liability must be sought. The applicant or member must fully disclose to OHCA that another resource may be available to pay for care. If OKDHS obtains information regarding other available resources from a third party, the worker must complete OKDHS Form 08AD050E, and submit to OHCA, Third Party Liability Unit. Certification or payment in behalf of an eligible individual may not be withheld because of the liability of a third party when such liability or the amount cannot be currently established or is not currently available to pay the individual's medical expense. The rules in this Section also apply when an individual categorically related to pregnancy-related services plans to put the child up for adoption. Any agreement with an adoption agency or attorneys shall include payment of medical care and must be considered as a possibly

liable third party, regardless of whether agreement is made during prenatal, delivery or postpartum periods.

(1) **Insurance.**

(A) **Private insurance.** An individual requesting SoonerCare is responsible for identifying and providing information on any private medical insurance. He/she is also responsible for reporting subsequent changes in insurance coverage.

(B) **Government benefits.** Individuals requesting SoonerCare who are also eligible for Civilian Health and Medical Programs for Uniformed Services (CHAMPUS), must disclose that the coverage is available. They are considered a third party liability source.

(2) **Workers' Compensation.** An applicant for SoonerCare or a SoonerCare member that requires medical care because of a work injury or occupational disease must notify OHCA/TPL immediately and assist OHCA in ascertaining the facts related to the injury or disease (such as date, details of the accident, etc.). The OHCA periodically matches data with the Worker's Compensation Court on all cases under its jurisdiction. When any information regarding an applicant for SoonerCare or a SoonerCare member is obtained, the member must assist OHCA with the subrogation claim with the employer/insurer.

(3) **Third party liability (accident or injury).** When medical services are required for an applicant of SoonerCare or a SoonerCare member as the result of an accident or injury known to the worker, the member is responsible for reporting to OHCA/TPL the persons involved in the accident, date and details of the accident and possible insurance benefits which might be made available. If an automobile accident involves more than one car it is necessary to report liability insurance on all cars involved.

(A) If OKDHS receives information regarding a SoonerCare member or applicant seeking medical services due to an accident, the worker submits any information available to OHCA/TPL.

(B) If OHCA receives a claim for payment from SoonerCare funds and the diagnosis indicates the need for services may have resulted from an accident or injury involving third party liability, OHCA will attempt to contact the member to obtain details of the incident. If additional contact is necessary with the member, the local OKDHS office or OHCA representative may be requested by the OHCA/TPL Unit to submit the appropriate information.

(4) **Medicare eligibility.** If it appears the applicant may be eligible for Medicare but does not have a Medicare card

or other verification, the information is cleared with the Social Security Office and the findings entered with the date of the verification in the record. If the applicant did not enroll for Part A or Part B at the time he/she became eligible for Medicare and is now subject to pay an escalated premium for Medicare enrollment, he/she is ~~not~~ required to do so. Payment can be made for services within the scope of SoonerCare.

(5) **Absent parent.**

(A) Applicants are required to cooperate with the Oklahoma Department of Human Services Oklahoma Child Support Services (OCSS) in the assignment of child/spousal support rights. The families involved are those with a minor child(ren) in the home. The child(ren) must be related to AFDC, AB or AD and have a parent(s) absent from the home. Any support collected on behalf of these families will be paid to them as if they were receiving non-public assistance child support services, with one exception. The exception is regarding child support collected for foster care child(ren) in OKDHS temporary custody. This support is paid to OKDHS Children and Family Services Division (CFSD). The child support income continues to be counted in determining SoonerCare eligibility. The rules in OAC 317:10 are used, with the following exceptions:

(i) In the event the family already has an existing child support case, the only action required is a memo to the appropriate OCSS district office notifying them of the certification.

(ii) Child/spousal support is always counted as income less any applicable income disregard. This income inclusion applies whether it is redirected to the CFSD or retained by the member.

(iii) Children who are in custody of OKDHS may be exempt from referral to OCSS. Should the pursuit of the OCSS services be determined to be detrimental to the OKDHS CFSD service plan, an exemption may be approved.

(B) Cash medical support may be ordered to be paid to the OHCA by the non-custodial parent if there is no access to health insurance at a reasonable cost or if the health insurance is determined not accessible to the child according to OCSS Rules. Reasonable is deemed to be 5% or less of the non-custodial parent's gross income. The administration and collection of cash medical support will be determined by OKDHS OCSS and will be based on the income guidelines and rules that are applicable at the

time. However, at no time will the non-custodial parent be required to pay more than 5% of his/her gross income for cash medical support unless payment in excess of 5% is ordered by the Court. The disbursement and hierarchy of payments will be determined pursuant to OKDHS/OCSS guidelines.

SUBCHAPTER 22. PREGNANCY RELATED BENEFITS COVERED UNDER TITLE XXI

317:35-22-1. Pregnancy related benefits covered under Title XXI

(a) The revision of the definition of child at 42 CFR 457.10, allows states to cover pregnancy related services under Title XXI, individuals who would not otherwise qualify for services under SoonerCare. This coverage is intended to benefit newborn children who are Oklahoma residents at birth.

(b) To receive pregnancy related services under Title XXI, the pregnant woman must:

(1) be otherwise ineligible for any other categorically SoonerCare eligibility group;

(2) reside in Oklahoma with the intent to remain, at the time services are rendered;

(3) have household income at or below 185% FPL; and

(4) not be covered by creditable insurance, the term creditable insurance means coverage under a group health plan or other health insurance as defined in the Health Insurance Portability and Accountability Act (HIPAA).

(c) All services are subject to post payment review by the OHCA or its designated agent.

Oklahoma Health Care Authority

It is very important that you provide your comments regarding the proposed rule change by the comment due date. Comments are directed to Oklahoma Health Care Authority (OHCA) Health Policy Unit http://www.okhca.org/proposed-rule-changes.aspx

OHCA COMMENT DUE DATE: January 18, 2012

The proposed policy is a Permanent Rule. This proposal is scheduled to be presented to the Medical Advisory Committee (MAC) on January 19, 2012 and the (OHCA) Board of Directors on March 08, 2012.
Reference: APA WF 11-41

SUMMARY:
Rules are revised to add Oklahoma Department of Mental Health Substance Abuse Service (ODMHSAS) Mental Health Service Program certification as an option for provider participation standards in lieu of national accreditation.

LEGAL AUTHORITY
The Oklahoma Health Care Authority Board; Then Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes;43A Oklahoma Statutes §3-323A

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

TO: Tywanda Cox
Policy Development

From: LeKenya Samilton

SUBJECT: Rule Impact Statement
APA WF # 11-41

A. Brief description of the purpose of the rule:

Outpatient Behavioral Health rules are revised to comply with Title 43A of the Oklahoma Statutes that allows outpatient behavioral health facilities/organizations the option of using Oklahoma Department of Mental Health and Substance Abuses

Services (ODMHSAS) certification in lieu of national accreditation for complying with SoonerCare provider participation standards.

B. A description of the classes of persons who most likely will be affected by the proposed rule, including classes that will bear the cost of the proposed rule, and any information on cost impacts received by the agency from any private or public entities:

The classes of persons most affected by this rule are outpatient behavioral health facilities/organizations that require national accreditation as a requirement of provider participation.

C. A description of the classes of persons who will benefit from the proposed rule:

The persons who will most likely benefit from the proposed rule will be the outpatient behavioral health facilities/organizations. These providers will now have additional options that will assist facilities/organizations in meeting participation standards for SoonerCare contracting.

D. A description of the probable economic impact of the proposed rule upon the affected classes of persons or political subdivisions, including a listing of all fee changes and, whenever possible, a separate justification for each fee change:

There is no probable economic impact of the proposed rule upon any classes of persons or political subdivisions.

E. The probable costs and benefits to the agency and to any other agency of the implementation and enforcement of the proposed rule, the source of revenue to be used for implementation and enforcement of the proposed rule, and any anticipated affect on state revenues, including a projected net loss or gain in such revenues if it can be projected by the agency:

There is no budgetary impact as a result of this rule.

F. A determination of whether implementation of the

proposed rule will have an economic impact on any political subdivisions or require their cooperation in implementing or enforcing the rule:

The proposed rule will not have an economic impact on any political subdivision or require their cooperation in implementing or enforcing the rule.

G. A determination of whether implementation of the proposed rule will have an adverse effect on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act:

The proposed rule will not have an adverse effect on small businesses as provided by the Oklahoma Small Business Regulatory Flexibility Act.

H. An explanation of the measures the agency has taken to minimize compliance costs and a determination of whether there are less costly or nonregulatory methods or less intrusive methods for achieving the purpose of the proposed rule:

There agency has taken measures to determine that there is no less costly or non-regulatory method or less intrusive method for achieving the purpose of the proposed rule.

I. A determination of the effect of the proposed rule on the public health, safety and environment and, if the proposed rule is designed to reduce significant risks to the public health, safety and environment, an explanation of the nature of the risk and to what extent the proposed rule will reduce the risk:

The proposed rule should have no effect on the public health, safety, or environment.

J. A determination of any detrimental effect on the public health, safety and environment if the proposed rule is not implemented:

The agency does not anticipate any detrimental effects on the public health, safety, or environment.

K. The date the rule impact statement was prepared and if modified, the date modified:

This rule impact statement was prepared on December 23, 2011.

RULE TEXT

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 21. OUTPATIENT BEHAVIORAL HEALTH SERVICES

317:30-5-240. Eligible providers

All outpatient behavioral health providers eligible for reimbursement under OAC 317:30-5-240 et seq. must be an accredited or Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) certified organization/agency in accordance with Section(s) 3-317, 3-323A, 3-306.1 and 3-415 of Title 43A of the Oklahoma Statutes and have a current contract on file with the Oklahoma Health Care Authority. Eligibility requirements for independent professionals (e.g., physicians and Licensed Behavioral Health Professionals), who provide outpatient behavioral health services and bill under their own national provider identification (NPI) number are covered under OAC 317:30-5-1 and OAC 317:30-5-275. Other outpatient ambulatory clinics (e.g. Federally Qualified Health Centers, Indian Health Clinics, school-based clinics) that offer outpatient behavioral health services are covered elsewhere in the agency rules.

317:30-5-240.1. Definitions

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

"Accrediting body" means one of the following:

(A) Accreditation Association for Ambulatory Health Care (AAAHC);

(B) American Osteopathic Association (AOA);

(C) Commission on Accreditation of Rehabilitation Facilities (CARF);

(D) Council on Accreditation of Services for Families and Children, Inc. (COA);

(E) The Joint Commission (TJC) formerly known as Joint Commission on Accreditation of Healthcare Organizations; or

(F) other OHCA approved accreditation.

"Adult" means an individual 21 and over, unless otherwise specified.

"AOD" means Alcohol and Other Drug.

"AODTP" means Alcohol and Other Drug Treatment Professional.

"BH" means behavioral health, which relates to mental, substance abuse, addictions, gambling, and other diagnosis and treatment.
"BHAs" means Behavioral Health Aides.
"BHRS" means Behavioral Health Rehabilitation Specialist.
"Certifying Agency" means the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS).
"Child" means an individual younger than 21, unless otherwise specified.
"CM" means case management.
"CMHC's" means Community Mental Health Centers who are state operated or privately contracted providers of behavioral health services for adults with severe mental illnesses, and youth with serious emotional disturbances.
"Cultural competency" means the ability to recognize, respect, and address the unique needs, worth, thoughts, communications, actions, customs, beliefs and values that reflect an individual_s racial, ethnic, age group, religious, sexual orientation, and/or social group.
"DSM" means the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.
"EBP" means an Evidence Based Practice per the Substance Abuse & Mental Health Services Administration (SAMHSA).
"FBCS" means Facility Based Crisis Stabilization.
"FSPs" means Family Support Providers.
"ICF/MR" means Intermediate Care Facility for the Mentally Retarded.
"Institution" means an inpatient hospital facility or Institution for Mental Disease (IMD).
"IMD" means Institution for Mental Disease as per 42 CFR 435.1009 as a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care and related services. The regulations indicate that an institution is an IMD if its overall character is that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases. Title XIX of the Social Security Act provides that, except for individuals under age 21 receiving inpatient psychiatric care, Medicaid (Title XIX) does not cover services to IMD patients under 65 years of age [section 1905(a)(24)(B)].
"LBHP" means a Licensed Behavioral Health Professional.
"MST" means the EBP Multi-Systemic Therapy.
"OAC" means Oklahoma Administrative Code, the publication authorized by 75 O.S. 256 known as The Oklahoma Administrative Code, or, prior to its publication, the

compilation of codified rules authorized by 75 O.S. 256(A)(1)(a) and maintained in the Office of Administrative Rules.

"Objectives" means a specific statement of planned accomplishments or results that are specific, measurable, attainable, realistic, and time-limited.

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

"ODMHSAS contracted facilities" means those providers that have a contract with the ODMHSAS to provide mental health or substance abuse treatment services, and also contract directly with the Oklahoma Health Care Authority to provide Outpatient Behavioral Health Services.

"OHCA" means the Oklahoma Health Care Authority.

"OJA" means the Office of Juvenile Affairs.

"Provider Manual" means the OHCA BH Provider Billing Manual.

"RBMS" means Residential Behavioral Management Services within a group home or therapeutic foster home.

"Recovery" means an ongoing process of discovery and/or rediscovery that must be self defined, individualized and may contain some, if not all, of the ten fundamental components of recovery as outlined by SAMHSA.

"RSS" means Recovery Support Specialist.

"SAMHSA" means the Substance Abuse and Mental Health Services Administration.

"SED" means Severe Emotional Disturbance.

"SMI" means Severely Mentally Ill.

"Trauma informed" means the recognition and responsiveness to the presence of the effects of past and current traumatic experiences in the lives of members.

317:30-5-240.2 Provider participation standards

(a) **Accreditation and certification status**. Any agency may participate as an OPBH provider if the agency is qualified to render a covered service and meets the OHCA requirements for provider participation.

(1) Private, Community-based Organizations must be accredited as a provider of outpatient behavioral health services from one of the accrediting bodies and be an incorporated organization governed by a board of directors or be certified by the certifying agency in accordance with Section(s) 3-317, 3-323A, 3-306.1 and 3-415 of Title 43A of the Oklahoma Statutes;

(2) State-operated programs under the direction of ODMHSAS must be accredited by one of the accrediting bodies or be certified by the certifying agency in accordance with

Section(s) 3-317, 3-323A, 3-306.1 and 3-415 of Title 43A of the Oklahoma Statutes;

(3) Freestanding Psychiatric Hospitals must be licensed and certified by the State Survey Agency as meeting Medicare psychiatric hospital standards and JCAHO accreditation;

(4) General Medical Surgical Hospitals must be appropriately licensed and certified by the State Survey Agency as meeting Medicare standards, including a JCAHO or AOA accreditation;

(5) Federally Qualified Health Centers/Community Health Centers facilities that qualify under OAC 317:30-5-660;

(6) Indian Health Services/Tribal Clinics/Urban Tribal Clinics facilities that qualify under Federal regulation;

(7) Rural Health Clinics facilities that qualify under OAC 317:30-5-355;

(8) Public Health Clinics and County Health Departments;

(9) Public School Systems.

(b) **Certifications.** In addition to the accreditation in paragraph (a) above or ODMHSAS certification(s) in accordance with Section(s) 3-317, 3-323A, 3-306.1 and 3-415 of Title 43A of the Oklahoma Statutes, provider specific credentials are required for the following:

(1) Substance Abuse agencies (OAC 450:18-1-1);

(2) Evidenced Based Best Practices but not limited to:

(A) Assertive Community Treatment (OAC 450:55-1-1);

(B) Multi-Systemic Therapy (Office of Juvenile Affairs); and

(C) Peer Support/Community Recovery Support;

(3) Systems of Care (OAC 340:75-16-46);

(4) Mobile and Facility-based Crisis Intervention (OAC 450:23-1-1);

(5) Case Management (OAC 450:50-1-1);

(6) RBMS in group homes (OAC 377:10-7) or foster care settings (OAC 340:75-8-4);

(7) Day Treatment - CARF, JCAHO, and COA will be required as of December 31, 2009; and

(8) Partial Hospitalization/Intensive Outpatient CARF, JCAHO, and COA will be required as of December 31, 2009.

(c) **Provider enrollment and contracting.**

(1) Organizations who have JCAHO, CARF, COA or AOA accreditation or ODMHSAS certification in accordance with Section(s) 3-317, 3-323A, 3-306.1 and 3-415 of Title 43A of the Oklahoma Statutes will supply the documentation from the accrediting body or certifying agency, along with other information as required for contracting purposes to the OHCA. The contract must include copies of all required state licenses, accreditation and certifications.

(2) If the contract is approved, a separate provider identification number for each outpatient behavioral health service site will be assigned. Each site operated by an outpatient behavioral health facility must have a separate provider contract and site-specific accreditation and/or certification as applicable. A site is defined as an office, clinic, or other business setting where outpatient behavioral health services are routinely performed. When services are rendered at the member's residence, a school, or when provided occasionally at an appropriate community based setting, a site is determined according to where the professional staff perform administrative duties and where the member's chart and other records are kept. Failure to obtain and utilize site specific provider numbers will result in disallowance of services.

(3) Effective 07/01/10, all behavioral health providers are required to have an individual contract with OHCA in order to receive SoonerCare reimbursement. This requirement includes outpatient behavioral health agencies and all individual rendering providers who work within an agency setting. Individual contracting requirements are set forth in the OHCA BH Provider Manual.

(d) **Standards and criteria.** Eligible organizations must meet each of the following:

(1) Have a well-developed plan for rehabilitation services designed to meet the recovery needs of the individuals served.

(2) Have a multi-disciplinary, professional team. This team must include all of the following:

(A) One of the LBHPs;

(B) A BHRS, if individual or group rehabilitative services for behavioral health disorders are provided;

(C) An AODTP, if treatment of alcohol and other drug disorders is provided;

(D) A registered nurse or physician assistant, with a current license to practice in the state in which the services are delivered if Medication Training and Support service is provided;

(E) The member for whom the services will be provided, and parent/guardian for those under 18 years of age.

(F) A member treatment advocate if desired and signed off on by the member.

(3) Demonstrate the ability to provide each of the following outpatient behavioral health treatment services as described in OAC 317:30-5-241 et seq., as applicable to their program. Providers must provide proper referral and linkage to

providers of needed services if their agency does not have appropriate services.

(A) Assessments and Treatment Plans;
(B) Psychotherapies;
(C) Behavioral Health Rehabilitation services;
(D) Crisis Intervention services;
(E) Support Services; and
(F) Day Treatment/Intensive Outpatient.

(4) Be available 24 hours a day, seven days a week, for Crisis Intervention services.

(5) Provide or have a plan for referral to physician and other behavioral health services necessary for the treatment of the behavioral disorders of the population served.

(6) Comply with all applicable Federal and State Regulations.

(7) Have appropriate written policy and procedures regarding confidentiality and protection of information and records, member grievances, member rights and responsibilities, and admission and discharge criteria, which shall be posted publicly and conspicuously.

(8) Demonstrate the ability to keep appropriate records and documentation of services performed.

(9) Maintain and furnish, upon request, a current report of fire and safety inspections of facilities clear of any deficiencies.

(10) Maintain and furnish, upon request, all required staff credentials including certified transcripts documenting required degrees.

Oklahoma Health Care Authority

It is very important that you provide your comments regarding the proposed rule change by the comment due date. Comments are directed to Oklahoma Health Care Authority (OHCA) Health Policy Unit http://www.okhca.org/proposed-rule-changes.aspx

OHCA COMMENT DUE DATE: January 18, 2012

The proposed policy is a Permanent Rule. This proposal is scheduled to be presented to the Medical Advisory Committee (MAC) on January 19, 2012 and the (OHCA) Board of Directors on March 8, 2012.
Reference: APA WF 11-42

SUMMARY:
Member Sanctions — Eligibility policy is revised to address sanctioning of members who abuse SoonerCare benefits. For members who OHCA has determined to have abused their benefits, sanctions are put in place such that on the first violation, the member's eligibility will be suspended for up to six months; for the second violation, the member's eligibility will be suspended for up to twelve months; and for the third violation, the member's eligibility will be suspended indefinitely. All sanctions, including the length of the penalty period, are subject to administrative due process.

LEGAL AUTHORITY
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes

RULE IMPACT STATEMENT:
TO: Tywanda Cox
Health Policy

FROM: Joseph Fairbanks
Health Policy

SUBJECT: Rule Impact Statement
APA WF # 11-42

A. Brief description of the purpose of the rule:

Eligibility policy is revised to address sanctioning of members who abuse SoonerCare benefits. For members who OHCA

has determined to have abused their benefits, sanctions are put in place such that on the first violation, the member's eligibility will be suspended for up to six months; for the second violation, the member's eligibility will be suspended for up to twelve months; and for the third violation, the member's eligibility will be suspended indefinitely. All sanctions, including the length of the penalty period, are subject to administrative due process.

B. A description of the classes of persons who most likely will be affected by the proposed rule, including classes that will bear the cost of the proposed rule, and any information on cost impacts received by the agency from any private or public entities:

SoonerCare members who OHCA has determined to have abused their SoonerCare benefits will be affected by the proposed rule, as they are subject to sanctions. There is no cost associated with the proposed rule.

C. A description of the classes of persons who will benefit from the proposed rule:

No classes of persons will benefit from the proposed rule.

D. A description of the probable economic impact of the proposed rule upon the affected classes of persons or political subdivisions, including a listing of all fee changes and, whenever possible, a separate justification for each fee change:

There is no economic impact and there are no fee changes associated with the rule change for the above classes of persons or any political subdivision.

E. The probable costs and benefits to the agency and to any other agency of the implementation and enforcement of the proposed rule, the source of revenue to be used for implementation and enforcement of the proposed rule, and any anticipated effect on state revenues, including a projected net loss or gain in such revenues if it can be projected by the agency:

The rule change will not result in any additional costs or revenue changes to the agency.

F. A determination of whether implementation of the proposed rule will have an economic impact on any political subdivisions or require their cooperation in implementing or enforcing the rule:

There is no economic impact on political subdivisions.

G. A determination of whether implementation of the proposed rule will have an adverse effect on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act:

There is no adverse economic impact on small businesses as a result of this rule.

H. An explanation of the measures the agency has taken to minimize compliance costs and a determination of whether there are less costly or non-regulatory methods or less intrusive methods for achieving the purpose of the proposed rule:

The agency has taken measures to determine that there is no less costly or non-regulatory method or less intrusive method for achieving the purpose of the proposed rule.

I. A determination of the effect of the proposed rule on the public health, safety and environment and, if the proposed rule is designed to reduce significant risks to the public health, safety and environment, an explanation of the nature of the risk and to what extent the proposed rule will reduce the risk:

The proposed rule should have no effect on the public health, safety, and environment.

J. A determination of any detrimental effect on the public health, safety and environment if the proposed rule is not implemented:

OHCA does not believe there is a detrimental effect on the public health and safety if the rule is not passed.

K. The date the rule impact statement was prepared and if modified, the date modified:

The rule impact statement was prepared December 14, 2011.

RULE TEXT

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
SUBCHAPTER 13. ~~CLIENT~~ MEMBER RIGHTS AND RESPONSIBILITIES

317:35-13-7. Program Abuse and Administrative Sanctions

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

(1) ~~"Abuse"~~ **"Abuse"** means ~~recipient~~ member actions that defraud the Oklahoma Health Care Authority (OHCA), cause unnecessary medical expenses to the program or over-utilize services provided by the OHCA. It shall also mean causing unnecessary or excessive claims to be submitted to the OHCA.

(2) ~~"Conviction"~~ **"Conviction"** or ~~"Convicted"~~ **"Convicted"** means a judgment of conviction has been entered by a Federal, State or local court, regardless of whether an appeal from that judgment is pending.

(3) ~~"Exclusion"~~ **"Exclusion"** means not being able to be certified for Medicaid benefits under the State Plan or Waivered services in Oklahoma.

(4) ~~"Fraud"~~ **"Fraud"** means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

(5) ~~"Knowingly"~~ **"Knowingly"** means that a person, with respect to information:

(A) has actual knowledge of the information;

(B) acts in deliberate ignorance of the truth or falsity of the information; or

(C) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.

(6) ~~"Medical Services Providers"~~ **"Medical Services Providers"** means:

(A) ~~"Practitioner"~~ **"Practitioner"** means a physician or other individual licensed under State law to practice his or her profession or a physician who meets all requirements for employment by the Federal Government as a physician and is employed by the Federal Government in an IHS facility or affiliated with a 638 Tribal facility.

(B) ~~"Supplier"~~ **"Supplier"** means an individual or entity, other than a provider or practitioner, who furnishes

health care services under Medicaid or other medical services programs administered by the OHCA.

(C) ~~"Provider"~~ **"Provider"** means:

(i) a hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, or a hospice that has in effect an agreement to participate in Medicaid, or any other medical services program administered by the OHCA, or

(ii) a clinic, a rehabilitation agency, or a public health agency that has a similar agreement.

(D) ~~"Laboratories"~~ **"Laboratories"** means any laboratory or place equipped for experimental study in science or for testing or analysis which has an agreement with the OHCA to receive Medicaid monies.

(E) ~~"Pharmacy"~~ **"Pharmacy"** means any pharmacy or place where medicines are compounded or dispensed or any pharmacist who has an agreement with OHCA to receive Medicaid monies for the dispensing of drugs.

(F) ~~"Any other provider"~~ **"Another other provider"** means any provider who has an agreement with OHCA to deliver health services, medicines, or medical services for the receipt of Medicaid monies.

(7) ~~"OIG"~~ **"OIG"** means the Office of Inspector General of the Department of Health and Human Services.

(8) ~~"Recipient"~~ **"Member"** means a beneficiary, patient or person served by the OHCA.

(9) ~~"Sanctions"~~ **"Sanctions"** means any administrative decision by OHCA to suspend or exclude a ~~recipient~~ member from the ability to be certified for medical assistance. A sanction may include a decision to use the remedy provided in OAC 317:30-3-14(b) or to require payment by the ~~recipient~~ member of the service.

(10) ~~"Suspension"~~ **"Suspension"** means an administrative action to suspend temporarily the certification of a case for medical assistance.

(11) ~~"Willfully"~~ **"Willfully"** means proceeding from a conscious motion of the will; voluntary, intending the result which comes to pass; intentional.

(b) **Basis for sanctions.**

(1) The OHCA may sanction a ~~recipient~~ member who has or has had a certified medical assistance case with OHCA for the following reasons:

(A) Knowingly or willfully made, or causing to be made, any false statement or misrepresentation of material fact to get a case certified or causing services to be rendered to the ~~recipient~~ member;

(B) Caused or ordered services under ~~Medicaid~~ SoonerCare

that are substantially in excess of the ~~**recipient's**~~ **member's** needs or that fail to meet professionally recognized standards for health care;

(C) Submitted or caused to be submitted to the ~~Medicaid~~ SoonerCare program, bills or requests for payment containing charges or costs that are substantially in excess of customary charges or costs; or

(D) Threatened harm to medical providers or state officials.

(2) The agency may base its determination that services are excessive or unnecessary based upon reports, including sanction reports, from any of the following sources:

(A) The PRO for the area served by the provider or the PRO contracted by OHCA;

(B) State or local law enforcement agencies and licensing or certification authorities;

(C) Peer review committees of fiscal agents or contractors;

(D) State or local professional societies;

(E) ~~Surveillance and Utilization Review Section~~ Program Integrity Reports done by OHCA;

(F) Medicaid Fraud Control Unit;

(G) Other sources, including internal investigations, deemed appropriate by the Medicaid agency or the OIG.

(3) OHCA must suspend from the ~~Medicaid program~~ SoonerCare any ~~recipient~~ member who has been suspended from participation in Medicare or Medicaid due to a conviction of a program related crime. This suspension must be at a minimum, the same period as the Medicare suspension.

(c) **Procedures for imposing sanctions.**

(1) Notice of proposed administrative sanction.

(A) If the OHCA proposes to sanction, it will send the ~~recipient~~ member a written notice stating:

(i) the reasons for the proposed sanction;

(ii) the date upon which the sanction will be effective;

(iii) the result of the sanction should it be imposed; and

(iv) a statement that the ~~recipient~~ member has a right to an evidentiary hearing prior to the imposition of the sanction.

(B) A copy of this section of the rules will be attached to the letter of proposed action.

(2) Notice of sanction.

(A) After an evidentiary hearing is conducted under OAC 317:2-1-2, the Agency will make a final administrative decision regarding the decision to sanction.

(B) Based upon its final decision, the Agency shall send a notice to the ~~recipient~~ member that provides:

(i) the reasons for the decision;

(ii) the effective date of the sanction;

(iii) the effect of the sanction on the party's participation in ~~the Medicaid program~~ SoonerCare;

(iv) the ~~recipient's~~ member's right to request a reconsideration of the Agency's final decision;

(v) the earliest date in which the Agency will accept a request for reinstatement;

(vi) the requirements and procedures for reinstatement; and

(vii) instructions on how to ask for reconsideration.

(d) **Effect of sanction.** OHCA will advise its eligibility agent of the closure or suspension of the case and when the ~~recipient~~ member can be recertified. The sanctions are as follows:

(1) For the first violation in which the Agency finds a member has abused SoonerCare benefits or SoonerCare waiver benefits, the member's eligibility may be suspended for a period of up to 6 months.

(2) For the second violation in which the Agency finds a member has abused SoonerCare benefits or SoonerCare waiver benefits, the member's eligibility may be suspended for a period of up to 12 months.

(3) For the third violation in which the Agency finds a member has abused SoonerCare benefits or SoonerCare waiver benefits, the member's eligibility may be suspended indefinitely.

(4) All member sanctions, including the length of the penalty period, are subject to administrative due process as described in this Section.

(e) **Criteria for reinstatement.**

(1) Upon the request for reinstatement made by the ~~recipient~~ member, OHCA may consider the following factors to reinstate the ~~recipient~~ member;

(A) The number and nature of the program violations and other related offenses.

(B) The nature and extent of any adverse impact the violations have had on providers or other ~~recipients~~ members;

(C) The amount of any damages;

(D) Any mitigating circumstances;

(E) Other facts bearing on the nature and seriousness of the program violations and related offenses;

(F) Convictions in a federal, state, or local court of other offenses related to participation in the Medicare or Medicaid program which were not considered during the

development of the exclusion; and

(G) Whether the state or local licensing authorities have taken any adverse action against the party for offenses related to participation in the Medicare or Medicaid program which were not considered during the development of the exclusion.

(2) Regardless of the applicability of one or many of the factors in paragraph (1) of this subsection, reinstatement shall not be granted unless it is reasonably certain that the violation(s) that led to the exclusion will not be repeated.

Oklahoma Health Care Authority

It is very important that you provide your comments regarding the proposed rule change by the comment due date. Comments are directed to Oklahoma Health Care Authority (OHCA) Health Policy Unit http://www.okhca.org/proposed-rule-changes.aspx

OHCA COMMENT DUE DATE: January 18, 2012

The proposed policy is a Permanent Rule. This proposal is scheduled to be presented to the Medical Advisory Committee (MAC) on January 19, 2012 and the (OHCA) Board of Directors on March 8, 2012.
Reference: APA WF 11-43

SUMMARY:
Pain Management During Anesthesia— Agency policy on anesthesia is revised to allow reimbursement for a pain management procedure when performed during an anesthesia session.

LEGAL AUTHORITY
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes

RULE IMPACT STATEMENT:

TO: Tywanda Cox
Health Policy

FROM: Joseph Fairbanks
Health Policy

SUBJECT: Rule Impact Statement
APA WF # 11-43

A. Brief description of the purpose of the rule:

Agency policy on anesthesia is revised to allow reimbursement for a pain management procedure when performed during an anesthesia session.

B. A description of the classes of persons who most likely will be affected by the proposed rule, including classes that will bear the cost of the proposed rule, and any information

on cost impacts received by the agency from any private or public entities:

There is no class of persons who will be affected by or bear the cost of the proposed rule.

C. A description of the classes of persons who will benefit from the proposed rule:

No classes of person will benefit from this proposed rule. This rule, however, will allow physicians to perform a pain management procedure during anesthesia, which will be beneficial primarily to children who require such a procedure.

D. A description of the probable economic impact of the proposed rule upon the affected classes of persons or political subdivisions, including a listing of all fee changes and, whenever possible, a separate justification for each fee change:

There is no economic impact and there are no fee changes associated with the rule change for the above classes of persons or any political subdivision.

E. The probable costs and benefits to the agency and to any other agency of the implementation and enforcement of the proposed rule, the source of revenue to be used for implementation and enforcement of the proposed rule, and any anticipated affect on state revenues, including a projected net loss or gain in such revenues if it can be projected by the agency:

The rule change is budget neutral.

F. A determination of whether implementation of the proposed rule will have an economic impact on any political subdivisions or require their cooperation in implementing or enforcing the rule:

There is no economic impact on political subdivisions.

G. A determination of whether implementation of the proposed rule will have an adverse effect on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act:

There is no adverse economic impact on small businesses as a result of this rule.

H. An explanation of the measures the agency has taken to minimize compliance costs and a determination of whether there are less costly or non-regulatory methods or less intrusive methods for achieving the purpose of the proposed rule:

The agency has taken measures to determine that there is no less costly or non-regulatory method or less intrusive method for achieving the purpose of the proposed rule.

I. A determination of the effect of the proposed rule on the public health, safety and environment and, if the proposed rule is designed to reduce significant risks to the public health, safety and environment, an explanation of the nature of the risk and to what extent the proposed rule will reduce the risk:

The proposed rule should have no effect on the public health, safety, and environment.

J. A determination of any detrimental effect on the public health, safety and environment if the proposed rule is not implemented:

OHCA does not believe there is a detrimental effect on the public health and safety if the rule is not passed.

K. The date the rule impact statement was prepared and if modified, the date modified:

The rule impact statement was prepared December 21, 2011.

RULE TEXT

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 1. PHYSICIANS

317:30-5-7. Anesthesia

(a) **Procedure codes.** Anesthesia codes from the Physicians' Current Procedural Terminology should be used. Payment is made only for the major procedure during an operative session.

(b) **Modifiers.** All anesthesia procedure codes must have a modifier. Without the modifier, the claim will be denied.
(c) **Qualifying circumstances.** Certain codes in the Medicine section of the CPT are used to identify extraordinary anesthesia services. The appropriate modifiers should be added to these codes. Additional payment can be made for extremes of age, total body hypothermia, and controlled hypertension.
(d) **Hypothermia.** Hypothermia total body or regional is not covered unless medical necessity is documented and approved through review by the Authority's Medical Consultants.
(e) **Anesthesia with Blood Gas Analysis.** Blood gas analysis is part of anesthesia service. Payment for anesthesia includes payment for blood gas analysis.
(f) **Steroid injections.** Steroid injections administered by an anesthesiologist are covered as nerve block. The appropriate CPT procedure code is used to bill services.
(g) **Local anesthesia.** If local anesthesia is administered by attending surgeon, payment is included in the global surgery fee, except for spinal or epidural anesthesia in conjunction with childbirth.
(h) **Stand by anesthesia.** This is not covered unless the physician is actually in the operating room administering medication, etc. If this is indicated, claim will be processed as if anesthesia was given. Use appropriate anesthesia code.
(i) **Other qualifying circumstances.** All other qualifying circumstances, i.e., physical status, emergency, etc. have been structured into the total allowable for the procedure.
(j) **Central venous catheter and anesthesia.** Payment for placement of central venous catheter, injection of anesthesia substance or similar procedures will be made only when the procedure is distinctly separate from the anesthesia procedure.
(k) **Pain management.** Pain management procedures performed during the anesthesia session will be covered when medically necessary to adequately control anticipated post-operative pain.