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: February 16, 2016

The proposed policy was submitted to the Medical Advisory Committee (MAC) on July 16, 2015 as an emergency policy change. The proposed policy was presented for Tribal Consultation on May 5, 2015. The proposed Permanent rule change is scheduled to be presented to the MAC on March 10, 2016 and the (OHCA) Board of Directors on March 24, 2016.

Reference: APA WF# 15-01

SUMMARY:
Dental Coverage for Organ Transplant Clearance and Coverage for Emergency Oral Examinations – The proposed Dental policy revisions add coverage for medically necessary dental services for adult SoonerCare members needing dental clearance for organ transplant approval. **The aforementioned changes were approved during promulgation of the emergency rule. The following are proposed changes not previously reviewed:** The proposed Dental policy is revised to mirror new terminology from the Code on Dental Procedures and Nomenclature (CDT), to clean up outdated language, and allow dentist to perform emergency evaluations as medically necessary. Proposed revisions also clarify the separate note requirement must address the 5A's and that the signature is one office note signature provided at the end of the visit.

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 440.100.

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

TO: Tywanda Cox
Health Policy

FROM: Likita Gunn
Federal and State Policy

SUBJECT: Rule Impact Statement
APA WF # 15-01

A. Brief description of the purpose of the rule:

The proposed Dental policy revisions add limited dental services for adult SoonerCare members who meet all medical criteria, but need dental clearance to obtain organ transplant approval. The proposed rule states that services must be prior authorized and are limited to: Comprehensive oral evaluation, two radiographic bitewings, prophylaxis, fluoride application, limited restorative procedures, and periodontal scaling/root planing. **The aforementioned changes were approved during promulgation of the emergency rule. The following are proposed changes not previously reviewed:** The proposed Dental policy is revised to mirror new terminology from the Code on Dental Procedures and Nomenclature (CDT) and to clean up outdated language. Revisions also include removing the 36 month language for comprehensive oral evaluations. Appropriate utilization parameters for comprehensive evaluations are identified in the CDT and eliminating limits in policy will allow the agency to continue to align with parameters set forth in the CDT without future promulgation of rules. In addition, a change includes removing language which restricts emergency examination/limited oral evaluation from being performed within two months, the new proposed language will allow dentist to perform emergency evaluations as medically necessary. Proposed revisions also clarify the separate note requirement must address the 5A's and that the signature is one office note signature provided at the end of the visit.

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:

Dental providers will be affected by the proposed rule as they will now be reimbursed for providing medically necessary dental services for adult members approved for an organ transplant. Additionally, dental providers will be allowed to perform emergency evaluations as medically necessary.

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

Adult SoonerCare members needing an emergency evaluation and those needing dental clearance to receive organ transplant approval will benefit from the proposed 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:

Reimbursing providers for medically necessary services will result in a positive economic impact on providers.

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 cost for services rendered for a member to gain organ transplant clearance was approved during promulgation of the emergency rule and no additional cost will be incurred.

The proposed rule to remove restrictions on when dentist can perform emergency examination/limited oral evaluation will result in additional costs to the agency. The rule change has total projected cost of: $130,597; a federal share of $79,155 and a state share of $51,442 for SFY 2017. The agency has identified administrative cost savings that could offset the cost of implementing the proposed policy change. There is an expenditure of approximately $42,000 a year in staff costs to manually process claims for emergency examination/limited oral evaluation. The impact of these administrative dollars could be better utilized by the agency permitting the Dental Services Unit to devote resources to other duties.

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:

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. Opportunities for public input are provided throughout the rulemaking process, in addition to formal public comment periods and tribal consultations. Additionally, OHCA presented the proposed change during the OHCA Dental Focus Group Quarterly Meeting.

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 a positive effect on the public health, safety, and environment as adult SoonerCare members will now receive emergency evaluations with no time restriction between service dates, and those needing dental clearance to receive organ transplant approval will also positively benefit from the proposed rule change.

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 30, 2015.
The rule impact statement was modified January 21, 2016.

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) medically necessary extractions and approved boney adjustments. Tooth extraction must have medical need documented;

(ii) Smoking and Tobacco Use Cessation Counseling; and

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

(B) Payment is made for dental care for adults residing in private Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) and who have been approved for ICF/IID level of care, similar to the scope of services available to individuals under age 21.

(C) Limited dental services are available for members who meet all medical criteria, but need dental clearance to obtain organ transplant approval. Providers must obtain prior authorization before delivery of dental service, with the exception of evaluation and extractions. All requests must be filed on the currently approved ADA form and must include diagnostic images, six-point periodontal charting, narratives and comprehensive treatment plans. The OHCA will notify the provider of determination using OHCA Prior Authorization Request Decision form. Prior authorized services must be billed exactly as they appear on the prior authorization request. The following dental services are available:

(i) Comprehensive oral evaluation,

(ii) two image bitewings,

(iii) prophylaxis,

(iv) fluoride application,

(v) limited restorative procedures, and

(vi) periodontal scaling/root planing.

(2) **Home and community based waiver services (HCBWS) for the 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 may be performed for any member every 36 months. An examination should precede any radiographs, and chart documentation must include radiographic interpretations, caries risk assessment~~

~~and both medical and dental health history of member.~~ This procedure should precede any images, and chart documentation must include image interpretations, caries risk assessment and both medical and dental health history of member. The comprehensive treatment plan should be the final results of this procedure.

(B) **Periodic oral evaluation.** This procedure may be provided for a member of record if not seen by ~~a~~any dentist for more than six months. An examination should precede any ~~radiographs~~images, and chart documentation must include ~~radiographic~~images interpretations, caries risk assessment and both medical and dental health history of member. The comprehensive treatment plan should be the final results of this procedure.

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

(D) ~~**Radiographs (x-rays)**~~**Images.** To be SoonerCare compensable, ~~x-rays~~images must be of diagnostic quality and medically necessary. A clinical examination must precede any ~~radiographs~~images, and chart documentation must include member history, prior ~~radiographs~~images, caries risk assessment and both dental and general health needs of the member. The referring dentist is responsible for providing properly identified ~~x-rays~~images of acceptable quality with a referral, if that provider chooses to expose and submit for reimbursement prior to referral. Periapical ~~radiograph~~images must include at least ~~3~~three millimeters beyond the apex of the tooth being ~~x-rayed~~imaged. ~~Panoramic films and full mouth radiographs (minimum of 12 periapical films and two posterior bitewings) are allowable once in a three year period and must be of diagnostic quality.~~ Panoramic films and two bitewings are considered full mouth images. Full mouth images as noted above or traditional (minimum of 12 periapical films and two posterior bitewings) are allowable once in a three year period and must be of diagnostic quality. Individually listed intraoral ~~radiographs~~images by the same dentist/dental office are considered a complete series if the ~~fee for~~number of individual ~~radiographs~~images equals or exceeds the ~~fee~~traditional number for a complete series. Panoramic films are only compensable when chart documentation clearly indicates reasons for the exposure based on clinical findings. This type of exposure is not to rule out or evaluate caries. Prior authorization and a detailed medical need narrative are required for additional panoramic films

taken within three 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 once every 36 months if medical necessity is documented.

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

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

(i) Stainless steel crowns are allowed if:

(I) the child is five 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 treated with pulpal therapy, 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) Preoperative periapical ~~x-rays~~images and/or written documentation explaining the extent of decay must be available for review, if requested.

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

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

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

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

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

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

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

(iii) Placement of a stainless steel crown excludes placement of any other type of crown for a period of 24 months. No other restoration on that tooth is compensable during that period of time. ~~A stainless steel crown is not a temporizing treatment to be used while a permanent~~

~~crown is being fabricated.~~

(I) **Pulpotomies and pulpectomies.**

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

(I) Primary molars having at least 70 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~~five years;

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

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

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

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

(J) **Endodontics.** Payment is made for the services provided in accordance with the following:

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

(ii) The provider documents history of member's improved oral hygiene and flossing ability in records.

(iii) Prior authorization is required for members who have a treatment plan requiring more than two anterior and/or two posterior root canals.

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

(v) Pulpal debridement may be performed for the relief of pain while waiting for the decision from the OHCA.

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

(vii) Endodontically treated teeth should be restored to limited occlusal function and all contours should be replaced. These teeth are not automatically approved for any type of crown.

(K) **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.

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

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

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

(V) Post-operative bitewing ~~x-rays~~images 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 the second primary molar (K or T) is missing in the same arch.

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

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

(L) **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 medical need for this service must be documented in the member's record.

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

(M) **Pulp caps.** Indirect and direct pulp cap must be ADA accepted calcium hydroxide or Mineral Trioxide Aggregate

materials, not a cavity liner or chemical used for dentinal hypersensitivity. Indirect and direct pulp cap codes require specific narrative support addressing materials used, intent and reasons for use. Application of chemicals used for dentinal hypersensitivity is not allowed as indirect pulp cap. Utilization of these codes is verified by post payment review.

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

(O) **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, Oklahoma State Health Department and FQHC nursing, and Maternal/Child Health Licensed Clinical Social Workers with a certification as a Tobacco Treatment Specialist Certification (CTTS) staff in addition to other appropriate services rendered. Chart documentation must include a separate note~~,~~ that addresses the 5A's, 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.

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: July 16, 2015

The proposed policy is an Emergency Rule. This proposal is scheduled to be presented to the Medical Advisory Committee (MAC) on July 16, 2015 and the (OHCA) Board of Directors on August 12, 2015.
Reference: APA WF# 15-01

SUMMARY:
Adult dental coverage for organ transplant clearance— The proposed policy revisions add coverage for medically necessary dental services for adult SoonerCare members needing dental clearance for organ transplant approval.

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 440.100.

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

TO: Tywanda Cox
Health Policy

FROM: Likita Gunn
Federal and State Policy

SUBJECT: Rule Impact Statement
APA WF # 15-01

A. Brief description of the purpose of the rule:

The proposed policy revisions add limited dental services for adult SoonerCare members who meet all medical criteria, but need dental clearance to obtain organ transplant approval. The proposed rule states that services must be prior authorized and are limited to: Comprehensive oral evaluation, two radiographic

bitewings, prophylaxis, fluoride application, limited restorative procedures, and periodontal scaling/root planning.

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:

Dental providers will be affected by the proposed rule as they will now be reimbursed for providing medically necessary dental services for adult members approved for an organ transplant.

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

Adult SoonerCare members needing dental clearance to receive organ transplant approval will benefit from the proposed 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 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 proposed rule change has a projected cost to the agency of $60,000 state only dollars. This is a limited set of covered dental services specific to SoonerCare adults needing organ transplant clearance. Federal regulation prohibits Oklahoma from limiting services to a subgroup of SoonerCare members; therefore, the agency has elected to use state only dollars to reimburse dental providers for services rendered. Due to State budgetary constraints, all other SoonerCare adults will still be limited to emergency extractions as set forth in state statute. There are approximately 60 SoonerCare adults pending approval for organ transplant clearance and the agency has estimated dental services at a cost of $1,000 per member.

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:

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 June 16, 2015.

RULE TEXT:

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 79. DENTIST

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) medically necessary extractions and approved boney adjustments. Tooth extraction must have medical need documented;

(ii) Smoking and Tobacco Use Cessation Counseling; and

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

(B) Payment is made for dental care for adults residing in private Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) and who have been approved for ICF/IID level of care, similar to the scope of services available to individuals under age 21.

(C) Limited dental services are available for members who meet all medical criteria, but need dental clearance to obtain organ transplant approval. Providers must have prior authorization for all services before delivery of dental service, with the exception of evaluation and extractions. All requests must be filed on the currently approved ADA form and must include diagnostic X-rays, six-point periodontal charting, narratives and comprehensive treatment plans. The OHCA will notify the provider of determination using OHCA Prior Authorization Request Decision form. Prior authorized services must be billed exactly as they appear on the prior authorization request. The following dental services are available:

(i)Comprehensive oral evaluation,
(ii)two radiographic bitewings,
(iii)prophylaxis,
(iv)fluoride application,
(v)limited restorative procedures, and
(vi)periodontal scaling/root planing.

(2) **Home and community based waiver services (HCBWS) for the 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 may be performed for any member every 36 months. An examination should precede any radiographs, and chart documentation must include radiographic interpretations, caries risk assessment and both medical and dental health history of member. The comprehensive treatment plan should be the final results of this procedure.

(B) **Periodic oral evaluation.** This procedure may be provided for a member of record if not seen by a dentist for more than six months. An examination should precede any radiographs, and chart documentation must include radiographic interpretations, caries risk assessment and both medical and dental health history of member. The comprehensive treatment plan should be the final results of this procedure.

(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. This procedure is only compensable to the same dentist or practice for two visits prior to an examination being completed.

(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. Periapical radiograph must include at least 3 millimeters beyond the apex of the tooth being x-rayed. Panoramic films and full mouth radiographs (minimum of 12 periapical films and two posterior bitewings) are allowable once in a three year period and must be of diagnostic quality. Individually listed intraoral radiographs by the same dentist/dental office are considered a complete series if the fee for individual radiographs equals or exceeds the fee for a complete series. Panoramic films are only compensable when chart documentation clearly indicates reasons for the exposure based on clinical

findings. This type of exposure is not to rule out or evaluate caries. Prior authorization and a detailed medical need narrative are required for additional panoramic films taken within three 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 once every 36 months if medical necessity is documented.

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

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

(i) Stainless steel crowns are allowed if:

(I) the child is five 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 treated with pulpal therapy, 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) Preoperative periapical x-rays and/or written documentation explaining the extent of decay must be available for review, if requested.

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

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

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

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

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

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

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

(iii) Placement of a stainless steel crown excludes placement of any other type of crown for a period of 24 months. No other restoration on that tooth is compensable during that period of time. A stainless steel crown is not a temporizing treatment to be used while a permanent crown is being fabricated.

(I) **Pulpotomies and pulpectomies.**

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

(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;

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

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

(J) **Endodontics.** Payment is made for the services provided in accordance with the following:

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

(ii)The provider documents history of member's improved oral hygiene and flossing ability in records.

(iii) Prior authorization is required for members who have a treatment plan requiring more than two anterior and/or two posterior root canals.

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

(v) Pulpal debridement may be performed for the relief of pain while waiting for the decision from the OHCA.

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

(vii) Endodontically treated teeth should be restored to limited occlusal function and all contours should be replaced. These teeth are not automatically approved for any type of crown.

(K) **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.

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

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

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

(V) Post-operative bitewing 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 the second primary molar (K or T) is missing in the same arch.

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

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

(L) **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 medical need for this service must be documented in the member's record.

(ii) **Non-intravenous conscious sedation.** Non-intravenous conscious sedation is not separately reimbursable, if provided on the same date by the same provider as analgesia, anxiolysis, inhalation of nitrous oxide, IV sedation or general anesthesia. Non-intravenous conscious sedation is reimbursable when determined to be medically necessary for documented handicapped members,

uncontrollable members or justifiable medical or dental conditions. The report must detail the member's condition. No services are reimbursable when provided primarily for the convenience of the member and /or the dentist, it must be medically necessary.

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

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

(O) **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, Oklahoma State Health Department and FQHC nursing, and Maternal/Child Health Licensed Clinical Social Workers with a certification as a Tobacco Treatment Specialist Certification (CTTS) staff in addition to other appropriate services rendered. 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.

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 15, 2016

The proposed policy is a Permanent Rule. This proposal is scheduled to be presented to the Medical Advisory Committee (MAC) on January 21, 2016 and the (OHCA) Board of Directors on February 11, 2016.
Reference: APA WF 15-02

SUMMARY:
OHCA proposes rules to clean up language by referencing an OHCA income chart for determining eligibility instead of a DHS chart because OHCA now determines eligibility for certain eligibility groups. OHCA also proposes rules to update policy regarding Transitional Medical Assistance (TMA) benefits due to MAGI rules for income eligibility. OHCA also proposes rule revisions to update policy regarding Family Planning Program because TPL information is stored on OHCA systems.

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:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

TO: Tywanda Cox
Health Policy

FROM: Harvey Reynolds
Health Policy

SUBJECT: Rule Impact Statement
APA WF # 15-02

A. Brief description of the purpose of the rule:
OHCA proposes to revise rules to clean up language where policy references Appendix C-1 (Maximum Income, Resource, and Payment Standards) which is a Department of Human Services

(DHS) document. The Appendix C-1 language will be replaced with SoonerCare Income Guidelines when referencing eligibility groups for which the Oklahoma Health Care Authority (OHCA) determines eligibility. The previous language was appropriate when DHS was determining eligibility for those groups. Also, the language referencing Categorically Needy Standards will be deleted.
OHCA also proposes to revise rules to update Transitional Medical Assistance (TMA) policy to match Federal regulations on MAGI eligibility determinations. Policy states that health benefits are continued when SoonerCare case closure is due to the receipt of new or increased child support. These health benefits are called TMA. However, under MAGI rules a case would never be closed due to Child Support income because Child Support income is not counted under MAGI rules.
OHCA also proposes to revise rules to update policy dealing with eligibility for the SoonerPlan Family Planning Program because policy states that all health insurance is listed on the OKDHS computer systems. This policy is outdated as a member's health insurance information (TPL) would now be stored on OHCA systems.

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 SoonerCare members or other classes of persons will be affected by this rule, as revisions are for clarification purposes only.

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

No SoonerCare members or other classes of persons will benefit from this 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 any 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:

There is no estimated budget impact for this rule because the rule only addresses policy language clean up and policy language updating.

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 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:

Prepared date: August 6, 2015

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 5. DETERMINATION OF ELIGIBILITY FOR SOONERCARE HEALTH BENEFITS FOR PREGNANT WOMEN AND FAMILIES WITH CHILDREN

317:35-6-37. Financial eligibility of categorically needy individuals related to AFDC or pregnancy-related services

Individuals whose income is less than the ~~standards on DHS Appendix C-1~~SoonerCare Income Guidelines for the applicable eligibility group are financially eligible for SoonerCare.

(1) **~~Categorically needy standards/categorically~~Categorically related to pregnancy-related services.** For an individual related to pregnancy-related services to be financially eligible, the countable income must be less than the appropriate standard according to the family size on ~~DHS Appendix C-1~~the SoonerCare Income Guidelines. In determining the household size, the pregnant woman and her unborn child(ren) are included.

(2) **~~Categorically needy standards/categorically~~Categorically related to children's and parent/caretakers' groups.**

(A) **~~Categorical relationship.~~Parent/caretakers' group.** For the individual ~~related to AFDC~~in the parent/caretakers' group to be considered categorically needy, the ~~standards on DHS Appendix C-1 schedules~~SoonerCare Income Guidelines must be used.

(i) **~~DHS Appendix C-1, Schedule X.~~SoonerCare Income Guidelines.** Individuals age 19 years or older, other than pregnant women, are determined categorically needy if countable income is less than the Categorically

Needy Standard, according to the family size.

(ii) ~~**DHS Appendix C-1, Schedule I.A.**~~**SoonerCare Income Guidelines.** All individuals under 19 years of age are determined categorically needy if countable income is equal to or less than the Categorically Needy Standard, according to the size of the family.

(B) **Families with children.** Individuals who meet financial eligibility criteria for the children's and parent/caretakers' groups are:

(i) All persons included in an active TANF case.

(ii) Individuals related to the children's or parent/caretakers' groups whose countable income is within the current appropriate income standard, but who do not receive TANF assistance.

(iii) All persons in a TANF case in Work Supplementation status who meet TANF eligibility conditions other than earned income.

(iv) Those individuals who continue to be eligible for Medicaid in a TANF case after they become ineligible for a TANF payment. These individuals will continue to be considered categorically needy if the TANF case was closed due to child or spousal support, the loss or reduction of earned income exemption by any member of the assistance unit, or the new or increased earnings of the caretaker relative.

317:35-6-39. General calculation of countable income for MAGI eligibility groups

(a) The income that is counted in determining eligibility for an individual is that individual's household income.

(b) In order to calculate the countable household income for an individual:

(1) Determine who is in the individual's household (see OAC 317:35-6-40 to 317:35-6-43);

(2) Identify all sources of income for all household members;

(3) Determine whether each source of income is considered for SoonerCare eligibility or is excluded (see Part 6, Countable Income, of this Subchapter);

(4) Determine the gross monthly amount of each source of countable income (see Part 6, Countable Income, of this subchapter);

(5) Determine whether each household member's income counts toward the household (see 317:35-6-44);

(6) Sum the gross monthly amounts of all countable sources of income of all household members whose income is counted;

(7) Subtract allowable adjustments to income (see OAC 317:35-6-52); and

(8) Compare the result to the income limit for the individual's eligibility group ~~(see the appropriate Schedule of OKDHS Appendix C-1)~~(see SoonerCare Income Guidelines). If the result is equal to or less than the dollar amount of the income limit, the individual is financially eligible.

(9) When calculating the percentage of the Federal Poverty Level (FPL) that corresponds to the individual's monthly countable income, subtract 5% from the FPL percentage reached to determine the countable FPL level for the individual. This countable percentage of FPL is compared to the FPL limit for the individual's eligibility group in order to determine whether the individual is financially eligible. This 5% deduction from FPL has already been accounted for in the dollar amounts of the income limits given in ~~OKDHS Appendix C-1~~the SoonerCare Income Guidelines.

(c) If an individual's household income using this methodology is over the income limit for SoonerCare eligibility and that individual's household income using the MAGI household and income-counting methodology used by the Federally Facilitated Exchange (FFE) is less than 100% of FPL, the FFE's MAGI rules, as promulgated by the Internal Revenue Service, are used to determine SoonerCare eligibility in place of the rules in this Chapter. The FFE rules including, but not limited to, those in the following areas may need to be followed in place of the SoonerCare rules in this Chapter:

(1) Rules on household composition;

(2) Rules on countable sources of income; and

(3) Rules on the budget period used to calculate income, i.e. annual income (FFE) versus current monthly income (SoonerCare).

PART 7. CERTIFICATION, REDETERMINATION AND NOTIFICATION

317:35-6-64.1. Transitional Medical Assistance (TMA)

(a) **Conditions for TMA.**

(1) **Transitional Medical Assistance.** Health benefits are continued when the benefit group loses eligibility due to new or increased earnings of the parent(s)/caretaker relative or the receipt of ~~child or~~ spousal support. The health benefit coverage is of the same amount, duration, and scope as if the benefit group continued receiving SoonerCare. Eligibility for TMA begins with the effective date of case closure or the effective date of closure had the income been reported timely. An individual is included for TMA only if that individual was eligible for SoonerCare and included in the benefit group at the time of the closure. To be eligible for TMA the benefit group must meet all of the requirements

listed in (A) - (C) of this paragraph.

(A) At least one member of the benefit group was included in at least three of the six months immediately preceding the month of ineligibility.

(B) The health benefit cannot have been received fraudulently in any of the six months immediately preceding the month of ineligibility.

(C) The benefit group must have included a dependent child who met the age and relationship requirements for SoonerCare and whose needs were included in the benefit group at the time of closure, unless the only eligible child is a Supplemental Security Income (SSI) recipient.

(2) **Closure due to ~~child support or~~ spousal support.** Health benefits are continued if the case closure is due to the receipt of new or increased ~~child support or~~ payments for spousal support in the form of alimony. The needs of the parent(s)or caretaker relative must be included in the benefit group at the time of closure. The health benefits are continued for four months.

(3) **Closure due to new or increased earnings of parent(s) or caretaker relative.** Health benefits are continued if the closure is due to the new or increased earnings of the parent(s) or caretaker relative. The needs of the parent(s)or caretaker relative must be included in the benefit group at the time of closure. The parent(s) or caretaker relative is required to cooperate with OKDHS Oklahoma Child Support Services during the period of time the family is receiving TMA.

(4) **Eligibility period.** Health benefits may be continued for a period up to 12 months if the reason for closure is new or increased earnings of the parent(s) or caretaker relative. This period is divided into two six-month periods with eligibility requirements and procedures for each period.

(A) **Initial six-month period.**

(i) The benefit group is eligible for an initial six-month period of TMA without regard to income or resources if:

(I) an eligible child remains in the home;

(II) the parent(s) or caretaker relative remains the same; and

(III) the benefit group remains in the state.

(ii) An individual benefit group family member remains eligible for the initial six-month period of TMA unless the individual:

(I) moves out of the state,

(II) dies,

(III) becomes an inmate of a public institution,

(IV) leaves the household,

(V) does not cooperate, without good cause, with the OKDHS Oklahoma Child Support Services or third party liability requirements.

(B) **Additional Six-month period.**

(i) Health benefits are continued for the additional six-month period if:

(I) an eligible child remains in the home;

(II) the parent(s) or caretaker relative remains the same;

(III) the benefit group remains in the state;

(IV) the benefit group was eligible for and received TMA for each month of the initial six-month period;

(V) the benefit group has complied with reporting requirements in subsection (g) of this Section;

(VI) the benefit group has average monthly earned income (less child care costs that are necessary for the employment of the parent or caretaker relative) that does not exceed the 185% of the Federal Poverty Level ~~(see OKDHS Appendix C-1, Schedule I.A;)~~(see SoonerCare Income Guidelines); and

(VII) the parent(s) or caretaker relative had earnings in each month of the required three-month reporting period described in (g)(2) of this Section, unless the lack of earnings was due to an involuntary loss of employment, illness, or other good cause.

(ii) An individual benefit group family member remains eligible for the additional six-month period unless the individual meets any of the items listed in (4)(A)(ii) of this paragraph.

(b) **Income and resource eligibility.**

(1) The unearned income and resources of the benefit group are disregarded in determining eligibility for TMA. There is no earned income test for the initial six-month period.

(2) Health benefits are continued for the additional six-month period if the benefit group's countable earnings less child care costs that are necessary for the employment of the parent(s) or caretaker relative are below 185% of the Federal Poverty Level (see the standards on the OHCA website or the OKDHS Form 08AX001E, Schedule I.A) and the benefit group meets the requirements listed in (a)(4)(B).

(A) The earnings of all benefit group members are used in determining the earned income test. The only exception is that earnings of full time students included in the benefit group are disregarded.

(B) Income is determined by averaging the benefit group's gross monthly earnings (except full time student earnings) for the required three-month reporting period.

(C) A deduction from the benefit group's earned income is allowed for the cost of approved child care necessary for the employment of the parent(S) or caretaker relative. The child care deduction is averaged for the same three-month reporting period. There is no maximum amount for this deduction.

(D) All individuals whose earnings are considered are included in the benefit group. The family size remains the same during both reporting periods.

(c) **Eligible child.** When the SoonerCare benefit is closed and TMA begins, the benefit group must include an eligible child whose needs were included in the SoonerCare benefit at the time of closure, unless the only eligible child is a SSI recipient. After the TMA begins, the benefit group must continue to include an eligible child. Age is the only requirement an eligible child must meet.

(d) **Additional members.** After the TMA begins, family members who move into the home cannot be added to the TMA coverage. This includes siblings and a natural or adoptive parent(s) or caretaker relative. If the additional member is in need of health benefits, an application for services under the SoonerCare program is completed. If a benefit group member included in TMA leaves the home and then returns, that member may be added back to TMA coverage if all conditions of eligibility are met.

(e) **Third party liability.** The benefit group's eligibility for TMA is not affected by a third party liability. However, the benefit group is responsible for reporting all insurance coverage and any changes in the coverage. The worker must explain the necessity for applying benefits from private insurance to the cost of medical care.

(f) **Notification.**

(1) **Notices.** Notices are sent to the benefit group, both at the onset of and throughout the TMA period. These notices, which are sent at specific times, inform the benefit group of its rights and responsibilities. When SoonerCare is closed and the benefit group is eligible for TMA, the computer generated closure notice includes notification of the continuation of health benefits. Another computer generated notice is sent at the same time to advise the benefit group of the reporting requirements and under what circumstances the health benefits may be discontinued. Each notice listed in (A)-(C) of this paragraph includes specific information about what the benefit group must report. The notices serve as the required advance notification in the event benefits are discontinued as a result of the information furnished in response to these notices.

(A) **Notice #1.** Notice #1 is issued in the third month of

the initial TMA period. This notice advises the benefit group of the additional six-month period of TMA, the eligibility conditions, reporting requirements, and appeal rights.

(B) **Notice #2.** Notice #2 is issued in the sixth month of the TMA period, but only if the benefit group is eligible for the additional six-month period. This notice advises the benefit group of the eligibility conditions, reporting requirements, and appeal rights.

(C) **Notice #3.** Notice #3 is issued in the ninth month of the TMA period, or the third month of the additional six-month period. This notice advises the benefit group of the eligibility conditions, the reporting requirements, appeal rights, and the expiration of TMA coverage.

(2) **Notices not received.** In some instances the benefit group does not receive all of the notices listed in (1) of this subsection. The notices and report forms are not issued retroactively.

(g) **Reporting.** The benefit group is required to periodically report specific information. The information may be reported by telephone or by letter.

(1) The benefit group must report:

(A) gross earned income of the entire benefit group for the appropriate three-month period;

(B) child care expenses, for the appropriate three-month period, necessary for the continued employment of the parent(s) or caretaker relative;

(C) changes in members of the benefit group;

(D) residency; and

(E) third party liability.

(2) The reporting requirement time frames are explained in this subparagraph.

(A) The information requested in the third month must be received by the 21st day of the fourth month and is used to determine the benefit group's eligibility for the additional six-month period. While this report is due in the fourth month, negative action cannot be taken during the initial period for failure to report. If the benefit group fails to submit the requested information, benefits are automatically suspended effective the seventh month. If action to reinstate is not taken by deadline of the suspension month, the computer automatically closes the case effective the next month.

(B) The information requested in the sixth month must be furnished by the 21st day of the seventh month. The decision to continue benefits into the eighth month is determined by the information reported.

(C) The information requested in the ninth month must be

furnished by the 21st day of the tenth month. The decision to continue health benefits into the 11th month is determined by the information reported. When the information is not reported timely, the TMA is automatically suspended by the computer for the appropriate effective date. If the benefit group subsequently reports the necessary information, the worker determines eligibility. If all eligibility factors are met during and after the suspension period, the health benefits are reinstated. The effective date of the reinstatement is the same as the effective date of the suspension so the benefit group has continuous medical coverage.

(h) **Termination of TMA.** The TMA coverage is discontinued any time the benefit group fails to meet the eligibility requirements as shown in this Section. If it becomes necessary to discontinue the TMA coverage for the benefit group or any member of the benefit group, the individual(s) must be advised that he or she may be eligible for health benefits under the SoonerCare program and how to obtain these benefits.

(i) **Receipt of health benefits after TMA ends.** To ensure continued medical coverage a computer generated recertification form is mailed to the benefit group during the third month of TMA for benefits closed due to the receipt of child or spousal support or the 11th month of TMA for benefits closed due to increased earnings. The benefit group must return the form prior to the termination of the TMA benefits. When determined eligible, health benefits continue as SoonerCare, not TMA. If the benefit group fails to return the recertification form, TMA benefits are terminated.

SUBCHAPTER 7. MEDICAL SERVICES

PART 5. DETERMINATION OF ELIGIBILITY FOR MEDICAL SERVICES

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

(a) 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 the applicable standard on the ~~OKDHS Appendix C-1~~SoonerCare Income Guidelines. Prior to October 1, 2013, 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). Effective October 1, 2013, MAGI financial eligibility rules are used to determine eligibility for SoonerPlan.

(2) Prior to October 1, 2013, 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. October 1, 2013, MAGI household composition rules are used to determine eligibility for SoonerPlan.

(3) SoonerPlan members with minor dependent children and a parent absent from the home are required to cooperate with the Oklahoma Department of Human Services, Child Support Services Division (OCSS) in the collection of child support payments. Federal regulations provide a waiver of this requirement when cooperation is not in the best interest of the child.

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

(5) Persons who have Medicare or creditable health insurance coverage are not precluded from applying for the SoonerPlan Family Planning program.

(b) All health insurance is listed on ~~the OKDHS computer system~~applicable systems 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 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 Program.

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 15, 2016

The proposed policy is a Permanent Rule. This proposal is scheduled to be presented to the Medical Advisory Committee (MAC) on January 21, 2016 and the OHCA Board of Directors on February 11, 2016.
Reference: APA WF 15-03

SUMMARY:
DRG Hospital — The proposed policy revisions clarify reimbursement methodology for DRG hospitals. DRG outlier payments to transferring hospitals, previously removed in emergency rules, is restored.

LEGAL AUTHORITY
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; Article 10, Section 23 of the Oklahoma Constitution; 42 CFR 412.20

RULE IMPACT STATEMENT:
TO: Tywanda Cox
Health Policy

FROM: William Baker
Health Policy

SUBJECT: Rule Impact Statement
APA WF # 15-03

A. Brief description of the purpose of the rule:

The proposed policy revisions clarify reimbursement methodology for DRG hospitals. Rules state that covered inpatient services provided to eligible members admitted to acute care and critical access hospitals will be reimbursed the lesser of the billed charges or the DRG amount. The aforementioned changes were approved during promulgation of the emergency rule. Elimination of certain DRG outlier payments, also approved in the emergency rule, is restored in the permanent rule and will continue to be paid in the case of a qualifying transfer.

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:

Hospitals that submit claims in which the billed charges are less than the DRG amount will be affected by this change in policy.

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

No classes of person will receive benefit from this 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 decrease in federal funds resulting from the lower reimbursement to hospitals may create an economic impact for these entities. 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:

Budget Impact: Savings approved during promulgation of the emergency rule, the rule change will not result in any additional costs and/or savings 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:

Without the recommended revisions, the Agency is at risk of exhausting its State appropriated dollars required to maintain the State's Medicaid Program.

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

The rule impact statement was prepared September 21, 2015.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 3. HOSPITALS

317:30-5-41. Inpatient hospital coverage/limitations

(a) Covered hospital inpatient services are those medically necessary services which require an inpatient stay ordinarily furnished by a hospital for the care and treatment of inpatients and which are provided under the direction of a physician or dentist in an institution approved under OAC:317:30:5-40.1(a) or (b). ~~Effective October 1, 2005, claims for inpatient admissions provided on or after October 1st in acute care or critical access hospitals are reimbursed utilizing a Diagnosis Related Groups (DRG) methodology.~~Claims for inpatient admissions in acute care or critical access hospitals are reimbursed the lesser of the billed charges or the Diagnosis Related Groups (DRG) amount.

(b) **Inpatient status.** OHCA considers a member an inpatient when the member is admitted to the hospital and is counted in the midnight census. In situations when a member inpatient admission occurs and the member dies, is discharged following an obstetrical stay, or is transferred to another facility on the day of admission, the member is also considered an inpatient of the hospital.

(1) **Same day admission.** If a member is admitted and dies before the midnight census on the same day of admission, the member is considered an inpatient.

(2) **Same day admission/discharge ~~C~~- obstetrical and newborn stays.** A hospital stay is considered inpatient stay when a member is admitted and delivers a baby, even when the mother and baby are discharged on the date of admission (i.e., they are not included in the midnight census). This rule applies when the mother and/or newborn are transferred to another hospital.

(3) **Same day admission/discharges other than obstetrical and newborn stays.** In the event a member is admitted as an inpatient, but is determined to not qualify for an inpatient payment based on OHCA criteria, the hospital may bill on an outpatient claim for the ancillary services provided during that time.

(4) **Discharges and Transfers.** A hospital inpatient is considered discharged from a hospital paid under the DRG-based payment system when:

~~(A) **Discharges.** A hospital inpatient is considered discharged from a hospital paid under the DRG-based payment system when:~~

~~(i)~~(A) The patient is formally released from the hospital; or

~~(ii)~~(B) The patient dies in the hospital; or

~~(iii)~~(C) The patient is transferred to a hospital that is excluded from the DRG-based payment system, or transferred to a distinct part psychiatric or rehabilitation unit of the same hospital. Such instances will result in two or more claims. Effective January 1, 2007, distinct part

psychiatric and rehabilitation units excluded from the Medicare Prospective Payment System (PPS) of general medical surgical hospitals will require a separate provider identification number.

317:30-5-47. Reimbursement for inpatient hospital services

Reimbursement will be made for inpatient hospital services ~~rendered on or after October 1, 2005,~~ in the following manner:

(1) Covered inpatient services provided to eligible SoonerCare members admitted to in-state acute care and critical access hospitals will be reimbursed ~~at a prospectively set rate which compensates hospitals an amount per discharge for discharges classified according to the Diagnosis Related Group (DRG) methodology. For each SoonerCare member's stay, a peer group base rate is multiplied by the relative weighting factor for the DRG which applies to the hospital stay.~~ the lesser of the billed charges or the Diagnosis Related Group (DRG) amount. In addition to the billed charges or DRG payment, whichever is less, an outlier payment may be made to the hospital for very high cost stays. Additional outlier payment is applicable if ~~the DRG payment~~ either the amount billed by the hospital or DRG payment, whichever applies, is less than a threshold amount of the hospital cost. Each inpatient hospital claim is tested to determine whether the claim qualified for a cost outlier payment. Payment is equal to a percentage of the cost after the threshold is met.

(2) ~~The DRG payment~~The lesser of the billed charges or DRG amount and outlier, if applicable, represent full reimbursement for all non-physician services provided during the inpatient stay. Payment includes but is not limited to:

(A) laboratory services;

(B) prosthetic devices, including pacemakers, lenses, artificial joints, cochlear implants, implantable pumps;

(C) technical component on radiology services;

(D) transportation, including ambulance, to and from another facility to receive specialized diagnostic and therapeutic services;

(E) pre-admission diagnostic testing performed within 72 hours of admission; and

(F) organ transplants.

(3) Hospitals may submit a claim for payment only upon the final discharge of the patient or upon completion of a transfer of the patient to another hospital.

(4) Covered inpatient services provided to eligible members of the Oklahoma SoonerCare program, when treated in out-of-state hospitals will be reimbursed in the same manner as in-state hospitals.

(5) Cases which indicate transfer from one acute care hospital to another will be monitored under a retrospective utilization review policy to help ensure that payment is not made for inappropriate transfers.

(6) The transferring hospital will be paid the lesser of the calculated transfer fee or the DRG base payment amount for a non-transfer.

~~(6)~~ (7) If the transferring or discharge hospital or unit is exempt from the DRG, that hospital or unit will be reimbursed according to the method of payment applicable to the particular facility or units.

~~(7)~~ (8) Covered inpatient services provided in out-of-state specialty hospitals may be reimbursed at a negotiated rate not to exceed 100% of the cost to provide the service. Negotiation of rates will only be allowed when the OHCA determines that the specialty hospital or specialty unit provides a unique (non-experimental) service required by SoonerCare members and the provider will not accept the DRG payment rate. Prior authorization is required.

~~(8)~~ (9) New providers entering the SoonerCare program will be assigned a peer group and will be reimbursed at the peer group base rate for the DRG payment methodology or the statewide median rate for per diem methods.

~~(9)~~ (10) When services are delivered via telemedicine to hospital inpatients, the originating site facility fee will be paid outside the DRG payment.

~~(10)~~ (11) All inpatient services are reimbursed per the ~~DRG~~ methodology described in this section and/or as approved under the Oklahoma State Medicaid Plan.

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: June 7, 2015

The proposed policy is an Emergency Rule. This proposal is scheduled to be presented to the Medical Advisory Committee (MAC) on May 21, 2015 and the OHCA Board of Directors on June 25, 2015.
Reference: APA WF 15-03

SUMMARY:
DRG Hospital – The proposed policy revisions clarify reimbursement methodology for DRG hospitals. These emergency revisions are necessary to reduce the Agency's operations budget in order to meet the balanced budget requirements as mandated by State law. Without the recommended revisions, the Agency is at risk of exhausting its State appropriated dollars required to maintain the State's Medicaid Program.

LEGAL AUTHORITY
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; Article 10, Section 23 of the Oklahoma Constitution; 42 CFR 412.20; 42 CFR 412.40; 42 CFR 412.60

RULE IMPACT STATEMENT:
TO: Tywanda Cox
Health Policy

FROM: Sandra Manzo de Puebla
Health Policy

SUBJECT: Rule Impact Statement
APA WF # 15-03

A. Brief description of the purpose of the rule:

The proposed policy revisions clarify reimbursement methodology for DRG hospitals. Rules state that covered inpatient services provided to eligible members admitted to acute care and critical access hospitals will be reimbursed

the lesser of the billed charges or the DRG amount. These emergency revisions are necessary to reduce the Agency's operations budget in order to meet the balanced budget requirements as mandated by State law. Without the recommended revisions, the Agency is at risk of exhausting its State appropriated dollars required to maintain the State's Medicaid Program.

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:

Hospitals that submit claims in which the billed charges are less than the DRG amount will be affected by this change in policy.

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

No classes of person will receive benefit from this 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 decrease in federal funds resulting from the lower reimbursement to hospitals may create an economic impact for these entities. 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 agency will observe a total savings of $11,181,897; state savings (11 month) of $3,964,760.

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:

Without the recommended revisions, the Agency is at risk of exhausting its State appropriated dollars required to maintain the State's Medicaid Program.

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

The rule impact statement was prepared April 28, 2015.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 3. HOSPITALS

317:30-5-41. Inpatient hospital coverage/limitations

(a) Covered hospital inpatient services are those medically necessary services which require an inpatient stay ordinarily furnished by a hospital for the care and treatment of inpatients and which are provided under the direction of a physician or dentist in an institution approved under OAC:317:30:5-40.1(a) or (b). ~~Effective October 1, 2005, claims for inpatient admissions provided on or after October 1st in acute care or critical access hospitals are reimbursed utilizing a Diagnosis Related Groups (DRG) methodology.~~Claims for inpatient admissions in acute care or critical access hospitals are reimbursed the lesser of the billed charges or the Diagnosis Related Groups (DRG) amount.

(b) **Inpatient status.** OHCA considers a member an inpatient when the member is admitted to the hospital and is counted in the midnight census. In situations when a member inpatient admission occurs and the member dies, is discharged following an obstetrical stay, or is transferred to another facility on the day of admission, the member is also considered an inpatient of the hospital.

(1) **Same day admission.** If a member is admitted and dies before the midnight census on the same day of admission, the member is considered an inpatient.

(2) **Same day admission/discharge — obstetrical and newborn stays.** A hospital stay is considered inpatient stay when a member is admitted and delivers a baby, even when the mother and baby are discharged on the date of admission (i.e., they are not included in the midnight census). This rule applies when the mother and/or newborn are transferred to another hospital.

(3) **Same day admission/discharges other than obstetrical and newborn stays.** In the event a member is admitted as an inpatient, but is determined to not qualify for an inpatient payment based on OHCA criteria, the hospital may bill on an outpatient claim for the ancillary services provided during that time.

(4) **Discharges and Transfers**. A hospital inpatient is considered discharged from a hospital paid under the DRG-based payment system when:

~~(A) **Discharges.** A hospital inpatient is considered discharged from a hospital paid under the DRG-based payment system when:~~

~~(i)~~(A) The patient is formally released from the hospital; or

~~(ii)~~(B) The patient dies in the hospital; or

~~(iii)~~(C) The patient is transferred to a hospital that is excluded from the DRG-based payment system, or transferred to a distinct part psychiatric or rehabilitation unit of the same hospital. Such instances will result in two or more claims. Effective January 1, 2007, distinct part psychiatric and rehabilitation units excluded from the Medicare Prospective Payment System (PPS) of general medical surgical hospitals will require a separate provider identification number.

317:30-5-47. Reimbursement for inpatient hospital services

Reimbursement will be made for inpatient hospital services ~~rendered on or after October 1, 2005,~~ in the following manner:

(1) Covered inpatient services provided to eligible SoonerCare members admitted to in-state acute care and critical access hospitals will be reimbursed ~~at a prospectively set rate which compensates hospitals an amount per discharge for discharges classified according to the Diagnosis Related Group (DRG) methodology. For each SoonerCare member's stay, a peer group base rate is multiplied by the relative weighting factor for the DRG which applies to the hospital stay.~~ the lesser of the billed charges or the Diagnosis Related Group (DRG) amount. In addition to the billed charges or DRG payment, whichever is less, an outlier payment may be made to the hospital for very high cost stays. Additional outlier payment is applicable if ~~the DRG payment~~ either the amount billed by the hospital or DRG payment, whichever applies, is less than a threshold amount of the hospital cost. Each inpatient hospital claim is tested to determine whether the claim qualified for a cost outlier payment. Payment is equal to a percentage of the cost after the threshold is met.

(2) ~~The DRG payment~~The lesser of the billed charges or DRG amount and outlier, if applicable, represent full reimbursement for all non-physician services provided during the inpatient stay. Payment includes but is not limited to:

(A) laboratory services;

(B) prosthetic devices, including pacemakers, lenses, artificial joints, cochlear implants, implantable pumps;

(C) technical component on radiology services;

(D) transportation, including ambulance, to and from another facility to receive specialized diagnostic and therapeutic services;
(E) pre-admission diagnostic testing performed within 72 hours of admission; and
(F) organ transplants.

(3) Hospitals may submit a claim for payment only upon the final discharge of the patient or upon completion of a transfer of the patient to another hospital.

(4) Covered inpatient services provided to eligible members of the Oklahoma SoonerCare program, when treated in out-of-state hospitals will be reimbursed in the same manner as in-state hospitals.

(5) Cases which indicate transfer from one acute care hospital to another will be monitored under a retrospective utilization review policy to help ensure that payment is not made for inappropriate transfers.

(6) The transferring hospital will be paid the lesser of the calculated transfer fee or the DRG base payment amount for a non-transfer. No outlier payment will be made on transfers.

~~(6)~~(7) If the transferring or discharge hospital or unit is exempt from the DRG, that hospital or unit will be reimbursed according to the method of payment applicable to the particular facility or units.

~~(7)~~(8) Covered inpatient services provided in out-of-state specialty hospitals may be reimbursed at a negotiated rate not to exceed 100% of the cost to provide the service. Negotiation of rates will only be allowed when the OHCA determines that the specialty hospital or specialty unit provides a unique (non-experimental) service required by SoonerCare members and the provider will not accept the DRG payment rate. Prior authorization is required.

~~(8)~~(9) New providers entering the SoonerCare program will be assigned a peer group and will be reimbursed at the peer group base rate for the DRG payment methodology or the statewide median rate for per diem methods.

~~(9)~~(10) When services are delivered via telemedicine to hospital inpatients, the originating site facility fee will be paid outside the DRG payment.

~~(10)~~(11) All inpatient services are reimbursed per the ~~DRG~~ methodology described in this section and/or as approved under the Oklahoma State Medicaid Plan.

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: February 16, 2016

The proposed policy was submitted to the MAC on May 21, 2015 as an emergency policy change. The proposed policy was presented for Tribal Consultation on May 5, 2015. The proposed Permanent rule change is scheduled to be presented the MAC on March 10, 2016 and to the (OHCA) Board of Directors on March 24, 2016.
Reference: APA WF 15-04

SUMMARY:
Eliminate adult sleep studies and remove coverage for removal of benign skin lesions for adults - The proposed policy revisions remove coverage for removal of benign skin lesions for adults and eliminate adult sleep studies.

LEGAL AUTHORITY
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; Article 10, Section 23 of the Oklahoma Constitution

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

TO: Tywanda Cox
Health Policy

FROM: Harvey Reynolds
Health Policy

SUBJECT: Rule Impact Statement
APA WF # 15-04

A. Brief description of the purpose of the rule:

The proposed policy revisions revoke payment for removal of benign skin lesions for adults and eliminate coverage for adult sleep studies. The aforementioned proposed rules were promulgated through the Emergency Rulemaking 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:

Adults in the SoonerCare program in need of sleep studies will be affected by the proposed rule. Providers in the SoonerCare program who provide sleep studies will be affected by the proposed rule. Removal of benign skin lesions was not a covered benefit unless it was medically necessary which typically was not the case for a benign skin lesion. Removal of a benign skin lesion was typically for cosmetic purposes. The benefit still exists for those adults with non-benign skin lesion treatment and for medically indicated biopsy of said lesions.

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

There are no classes of person 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 rules ~~may have an~~ should have little economic impact on providers who remove benign skin lesions from SoonerCare adult members as that was not a covered benefit unless it was medically necessary which typically was not the case for a benign skin lesion. The proposed rules may have an economic impact on ~~as well as~~ providers who perform sleep studies on SoonerCare adult members.

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:

Budget Impact: Savings approved during promulgation of the emergency rule, the rule change will not result in any additional costs and/or savings 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:

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 may have an adverse effect on provider reimbursements for the providers who perform the related services.

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 measures taken include stakeholder meetings with the Oklahoma Hospital Association, Tribal and IHS entities, Oklahoma State Medical Association, OU Physicians Tulsa, St. Francis Hospital and OU Hospital.

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:

Since adult sleep studies are classified as an optional Medicaid service, OHCA has chosen to eliminate sleep study coverage for adults due to budget constraints. The elimination of coverage for adult sleep studies may increase the risk of undiagnosed obstructive sleep apnea or could exacerbate other medical morbidities. However, the physician could still order these therapies and the member could pay out of pocket if able.

Removal of benign skin lesions was not a covered benefit unless it was medically necessary which typically was not the case for a benign skin lesion. Removal of a benign skin lesion was typically for cosmetic purposes. The benefit still exists for those adults with non-benign skin lesion treatment and for medically indicated biopsy of said lesions.

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

Since adult sleep studies are classified as an optional Medicaid

service, OHCA has chosen to eliminate coverage due to budget constraints. If the proposed rule is not implemented, there will be no detrimental effect on the public health, safety and environment; however, this will negatively impact the limited OHCA budget.

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

Prepared April 30, 2015
Modified September 28, 2015; January 20, 2016

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

317:30-3-59. General program exclusions - adults

The following are excluded from SoonerCare coverage for adults:
(1) Inpatient admission for diagnostic studies that could be performed on an outpatient basis.
(2) Services or any expense incurred for cosmetic surgery.
(3) Services of two physicians for the same type of service to the same member on the same day, except when supplemental skills are required and different specialties are involved.
(4) Refractions and visual aids.
(5) Pre-operative care within 24 hours of the day of admission for surgery and routine post-operative care as defined under the global surgery guidelines promulgated by Current Procedural Terminology (CPT) and the Centers for Medicare and Medicaid Services (CMS).
(6) Sterilization of members who are under 21 years of age, mentally incompetent, or institutionalized or reversal of sterilization procedures for the purposes of conception.
(7) Non-therapeutic hysterectomies.
(8) Induced abortions, except when certified in writing by a physician that the abortion was necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, or that the pregnancy is the result of an act of rape or incest. (Refer to OAC 317:30-5-6 or 317:30-5-50.)
(9) Medical services considered experimental or investigational.
(10) Services of a Certified Surgical Assistant.

(11) Services of a Chiropractor. Payment is made for Chiropractor services on Crossover claims for coinsurance and/or deductible only.
(12) Services of an independent licensed Physical and/or Occupational Therapist.
(13) Services of a Psychologist.
(14) Services of an independent licensed Speech and Hearing Therapist.
(15) Payment for more than four outpatient visits per month (home or office) per member, except those visits in connection with family planning or related to emergency medical conditions.
(16) Payment for more than two nursing facility visits per month.
(17) More than one inpatient visit per day per physician.
(18) Payment for removal of benign skin lesions ~~unless medically necessary~~.
(19) Physician services which are administrative in nature and not a direct service to the member including such items as quality assurance, utilization review, treatment staffing, tumor board review or multidisciplinary opinion, dictation, and similar functions.
(20) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.
(21) Payment for the services of social workers, licensed family counselors, registered nurses or other ancillary staff, except as specifically set out in OHCA rules.
(22) Mileage.
(23) A routine hospital visit on the date of discharge unless the member expired.
(24) Direct payment to perfusionist as this is considered part of the hospital reimbursement.
(25) Inpatient chemical dependency treatment.
(26) Fertility treatment.
(27) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.
(28) Sleep studies.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 3. HOSPITALS

317:30-5-42.17. Non-covered services

In addition to the general program exclusions [OAC 317:30-5-2(a)(2)] the following are excluded from coverage:
(1) Inpatient admission for diagnostic studies that could be performed on an outpatient basis.
(2) Procedures that result in sterilization which do not meet the guidelines set forth in this Chapter of rules.
(3) Reversal of sterilization procedures for the purposes of conception are not covered.

(4) Medical services considered experimental or investigational.
(5) Payment for removal of benign skin lesions ~~unless medically necessary~~ for adults.
(6) Refractions and visual aids.
(7) Charges incurred while the member is in a skilled nursing or swing bed.
(8) Sleep studies for adults.

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: June 7, 2015

The proposed policy is an Emergency Rule. This proposal is scheduled to be presented to the Medical Advisory Committee (MAC) on May 21, 2015 and the (OHCA) Board of Directors on June 25, 2015. **Reference: APA WF 15-04**

SUMMARY:
These emergency revisions are necessary to reduce the Agency's operations budget in order to meet the balanced budget requirements as mandated by State law. Without the recommended revisions, the Agency is at risk of exhausting its State appropriated dollars required to maintain the State's Medicaid Program. The proposed policy revisions remove coverage for removal of benign skin lesions for adults and eliminate adult sleep studies.

LEGAL AUTHORITY
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; Article 10, Section 23 of the Oklahoma Constitution

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

TO: Tywanda Cox
Health Policy

FROM: Harvey Reynolds
Health Policy

SUBJECT: Rule Impact Statement
APA WF # 15-04

A. Brief description of the purpose of the rule:

The proposed policy revisions revoke payment for removal of benign skin lesions for adults. In addition, the proposed policy

revisions eliminate coverage for adult sleep studies.

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:

Adults in the SoonerCare program will be affected by the proposed rule.

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

There are no classes of person 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 rules may have an economic impact on providers who remove benign skin lesions from SoonerCare adult members as well as providers who perform sleep studies on SoonerCare adult members.

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 agency estimates that the savings from revoking payment for removal of benign skin lesions for adults will be $37,879 state dollars and $106,832 total dollars for FFY ’16. The agency estimates that the savings from eliminating adult sleep studies will be $517,420 state dollars for and $1,459,302 total dollars for FFY ’16.

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 may have an adverse effect on provider reimbursements for the providers who perform the related services.

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, or 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:

Prepared April 30, 2015
Modified N/A

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

317:30-3-59. General program exclusions - adults

The following are excluded from SoonerCare coverage for adults:
(1) Inpatient admission for diagnostic studies that could be performed on an outpatient basis.
(2) Services or any expense incurred for cosmetic surgery.
(3) Services of two physicians for the same type of service to the same member on the same day, except when supplemental skills are required and different specialties are involved.
(4) Refractions and visual aids.
(5) Pre-operative care within 24 hours of the day of admission for surgery and routine post-operative care as defined under the global surgery guidelines promulgated by Current Procedural Terminology (CPT) and the Centers for Medicare and Medicaid Services (CMS).
(6) Sterilization of members who are under 21 years of age, mentally incompetent, or institutionalized or reversal of sterilization procedures for the purposes of conception.
(7) Non-therapeutic hysterectomies.
(8) Induced abortions, except when certified in writing by a physician that the abortion was necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, or that the pregnancy is the result of an act of rape or incest. (Refer to OAC 317:30-5-6 or 317:30-5-50.)
(9) Medical services considered experimental or investigational.
(10) Services of a Certified Surgical Assistant.
(11) Services of a Chiropractor. Payment is made for Chiropractor services on Crossover claims for coinsurance and/or deductible only.
(12) Services of an independent licensed Physical and/or Occupational Therapist.
(13) Services of a Psychologist.
(14) Services of an independent licensed Speech and Hearing Therapist.
(15) Payment for more than four outpatient visits per month (home or office) per member, except those visits in connection with family planning or related to emergency medical conditions.
(16) Payment for more than two nursing facility visits per month.

(17) More than one inpatient visit per day per physician.
(18) Payment for removal of benign skin lesions ~~unless medically necessary~~.
(19) Physician services which are administrative in nature and not a direct service to the member including such items as quality assurance, utilization review, treatment staffing, tumor board review or multidisciplinary opinion, dictation, and similar functions.
(20) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.
(21) Payment for the services of social workers, licensed family counselors, registered nurses or other ancillary staff, except as specifically set out in OHCA rules.
(22) Mileage.
(23) A routine hospital visit on the date of discharge unless the member expired.
(24) Direct payment to perfusionist as this is considered part of the hospital reimbursement.
(25) Inpatient chemical dependency treatment.
(26) Fertility treatment.
(27) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.
(28) Sleep studies.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 1. PHYSICIANS

317:30-5-2. General coverage by category

(a) **Adults.** Payment for adults is made to physicians for medical and surgical services within the scope of the Oklahoma Health Care Authority's (OHCA) SoonerCare program, provided the services are reasonable and necessary for the diagnosis and treatment of illness or injury, or to improve the functioning of a malformed body member. Coverage of certain services must be based on a determination made by the OHCA's medical consultant in individual circumstances.

(1) Coverage includes the following medically necessary services:

(A) Inpatient hospital visits for all SoonerCare covered stays. All inpatient services are subject to post-payment review by the OHCA, or its designated agent.
(B) Inpatient psychotherapy by a physician.
(C) Inpatient psychological testing by a physician.
(D) One inpatient visit per day, per physician.
(E) Certain surgical procedures performed in a Medicare certified free-standing ambulatory surgery center (ASC) or a

Medicare certified hospital that offers outpatient surgical services.
(F) Therapeutic radiology or chemotherapy on an outpatient basis without limitation to the number of treatments per month for members with proven malignancies or opportunistic infections.
(G) Direct physician services on an outpatient basis. A maximum of four visits are allowed per month per member in office or home regardless of the number of physicians providing treatment. Additional visits per month are allowed for those services related to emergency medical conditions and for services in connection with Family Planning.
(H) Direct physician services in a nursing facility for those members residing in a long-term care facility. A maximum of two nursing facility visits per month are allowed. To receive payment for a second nursing facility visit in a month denied by Medicare for a Medicare/SoonerCare member, attach the EOMB from Medicare showing denial and mark "carrier denied coverage".
(I) Diagnostic x-ray and laboratory services.
(J) Mammography screening and additional follow-up mammograms.
(K) Obstetrical care.
(L) Pacemakers and prostheses inserted during the course of a surgical procedure.
(M) Prior authorized examinations for the purpose of determining medical eligibility for programs administered by OHCA. A copy of the authorization, OKDHS form 08MA016E, Authorization for Examination and Billing, must accompany the claim.
(N) If a physician renders direct care to a member on the same day as a dialysis treatment, payment is allowed for a separately identifiable service unrelated to the dialysis.
(O) Family planning includes sterilization procedures for legally competent members 21 years of age and over who voluntarily request such a procedure and execute the federally mandated consent form with his/her physician. A copy of the consent form must be attached to the claim form. Separate payment is allowed for the insertion and/or implantation of contraceptive devices during an office visit. Certain family planning products may be obtained through the Vendor Drug Program. Reversal of sterilization procedures for the purposes of conception is not allowed. Reversal of sterilization procedures are allowed when medically indicated and substantiating documentation is attached to the claim.
(P) Genetic counseling.
(Q) Laboratory testing (such as complete blood count (CBC), platelet count, or urinalysis) for monitoring members

receiving chemotherapy, radiation therapy, or medications that require monitoring during treatment.

(R) Payment for ultrasounds for pregnant women as specified in OAC 317:30-5-22.

(S) Payment to the attending physician in a teaching medical facility for compensable services when the physician signs as claimant and renders personal and identifiable services to the member in conformity with federal regulations.

(T) Payment to clinical fellow or chief resident in an outpatient academic setting when the following conditions are met:

(i) Recognition as clinical faculty with participation in such activities as faculty call, faculty meetings, and having hospital privileges;

(ii) Board certification or completion of an accredited residency program in the fellowship specialty area;

(iii) Hold unrestricted license to practice medicine in Oklahoma;

(iv) If Clinical Fellow, practicing during second or subsequent year of fellowship;

(v) Seeing members without supervision;

(vi) Services provided not for primary purpose of medical education for the clinical fellow or chief resident;

(vii) Submit billing in own name with appropriate Oklahoma SoonerCare provider number;

(viii) Additionally if a clinical fellow practicing during the first year of fellowship, the clinical fellow must be practicing within their area of primary training. The services must be performed within the context of their primary specialty and only to the extent as allowed by their accrediting body.

(U) Payment to the attending physician for the services of a currently Oklahoma licensed physician in training when the following conditions are met.

(i) Attending physician performs chart review and signs off on the billed encounter;

(ii) Attending physician is present in the clinic/or hospital setting and available for consultation;

(iii) Documentation of written policy and applicable training of physicians in the training program regarding when to seek the consultation of the attending physician.

(V) Payment to the attending physician for the outpatient services of an unlicensed physician in a training program when the following conditions are met:

(i) The member must be at least minimally examined by the attending physician or a licensed physician under the supervision of the attending physician;

(ii) The contact must be documented in the medical record.

(W) The payment to a physician for medically directing the services of a CRNA or for the direct supervision of the services of an Anesthesiologist Assistant (AA) is limited. The maximum allowable fee for the services of both providers combined is limited to the maximum allowable had the service been performed solely by the anesthesiologist.

(X) One pap smear per year for women of child bearing age. Two follow-up pap smears are covered when medically indicated.

(Y) Medically necessary solid organ and bone marrow/stem cell transplantation services for children and adults are covered services based upon the conditions listed in (i)-(iv) of this subparagraph:

(i) Transplant procedures, except kidney and cornea, must be prior authorized to be compensable.

(ii) To be prior authorized all procedures are reviewed based on appropriate medical criteria.

(iii) To be compensable under the SoonerCare program, all organ transplants must be performed at a facility which meets the requirements contained in Section 1138 of the Social Security Act.

(iv) Procedures considered experimental or investigational are not covered.

(Z) Donor search and procurement services are covered for transplants consistent with the methods used by the Medicare program for organ acquisition costs.

(i) Donor expenses incurred for complications are covered only if they are directly and immediately attributable to the donation procedure.

(ii) Donor expenses that occur after the 90 day global reimbursement period must be submitted to the OHCA for review.

(AA) Total parenteral nutritional therapy (TPN) for identified diagnoses and when prior authorized.

(BB) Ventilator equipment.

(CC) Home dialysis equipment and supplies.

(DD) Ambulatory services for treatment of members with tuberculosis (TB). This includes, but is not limited to, physician visits, outpatient hospital services, rural health clinic visits and prescriptions. Drugs prescribed for the treatment of TB beyond the prescriptions covered under SoonerCare require prior authorization by the University of Oklahoma College of Pharmacy Help Desk using form "Petition for TB Related Therapy". Ambulatory services to members infected with TB are not limited to the scope of the SoonerCare program, but require prior authorization when the scope is exceeded.

(EE) Smoking and Tobacco Use Cessation Counseling for treatment of individuals using tobacco.

(i) Smoking and Tobacco Use Cessation Counseling consists of the 5As:

(I) Asking the member to describe their smoking use;
(II) Advising the member to quit;
(III) Assessing the willingness of the member to quit;
(IV) Assisting the member with referrals and plans to quit; and
(V) Arranging for follow-up.

(ii) Up to eight sessions are covered per year per individual.

(iii) Smoking and Tobacco Use Cessation Counseling is a covered service when performed by physicians, physician assistants, advanced registered nurse practitioners, certified nurse midwives, dentists, Oklahoma State Health Department and FQHC nursing staff, and Maternal/Child Health Licensed Clinical Social Workers with a certification as a Tobacco Treatment Specialist Certification (CTTS). It is reimbursed in addition to any other appropriate global payments for obstetrical care, PCP care coordination payments, evaluation and management codes, or other appropriate services rendered. It must be a significant, separately identifiable service, unique from any other service provided on the same day.

(iv) Chart documentation must include a separate note and signature along with 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.

(FF) Immunizations as specified by the Advisory Committee on Immunization Practices (ACIP) guidelines.

(GG) Genetic testing is covered when medically necessary. Genetic testing may be considered medically necessary when the following conditions are met:

(i) The member displays clinical features of a suspected genetic condition or is at direct risk of inheriting the genetic condition in question (e.g., a causative familial variant has been identified); and

(ii) Clinical studies published in peer-reviewed literature have established strong evidence that the result of the test will positively impact the clinical decision-making or clinical outcome for the member; and

(iii) The testing method is proven to be scientifically valid for the identification of a specific genetically-linked inheritable disease or clinically important molecular marker; and

(iv) Documentation is provided from a licensed genetic counselor or physician with genetic expertise that

supports the recommendation for testing based on a review of risk factors, clinical scenario, and family history.

(2) General coverage exclusions include the following:

(A) Inpatient admission for diagnostic studies that could be performed on an outpatient basis.

(B) Services or any expense incurred for cosmetic surgery.

(C) Services of two physicians for the same type of service to the same member on the same day, except when supplemental skills are required and different specialties are involved.

(D) Refractions and visual aids.

(E) Pre-operative care within 24 hours of the day of admission for surgery and routine post-operative care as defined under the global surgery guidelines promulgated by Current Procedural Terminology (CPT) and the Centers for Medicare and Medicaid Services (CMS).

(F) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.

(G) Sterilization of members who are under 21 years of age, mentally incompetent, or institutionalized or reversal of sterilization procedures for the purposes of conception.

(H) Non-therapeutic hysterectomies.

(I) Medical services considered experimental or investigational.

(J) Payment for more than four outpatient visits per month (home or office) per member, except those visits in connection with family planning or related to emergency medical conditions.

(K) Payment for more than two nursing facility visits per month.

(L) More than one inpatient visit per day per physician.

(M) Physician services which are administrative in nature and not a direct service to the member including such items as quality assurance, utilization review, treatment staffing, tumor board review or multidisciplinary opinion, dictation, and similar functions.

(N) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.

(O) Payment for the services of social workers, licensed family counselors, registered nurses or other ancillary staff, except as specifically set out in OHCA rules.

(P) Induced abortions, except when certified in writing by a physician that the abortion was necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, or that the pregnancy is the result of an act of rape or incest. (Refer to OAC 317:30-5-6 or 317:30-5-50.)

(Q) Speech and Hearing services.

(R) Mileage.

(S) A routine hospital visit on the date of discharge unless the member expired.
(T) Direct payment to perfusionist as this is considered part of the hospital reimbursement.
(U) Inpatient chemical dependency treatment.
(V) Fertility treatment.
(W) Payment for removal of benign skin lesions ~~unless medically necessary~~.
(X) Sleep studies.

PART 3. HOSPITALS

317:30-5-42.17. Non-covered services

In addition to the general program exclusions [OAC 317:30-5-2(a)(2)] the following are excluded from coverage:

(1) Inpatient admission for diagnostic studies that could be performed on an outpatient basis.
(2) Procedures that result in sterilization which do not meet the guidelines set forth in this Chapter of rules.
(3) Reversal of sterilization procedures for the purposes of conception are not covered.
(4) Medical services considered experimental or investigational.
(5) Payment for removal of benign skin lesions ~~unless medically necessary~~ for adults.
(6) Refractions and visual aids.
(7) Charges incurred while the member is in a skilled nursing or swing bed.
(8) Sleep studies for adults.

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: June 7, 2015

The proposed policy is an Emergency Rule. This proposal is scheduled to be presented to the Medical Advisory Committee (MAC) on May 21, 2015 and the (OHCA) Board of Directors on June 25, 2015. **Reference: APA WF 15-05**

SUMMARY:
High Risk Obstetrical Services – These emergency revisions are necessary to reduce the Agency's operations budget in order to meet the balanced budget requirements as mandated by State law. Without the recommended revisions, the Agency is at risk of exhausting its State appropriated dollars required to maintain the State's Medicaid Program. Rules are revised to decrease the number of ultrasounds and biophysical profiles/non-stress test for high risk pregnancy members.

LEGAL AUTHORITY:
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; Article 10, Section 23 of the Oklahoma Constitution; Section 1902 of Social Security Act.

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

TO: Tywanda Cox
Health Policy

FROM: Likita Gunn
Federal and State Policy

SUBJECT: Rule Impact Statement
APA WF #15-05

A. Brief description of the purpose of the rule:

The proposed policy revisions to the High risk Obstetrical program include: Allowing the provider to be Board Eligible or

Board Certified, decreasing the number of units allowed for ultrasounds from six to three; decreasing the number of units for a singleton fetus for biophysical profiles/non-stress tests or any combination thereof to a total of 5, with one test per week beginning at 34 weeks gestation and continuing to 38 weeks; and, decreasing the number of ultrasounds currently granted to the Maternal Fetal Medicine (MFM) doctors to assist in the diagnosis of a high risk condition from six to one. These changes align with the current standards of care and reflect the current number of ultrasounds and biophysical profiles currently being utilized.

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:

General obstetrical providers and MFM doctors will be affected by the proposed rule as they will be limited in the scope and duration of services performed, unless medical necessitate indicates otherwise.

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 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:

The proposed rule may have an economic impact on MFM providers who perform the services being reduced.

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 proposed rule change is projected to save $292,433 total dollars and $103,687 state 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 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 29, 2015.

RULE TEXT

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

317:30-5-22. Obstetrical care

(a) Obstetrical (OB) care is billed using the appropriate CPT codes for Maternity Care and Delivery. The date of delivery is used as the date of service for charges for total obstetrical care. Inclusive dates of care should be indicated on the claim form as part of the description. Payment for total obstetrical care includes all routine care, and any ultrasounds performed by the attending physician provided during the maternity cycle unless otherwise specified in this Section. For payment of total OB care, a physician must have provided care for more than one trimester. To bill for prenatal care only, the claim is filed after the member leaves the provider's care. Payment for routine or minor medical problems will not be made separately to the OB physician outside of the ante partum visits. The ante partum care during the prenatal care period includes all care by the OB attending physician except major illness distinctly unrelated to the pregnancy.

(b) Procedures paid separately from total obstetrical care are listed in (1) - (8) of this subsection.

(1) The completion of an American College of Obstetricians and Gynecologist (ACOG) assessment form or form covering same elements as ACOG and the most recent version of the Oklahoma Health Care Authority's Prenatal Psychosocial Assessment are reimbursable when both documents are included in the prenatal record. SoonerCare allows one assessment per provider and no more than two per pregnancy.

(2) Medically necessary real time ante partum diagnostic ultrasounds will be paid for in addition to ante partum care, delivery and post partum obstetrical care under defined circumstances. To be eligible for payment, ultrasound reports must meet the guideline standards published by the American Institute of Ultrasound Medicine (AIUM).

(A) One abdominal or vaginal ultrasound will be covered in the first trimester of pregnancy. The ultrasound must be performed by a Board Eligible/Board Certified Obstetrician-Gynecologist (OB-GYN), Radiologist, or a Board Eligible/Board Certified Maternal-Fetal Medicine specialist. In addition, this ultrasound may be performed by a Nurse Midwife, Family Practice Physician or Advance Practice Nurse Practitioner in Obstetrics with a certification in obstetrical ultrasonography.

(B) One ultrasound after the first trimester will be covered. This ultrasound must be performed by a Board Eligible/Board Certified Obstetrician-Gynecologist (OB-GYN), Radiologist, or a Board Eligible/Board Certified Maternal-Fetal Medicine specialist. In addition, this ultrasound may be performed by a Nurse Midwife, Family Practice Physician or Advance Practice Nurse Practitioner in Obstetrics with certification

in obstetrical ultrasonography.

~~(C) Additional ultrasounds, including detailed ultrasounds and re-evaluations of previously identified or suspected fetal or maternal anomalies must be performed by an active candidate or Board Certified diplomat in Maternal-Fetal Medicine. Up to six repeat ultrasounds are allowed after which, prior authorization is required.~~

(C) One additional ultrasound is allowed by a Board Eligible/Board Certified Maternal Fetal Specialist to identify or confirm a suspected fetal/maternal anomaly. This additional ultrasound does not require prior authorization. Any subsequent ultrasounds will require prior authorization.

(3) Standby attendance at Cesarean Section (C-Section), for the purpose of attending the baby, is compensable when billed by a physician not participating in the delivery.

(4) Spinal anesthesia administered by the attending physician is a compensable service and is billed separately from the delivery.

(5) Amniocentesis is not included in routine obstetrical care and is billed separately. Payment may be made for an evaluation and management service and amniocentesis on the same date of service. This is an exception to general information regarding surgery found at OAC 317:30-5-8.

(6) Additional payment is not made for the delivery of twins. If one twin is delivered vaginally and one is delivered by C-section by the same physician, the higher level procedure is paid. If one twin is delivered vaginally and one twin is delivered by C-Section, by different physicians, each should bill the appropriate procedure codes without a modifier. Payment is not made to the same physician for both standby and assistant at C-Section.

~~(7) One non stress test and/or biophysical profile to confirm a suspected high risk pregnancy diagnosis. The non stress test and/or biophysical profile must be performed by an active candidate or Board Certified diplomate in Maternal Fetal Medicine.~~

~~(8)~~(7) Nutritional counseling in a group setting for members with gestational diabetes. Refer to OAC 317:30-5-1076(5).

(c) Assistant surgeons are paid for C-Sections which include only in-hospital post-operative care. Family practitioners who provide prenatal care and assist at C-Section bill separately for the prenatal and the six weeks postpartum office visit.

(d) Procedures listed in (1) - (5) of this subsection are not paid or not covered separately from total obstetrical care.

(1) ~~Additional non stress tests~~ Non stress test, unless the pregnancy is determined medically high risk. See OAC 317:30-5-22.1.

(2) Standby at C-Section is not compensable when billed by a physician participating in delivery.

(3) Payment is not made for an assistant surgeon for obstetrical procedures that include prenatal or post partum care.

(4) An additional allowance is not made for induction of labor, double set-up examinations, fetal stress tests, or pudendal anesthetic. Providers must not bill separately for these procedures.

(5) Fetal scalp blood sampling is considered part of the total OB care.

(e) Obstetrical coverage for children is the same as for adults with additional procedures being covered due to EPSDT provisions if determined to be medically necessary.

(1) Services deemed medically necessary and allowable under federal Medicaid regulations are covered by the EPSDT/OHCA Child Health Program even though those services may not be part of the Oklahoma Health Care Authority SoonerCare program. Such services must be prior authorized.

(2) Federal Medicaid regulations also require the State to make the determination as to whether the service is medically necessary and do not require the provision of any items or services that the State determines are not safe and effective or which are considered experimental.

317:30-5-22.1. Enhanced services for medically high risk pregnancies

(a) **Enhanced services.** Enhanced services are available for pregnant women eligible for SoonerCare and are in addition to services for uncomplicated maternity cases. Women deemed high risk based on criteria established by the OHCA may receive prior authorization for medically necessary enhanced benefits which include:

(1) prenatal at risk ante partum management;

(2) a combined maximum of ~~12~~ 5 fetal non stress test(s) and biophysical profiles (additional units can be prior authorized for multiple fetuses~~; and~~ with one test per week beginning at 34 weeks gestation and continuing to 38 weeks; and

(3) a maximum of ~~6~~ 3 repeat ultrasounds not covered under OAC 317:30-5-22(b)(2).

(b) **Prior authorization.** To receive enhanced services, the following documentation must be received by the OHCA Medical Authorizations Unit for review and approval:

(1) ACOG or other comparable comprehensive prenatal assessment;

(2) chart note identifying and detailing the qualifying high risk condition; and

(3) an OHCA High Risk OB Treatment Plan/Prior Authorization Request (CH-17) signed by a Board Eligible/Board Certified Maternal Fetal Medicine (MFM) specialist.

(c) **Reimbursement.** When prior authorized, enhanced benefits will be reimbursed as follows:

(1) Ante partum management for high risk is reimbursed to the primary obstetrical provider. If the primary provider of obstetrical care is not the MFM and wishes to request authorization of the ante partum management fee, the OHCA CH-17 must be signed by the primary provider of OB care. Additionally, reimbursement for enhanced at risk ante partum management is not made during an in-patient hospital stay.

(2) Non stress tests, biophysical profiles and ultrasounds (in addition to those covered under OAC 317:30-5-22(a)(2) subparagraphs (A) through (C) are reimbursed when prior authorized.

(3) Reimbursement for enhanced at risk ante partum management is not available to physicians who already qualify for enhanced reimbursement as state employed physicians.

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 15, 2016

The proposed policy is a Permanent Rule. This proposal was presented to the Medical Advisory Committee (MAC) as an emergency rule change on May 21, 2015 and presented at Tribal Consultation on May 5, 2015. The proposed Permanent rule change is scheduled to be presented at the (OHCA) Board of Directors on February 11, 2016.

Reference: APA WF 15-06

SUMMARY:
Coverage for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) - The proposed policy revisions regarding coverage for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) restrict coverage for continuous positive airway pressure devices (CPAP) to children only. These proposed revisions were promulgated during the Emergency rule 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; Article 10, Section 23 of the Oklahoma Constitution

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

TO: Tywanda Cox
Health Policy

FROM: William Baker
Health Policy

SUBJECT: Rule Impact Statement
APA WF # 15-06

A. Brief description of the purpose of the rule:

The proposed policy revisions regarding coverage for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) restrict coverage for continuous positive airway pressure devices (CPAP) to children only. These proposed revisions were promulgated during the Emergency rule 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:

Adult members requiring CPAP after implementation of the 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 affect on state revenues, including a projected net loss or gain in such revenues if it can be projected by the agency:

Savings approved during promulgation of the emergency rule. The rule change will not result in any additional costs and/or savings 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:

Without the recommended revisions, the Agency is at risk of exhausting its State appropriated dollars required to maintain the State's Medicaid Program.

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

The rule impact statement was prepared September 30, 2015.

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

317:30-5-210.2. Coverage for children

(a) **Coverage.** Coverage of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) for children includes the specified coverage for adults found in OAC 317:30-5-211.1 through OAC 317:30-5-211.18. In addition the following are covered items for children only:

(1) Orthotics and prosthetics.

(2) Enteral nutrition is considered medically necessary for certain conditions in which, without the products, the member's condition would deteriorate to the point of severe malnutrition.

(A) Enteral nutrition must be prior authorized. PA requests must include:

(i) the member's diagnosis;

(ii) the impairment that prevents adequate nutrition by conventional means;

(iii) the member's weight history before initiating enteral nutrition that demonstrates oral intake without enteral nutrition is inadequate;

(iv) the percentage of the member's average daily nutrition taken by mouth and by tube; and

(v) prescribed daily caloric intake.

(B) Enteral nutrition products that are administered orally and related supplies are not covered.

(3) Continuous positive airway pressure devices (CPAP).

(b) **EPSDT.** Services deemed medically necessary and allowable under federal regulations may be covered by the EPSDT Child Health program even though those services may not be part of the SoonerCare program. These services must be prior authorized.

(c) **Medical necessity.** Federal regulations require OHCA to make the determination as to whether the service is medically necessary and do not require the provision of any items or services that the State determines are not safe and effective or that are considered experimental.

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: June 7, 2015

The proposed policy is an Emergency Rule. This proposal is scheduled to be presented to the Medical Advisory Committee (MAC) on May 21, 2015 and the OHCA Board of Directors on June 25, 2015. **Reference: APA WF 15-06**

SUMMARY:
Coverage for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) – These emergency revisions are necessary to reduce the Agency's operations budget in order to meet the balanced budget requirements as mandated by State law. Without the recommended revisions, the Agency is at risk of exhausting its State appropriated dollars required to maintain the State's Medicaid Program. Rules are amended to restrict coverage for continuous positive airway pressure devices (CPAP) to children only. These changes are needed in order to reduce the overall costs of the Medicaid Program.

LEGAL AUTHORITY
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; Article 10, Section 23 of the Oklahoma Constitution

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

TO: Tywanda Cox
Health Policy

FROM: William Baker
Health Policy

SUBJECT: Rule Impact Statement
APA WF # 15-06

A. Brief description of the purpose of the rule:

The proposed policy revisions regarding coverage for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) restrict coverage for continuous positive airway pressure devices (CPAP) to children only. These emergency revisions are necessary to reduce the Agency's operations budget in order to meet the balanced budget requirements as mandated by State law. Without the recommended revisions, the Agency is at risk of exhausting its State appropriated dollars required to maintain the State's Medicaid Program.

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 members requiring CPAP after implementation of the 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 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 has total projected savings of $506,630; total state savings are projected as $179,634 for SFY 2016.

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:

Without the recommended revisions, the Agency is at risk of exhausting its State appropriated dollars required to maintain the State's Medicaid Program.

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

The rule impact statement was prepared May 1, 2015.

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

317:30-5-210.2. Coverage for children

(a) **Coverage.** Coverage of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) for children includes the specified coverage for adults found in OAC 317:30-5-211.1 through OAC 317:30-5-211.18. In addition the following are covered items for children only:

(1) Orthotics and prosthetics.

(2) Enteral nutrition is considered medically necessary for certain conditions in which, without the products, the member's condition would deteriorate to the point of severe malnutrition.

(A) Enteral nutrition must be prior authorized. PA requests must include:

(i) the member's diagnosis;

(ii) the impairment that prevents adequate nutrition by conventional means;

(iii) the member's weight history before initiating enteral nutrition that demonstrates oral intake without enteral nutrition is inadequate;

(iv) the percentage of the member's average daily nutrition taken by mouth and by tube; and

(v) prescribed daily caloric intake.

(B) Enteral nutrition products that are administered orally and related supplies are not covered.

(3) Continuous positive airway pressure devices (CPAP).

(b) **EPSDT.** Services deemed medically necessary and allowable under federal regulations may be covered by the EPSDT Child Health program even though those services may not be part of the SoonerCare program. These services must be prior authorized.

(c) **Medical necessity.** Federal regulations require OHCA to make the determination as to whether the service is medically necessary and do not require the provision of any items or services that the State determines are not safe and effective or that are considered experimental.

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: February 16, 2016

The proposed policy was submitted to the Medical Advisory Committee (MAC) on May 21, 2015 as an emergency policy change. The proposed policy was presented for Tribal Consultation on May 5, 2015. The proposed Permanent rule change is scheduled to be presented to the MAC on March 10, 2016 and the (OHCA) Board of Directors on March 24, 2016.
Reference: APA WF 15-07A

SUMMARY:
General Coverage by Category and Obstetrical Reimbursement-The proposed Obstetrical policy revisions decrease the number of ultrasounds and biophysical profiles/non-stress test for high risk pregnancy members. The proposed revisions also amend rules to allow for a general OB to request the high risk obstetrical (HROB) services/package for pregnant women to ensure pregnant women with high risk conditions receive HROB services.

The proposed General Coverage policy revisions revoke payment for removal of benign skin lesions for adults and eliminate coverage for adult sleep studies.

The aforementioned changes were approved during promulgation of the emergency rule. The following are proposed changes not previously reviewed: Further proposed revisions to Obstetrical policy modify the billing and payment methodology for obstetrical care.

Additional changes amend the General Coverage policy to clarify the separate note and signature requirement for providers performing tobacco use cessation counseling. The revisions clarify that the separate note requirement must address the 5A's and the signature is one office note signature provided at the end of the visit.

An additional change includes general clean-up of terms.

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 1902 of Social Security Act; 42 CFR 483.40.

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA

OKLAHOMA HEALTH CARE AUTHORITY

TO: Tywanda Cox
Health Policy

FROM: Likita Gunn
Federal and State Policy

SUBJECT: Rule Impact Statement
APA WF #15-07A

A. Brief description of the purpose of the rule:

The proposed policy revisions to the Obstetrical policy decrease the number of units allowed for ultrasounds from six to three. The proposed changes also decrease the number of units for a singleton fetus for biophysical profiles/non-stress tests or any combination thereof to a total of five, with one test per week beginning at 34 weeks gestation and continuing to 38 weeks. An additional change to Obstetrical policy decrease the number of ultrasounds currently granted to the Maternal Fetal Medicine (MFM) doctors to assist in the diagnosis of a high risk condition from six to one.

Further proposed policy changes to General Coverage policy revokes payment for removal of benign skin lesions for adults and eliminates coverage for adult sleep studies. **The aforementioned changes were approved during promulgation of the emergency rule. The following are proposed changes not previously reviewed:** Additional proposed revisions to Obstetrical policy amend the reimbursement structure for OB services. Currently the agency utilizes the global care CPT codes for routine obstetrical care billing, which can be used if the provider provided care for a member for greater than one trimester. The proposed policy will require obstetrical care be billed using the appropriate evaluation and management codes for antepartum care, as well as the appropriate delivery only and postpartum care services when rendered. The change allows for more accurate tracking of each antepartum service provided as well as the postpartum service.

Additionally, proposed policy is amended to clarify the separate note and signature requirement for providers performing tobacco use cessation counseling. Proposed revisions clarify the separate note requirement must address the 5A's and that the signature is one office note signature provided at the end of the visit.

In addition, revisions include striking reimbursement language for clinical fellows or chief residents in an outpatient

academic setting. OHCA reimburses chief residents the same as residents and the separate payment distinction based on practice setting is not needed.

Additional changes include general language clean-up to terms and services to ensure language is consistent throughout Chapter 30.

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:

General obstetrical providers and MFM doctors will be affected by the proposed rule as they will be limited in the scope and duration of services performed, unless medical necessitate indicates otherwise. These providers will also be affected by the change in the billing requirement. All Contracted providers who perform tobacco cessation counseling will be affected by the proposed rule. Additionally, adults in the SoonerCare program will be affected by the proposed rule.

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

The OHCA will benefit from the proposed rule change as the change allows for more accurate tracking of each antepartum and postpartum service provided to SoonerCare members. SoonerCare members will also benefit from the proposed rule as the changes will result in an improved quality 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:

The proposed rule may have an economic impact on MFM providers who perform the services being reduced. General OB and MFM providers will also be affected by the change in the reimbursement structure for OB services. The proposed rules may also have an economic impact on providers who remove benign skin lesions from SoonerCare adult members as well as providers who perform sleep studies on SoonerCare adult members. Additionally, adult SoonerCare members will be affected by the proposed rule as sleep studies and the removal of benign skin lesions will no longer be covered services.

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:

Savings identified with decreasing the number of ultrasounds and biophysical profiles/non-stress test for pregnant women, revoking payment for the removal of benign skin lesions for adults, and elimination of coverage for adult sleep studies were approved during the promulgation of the emergency rule. No additional cost will be incurred.

The proposed rule change restructuring payment for OB services will result in additional savings to the agency. There would be an estimated savings for SFY 2016 of $3,831,661 total dollars; total state savings are projected at $1,444,537.

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:

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. For portions of the proposed rule that were approved during the emergency rule making session, the OHCA hosted 20 stakeholder meetings with providers and members who could potentially be impacted by proposed cuts to the SoonerCare program. Participants in the meetings were informed about the budget reduction items the agency was considering, in addition to possible provider rate cuts. Participants were given the opportunity to contribute any measures that could be used to offset the budget shortfall.

For the proposed rules that were not taken during the emergency rule making session, opportunities for public input are provided throughout the rulemaking process, in addition to formal public comment periods and tribal consultations.

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 portion of the proposed rule to eliminate coverage for sleep studies for adult SoonerCare members may have an 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, 2015.
The rule impact statement was modified January 22, 2016.

RULE TEXT

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 1. PHYSICIANS

317:30-5-2. General coverage by category

(a) **Adults**. Payment for adults is made to physicians for medical and surgical services within the scope of the Oklahoma Health Care Authority's (OHCA) SoonerCare program, provided the services are reasonable and necessary for the diagnosis and treatment of illness or injury, or to improve the functioning of a malformed body member. Coverage of certain services must be based on a determination made by the OHCA's medical consultant in individual circumstances.

(1) Coverage includes the following medically necessary services:

(A) Inpatient hospital visits for all SoonerCare covered stays. All inpatient services are subject to post-payment review by the OHCA, or its designated agent.
(B) Inpatient psychotherapy by a physician.
(C) Inpatient psychological testing by a physician.
(D) One inpatient visit per day, per physician.
(E) Certain surgical procedures performed in a Medicare certified free-standing ambulatory surgery center (ASC) or a Medicare certified hospital that offers outpatient surgical

services.
(F) Therapeutic radiology or chemotherapy on an outpatient basis without limitation to the number of treatments per month for members with proven malignancies ~~or opportunistic infections~~.
(G) Direct physician services on an outpatient basis. A maximum of four visits are allowed per month per member in office or home regardless of the number of physicians providing treatment. Additional visits per month are allowed for those services related to emergency medical conditions and for services in connection with Family Planning.
(H) Direct physician services in a nursing facility for those members residing in a long-term care facility. A maximum of two nursing facility visits per month are allowed. To receive payment for a second nursing facility visit in a month denied by Medicare for a Medicare/SoonerCare member, attach the EOMB from Medicare showing denial and mark "carrier denied coverage".
(I) Diagnostic x-ray and laboratory services.
(J) Mammography screening and additional follow-up mammograms as per current guidelines.
(K) Obstetrical care.
(L) Pacemakers and prostheses inserted during the course of a surgical procedure.
(M) Prior authorized examinations for the purpose of determining medical eligibility for programs administered by OHCA. A copy of the authorization, OKDHS form 08MA016E, Authorization for Examination and Billing, must accompany the claim.
(N) If a physician renders direct care to a member on the same day as a dialysis treatment, payment is allowed for a separately identifiable service unrelated to the dialysis.
(O) Family planning includes sterilization procedures for legally competent members 21 years of age and over who voluntarily request such a procedure and execute the federally mandated consent form with his/her physician. A copy of the consent form must be attached to the claim form. Separate payment is allowed for the insertion and/or implantation of contraceptive devices during an office visit. Certain family planning products may be obtained through the Vendor Drug Program. Reversal of sterilization procedures for the purposes of conception is not allowed. Reversal of sterilization procedures are allowed when medically indicated and substantiating documentation is attached to the claim.
(P) Genetic counseling.
(Q) Laboratory testing ~~(such as complete blood count (CBC), platelet count, or urinalysis) for monitoring members receiving chemotherapy, radiation therapy, or medications that require monitoring during treatment~~.
(R) Payment for ultrasounds for pregnant women as specified in OAC 317:30-5-22.
(S) Payment to the attending physician in a teaching medical

facility for compensable services when the physician signs as claimant and renders personal and identifiable services to the member in conformity with federal regulations.

~~(T) Payment to clinical fellow or chief resident in an outpatient academic setting when the following conditions are met:~~

~~(i) Recognition as clinical faculty with participation in such activities as faculty call, faculty meetings, and having hospital privileges;~~

~~(ii) Board certification or completion of an accredited residency program in the fellowship specialty area;~~

~~(iii) Hold unrestricted license to practice medicine in Oklahoma;~~

~~(iv)If Clinical Fellow, practicing during second or subsequent year of fellowship;~~

~~(v) Seeing members without supervision;~~

~~(vi) Services provided not for primary purpose of medical education for the clinical fellow or chief resident;~~

~~(vii) Submit billing in own name with appropriate Oklahoma SoonerCare provider number;~~

~~(viii) Additionally if a clinical fellow practicing during the first year of fellowship, the clinical fellow must be practicing within their area of primary training. The services must be performed within the context of their primary specialty and only to the extent as allowed by their accrediting body.~~

~~(U)~~(T) Payment to the attending physician for the services of a currently Oklahoma licensed physician in training when the following conditions are met.

(i) Attending physician performs chart review and signs off on the billed encounter;

(ii) Attending physician is present in the clinic/or hospital setting and available for consultation;

(iii) Documentation of written policy and applicable training of physicians in the training program regarding when to seek the consultation of the attending physician.

~~(V)~~(U) Payment to the attending physician for the outpatient services of an unlicensed physician in a training program when the following conditions are met:

(i) The member must be at least minimally examined by the attending physician or a licensed physician under the supervision of the attending physician;

(ii) The contact must be documented in the medical record.

~~(W)~~(V) The payment to a physician for medically directing the services of a CRNA or for the direct supervision of the services of an Anesthesiologist Assistant (AA) is limited. The maximum allowable fee for the services of both providers combined is limited to the maximum allowable had the service been performed solely by the anesthesiologist.

~~(X) One pap smear per year for women of child bearing age. Two follow-up pap smears are covered when medically~~

~~indicated.~~(W) Screening and follow up Pap Smears as per current guidelines.

~~(Y)~~(X) Medically necessary solid organ and bone marrow/stem cell transplantation services for children and adults are covered services based upon the conditions listed in (i)-(iv) of this subparagraph:

(i) Transplant procedures, except kidney and cornea, must be prior authorized to be compensable.

(ii) To be prior authorized all procedures are reviewed based on appropriate medical criteria.

(iii) To be compensable under the SoonerCare program, all organ transplants must be performed at a facility which meets the requirements contained in Section 1138 of the Social Security Act.

(iv)Procedures considered experimental or investigational are not covered.

~~(Z)~~(Y) Donor search and procurement services are covered for transplants consistent with the methods used by the Medicare program for organ acquisition costs.

~~(i) Donor expenses incurred for complications are covered only if they are directly and immediately attributable to the donation procedure.~~

~~(ii) Donor expenses that occur after the 90 day global reimbursement period must be submitted to the OHCA for review.~~

(Z) Donor expenses incurred for complications are covered only if they are directly and immediately attributable to the donation procedure. Donor expenses that occur after the 90 day global reimbursement period must be submitted to the OHCA for review.

(AA) Total parenteral nutritional therapy (TPN) for identified diagnoses and when prior authorized.

(BB) Ventilator equipment.

(CC) Home dialysis equipment and supplies.

(DD) Ambulatory services for treatment of members with tuberculosis (TB). This includes, but is not limited to, physician visits, outpatient hospital services, rural health clinic visits and prescriptions. Drugs prescribed for the treatment of TB beyond the prescriptions covered under SoonerCare require prior authorization by the University of Oklahoma College of Pharmacy Help Desk using form "Petition for TB Related Therapy". Ambulatory services to members infected with TB are not limited to the scope of the SoonerCare program, but require prior authorization when the scope is exceeded.

(EE) Smoking and Tobacco Use Cessation Counseling for treatment of ~~individuals~~members using tobacco.

(i) Smoking and Tobacco Use Cessation Counseling consists of the 5As:

(I) Asking the member to describe their smoking use;

(II) Advising the member to quit;

(III) Assessing the willingness of the member to quit;
(IV) Assisting the member with referrals and plans to quit; and
(V) Arranging for follow-up.

(ii) Up to eight sessions are covered per year per individual.

(iii) Smoking and Tobacco Use Cessation Counseling is a covered service when performed by physicians, physician assistants, advanced registered nurse practitioners, certified nurse midwives, dentists, Oklahoma State Health Department and FQHC nursing staff, and Maternal/Child Health Licensed Clinical Social Workers with a certification as a Tobacco Treatment Specialist Certification (CTTS). It is reimbursed in addition to any other appropriate ~~global payments~~claims for obstetrical care, PCP care coordination payments, evaluation and management codes, or other appropriate services rendered. It must be a significant, separately identifiable service, unique from any other service provided on the same day.

(iv) Chart documentation must include a separate note ~~and~~that addresses the 5A's and office note signature along with 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 and not separately billable.

(FF) Immunizations as specified by the Advisory Committee on Immunization Practices (ACIP) guidelines.

(GG) Genetic testing is covered when medically necessary. Genetic testing may be considered medically necessary when the following conditions are met:

(i) The member displays clinical features of a suspected genetic condition or is at direct risk of inheriting the genetic condition in question (e.g., a causative familial variant has been identified); and

(ii) Clinical studies published in peer-reviewed literature have established strong evidence that the result of the test will positively impact the clinical decision-making or clinical outcome for the member; and

(iii) The testing method is proven to be scientifically valid for the identification of a specific genetically-linked inheritable disease or clinically important molecular marker; and

(iv) ~~Documentation is provided from a licensed genetic counselor or physician with genetic that supports the recommendation for testing based on a review of risk factors, clinical scenario, and family history.~~A medical geneticist physician or licensed genetic counselor provides documentation that supports the recommendation for testing based on a review of risk factors, clinical scenario, and family history.

(2) General coverage exclusions include the following:

(A) Inpatient admission for diagnostic studies that could be performed on an outpatient basis.

(B) Services or any expense incurred for cosmetic surgery.

(C) Services of two physicians for the same type of service to the same member on the same day, except when supplemental skills are required and different specialties are involved.

(D) ~~Refractions and visual aids.~~Routine eye examinations for the sole purpose of prescribing glasses or visual aids, determination of refractive state, treatment of refractive errors or purchase of lenses, frames or visual aids.

(E) Pre-operative care within 24 hours of the day of admission for surgery and routine post-operative care as defined under the global surgery guidelines promulgated by Current Procedural Terminology (CPT) and the Centers for Medicare and Medicaid Services (CMS).

(F) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.

(G) Sterilization of members who are under 21 years of age, mentally incompetent, or institutionalized or reversal of sterilization procedures for the purposes of conception.

(H) Non-therapeutic hysterectomies.

(I)Medical services considered experimental or investigational.

(J) Payment for more than four outpatient visits per month (home or office) per member, except those visits in connection with family planning or related to emergency medical conditions.

(K) Payment for more than two nursing facility visits per month.

(L) More than one inpatient visit per day per physician.

(M) Physician services which are administrative in nature and not a direct service to the member including such items as quality assurance, utilization review, treatment staffing, tumor board review or multidisciplinary opinion, dictation, and similar functions.

(N) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.

(O) Payment for the services of social workers, licensed family counselors, registered nurses or other ancillary staff, except as specifically set out in OHCA rules.

(P) Induced abortions, except when certified in writing by a physician that the abortion was necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, or that the pregnancy is the result of an act of rape or incest. (Refer to OAC 317:30-5-6 or 317:30-5-50.)

(Q) Speech and Hearing services.

(R) Mileage.

(S) A routine hospital visit on the date of discharge unless

the member expired.

(T) Direct payment to perfusionist as this is considered part of the hospital reimbursement.

(U) Inpatient chemical dependency treatment.

(V) Fertility treatment.

(W) Payment for removal of benign skin lesions~~ unless medically necessary~~.

(X) Sleep studies.

(b) **Children**. Payment is made to physicians for medical and surgical services for members under the age of 21 within the scope of the Authority's SoonerCare program, provided the services are medically necessary for the diagnosis and treatment of illness or injury, or to improve the functioning of a malformed body member. Medical and surgical services for children are comparable to those listed for adults. For services rendered to a minor child, the child's parent or court-appointed legal guardian must provide written authorization prior to the service being rendered, unless there is an explicit state or federal exception to this requirement. In addition to those services listed for adults, the following services are covered for children.

(1) **Pre-authorization of inpatient psychiatric services**. All inpatient psychiatric services for members under 21 years of age must be prior authorized by an agency designated by the Oklahoma Health Care Authority. All psychiatric services are prior authorized for an approved length of stay. Non-authorized inpatient psychiatric services are not SoonerCare compensable.

(A) All residential and acute psychiatric services are authorized based on the medical necessity criteria as described in OAC 317:30-5-95.25,317:30-5-95.27 and 317:30-5-95.29.

(B) Out of state placements are not authorized unless it is determined that the needed medical services are more readily available in another state or it is a general practice for members in a particular border locality to use resources in another state. If a medical emergency occurs while a member is out of the State, treatment for medical services is covered as if provided within the State. A prime consideration for placements is proximity to the family or guardian in order to involve the family or guardian in discharge and reintegration planning.

(2) **General acute care inpatient service limitations**. All general acute care inpatient hospital services for members under the age of 21 are not limited. All inpatient care must be medically necessary.

(3) **Procedures for requesting extensions for inpatient services**. The physician and/or facility must provide necessary justification to enable OHCA, or its designated agent, to make a determination of medical necessity and appropriateness of treatment options. Extension requests for psychiatric admissions must be submitted to the OHCA or its designated agent. Extension requests must contain the appropriate documentation validating

the need for continued treatment in accordance with the medical necessity criteria described in OAC 317:30-5-95.26, 317:30-5-95.28 and 317:30-5-95.30. Requests must be made prior to the expiration of the approved inpatient stay. All decisions of OHCA or its designated agent are final.

(4) **Utilization control requirements for psychiatric beds.** Utilization control requirements for inpatient psychiatric services for members under 21 years of age apply to all hospitals and residential psychiatric treatment facilities.

(5) **Early and periodic screening diagnosis and treatment program.** Payment is made to eligible providers for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) of members under age 21. These services include medical, dental, vision, hearing and other necessary health care. Refer to OAC 317:30-3-65.2 through 317:30-3-65.11 for specific guidelines.

(6) **Child abuse/neglect findings.** Instances of child abuse and/or neglect discovered through screenings and regular exams are to be reported in accordance with State Law. Section 7103 of Title 10 of the Oklahoma Statutes mandates reporting suspected abuse or neglect to the Oklahoma Department of Human Services. Section 7104 of Title 10 of the Oklahoma Statutes further requires reporting of criminally injurious conduct to the nearest law enforcement agency.

(7) **General exclusions.** The following are excluded from coverage for members under the age of 21:

(A) Inpatient admission for diagnostic studies that could be performed on an outpatient basis.

(B) Services or any expense incurred for cosmetic surgery unless the physician certifies the procedure emotionally necessary.

(C) Services of two physicians for the same type of service to the same member on the same day, except when supplemental skills are required and different specialties are involved.

(D) Pre-operative care within 24 hours of the day of admission for surgery and routine post-operative care as defined under the global surgery guidelines promulgated by Current Procedural Terminology (CPT) and the Centers for Medicare and Medicaid Services (CMS).

(E) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.

(F) Sterilization of members who are under 21 years of age, mentally incompetent, or institutionalized or reversal of sterilization procedures for the purposes of conception.

(G) Non-therapeutic hysterectomies.

(H) Medical Services considered experimental or investigational.

(I) More than one inpatient visit per day per physician.

(J) Induced abortions, except when certified in writing by a physician that the abortion was necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy

itself, that would place the woman in danger of death unless an abortion is performed, or that the pregnancy is the result of an act of rape or incest. (Refer to OAC 317:30-5-6 or 317:30-5-50.)

(K) Physician services which are administrative in nature and not a direct service to the member including such items as quality assurance, utilization review, treatment staffing, tumor board review or multidisciplinary opinion, dictation, and similar functions.

(L) Payment for the services of social workers, licensed family counselors, registered nurses or other ancillary staff, except as specifically set out in OHCA rules.

(M) Direct payment to perfusionist as this is considered part of the hospital reimbursement.

(N) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.

(O) Mileage.

(P) A routine hospital visit on date of discharge unless the member expired.

(c) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the OHCA allowable for comparable services. Claims filed with Medicare Part B should automatically cross over to OHCA. The explanation of Medicare Benefits (EOMB) reflects a message that the claim was referred to SoonerCare. If such a message is not present, a claim for coinsurance and deductible must be filed with the OHCA within 90 days of the date of Medicare payment ~~or~~and within one year of the date of service in order to be considered timely filed.

(1) In certain circumstances, some claims do not automatically "cross over". Providers must file a claim for coinsurance and/or deductible to SoonerCare within 90 days of the Medicare payment ~~or~~and within one year from the date of service.

(2) If payment was denied by Medicare Part B and the service is a SoonerCare covered service, mark the claim "denied by Medicare" and attach the Medicare EOMB showing the reason for the denial.

317:30-5-22.Obstetrical care

~~(a) Obstetrical (OB) care is billed using the appropriate CPT codes for Maternity Care and Delivery. The date of delivery is used as the date of service for charges for total obstetrical care. Inclusive dates of care should be indicated on the claim form as part of the description. Payment for total obstetrical care includes all routine care, and any ultrasounds performed by the attending physician provided during the maternity cycle unless otherwise specified in this Section. For payment of total OB care, a physician must have provided care for more than one trimester. To bill for prenatal care only, the claim is filed after the member leaves the provider's care. Payment for routine or minor medical problems will not be made separately to the OB physician outside of the ante partum visits. The ante partum care during the prenatal~~

~~care period includes all care by the OB attending physician except major illness distinctly unrelated to the pregnancy.~~
~~(b)Procedures paid separately from total obstetrical care are listed in (1) - (8) of this subsection.~~
(a) Providers of obstetrical services must bill each antepartum visit separately, utilizing the appropriate evaluation and management service code. The OHCA does not recognize the codes for "global obstetrical care" which bundle these services under a single procedure code. Delivery only and postpartum care services are also billed separately by the rendering provider.
(b) The following routine obstetrical services are covered as detailed below:

(1) The completion of an American College of Obstetricians and Gynecologist (ACOG) assessment form or form covering same elements as ACOG and the most recent version of the Oklahoma Health Care Authority's Prenatal Psychosocial Assessment are reimbursable when both documents are included in the prenatal record. SoonerCare allows one assessment per provider and no more than two per pregnancy.

(2) Medically necessary real time ~~ante partum~~antepartum diagnostic ultrasounds will be paid ~~for~~ in addition to ~~ante partum~~antepartum care, delivery and ~~post partum~~postpartum obstetrical care under defined circumstances. To be eligible for payment,all ultrasound reports must meet the guideline standards published by the American Institute of Ultrasound Medicine (AIUM).

(A) One abdominal or vaginal ultrasound will be covered in the first trimester of pregnancy. The ultrasound must be performed by a ~~board certified~~Board Eligible/Board Certified Obstetrician-Gynecologist (OB-GYN), Radiologist, or a Board Eligible/Board Certified Maternal-Fetal Medicine specialist. In addition, this ultrasound may be performed by a Nurse Midwife, Family Practice Physician or Advance Practice Nurse Practitioner in Obstetrics with a certification in obstetrical ultrasonography.

(B)One ultrasound after the first trimester will be covered. This ultrasound must be performed by a ~~board certified~~Board Eligible/Board Certified Obstetrician-Gynecologist (OB-GYN), Radiologist, or a Board Eligible/Board Certified Maternal-Fetal Medicine specialist. In addition, this ultrasound may be performed by a Nurse Midwife, Family Practice Physician or Advance Practice Nurse Practitioner in Obstetrics with certification in obstetrical ultrasonography.

~~(C) Additional ultrasounds, including detailed ultrasounds and re-evaluations of previously identified or suspected fetal or maternal anomalies must be performed by an active candidate or Board Certified diplomat in Maternal-Fetal Medicine, or Board Certified Obstetrician-Gynecologist (OB-GYN). Up to six repeat ultrasounds are allowed after which, prior authorization is required.~~

(C) One additional detailed ultrasound is allowed by a Board Eligible/Board Certified Maternal Fetal Specialist or general obstetrician with documented specialty training in performing detailed ultrasounds. This additional ultrasound is allowed to identify or confirm a suspected fetal/maternal anomaly. This additional ultrasound does not require prior authorization. Any subsequent ultrasounds will require prior authorization.

(3) Standby attendance at Cesarean Section (C-Section), for the purpose of attending the baby, is compensable when billed by a physician or qualified health care provider not participating in the delivery.

(4) ~~Spinal anesthesia~~Anesthesia administered by the attending physician is a compensable service and ~~is~~may be billed separately from the delivery.

(5) ~~Amniocentesis is not included in routine obstetrical care and is billed separately.~~ Payment may be made for an evaluation and management service and a medically indicated amniocentesis on the same date of service. This is an exception to general information regarding surgery found at OAC 317:30-5-8.

(6) Additional payment is not made for the delivery of ~~twins~~multiple gestations. If one ~~twin~~fetus is delivered vaginally and ~~one is~~additional fetus(es)are delivered by C-section by the same physician, the higher level procedure is paid. If one ~~twin~~fetus is delivered vaginally and ~~one twin is~~ additional fetus(es)are delivered by C-Section, by different physicians, each should bill the appropriate procedure codes without a modifier. Payment is not made to the same physician for both standby and assistant at C-Section.

~~(7) One non stress test and/or biophysical profile to confirm a suspected high risk pregnancy diagnosis. The non stress test and/or biophysical profile must be performed by an active candidate or Board Certified diplomate in Maternal Fetal Medicine, or Board Certified Obstetrician-Gynecologist (OB-GYN).~~

~~(8)~~(7) Reimbursement is allowed for nutritional counseling in a group setting for members with gestational diabetes. Refer to OAC 317:30-5-1076(5).

(c) Assistant surgeons are paid for C-Sections which include only in-hospital post-operative care. Family practitioners who provide prenatal care and assist at C-Section may bill separately for the ~~prenatal~~antenatal and ~~the six weeks~~ postpartum office ~~visit~~visits.

(d) Procedures listed in (1) - (5) of this subsection are not ~~paid or not covered separately from total obstetrical care~~separately reimbursable.

(1) ~~Additional non stress tests~~Non stress test, unless the pregnancy is determined medically high risk. See OAC 317:30-5-22.1.

(2) Standby at C-Section is not compensable when billed by a physician participating in delivery.

~~(3) Payment is not made for an assistant surgeon for obstetrical procedures that include prenatal or post partum care.~~

(4) An additional allowance is not made for induction of labor, double set-up examinations, fetal stress tests, or pudendal anesthetic. Providers must not bill separately for these procedures.

(5) Fetal scalp blood sampling is considered part of ~~the total OB care~~DRG reimbursement.

(e) ~~Obstetrical coverage for children is the same as for adults with additional procedures being covered due to EPSDT provisions if determined to be medically necessary.~~Obstetrical coverage for children is the same as for adults. Additional procedures may be covered under EPSDT provisions if determined to be medically necessary.

(1) Services deemed medically necessary and allowable under federal Medicaid regulations are covered by the EPSDT/OHCA Child Health Program even though those services may not be part of the Oklahoma Health Care Authority SoonerCare program. Such services must be prior authorized.

(2) Federal Medicaid regulations also require the State to make the determination as to whether the service is medically necessary and do not require the provision of any items or services that the State determines are not safe and effective or which are considered experimental.

317:30-5-22.1. Enhanced services for medically high risk pregnancies

(a) **Enhanced services.** Enhanced services are available for pregnant women eligible for SoonerCare and are in addition to services for uncomplicated maternity cases. Women deemed high risk based on criteria established by the OHCA ~~may~~must receive prior authorization for medically necessary enhanced benefits which include:

(1) prenatal at risk ~~ante partum~~antepartum management;

(2) a combined maximum of ~~12~~five fetal non stress test(s) and biophysical profiles (additional units can be prior authorized for multiple fetuses)~~; and~~with one test per week beginning at 32 weeks gestation and continuing to 38 weeks; and

(3) a maximum of ~~6 repeat~~three follow-up ultrasounds not covered under OAC 317:30-5-22(b)(2).

(b) **Prior authorization**. To receive enhanced services, the following documentation must be received by the OHCA Medical Authorizations Unit for review and approval:

(1) ACOG or other comparable comprehensive prenatal assessment;

(2) chart note identifying and detailing the qualifying high risk condition; and

(3) an OHCA High Risk OB Treatment Plan/Prior Authorization Request (CH-17) signed by a Board Eligible/Board Certified Maternal Fetal Medicine (MFM) specialist, or Board Eligible/Board Certified Obstetrician-Gynecologist (OB-GYN).

(c) **Reimbursement**. When prior authorized, enhanced benefits will be reimbursed as follows:

(1) ~~Ante partum~~Antepartum management for high risk is reimbursed to the primary obstetrical provider. If the primary provider of obstetrical care is not the MFM and wishes to request authorization of the ~~ante partum~~antepartum management fee, the OHCA CH-17 must be signed by the primary provider of OB care. Additionally, reimbursement for enhanced at risk ~~ante partum~~antepartum management is not made during an in-patient hospital stay.
(2) Non stress tests, biophysical profiles and ultrasounds ~~(~~[in addition to those covered under OAC 317:30-5-22(a)(2) subparagraphs (A) through (C)] are reimbursed when prior authorized.
(3) Reimbursement for enhanced at risk ~~ante partum~~antepartum management is not available to physicians who already qualify for enhanced reimbursement as state employed physicians.

PART 19. CERTIFIED NURSE MIDWIVES

317:30-5-226. Coverage by category

(a) **Adults and children 21 and under.** Payment is made for certified nurse midwife services within the scope of practice as defined by state law including obstetrical care such as antepartum care, delivery, postpartum care, and care of the normal newborn during the first 28 days of life. Obstetrical care should be billed using the appropriate evaluation and management codes for antepartum care, as well as the appropriate delivery only and postpartum care services when rendered. Ultrasounds and other procedures for obstetrical care are paid in accordance with OAC 317:30-5-22(b).

~~(1) Providers must use OKDHS Form FSS-NB-1, or the eNB1 application on the Secure Website to notify the county DHS office of the child's birth. A claim may then be filed for charges for the baby under the case number and the baby's name and assigned person code.~~
~~(2) Charges billed on the mother's person code for services rendered to the child will be denied.~~
~~(3) Obstetrical care should be billed using the appropriate CPT codes for Maternity Care and Delivery. The date of delivery should be used as the date of service for charges for total obstetrical care. Inclusive dates of care should be indicated on the claim form as part of the description. The date the patient was first seen must be on the claim form. Payment for total obstetrical care includes all routine care. Ultrasounds and other procedures reimbursed separately from total obstetrical care are paid in accordance with provisions found at OAC 317:30-5-22(b). For payment of total OB care, the provider must have provided care for more than one trimester. To bill for prenatal care only, the claim is filed after the member leaves the provider's care. Payment for routine or minor medical problems will not be made separately to the OB provider outside of antepartum visits. The antepartum care during the prenatal care period includes all care by the OB provider except major illness distinctly unrelated to the pregnancy.~~

(b) **Newborn.** Payment to nurse midwives for services to newborn is the same as for adults and children under 21. A newborn is an infant during the first 28 days following birth.

(1) Providers must use OKDHS Form FSS-NB-1, or the eNB1 application on the Secure Website to notify the county DHS office of the child's birth. A claim may then be filed for charges for the baby under the case number and the baby's name and assigned person code.

(2) Charges billed on the mother's person code for services rendered to the child will be denied.

(c) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the Medicaid allowable for comparable services.

317:30-5-229. Reimbursement

In accordance with the Omnibus Budget Reconciliation Act of 1993, effective October 1, 1993, certified nurse midwife services include maternity services, as well as services outside the maternity cycle within the scope of their practice under state law.

(1) Medical verification of pregnancy is required. A ~~letter or~~ written statement from the physician or certified nurse midwife verifying the applicant is pregnant and the expected date of delivery is acceptable. Pregnancy may also be verified by submission of a copy of a laboratory report indicating the individual is pregnant.

(2) Newborn charges billed on the mother's person code will be denied.

(3) Providers must use OKDHS Form FSS-NB-1 to notify the county DHS office of the child's birth.

(4) ~~Obstetrical care should be billed using the appropriate CPT codes for Maternity Care and Delivery. The date of delivery should be used as the date of service for charges for total obstetrical care. Inclusive dates of care should be indicated on the claim form as part of the description. The date the patient was first seen must be on the claim form. Payment for total obstetrical care includes all routine care performed by the attending provider. For payment of total OB care, the provider must have provided care for more than one trimester. To bill for prenatal care only, the claim is filed after the member leaves the provider's care. Payment for routine or minor medical problems will not be made separately to the OB provider outside of antepartum visits. The antepartum care during the prenatal care period includes all care by the OB provider except major illness distinctly unrelated to the pregnancy.~~ Obstetrical care should be billed using the appropriate evaluation and management codes for antepartum care, as well as the appropriate delivery only and postpartum care services when rendered.

PART 35. RURAL HEALTH CLINICS

317:30-5-356. Coverage for adults

Payment is made to rural health clinics for adult services as

set forth in this Section.

(1) **RHC services.** Payment is made for one encounter per member per day. Payment is also limited to four visits per member per month. Refer to OAC 317:30-1, General Provisions, and OAC 317:30-3-65.2 for exceptions to the four visit limit for children under the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT). Additional preventive service exceptions include:

(A) **Obstetrical care.** A Rural Health Clinic should have a written contract with its physician, nurse midwife, advanced practice nurse, or physician assistant that specifically identifies how obstetrical care will be billed to SoonerCare, in order to avoid duplicative billing situations. The agreement should also specifically identify the physician's compensation for rural health and non-rural health clinic (other ambulatory) services.

(i) If the clinic compensates the physician, nurse midwife or advanced practice nurse to provide obstetrical care, then the clinic must bill the SoonerCare program for each prenatal visit using the appropriate CPT evaluation and management codes.

(ii)~~If the clinic does not compensate its practitioners to provide obstetrical care, then the independent practitioner must bill the OHCA for prenatal care according to the global method described in the SoonerCare provider specific rules for physicians, certified nurse midwives, physician assistants, and advanced practice nurses (refer to OAC 317:30-5-22).~~If the clinic does not compensate its practitioners to provide obstetrical care, then the independent practitioner must bill the SoonerCare program for each prenatal visit using the appropriate CPT code described in the SoonerCare provider specific rules for physicians, certified nurse midwives, physician assistants, and advanced practice nurses (refer to OAC 317:30-5-22).

~~(iii) Under both billing methods, payment for prenatal care includes all routine or minor medical problems. No additional payment is made to the prenatal provider except in the case of a major illness distinctly unrelated to pregnancy.~~

(B) **Family planning services.** Family planning services are available only to members with reproductive capability. Family planning visits do not count as one of the four RHC visits per month.

(2) **Other ambulatory services.** Services defined as "other ambulatory" services are not considered a part of a RHC visit and are therefore billable to the SoonerCare program by the RHC or provider of service on the appropriate claim forms. Other ambulatory services are subject to the same scope of coverage as other SoonerCare services billed to the program, i.e., limited adult services and some services for under 21 subject to same

prior authorization process. Refer to OAC 317:30-1, General Provisions, and OAC 317:30-3-57, 317:30-5-59, and 317:30-3-60 for general coverage and exclusions under the SoonerCare program. Some specific limitations are applicable to other ambulatory services as set forth in specific provider rules and excerpted as follows: Coverage under optometrists for adults is limited to treatment of eye disease not related to refractive errors. There is no coverage for eye exams for the purpose of prescribing eyeglasses, contact lenses or other visual aids. (See OAC 317:30-5-431.)

PART 75. FEDERALLY QUALIFIED HEALTH CENTERS

317:30-5-664.8. Obstetrical care provided by Health Centers

(a) **Billing written agreement.** In order to avoid duplicative billing situations, a Health Center must have a written agreement with its physician, certified nurse midwife, advanced practice nurse, or physician assistant that specifically identifies how obstetrical care will be billed. The agreement must specifically identify the service provider's compensation for Health Center core services and other health services that may be provided by the Center.

(b) **Prenatal or postpartum services.**

(1) If the Health Center compensates the physician, certified nurse midwife or advanced practice nurse for the provision of obstetrical care, then the Health Center bills the OHCA for each prenatal and postpartum visit separately using the appropriate CPT evaluation and management code(s) as provided in the Health Center billing manual.

(2) ~~If the clinic does not compensate the provider for the provision of obstetrical care, then the provider must bill the OHCA for prenatal care according to the global method described in the SoonerCare Traditional provider specific rules for physicians, certified nurse midwives, physician assistants, and advanced practice nurses (refer to OAC 317:30-5-22).~~ If the clinic does not compensate its practitioners to provide obstetrical care, then the independent practitioner must bill the SoonerCare program for each prenatal visit using the appropriate CPT code described in the SoonerCare provider specific rules for physicians, certified nurse midwives, physician assistants, and advanced practice nurses (refer to OAC 317:30-5-22).

~~(3) Under both billing methods, payment for prenatal care includes all routine or minor medical problems. No additional payment is made to the prenatal provider except in the case of a major illness distinctly unrelated to pregnancy.~~

(c) **Delivery services**. Delivery services are billed using the appropriate CPT codes for delivery. If the clinic does not compensate the provider for the provision of obstetrical care, then the provider must be individually enrolled and bill for those services using his or her assigned provider number. The costs

associated with the delivery must be excluded from the cost settlement/encounter rate setting process (see OAC 317:300-5-664.11).

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: February 16, 2016

The proposed policy is a Permanent Rule. This proposal is scheduled to be presented to the Medical Advisory Committee (MAC) on March 10, 2016 and the (OHCA) Board of Directors on March 24, 2016.

Reference: APA WF 15-07B

SUMMARY:
Obstetrical Reimbursement- Proposed Obstetrical policy amends the reimbursement structure for OB 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 1902 of Social Security Act.

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

TO: Tywanda Cox
Health Policy

FROM: Likita Gunn
Federal and State Policy

SUBJECT: Rule Impact Statement
APA WF #15-07B

A. Brief description of the purpose of the rule:

Proposed Obstetrical policy amends the reimbursement structure for OB services. Currently the agency utilizes the global care CPT codes for routine obstetrical care billing, which can be used if the provider had provided care for a member for greater than one trimester. The proposed policy will require obstetrical care be billed using the appropriate evaluation and management codes for antepartum care, as well as the appropriate delivery only and postpartum care services when rendered. The change allows for more accurate tracking of each antepartum service provided as well as the postpartum 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:

General family practice providers who provide obstetrical care, OB providers and Maternal Fetal Medicine doctors will be affected by the proposed rule change.

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

The OHCA will benefit from the proposed rule change as the change allows for more accurate tracking of each antepartum and postpartum service provided to SoonerCare members. SoonerCare members will also benefit from the proposed rule as the changes will result in an improved quality 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:

General Family Practice providers who provide obstetrical care, OB providers, and Maternal Fetal Medicine doctors will now have to bill using the appropriate evaluation and management codes for antepartum care, delivery only, and postpartum care services. These providers will no longer receive a global payment for services, regardless of the extent of services provided. Therefore, this proposed rule could result in loss of revenue for providers creating an economic 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 effect on state revenues, including a projected net loss or gain in such revenues if it can be projected by the agency:

Restructuring payment for OB services will result in savings for the agency. There would be an estimated total savings for SFY 2016 of $3,831,661; total state savings are projected as $1,444,537.

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:

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. Opportunities for public input are provided throughout the rulemaking process, in addition to formal public comment periods and tribal consultations. Additionally, OHCA staff engaged the Obstetrical provider community to garner feedback on the proposed rule change prior to amending the reimbursement language for obstetrical care.

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 amends the reimbursement structure for those SoonerCare providers who provide obstetrical care and does not affect actual services received by SoonerCare members. Therefore, the proposed rule should have no negative 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, 2015.
The rule impact statement was modified January 21, 2016.

RULE TEXT

CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-

ELIGIBILITY

SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME

PART 1. DETERMINATION OF QUALIFYING CATEGORICAL RELATIONSHIPS

317:35-5-2. Categorically related programs

(a) In order to be eligible for SoonerCare, an individual must first meet the description of a member eligibility group. For individuals related to the aged, blind, or disabled groups, categorical relationship is established using the same definitions of age, disability and blindness as used by the Social Security Administration (SSA) in determining eligibility for Supplemental Security Income (SSI) or SSA benefits. If the individual is a SSA/SSI recipient in current payment status (including presumptive eligibility), a TANF recipient, an adoption assistance or kinship guardianship assistance recipient, or is under age 19, categorical relationship is automatically established. Categorical relationship to the ~~pregnancygroup~~pregnancy group is established when the determination is made by medical evidence that the individual is or has been pregnant. Effective January 1, 2014, verification of pregnancy is only required if the individual's declaration that she is pregnant is not reasonably compatible with other information available to the agency. Pregnancy-related services include all medical services provided within the scope of the program during the prenatal, delivery and postpartum periods for women in this pregnancy group; see Subchapter 22 of this Chapter for services for unborn children covered under Title XXI. For an individual age 19 or over to be related to the parent and caretaker relative group, the individual must have a minor dependent child. For an individual to be related to the former foster care children group, the individual must not be eligible for the Title XIX pregnancy or parent or caretaker relative groups, must be aged 19-26, and must have been receiving SoonerCare as a foster care child when he/she aged out of foster care in Oklahoma. There is no income or resource test for the former foster care children group. 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 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 eligibility groups:~~Benefits for pregnancies covered under Title XXI medical services are provided within the limited scope of this particular program for antenatal care and delivery only. Each service must be billed using the

appropriate CPT codes. To be eligible for SoonerCare benefits, an individual must be related to one of the following eligibility groups:

(1) Aged
(2) Disabled
(3) Blind
(4) Pregnancy
(5) Children, also including
  (A) Newborns deemed eligible, and
  (B) Grandfathered CHIP children
(6) Parents and Caretaker Relatives
(7) Refugee
(8) Breast and Cervical Cancer Treatment program
(9) SoonerPlan Family Planning Program
(10) Benefits for pregnancies covered under Title XXI
(11) Former foster care children.

(b) The Authority may provide SoonerCare to reasonable categories of individuals under age 21.

(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.

SUBCHAPTER 22. PREGNANCY RELATED BENEFITS COVERED UNDER TITLE XXI

PART 17. CONDITIONS OF ELIGIBILITY-CITIZENSHIP AND ALIENAGE

317:35-22-2. Scope of coverage for Title XXI Pregnancy

(a)~~Pregnancy related services provided are prenatal, delivery, postnatal care when included in the global delivery fee, and other related services that are medically necessary to optimize pregnancy outcomes within the defined program benefits.~~Pregnancy related services provided are for antepartum and delivery only.

(b) ~~Only two visits per month for other related services to evaluate and/or treat conditions that may adversely impact the pregnancy are covered.~~Only two additional visits per month to other medical consultants, such as a dietitian or licensed genetic

counselor for related services to evaluate and/or treat conditions that may adversely impact the fetus are covered.

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: February 16, 2016

The proposed policy was submitted to the Medical Advisory Committee (MAC) on May 21, 2015 as an emergency policy change. The proposed policy was presented for Tribal Consultation on May 5, 2015. The proposed Permanent rule change is scheduled to be presented to the MAC on March 10, 2016 and the (OHCA) Board of Directors on March 24, 2016.

Reference: APA WF 15-08

SUMMARY:
Urine drug screening and testing— The proposed Urine Drug Screening policy establishes rules for the appropriate administration of urine drug screening and testing. Current policy does not specify controls on this service other than general medical necessity. Additionally, revisions are proposed to clean-up reimbursement language found in general laboratory services policy. **The aforementioned changes were approved during promulgation of the emergency rule. The following are proposed changes not previously reviewed:** The proposed Urine Drug Screening policy is also revised to add clarification to distinguish types of urine drug tests, and general clean-up for the administration of urine drug screenings. Lastly, proposed revisions include additional changes to reimbursement language for general laboratory 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; 42 CFR 410.32; Section 1902 of Social Security Act.

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

TO: Tywanda Cox
Health Policy

FROM: Likita Gunn
Federal and State Policy

SUBJECT: Rule Impact Statement
APA WF #15-08

A. Brief description of the purpose of the rule:

The proposed revisions establish policy for the appropriate administration of urine drug screening and testing to align with recommended allowances based on clinical evidence and standards of care. Criteria include: purpose for urine testing, coverage requirements, non-covered testing, provider qualifications, and medical record documentation requirements necessary to support medical necessity. Additionally, revisions include clean-up to reimbursement language from general laboratory services policy. **The aforementioned changes were approved during promulgation of the emergency rule. The following are proposed changes not previously reviewed:** Further proposed revisions to Urine Drug Screening policy clarifies the difference between quantitative and qualitative testing and when quantitative urine drug screening is an appropriate test to utilize. Changes are also proposed to general laboratory services policy to clarify appropriate billing for detection of individual infectious organisms.

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:

Clinical laboratories and providers that administer urine drug screening and testing will be affected by the proposed rule as they will be limited in the amount of tests that can be performed, unless medical necessitate indicates otherwise.

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

The OHCA will benefit from the proposed rule as the change will alleviate administrative burden on agency staff. SoonerCare members will benefit from the proposed rule as the changes will result in an improved quality 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:

The proposed rule may have an economic impact on clinics and providers who administer urine drug screening and testing as these facilities will be limited in the amount of test that can be performed, unless medically necessary.

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:

Budget Impact: Savings approved during promulgation of the emergency rule, the rule change will not result in any additional costs and/or savings 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:

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:

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. In 2015, the OHCA hosted 20 stakeholder meetings with providers and members who could potentially be impacted by proposed cuts to the SoonerCare program. Participants in the meetings were informed about the budget reduction items the agency was considering, in addition to possible provider rate cuts. Participants were given the opportunity to contribute any measures that could be used to offset the budget shortfall.

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 as this proposed change is aligning the OHCA with standards consistent with evidence based research, and other payer sources. Additionally, members needing additional testing above the proposed limits can still receive services if

it is determined medically necessary by the agency.

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 October 12, 2015.
The rule impact statement was modified January 22, 2016.

RULE TEXT:

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 1. PHYSICIANS

317:30-5-20. Laboratory services

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

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

(A) Reimbursement for lab services is made in accordance with the Clinical Laboratory Improvement Amendment of 1988 (CLIA). These regulations provide that payment may be made only for services furnished by a laboratory that meets CLIA conditions, including those furnished in physicians' offices. Eligible providers must be certified under the CLIA program and have obtained a CLIA ID number from CMS and have a current contract on file with the OHCA.

~~(B) Reimbursement rate for laboratory procedures is the lesser of the CMS National 60% fee or the local carrier's allowable (whichever is lower).~~

~~(C) Medically necessary laboratory services are covered~~.

(B) Only medically necessary laboratory services are compensable.

~~(2) **Compensable outpatient laboratory services.** Medically necessary laboratory services are covered.~~

~~(3)~~(2) **Non-compensable laboratory services.**

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

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

~~(C) Billing multiple units of nucleic acid detection, whether using the direct probe or amplified probe technique, for single infectious organisms when testing for more than one infectious organism in a specimen is not permissible.~~

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

(D) Laboratory services ~~not considered medically necessary are not covered.~~ must be medically indicated to be compensable.

~~(4)~~(3) **Covered services by a pathologist.**

(A) A pathologist may be paid for the interpretation of inpatient surgical pathology specimen~~. The appropriate CPT procedure code and modifier is used.~~ when the appropriate CPT procedure code and modifier is used.

(B) Full service or interpretation of surgical pathology for outpatient surgery performed in an outpatient hospital or Ambulatory Surgery Center setting.

~~(5)~~(4) **Non-compensable services by a pathologist.** The following are non-compensable pathologist services:

~~(A) Tissue examinations for identification of teeth and foreign objects.~~

~~(B)~~(A) Experimental or investigational procedures.

~~(C)~~(B) Interpretation of clinical laboratory procedures.

317:30-5-20.1. Urine drug screening and testing

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

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

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

(3) Specimen validity testing is used to determine if a urine specimen has been diluted, adulterated or substituted. Specimen

validity tests include, but are not limited to, creatinine, oxidants, specific gravity, urine pH, nitrates and alkaloids.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) A current treatment plan;

(2) Patient history and physical;

(3) Review of previous medical records if treated by a different physician for pain management;

(4) Review of all radiographs and/or laboratory studies pertinent to the patient's condition;

(5) Opioid agreement and informed consent of UDT, as applicable;

(6) List of prescribed medications;

(7) Risk assessment, as identified by use of a validated risk assessment tool/questionnaire, with appropriate risk stratification noted and utilized;

(8) Office/provider monitoring protocols, such as random pill counts; and

(9) Review of prescription drug monitoring data or pharmacy profile as warranted.

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: June 7, 2015

The proposed policy is an Emergency Rule. This proposal is scheduled to be presented to the Medical Advisory Committee (MAC) on May 21, 2015 and the (OHCA) Board of Directors on June 25, 2015. **Reference: APA WF 15-08**

SUMMARY:
Urine drug screening and testing— These emergency revisions are necessary to reduce the Agency's operations budget in order to meet the balanced budget requirements as mandated by State law. Without the recommended revisions, the Agency is at risk of exhausting its State appropriated dollars required to maintain the State's Medicaid Program. Rules are added to regulate urine drug screening and testing. Current policy does not specify controls on this service other than general medical necessity.

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 410.32; Article 10, Section 23 of the Oklahoma Constitution; Section 1902 of Social Security Act.

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

TO: Tywanda Cox
Health Policy

FROM: Likita Gunn
Federal and State Policy

SUBJECT: Rule Impact Statement
APA WF #15-08

A. Brief description of the purpose of the rule:

The proposed policy revisions establish policy for the appropriate administration of urine drug screening and testing to align with recommended allowances based on clinical evidence and standards of care. Criteria include: purpose for urine testing, coverage requirements, non-covered testing, provider qualifications, and medical record documentation requirements necessary to support medical necessity. Additionally, revisions include clean-up to reimbursement language from general laboratory services 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:

Clinical laboratories and providers that administer urine drug screening and testing will be affected by the proposed rule as they will be limited in the amount of tests that can be performed, unless medical necessitate indicates otherwise.

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 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:

The proposed rule may have an economic impact on clinics and providers who administer urine drug screening and testing.

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 proposed rule change is projected to save $11,703,400 total dollars and $4,149,635 state 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 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 1, 2015.

RULE TEXT:

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

317:30-5-20. Laboratory services

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

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

(A) Reimbursement for lab services is made in accordance with the Clinical Laboratory Improvement Amendment of 1988 (CLIA). These regulations provide that payment may be made only for services furnished by a laboratory that meets CLIA conditions, including those furnished in physicians' offices. Eligible providers must be certified under the CLIA program and have obtained a CLIA ID number from CMS and have a current contract on file with the OHCA.

~~(B) Reimbursement rate for laboratory procedures is the lesser of the CMS National 60% fee or the local carrier's allowable (whichever is lower).~~

~~(C) Medically necessary laboratory services are covered~~.

(B) Only medically necessary laboratory services are compensable.

~~(2) **Compensable outpatient laboratory services.** Medically necessary laboratory services are covered.~~

~~(3)~~ (2) **Non-compensable laboratory services.**

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

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

(C) Billing multiple units of nucleic acid detection, whether using the direct probe or amplified probe technique, for single infectious organisms when testing for more than one infectious organism in a specimen is not permissible.

(D) Laboratory services not considered medically necessary

are not covered.

~~(4)~~(3) **Covered services by a pathologist.**

(A) A pathologist may be paid for interpretation of inpatient surgical pathology specimen~~. The appropriate CPT procedure code and modifier is used.~~ when the appropriate CPT procedure code and modifier is used.

(B) Full service or interpretation of surgical pathology for outpatient surgery performed in an outpatient hospital or Ambulatory Surgery Center setting.

~~(5)~~(4) **Non-compensable services by a pathologist.** The following are non-compensable pathologist services:

(A) Tissue examinations for identification of teeth and foreign objects.

(B) Experimental or investigational procedures.

(C) Interpretation of clinical laboratory procedures.

317:30-5-20.1. Urine drug screening and testing

(a) **Purpose.** Urine Drug Testing (UDT) is performed to identify aberrant behavior, undisclosed drug use and/or abuse, and verify compliance with treatment. Aberrant behaviors may include early refill requests (self-escalation), reports of "lost or stolen" medications, treatment noncompliance, and UDT that does not include the prescribed drug and may include illicit or non-prescribed controlled substances. Testing for drugs of abuse to monitor treatment compliance should be included in the treatment plan for pain management when chronic opioid therapy is involved.

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

(2) Confirmation testing is used to verify the results of a point of care test result.

(3) Quantitative drug testing is specific to the drug or metabolite being tested and is expressed as a numeric result or numeric level.

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

(b) **Eligible providers**. Providers performing urine drug testing should have CLIA certification specific to the level of testing performed as described in 317:30-5-20(1)(A). High complexity laboratory services must be performed by an independent laboratory. Medical devices utilized for testing must have been certified by the Food and Drug Administration as approved to perform at the

level of testing being submitted for compensation.

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

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

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

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

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

(3) Confirmatory testing should be performed only for the drug class represented by the positive screening. A positive screening is indicated when:

(A) The initial test is positive for medications the member is NOT reported to be taking; or

(B) Negative for prescribed medications; or

(C) Positive for illicit drugs when the member denies utilization.

(4) Quantitative testing of urine is compensable when utilized for surveillance of therapeutic levels of prescribed medications, when there is no commercially available qualitative test available, or for when the specific level must be obtained for clinical decision making, i.e. the patient is comatose or obtunded.

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

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

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

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

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

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

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

(7) Automatic confirmatory testing for any drug is not medically

indicated without specific documented indications;

(8) Confirmatory testing exceeding 3 specific drug classes at an interval of greater than every 30 days will require specific documentation in the medical record to justify the medical necessity of testing; and

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

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

(1) A treatment plan which adheres to the appropriate state regulatory requirements;

(2) Patient history and physical;

(3) Review of previous medical records if treated by a different physician for pain management;

(4) Review of all radiographs and/or laboratory studies pertinent to the patient's condition;

(5) Current treatment plan;

(6) Opioid agreement and informed consent of UDT, as applicable;

(7) List of prescribed medications;

(8) Risk assessment, as identified by use of a validated risk assessment tool/questionnaire, with appropriate risk stratification noted and utilized;

(9) Office/provider monitoring protocols, such as random pill counts, etc.; and

(10) Review of prescription drug monitoring data or pharmacy profile as warranted.

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 15, 2016

The proposed policy was submitted to the MAC on May 21, 2015 as an emergency policy change. The proposed policy was presented for Tribal Consultation on May 5, 2015. The proposed Permanent rule change is scheduled to be presented the (OHCA) Board of Directors on February 11, 2016.

Reference: APA WF 15-09

SUMMARY:
Timely Filing — The proposed rules are revised to decrease the time for submitting and resubmitting claims for payment. These proposed revisions were promulgated during the emergency rule making 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; 42 CFR 447.45.

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

TO: Tywanda Cox
Health Policy

FROM: Likita Gunn
Federal and State Policy

SUBJECT: Rule Impact Statement
APA WF #15-09

A. Brief description of the purpose of the rule:

The proposed policy revisions are to restrict the timely filing of claims for reimbursement from 12 months to six months. In

addition, policy regarding resubmission is revised to update the deadline from 24 months to 12 months. Changes to the timely filing restrictions are in accordance with federal authority. These proposed revisions were promulgated during the emergency rule making 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:

All SoonerCare contracted providers would be affected by the proposed rule. However, there is no cost associated with the proposed rule changes.

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 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 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:

Budget Impact: Savings approved during promulgation of the emergency rule, the rule change will not result in any additional costs and/or savings 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:

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:

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 September 29, 2015.

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

317:30-3-11. Timely filing limitation

(a) ~~According to federal regulations, claims must be received by the Fiscal Agent within one year from the date of service.~~ According to federal regulations, the Authority must require providers to submit all claims no later than 12 months from the date of service. Federal regulations provide no exceptions to this requirement. For dates of service provided on or after July 1, 2015, the timely filing limit, for SoonerCare reimbursement, is 6 months from the date of service. Payment will not be made on claims when more than ~~12~~6 months have elapsed between the date the service was provided and the date of receipt of the claim by the Fiscal Agent. ~~Federal regulations provide no exceptions to this requirement. Because of this requirement, caution should be exercised to assure claims are filed timely in all cases where an application for assistance has been filed. The following procedure is recommended. If the service is approaching the one year time limit and a case number has not been assigned and an approval for medical assistance has not been received, or there is a case number but the medical assistance case has not been approved, or a provider contract has not been approved, file a claim. The claim will be denied, however, the denial is proof of timely filing.~~ A denied claim can be considered proof of timely filing.

(b) Claims may be submitted anytime during the month.

(c) To be eligible for payment under ~~Medicaid~~SoonerCare, claims for coinsurance and/or deductible must meet the Medicare timely filing requirements. If a claim for payment under Medicare has been filed in a timely manner, the Fiscal Agent must receive a ~~Medicaid~~SoonerCare claim relating to the same services within 90 days after the agency or the provider receives notice of the disposition of the Medicare claim.

317:30-3-11.1. Resolution of claim payment

(a) After the submission of a claim from a provider which had been adjudicated by the Authority, a provider may resubmit the claim under the following rules.

(b) The provider must have submitted the claim initially under the timely filing requirements found at OAC 317:30-3-11.

(c) ~~The provider's resubmission of the claim must be received by the Oklahoma Health Care Authority no later than 24 months from the date of service.~~ For dates of service provided on or after July 1, 2015, the provider's resubmission of the claim must be received by the Oklahoma Health Care Authority no later than 12 months from the date of service. The only exceptions to the ~~24~~12 month resubmission claim deadline are the following:

(1) administrative agency corrective action or agency actions taken to resolve a dispute, or

(2) reversal of the eligibility determination, or
(3) investigation for fraud or abuse of the provider, or
(4) court order or hearing decision.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 3. HOSPITALS

317:30-5-44. Medicare eligible individuals

Payment is made to hospitals for services to Medicare eligible individuals as set forth in this section.

(1) Claims filed with Medicare automatically cross over to OHCA. The explanation of Medicare Benefits (EOMB) reflects a message that the claim was referred to SoonerCare. If such a message is not present, a claim for coinsurance and deductible must be filed with the OHCA within 90 days of the date of Medicare payment ~~or~~and within one year of the date of service in order to be considered timely filed.

(2) If payment is denied by Medicare and the service is a SoonerCare covered service, mark the claim "denied by Medicare" and attach the Medicare EOMB showing the reason for denial.

(3) In certain circumstances, some claims do not automatically "cross over". Providers must file a claim for coinsurance and/or deductible to SoonerCare within 90 days of the Medicare payment ~~or~~and within one year from the date of service.

(4) For individuals who have exhausted Medicare Part A benefits, claims must be accompanied by a statement from the Medicare Part A intermediary showing the date benefits were exhausted.

PART 83. RESIDENTIAL BEHAVIOR MANAGEMENT SERVICES IN FOSTER CARE SETTINGS

317:30-5-744. Billing

~~(a) Claims must not be submitted prior to OHCA's determination of the member's eligibility, and must not be submitted later than 1 year after the date of service. If the eligibility of the individual has not been determined after ten months from the date of service, a claim should be submitted in order to assure that the claim is timely filed and reimbursement from SoonerCare funds can be made should the individual be determined eligible at a later date.~~

(a) Claims must be submitted in accordance with guidelines found at OAC 317:30-3-11 and 317:30-3-11.1.

(b) Claims for dually eligible individuals (Medicare/Medicaid) should be filed directly with the OHCA.

PART 87. BIRTHING CENTERS

317:30-5-893. Billing

Billing for birthing center services will be on HCFA-1500. ~~Under Medicaid, the claim must be received by OHCA within 12 months of the date of service in order to be eligible for payment. If the eligibility of the individual has not been determined after ten months from the date of services, a claim should be submitted in order to assure that the claim is timely filed and reimbursement from Title XIX funds can be made should the individual be determined eligible at a later date.~~ Claims must be submitted in accordance with guidelines found at OAC 317:30-3-11 and 317:30-3-11.1.

PART 97. CASE MANAGEMENT SERVICES FOR UNDER AGE 18 AT RISK OF OR IN THE TEMPORARY CUSTODY OR SUPERVISION OF OFFICE OF JUVENILE AFFAIRS

317:30-5-973. Billing

Billing for case management services is on Form HCFA-1500. ~~Claims should not be submitted until Medicaid eligibility of the individual has been determined. However, a claim must be received by OHCA within 12 months of the date of service. If the eligibility of the individual has not been determined after ten months from the date of service, a claim should be submitted in order to assure that the claim is timely filed and reimbursement from Title XIX funds can be made should the individual be determined eligible at a later date.~~ Claims must be submitted in accordance with guidelines found at OAC 317:30-3-11 and 317:30-3-11.1.

PART 99. CASE MANAGEMENT SERVICES FOR UNDER AGE 18 IN EMERGENCY, TEMPORARY OR PERMANENT CUSTODY OR SUPERVISION OF THE DEPARTMENT OF HUMAN SERVICES

317:30-5-993. Billing

Billing for case management services is on Form HCFA-1500. ~~Claims should not be submitted until Medicaid eligibility of the individual has been determined. However, a claim must be received by OHCA within 12 months of the date of service. If the eligibility of the individual has not been determined after ten months from the date of service, a claim must be submitted in order to assure that the claim is timely filed and reimbursement from Title XIX funds can be made should the individual be determined eligible at a later date.~~ Claims must be submitted in accordance with guidelines found at OAC 317:30-3-11 and 317:30-3-11.1.

PART 105. RESIDENTIAL BEHAVIORAL MANAGEMENT SERVICES IN GROUP SETTINGS AND NON-SECURE DIAGNOSTIC AND EVALUATION CENTERS

317:30-5-1045. Billing

(a) Billing is on the HCFA-1500.

~~(b) Claims should not be submitted until the Medicaid eligibility of the individual has been determined. However, a claim must be received by the fiscal agent within 12 months of the date of service. If the eligibility of the individual has not been determined after ten months from the date of service, a claim is submitted in order to assure that the claim is timely filed and reimbursement from Title XIX funds can be made should the individual be determined eligible at a later date.~~

(b) Claims must be submitted in accordance with guidelines found at OAC 317:30-3-11 and 317:30-3-11.1.

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: June 7, 2015

The proposed policy is an Emergency Rule. This proposal is scheduled to be presented to the Medical Advisory Committee (MAC) on May 21, 2015 and the (OHCA) Board of Directors on June 25, 2015.

Reference: APA WF 15-09

SUMMARY:
Timely Filing— These emergency revisions are necessary to reduce the Agency's operations budget in order to meet the balanced budget requirements as mandated by State law. Without the recommended revisions, the Agency is at risk of exhausting its State appropriated dollars required to maintain the State's Medicaid Program. Rules are revised to decrease the time period for submitting and resubmitting claims for payment.

LEGAL AUTHORITY:
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; Article 10, Section 23 of the Oklahoma Constitution; 42 CFR 447.45.

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

TO: Tywanda Cox
Health Policy

FROM: Likita Gunn
Federal and State Policy

SUBJECT: Rule Impact Statement
APA WF #15-09

A. Brief description of the purpose of the rule:

The proposed policy revisions are to restrict the timely filing of claims for reimbursement from 12 months to six months. In addition, policy regarding resubmission is revised to update the deadline from 24 months to 12 months. Changes to the timely filing restrictions are in accordance with federal authority.

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:

All SoonerCare contracted providers would be affected by the proposed rule. However, there is no cost associated with the proposed rule changes.

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 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 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 proposed rule change is projected to save $3,330,000 total dollars and $1,288,044 state dollars. The rule change would affect 10 percent of the total dollar amount of paid claims initially filed between 6 and 12 months from date of service.

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:

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, 2015.

RULE TEXT:

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES
PART 1. PHYSICIANS

317:30-3-11. Timely filing limitation

(a) ~~According to federal regulations, claims must be received by the Fiscal Agent within one year from the date of service.~~ According to federal regulations, the Authority must require providers to submit all claims no later than 12 months from the date of service. Federal regulations provide no exceptions to this requirement. For dates of service provided on or after July 1, 2015, the timely filing limit, for SoonerCare reimbursement, is 6 months from the date of service. Payment will not be made on claims when more than ~~12~~ 6 months have elapsed between the date the service was provided and the date of receipt of the claim by the Fiscal Agent. ~~Federal regulations provide no exceptions to this requirement. Because of this requirement, caution should be exercised to assure claims are filed timely in all cases where an application for assistance has been filed. The following procedure is recommended. If the service is approaching the one year time limit and a case number has not been assigned and an approval for medical assistance has not been received, or there is a case number but the medical assistance case has not been approved, or a provider contract has not been approved, file a claim. The claim will be denied, however, the denial is proof of timely filing.~~ A denied claim can be considered proof of timely filing.

(b) Claims may be submitted anytime during the month.

(c) To be eligible for payment under ~~Medicaid~~ SoonerCare, claims for coinsurance and/or deductible must meet the Medicare timely filing requirements. If a claim for payment under Medicare has been filed in a timely manner, the Fiscal Agent must receive a ~~Medicaid~~ SoonerCare claim relating to the same services within 90 days after the agency or the provider receives notice of the disposition of the Medicare claim.

317:30-3-11.1. Resolution of claim payment

(a) After the submission of a claim from a provider which had been adjudicated by the Authority, a provider may resubmit the claim under the following rules.

(b) The provider must have submitted the claim initially under the timely filing requirements found at OAC 317:30-3-11.

(c) ~~The provider's resubmission of the claim must be received by the Oklahoma Health Care Authority no later than 24 months from the date of service.~~ For dates of service provided on or after July 1, 2015, the provider's resubmission of the claim must be received by the Oklahoma health Care Authority no later than 12 months from the date of service. The only exceptions to the ~~24~~ 12 month resubmission claim deadline are the following:

(1) administrative agency corrective action or agency actions taken to resolve a dispute, or
(2) reversal of the eligibility determination, or
(3) investigation for fraud or abuse of the provider, or
(4) court order or hearing decision.

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 3. HOSPITALS

317:30-5-44. Medicare eligible individuals

Payment is made to hospitals for services to Medicare eligible individuals as set forth in this section.

(1) Claims filed with Medicare automatically cross over to OHCA. The explanation of Medicare Benefits (EOMB) reflects a message that the claim was referred to SoonerCare. If such a message is not present, a claim for coinsurance and deductible must be filed with the OHCA within 90 days of the date of Medicare payment ~~or~~ and within one year of the date of service in order to be considered timely filed.

(2) If payment is denied by Medicare and the service is a SoonerCare covered service, mark the claim "denied by Medicare" and attach the Medicare EOMB showing the reason for denial.

(3) In certain circumstances, some claims do not automatically "cross over". Providers must file a claim for coinsurance and/or deductible to SoonerCare within 90 days of the Medicare payment ~~or~~ and within one year from the date of service.

(4) For individuals who have exhausted Medicare Part A benefits, claims must be accompanied by a statement from the Medicare Part A intermediary showing the date benefits were exhausted.

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 83. RESIDENTIAL BEHAVIOR MANAGEMENT SERVICES IN FOSTER CARE SETTINGS

317:30-5-744. Billing

~~(a) Claims must not be submitted prior to OHCA's determination of the member's eligibility, and must not be submitted later than 1 year after the date of service. If the eligibility of the individual has not been determined after ten months from the date of service, a claim should be submitted in order to assure that the claim is timely filed and reimbursement from SoonerCare funds can be made should the individual be determined eligible at a later date.~~

(a) Claims must be submitted in accordance with guidelines found at

OAC 317:30-3-11 and 317:30-3-11.1.
(b) Claims for dually eligible individuals (Medicare/Medicaid) should be filed directly with the OHCA.

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 87. BIRTHING CENTERS

317:30-5-893. Billing

Billing for birthing center services will be on HCFA-1500. ~~Under Medicaid, the claim must be received by OHCA within 12 months of the date of service in order to be eligible for payment. If the eligibility of the individual has not been determined after ten months from the date of services, a claim should be submitted in order to assure that the claim is timely filed and reimbursement from Title XIX funds can be made should the individual be determined eligible at a later date.~~ Claims must be submitted in accordance with guidelines found at OAC 317:30-3-11 and 317:30-3-11.1.

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 97. CASE MANAGEMENT SERVICES FOR UNDER AGE 18 AT RISK OF OR IN THE TEMPORARY CUSTODY OR SUPERVISION OF OFFICE OF JUVENILE AFFAIRS

317:30-5-973. Billing

Billing for case management services is on Form HCFA-1500. ~~Claims should not be submitted until Medicaid eligibility of the individual has been determined. However, a claim must be received by OHCA within 12 months of the date of service. If the eligibility of the individual has not been determined after ten months from the date of service, a claim should be submitted in order to assure that the claim is timely filed and reimbursement from Title XIX funds can be made should the individual be determined eligible at a later date.~~ Claims must be submitted in accordance with guidelines found at OAC 317:30-3-11 and 317:30-3-11.1.

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 99. CASE MANAGEMENT SERVICES FOR UNDER AGE 18 IN EMERGENCY, TEMPORARY OR PERMANENT CUSTODY OR SUPERVISION OF THE DEPARTMENT OF HUMAN SERVICES

317:30-5-993. Billing

Billing for case management services is on Form HCFA-1500. ~~Claims should not be submitted until Medicaid eligibility of the individual has been determined. However, a claim must be received by OHCA within 12 months of the date of service. If the eligibility of the individual has not been determined after ten months from the date of service, a claim must be submitted in order to assure that the claim is timely filed and reimbursement from Title XIX funds can be made should the individual be determined eligible at a later date.~~ Claims must be submitted in accordance with guidelines found at OAC 317:30-3-11 and 317:30-3-11.1.

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 105. RESIDENTIAL BEHAVIORAL MANAGEMENT SERVICES IN GROUP SETTINGS AND NON-SECURE DIAGNOSTIC AND EVALUATION CENTERS

317:30-5-1045. Billing

(a) Billing is on the HCFA-1500.

~~(b) Claims should not be submitted until the Medicaid eligibility of the individual has been determined. However, a claim must be received by the fiscal agent within 12 months of the date of service. If the eligibility of the individual has not been determined after ten months from the date of service, a claim is submitted in order to assure that the claim is timely filed and reimbursement from Title XIX funds can be made should the individual be determined eligible at a later date.~~

(b) Claims must be submitted in accordance with guidelines found at OAC 317:30-3-11 and 317:30-3-11.1.

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 15, 2016

The proposed policy was submitted to the Medical Advisory Committee (MAC) on July 16, 2015. The proposed policy was presented for Tribal Consultation on January 6, 2015 and on May 5, 2015. The proposed Permanent rule change is scheduled to be presented to the (OHCA) Board of Directors on February 11, 2016.
Reference: APA WF 15-10

SUMMARY:
Long-Term Care Rule Changes — Proposed policy changes for long-term care eligibility are to be consistent with federal regulations in regards to home equity, home exemption criteria and the counting of annuities.

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. Code § 1396p

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

TO: Tywanda Cox
Health Policy

FROM: Harvey Reynolds
Health Policy

SUBJECT: Rule Impact Statement
APA WF# 15-10

A. Brief description of the purpose of the rule:

Long-term care eligibility rules are clarified to be more consistent with 42 U.S. Code § 1396p. Changes include increasing the home equity maximum amount to $500,000 plus the increase by the annual percentage increase in the urban component of the consumer price index, and allowing the

individual to decrease this equity interest through the use of a reverse mortgage or home equity loan. The term "relative" is removed from the home exemption rules for members who fail to return back home from a long-term care institution. The term "assets" is changed to also include annuities purchased by, or on behalf of, an annuitant seeking 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:

Members seeking long-term care services will be affected by the proposed rule, but they will not bear any cost due to the proposed rule since the rule changes are clarifications to current OHCA long-term care policies.

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

No classes of persons will benefit from the proposed 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 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:

This rule change will not have an impact on the budget because the changes are clarifications to current OHCA long-term care policies.

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.

K. 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 10, 2015.

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 (increased by the annual percentage increase in the urban component of the consumer price index beginning in 2011, rounded to the nearest $1,000).

(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 (increased by the annual percentage increase in the urban component of the consumer price index beginning in 2011, rounded to the nearest $1,000) 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.

(E) An individual may reduce their total equity interest in the home through the use of a reverse mortgage or home

equity loan.

(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 an 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~~minor child under 21, or child who is blind or permanently disabled 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~~, minor child, or child who is blind or permanently disabled 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)~~ (G) 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~~, and the value of such note, loan, or mortgage shall be 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.; or~~

~~(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.~~

(1) The purchase of an annuity shall be treated as the disposal of an asset for less than fair market value unless the Oklahoma Health Care Authority is named as the remainder beneficiary –

(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 is named in the first position if the spouse or a

representative of the child disposes of any such remainder for less than fair market value.

(2) For purposes of determining financial eligibility for long-term care services under this chapter, the term "assets" shall include an annuity purchased by or on behalf of an annuitant who has applied for SoonerCare nursing facility services or other long-term care services unless the annuity meets one of the following conditions.

(A) The annuity is an annuity described in subsection (b) or (q) of Section 408 of the United States Internal Revenue Code of 1986; or

(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 Service Code of 1986;

(iii) A Roth IRA described in Section 408A of the United States Internal Revenue Service Code of 1986; or

(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.

(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~~Long-Term Care Partnership Program policy.

(1) Benefits from the LTCP policy must be exhausted before the individual can be eligible for ~~long term~~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: July 16, 2015

The proposed policy is an Emergency Rule. This proposal is scheduled to be presented to the Medical Advisory Committee (MAC) on July 16, 2015 and the (OHCA) Board of Directors on August 12, 2015.
Reference: APA WF 15-10

SUMMARY:
Long-Term Care Rule Changes – Long-term care eligibility rules are clarified to be consistent with 42 U.S. Code § 1396p.

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. Code § 1396p

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

TO: Tywanda Cox
Health Policy

FROM: Harvey Reynolds
Health Policy

SUBJECT: Rule Impact Statement
APA WF# 15-10

A. Brief description of the purpose of the rule:

Long-term care eligibility rules are clarified to be more consistent with 42 U.S. Code § 1396p. Changes include increasing the home equity maximum amount to $500,000 plus the increase by the annual percentage increase in the urban component of the consumer price index, and allowing the individual to decrease this equity interest through the use of a reverse mortgage or home equity loan. The term "relative" is removed from the home exemption rules for

members who fail to return back home from a long-term care institution. The term "assets" is changed to also include annuities purchased by, or on behalf of, an annuitant seeking 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:

Members seeking long-term care services will be affected by the proposed rule, but they will not bear any cost due to the proposed rule since the rule changes are clarifications to current OHCA long-term care policies.

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

No classes of persons will benefit from the proposed 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 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:

This rule change will not have an impact on the budget because the changes are clarifications to current OHCA long-term care policies.

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.

K. 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 June 16, 2015.

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 (increased by the annual percentage increase in the urban component of the consumer price index beginning in 2011, rounded to the nearest $1,000).

(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 (increased by the annual percentage increase in the urban component of the consumer price index beginning in 2011, rounded to the nearest $1,000) 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.

(E) An individual may reduce their total equity interest in the home through the use of a reverse mortgage or home equity loan.

(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 an 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~~minor child under 21, or child who is blind or permanently disabled 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~~, minor child, or child who is blind or permanently disabled 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)~~(G) 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~~, and the value of such note, loan, or mortgage shall be 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.; or~~

~~(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.~~

(1) The purchase of an annuity shall be treated as the disposal of an asset for less than fair market value unless the Oklahoma Health Care Authority is named as the remainder beneficiary –

(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 is named in the first position if the spouse or a representative of the child disposes of any such remainder for less than fair market value.

(2) For purposes of determining financial eligibility for long-term care services under this chapter, the term “assets” shall include an annuity purchased by or on behalf of an annuitant who has applied for SoonerCare nursing facility services or other long-term care services unless the annuity meets one of the following conditions.

(A) The annuity is an annuity described in subsection (b) or (q) of Section 408 of the United States Internal Revenue Code of 1986; or

(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 Service Code of 1986;

(iii) A Roth IRA described in Section 408A of the United States Internal Revenue Service Code of 1986; or

(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.

(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~~Long-Term Care Partnership Program policy.

(1) Benefits from the LTCP policy must be exhausted before the individual can be eligible for ~~long term~~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: January 15, 2016

The proposed policy is a Permanent Rule. The proposed policy is scheduled to be presented to the Medical Advisory Committee (MAC) on January 21, 2016 and the (OHCA) Board of Directors on February 11, 2016.
Reference: APA WF 15-13

SUMMARY:
Joint Injections — Proposed physician policy changes will allow payment for a joint injection and office visit if the claim is billed appropriately and medical documentation supports separate payments.

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:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

TO: Tywanda Cox
Health Policy

FROM: Sandra Manzo de Puebla
Health Policy

SUBJECT: Rule Impact Statement
APA WF # 15-13

A. Brief description of the purpose of the rule:

Proposed physician policy changes will allow payment for a joint injection and office visit if the claim is billed appropriately and medical documentation supports separate payments. Further, current policy states that payment is made

for joint injections without a global coverage designation; however, all joint injection codes have a global coverage designation. Therefore, proposed policy changes are also needed to decrease provider confusion.

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. This rule should not place any cost burden on private or public entities.

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

Physicians who administer joint injections will benefit from the promulgation of this 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 not a probable economic impact for this proposed rule.

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:

This rule is budget neutral and will not have an impact on the OHCA budget.

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 September 18, 2015.

RULE TEXT

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

PART 1. PHYSICIANS

317:30-5-9. Medical services

(a) **Use of medical modifiers.** The Physicians' Current Procedural Terminology (CPT) and the second level HCPCS provide for 2-digit medical modifiers to further describe medical services. Modifiers are used when appropriate.

(b) **Covered office services.**

(1) Payment is made for four office visits (or home) per month per member, for adults (over age 21), regardless of the number of physicians involved. Additional visits per month are allowed for services related to emergency medical conditions.

(2) Visits for the purpose of family planning are excluded from the four per month limitation.

(3) Payment is allowed for the insertion and/or implantation of contraceptive devices in addition to the office visit.

(4) Separate payment will be made for the following supplies when furnished during a physician's office visit.

(A) Casting materials

(B) Dressing for burns

(C) Contraceptive devices

(D) IV Fluids

(5) Payment is made for routine physical exams only as prior authorized by the OKDHS and are not counted as an office visit.

(6) Medically necessary office lab and X-rays are covered.

(7) Hearing exams by physician for members between the ages of 21 and 65 are covered only as a diagnostic exam to determine type, nature and extent of hearing loss.

(8) Hearing aid evaluations are covered for members under 21 years of age.

(9) IPPB (Intermittent Positive Pressure Breathing) is covered when performed in physician's office.

~~(10) Payment is made for both an office visit and an injection of joints performed during the visit if the joint injection code does not have a global coverage designation.~~

~~(11)~~(10) Payment is made for an office visit in addition to allergy testing.

~~(12)~~(11) Separate payment is made for antigen.

~~(13)~~(12) Eye exams are covered for members between ages 21 and 65 for medical diagnosis only.

~~(14)~~(13) If a physician personally sees a member on the same day as a dialysis treatment, payment can be made for a separately identifiable service unrelated to the dialysis.

~~(15)~~(14) Separate payment is made for the following specimen

collections:

(A) Catheterization for collection of specimen; and

(B) Routine Venipuncture.

~~(16)~~(15) The Professional Component for electrocardiograms, electroencephalograms, electromyograms, and similar procedures are covered on an inpatient basis as long as the interpretation is not performed by the attending physician.

~~(17)~~(16) Cast removal is covered only when the cast is removed by a physician other than the one who applied the cast.

(c) **Non-covered office services.**

(1) Payment is not made separately for an office visit and rectal exam, pelvic exam or breast exam. Office visits including one of these types of exams should be coded with the appropriate office visit code.

(2) Payment cannot be made for prescriptions or medication dispensed by a physician in his office.

(3) Payment will not be made for completion of forms, abstracts, narrative reports or other reports, separate charge for use of office or telephone calls.

(4) Additional payment will not be made for mileage.

(5) Payment is not made for an office visit where the member did not keep appointment.

(6) Refractive services are not covered for persons between the ages of 21 and 65.

(7) Removal of stitches is considered part of post-operative care.

(8) Payment is not made for a consultation in the office when the physician also bills for surgery.

(9) Separate payment is not made for oxygen administered during an office visit.

(d) **Covered inpatient medical services.**

(1) Payment is allowed for inpatient hospital visits for all SoonerCare covered admissions. Psychiatric admissions must be prior authorized.

(2) Payment is allowed for the services of two physicians when supplemental skills are required and different specialties are involved.

(3) Certain medical procedures are allowed in addition to office visits.

(4) Payment for critical care is all-inclusive and includes payment for all services that day. Payment for critical care, first hour is limited to one unit per day.

(e) **Non-covered inpatient medical services.**

(1) For inpatient services, all visits to a member on a single day are considered one service except where specified. Payment is made for only one visit per day.

(2) A hospital admittance or visit and surgery on the same day would not be covered if post-operative days are included in the surgical procedure. If there are no post-operative days, a physician can be paid for visits.

(3) Drugs administered to inpatients are included in the hospital payment.

(4) Payment will not be made to a physician for an admission or new patient work-up when the member receives surgery in out-patient surgery or ambulatory surgery center.

(5) Payment is not made to the attending physician for interpretation of tests on his own patient.

(f) **Other medical services.**

(1) Payment will be made to physicians providing Emergency Department services.

(2) Payment is made for two nursing facility visits per month. The appropriate CPT code is used.

(3) When payment is made for "Evaluation of arrhythmias" or "Evaluation of sinus node", the stress study of the arrhythmia includes inducing the arrhythmia and evaluating the effects of drugs, exercise, etc. upon the arrhythmia.

(4) When the physician bills twice for the same procedure on the same day, it must be supported by a written report.

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 15, 2016

The proposed policy is a Permanent Rule. This proposal was presented to the Medical Advisory Committee (MAC) as an emergency rule change on November 19, 2015 and presented at Tribal Consultation on September 1, 2015. The proposed Permanent rule change is scheduled to be presented at the (OHCA) Board of Directors on February 11, 2016.

Reference: APA WF # 15-14A

SUMMARY:
Proposed policy at OAC 317:35-17-5 is revised to comply with 42 CFR 441.301 regarding conflict of interest provisions for case management services. These policy revisions are necessary as the regulation states providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual, must not provide case management services or develop the person centered service plan. The State is currently out of compliance. Without the recommended changes, the State may be in risk of losing federal funding.

LEGAL AUTHORITY
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, 42 CFR 441.301, 441710, and 441.730.

RULE IMPACT STATEMENT:
TO: Tywanda Cox
Health Policy

FROM: Princiss Rockmore
Health Policy

SUBJECT: Rule Impact Statement
APA WF # 15-14A

A. Brief description of the purpose of the rule:

Proposed policy at OAC 317:35-17-5 is revised to comply with 42 CFR 441.301 regarding conflict of interest provisions for case management services. These policy revisions are necessary as the regulation states providers of HCBS for the individual, or those

who have an interest in or are employed by a provider of HCBS for the individual, must not provide case management services or develop the person centered service plan. The State is currently out of compliance. Without the recommended changes, the State may be in risk of losing federal funding.

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:

Persons affected by the proposed rule change include ADvantage Home and Community Based (HCBS) waiver members whom receive case management and other HBCS services through the same contracted provider. Additionally, providers of HCBS who provide both case management and other HCBS for the same member will also be affected. The member must exercise their freedom of choice to comply with the final rule.

Providers will potentially experience a decline in revenue as members may choose to receive Home and Community Based Services from another contracted provider.

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

Providers may benefit by receiving additional members. Members may benefit from the proposed change as the rule is designed to ensure conflict-free case management.

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:

Providers may receive additional revenue due to an increase in member participation. However, some providers may see a decline in revenue due to members choosing to receive Home and Community Based Services from other contracted providers.

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 Agency has determined that there are no expected costs to OHCA or other agencies as a result of the proposed rules nor is there an anticipated effect on current State revenues.

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 will require separation of case management and other Home and Community Based Services; however, access is still available to all waiver members who wish to continue utilizing Home and Community Based Services. Therefore, the proposed rule should have no effects on 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 State is currently out of compliance with the Center for Medicare and Medicaid Services (CMS) and may be in risk of losing federal funding.

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

The rule impact statement was prepared August 12, 2015.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN ELIGIBILITY
SUBCHAPTER 1. ADVANTAGE WAIVER SERVICES

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

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

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

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

(B) ~~the~~ social ~~worker~~service specialist is responsible for contacting the ~~individual~~applicant within three ~~working~~business days to initiate the financial eligibility application process.

(2) Categorical relationship must be established for determination of eligibility for ADvantage services. If a categorical relationship to disability ~~has~~was not ~~already been~~ established, the local social ~~worker~~service specialist submits the same information ~~described in OAC~~per Oklahoma Administrative Code (OAC) 317:35-5-4(2) to the Level of Care Evaluation Unit (LOCEU) to request a determination of eligibility for categorical relationship. LOCEU renders a decision on the categorical relationship to the ~~disabled~~person with the disability using the ~~same definition used by SSA~~Social Security Administration (SSA) definition. A follow-up is required by the ~~OKDHS~~DHS social ~~worker~~service specialist with ~~the Social Security Administration~~SSA to ~~be sure their~~ensure the disability decision agrees with the LOCEU decision ~~of LOCEU~~.

(3) Community agencies complete the UCAT~~, Part~~ I, and ~~forwards~~forward the form to the county office. ~~If~~When the

UCAT~~, Part~~ I indicates ~~that~~ the applicant does not qualify for Medicaid long-term care services, the applicant is referred to appropriate community resources. Members may also call the care line at 800-435-4711.

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

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

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

(A) ~~If the member and/or family declines to make a provider choice, the OKDHS nurse documents that decision on the member choice form.~~Providers of ADvantage services for the member, or for those who have an interest in, or are employed by an ADvantage provider for the member must not provide case management or develop the person-centered service plan, except when the ADvantage Administration (AA) demonstrates the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area, also provides other ADvantage services.

(B) ~~The AA uses a rotating system to select an agency for the member from a list of all local certified case management and in-home care agencies.~~If the member and/or family declines to make a provider choice, the DHS nurse documents the decision on Form 02CB001, Member Consents and Rights.

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

to conflict free case management requirements.
(7) The ~~OKDHS~~DHS nurse documents the names of the chosen agencies and the agreement ~~(by dated signature)~~ of the member, by dated signature, to receive services provided by the agencies.
(8) ~~If~~When the ~~needs of the member~~member's needs require an immediate interdisciplinary team (IDT) meeting with home health agency nurse participation to develop a care plan and service plan, the ~~OKDHS~~DHS nurse documents the need for priority processing.
(9) The ~~OKDHS~~DHS nurse scores the UCAT, Part III. The ~~OKDHS~~DHS nurse forwards the UCAT, Parts I and III, documentation of financial eligibility, ~~and~~ documentation of the member's case management and in-home care agency choices to the area nurse, or nurse designee, for medical eligibility determination.
(10) If, based upon the information obtained during the assessment, the ~~OKDHS~~DHS nurse determines ~~that~~ the member may be at risk for health and safety, ~~OKDHS~~DHS Adult Protective Services ~~(APS)~~ staff ~~are~~is notified immediately and the referral is documented on the UCAT.
(11) Within ~~ten working~~10 business days of receipt of a complete ADvantage application, the area nurse~~,~~ or nurse designee, determines medical eligibility using ~~NF~~nursing facility level of care criteria and service eligibility criteria ~~[refer to~~per OAC 317:35-17-2 and ~~OAC~~ 317:35-17-3~~]~~ and enters the medical decision on the system.
(12) Upon notification of financial eligibility from the social ~~worker~~service specialist, medical eligibility ~~(MS-52~~), and approval for ADvantage entry from the area nurse~~,~~ or nurse designee, the AA communicates with the case management provider to begin care ~~plan~~ and service plan development. The AA communicates to the ~~client's~~ case management provider, the member's name, address, case number, ~~and social security~~Social Security number, the number of units of case management and, ~~if~~when applicable, the number of units of home health agency nurse evaluation authorized for ~~care plan and~~ service plan development. ~~If~~When the member requires an immediate home visit to develop a service plan within 24 hours, the AA contacts the case management provider directly to confirm availability and ~~then~~ sends the new case packet information to the case management provider via ~~facsimile~~email.
(13) ~~If~~When the services must be in place to ensure the health and safety of the member upon discharge to the home

from the ~~NF~~nursing facility or ~~Hospital~~hospital, a ~~nurse~~ case manager from an ADvantage case management provider selected by the ~~client~~member and referred by the AA follows the ADvantage ~~Institution Transition~~institution transition, case management procedures for care ~~plan~~ and service plan development and implementation.

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

(A) ~~from~~ State Plan Personal Care to ADvantage services~~.~~;

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

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

(D) ~~from~~ ADvantage to ~~Nursing Facility~~nursing facility services.

(15) A new medical level of care determination is not required when a member requests re-activation of ADvantage services after a short-term stay ~~(~~of 90 calendar-days or less~~)~~ in a ~~Nursing~~ ~~Facility~~nursing facility when the member has had previous ADvantage services and the ADvantage certification period has not expired.

(16) When a UCAT assessment ~~has been~~was completed more than 90 calendar-days prior to submission to the area nurse or nurse designee for a medical decision, a new assessment 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 16, 2015

The proposed policy is an Emergency Rule. This proposal is scheduled to be presented to the Medical Advisory Committee (MAC) on November 19, 2015 and the OHCA Board of Directors on December 10, 2015.

Reference: APA WF # 15-14A

SUMMARY:
Proposed policy at OAC 317:35-17-5 is revised to comply with 42 CFR 441.301 regarding conflict of interest provisions for case management services. These policy revisions are necessary as the regulation states providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual, must not provide case management services or develop the person centered service plan. The State is currently out of compliance. Without the recommended changes, the State may be in risk of losing federal funding.

LEGAL AUTHORITY
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, 42 CFR 441.301, 441710, and 441.730.

RULE IMPACT STATEMENT:
TO: Tywanda Cox
Health Policy

FROM: Princiss Rockmore
Health Policy

SUBJECT: Rule Impact Statement
APA WF # 15-14A

A. Brief description of the purpose of the rule:

Proposed policy at OAC 317:35-17-5 is revised to comply with 42 CFR 441.301 regarding conflict of interest provisions for case management services. These policy revisions are necessary as the regulation states providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual, must not provide case management services or develop the person centered service plan. The State is currently

out of compliance. Without the recommended changes, the State may be in risk of losing federal funding.

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:

Persons affected by the proposed rule change include ADvantage Home and Community Based (HCBS) waiver members whom receive case management and other HBCS services through the same contracted provider. Additionally, providers of HCBS who provide both case management and other HCBS for the same member will also be affected. The member must exercise their freedom of choice to comply with the final rule.

Providers will potentially experience a decline in revenue as members may choose to receive Home and Community Based Services from another contracted provider.

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

Providers may benefit by receiving additional members. Members may benefit from the proposed change as the rule is designed to ensure conflict-free case management.

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:

Providers may receive additional revenue due to an increase in member participation. However, some providers may see a decline in revenue due to members choosing to receive Home and Community Based Services from other contracted providers.

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 Agency has determined that there are no expected costs to OHCA or other agencies as a result of the proposed rules

nor is there an anticipated effect on current State revenues.

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 will require separation of case management and other Home and Community Based Services; however, access is still available to all waiver members who wish to continue utilizing Home and Community Based Services. Therefore, the proposed rule should have no effects on 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 State is currently out of compliance with the Center for Medicare and Medicaid Services (CMS) and may be in risk of losing federal funding.

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

The rule impact statement was prepared August 12, 2015.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 35. ADVANTAGE PROGRAM MEDICAL ELIGIBILITY DETERMINATION
SUBCHAPTER 1. ADVANTAGE WAIVER SERVICES

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

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

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

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

(B) ~~the~~ social ~~worker~~service specialist is responsible for contacting the ~~individual~~ within three ~~working~~business days to initiate the financial eligibility application process.

(2) Categorical relationship must be established for determination of eligibility for ADvantage services. If a categorical relationship to disability ~~has~~was not ~~already been~~ established, the local social ~~worker~~ service specialist submits the same information ~~described in OAC~~per Oklahoma Administrative Code (OAC) 317:35-5-4(2) to the Level of Care Evaluation Unit (LOCEU) to request a determination of eligibility for categorical relationship. LOCEU renders a decision on the categorical relationship to the ~~disabled~~person with the disability using the ~~same definition used by SSA~~Social Security Administration (SSA) definition. A follow-up is required by the ~~OKDHS~~DHS social ~~worker~~service specialist with ~~the Social Security Administration~~SSA to ~~be sure their~~ensure the disability decision agrees with the LOCEU decision ~~of LOCEU~~.

(3) Community agencies complete the UCAT~~, Part~~ I, and ~~forwards~~forward the form to the county office. ~~If~~When the UCAT~~, Part~~ I indicates ~~that~~ the applicant does not qualify for Medicaid long-term care services, the applicant is referred to appropriate community resources. Members may

also call the care line at 800-435-4711.

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

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

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

(A) ~~If the member and/or family declines to make a provider choice, the OKDHS nurse documents that decision on the member choice form.~~Providers of ADvantage services for the member, or for those who have an interest in, or are employed by an ADvantage provider for the member must not provide case management or develop the person-centered service plan, except when the AA demonstrates the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area, also provides other ADvantage services.

(B) ~~The AA uses a rotating system to select an agency for the member from a list of all local certified case management and in-home care agencies.~~If the member and/or family declines to make a provider choice, the DHS nurse documents the decision on Form 02CB001, Member Consents and Rights.

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

(7) The ~~OKDHS~~DHS nurse documents the names of the chosen agencies and the agreement ~~(by dated signature)~~ of the

member, by dated signature, to receive services provided by the agencies.
(8) ~~If~~When the ~~needs of the member~~member's needs The AA uses a rotating system to select an agency for the member from a list of all local certified case management and in-home care agencies. require an immediate interdisciplinary team (IDT) meeting with home health agency nurse participation to develop a care plan and service plan, the ~~OKDHS~~DHS nurse documents the need for priority processing.
(9) The ~~OKDHS~~DHS nurse scores the UCAT, Part III. The ~~OKDHS~~DHS nurse forwards the UCAT, Parts I and III, documentation of financial eligibility, ~~and~~ documentation of the member's case management and in-home care agency choices to the area nurse, or nurse designee, for medical eligibility determination.
(10) If, based upon the information obtained during the assessment, the ~~OKDHS~~DHS nurse determines ~~that~~ the member may be at risk for health and safety, ~~OKDHS~~DHS Adult Protective Services ~~(APS)~~ staff ~~are~~is notified immediately and the referral is documented on the UCAT.
(11) Within ~~ten working~~10 business days of receipt of a complete ADvantage application, the area nurse~~,~~ or nurse designee, determines medical eligibility using ~~NF~~nursing facility level of care criteria and service eligibility criteria ~~[refer to~~per OAC 317:35-17-2 and ~~OAC~~ 317:35-17-3~~]~~ and enters the medical decision on the system.
(12) Upon notification of financial eligibility from the social ~~worker~~service specialist, medical eligibility, ~~(MS-52)~~ and approval for ADvantage entry from the area nurse~~,~~ or nurse designee, the AA communicates with the case management provider to begin care ~~plan~~ and service plan development. The AA communicates to the ~~client's~~ case management provider, the member's name, address, case number, ~~and social security~~Social Security number, the number of units of case management and, ~~if~~when applicable, the number of units of home health agency nurse evaluation authorized for ~~care plan and~~ service plan development. ~~If~~When the member requires an immediate home visit to develop a service plan within 24 hours, the AA contacts the case management provider directly to confirm availability and ~~then~~ sends the new case packet information to the case management provider via ~~facsimile~~email.
(13) ~~If~~When the services must be in place to ensure the health and safety of the member upon discharge to the home from the ~~NF~~nursing facility or ~~Hospital~~hospital, a ~~nurse~~ case

manager from an ADvantage case management provider selected by the ~~client~~member and referred by the AA follows the ADvantage ~~Institution Transition~~institution transition, case management procedures for care ~~plan~~ and service plan development and implementation.

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

(A) ~~from~~ State Plan Personal Care to ADvantage services~~.~~;

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

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

(D) ~~from~~ ADvantage to ~~Nursing Facility~~nursing facility services.

(15) A new medical level of care determination is not required when a member requests re-activation of ADvantage services after a short-term stay ~~(~~of 90 calendar-days or less) in a ~~Nursing Facility~~nursing facility when the member has had previous ADvantage services and the ADvantage certification period has not expired.

(16) When a UCAT assessment ~~has been~~was completed more than 90 calendar-days prior to submission to the area nurse or nurse designee for a medical decision, a new assessment 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: January 15, 2016

The proposed policy is a Permanent Rule. This proposal was presented to the Medical Advisory Committee (MAC) as an emergency rule change on November 19, 2015 and presented at Tribal Consultation on September 1, 2015. The proposed Permanent rule change is scheduled to be presented at the (OHCA) Board of Directors on February 11, 2016.

Reference: APA WF # 15-14B

SUMMARY:
ADvantage Policy is revised to comply with 42 CFR 441.301 regarding conflict of interest provisions for case management services. These policy revisions are necessary as the regulation states providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual, must not provide case management services or develop the person centered service plan. The State is currently out of compliance. Without the recommended changes, the State may be in risk of losing federal funding.

LEGAL AUTHORITY
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, 42 CFR 441.301, 441.710, and 441.730.

RULE IMPACT STATEMENT:
TO: Tywanda Cox
Health Policy

FROM: Princiss Rockmore
Health Policy

SUBJECT: Rule Impact Statement
APA WF # 15-14B

A. Brief description of the purpose of the rule:

ADvantage Policy is revised to comply with 42 CFR 441.301 regarding conflict of interest provisions for case management

services. These policy revisions are necessary as the regulation states providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual, must not provide case management services or develop the person centered service plan. The State is currently out of compliance. Without the recommended changes, the State may be in risk of losing federal funding.

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:

Persons affected by the proposed rule change include ADvantage Home and Community Based (HCBS) waiver members whom receive case management and other HBCS services through the same contracted provider. Additionally, providers of HCBS who provide both case management and other HCBS for the same member will also be affected. The member must exercise their freedom of choice to comply with the final rule.

Providers will potentially experience a decline in revenue as members may choose to receive Home and Community Based Services from another contracted provider.

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

Providers may benefit by receiving additional members. Members may benefit from the proposed change as the rule is designed to ensure conflict-free case management.

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:

Providers may receive additional revenue due to an increase in member participation. However, some providers may see a decline in revenue due to members choosing to receive Home and Community Based Services from other contracted providers.

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 Agency has determined that there are no expected costs to OHCA or other agencies as a result of the proposed rules nor is there an anticipated effect on current State revenues.

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 will require separation of case management and other Home and Community Based Services; however, access is still available to all waiver members who wish to continue utilizing Home and Community Based Services. Therefore, the

proposed rule should have no effects on 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 State is currently out of compliance with the Center for Medicare and Medicaid Services (CMS) and may be in risk of losing federal funding.

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

The rule impact statement was prepared August 12, 2015.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 85. ADVANTAGE PROGRAM WAIVER SERVICES

317:30-5-763. Description of services

Services included in the ADvantage Program are ~~as follows~~:

(1) **Case ~~Management~~management.**

(A) Case ~~Management~~management services ~~are services that~~ assist a member in gaining access to medical, social, educational, or other services, regardless of payment source ~~of services,~~ that may benefit the member in maintaining health and safety. Case managers initiate and oversee necessary assessments and reassessments to establish or reestablish ~~waiver~~Waiver program eligibility. Case managers develop the member's comprehensive service plan ~~of care~~, listing only services ~~which are~~ necessary to prevent institutionalization of the member, as determined through the assessments. Case managers initiate the addition of necessary services or deletion of unnecessary services, as dictated by the member's condition and available support. Case managers monitor the member's condition to ensure delivery and appropriateness of services and initiate service plan ~~of care~~ reviews. Case managers submit an individualized Form 02CB014, Services Backup Plan, on all initial service plans, annually at reassessment, and on updates as appropriate throughout the year, reflecting risk factors and measures in place to

minimize risks. ~~If~~When a member requires hospital or nursing facility services, the case manager assists the member in accessing institutional care and, as appropriate, periodically monitors the member's progress during the institutional stay, ~~and~~ helps the member transition from institution to home by updating the service plan, and ~~preparing~~prepares services to start on the date the member is discharged from the institution. Case ~~Managers~~managers must meet ADvantage Program minimum requirements for qualification and training prior to providing services to ADvantage members. Providers of ADvantage services for the member, or for those who have an interest in, or are employed by an ADvantage provider for the member must not provide case management or develop the person-centered service plan, except when the AA demonstrates the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area, also provides other ADvantage services. Prior to providing services to members receiving Consumer-Directed Personal Assistance Services and Supports (CD-PASS), ~~Case Managers~~case manager supervisors and case managers are required to receive training and demonstrate knowledge regarding the CD-PASS service delivery model, "Independent Living Philosophy," and demonstrate ~~competency in Person-centered planning~~ person-centered planning competency.

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

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

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

(C) Case ~~Management~~management services are prior authorized and billed per 15-minute unit of service using

the rate associated with the location of residence of the member served.

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

(ii) Very ~~Rural/Difficult Service Area Rate~~rural/difficult service area rate: Case ~~Management~~management services are billed using a ~~Very Rural/Difficult Service Area~~very rural/difficult service area rate for billable service activities provided to a member who resides in a county with a population density equal to, or less than 25 persons per square mile. ~~An exception would be~~Exceptions are services to members ~~that~~who reside in Oklahoma Department of Human Services~~/~~ Aging Services ~~Division (OKDHS/ASD)~~ (DHS AS) identified zip codes in Osage County adjacent to the metropolitan areas of Tulsa and Washington Counties. Services to these members are prior authorized and billed using the ~~Standard~~standard rate.

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

(2) **Respite.**

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

(B) ~~In-Home Respite~~In-home respite services are billed per 15-minute ~~unit~~units of service. Within any one-day

period, a minimum of eight units must be provided with a maximum of 28 units provided. The service is provided in the member's home.

(C) ~~Facility-Based Extended Respite~~Facility-based extended respite is filed for a per diem rate ~~if~~when provided in ~~Nursing Facility~~a nursing facility. Extended ~~Respite~~respite must be at least eight hours in duration.

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

(3) **Adult ~~Day Health Care~~ day health care**.

(A) Adult ~~Day Health Care~~day health care is furnished on a regularly scheduled basis for one or more days per week in an outpatient setting. It provides both health and social services ~~which are~~ necessary to ensure the member's optimal functioning ~~of the member~~. Physical, occupational, and~~/or~~ speech therapies ~~may~~are only ~~be~~ provided as an enhancement to the basic ~~Adult Day Health Care~~adult day health care service when authorized by the service plan ~~of care~~ and are billed as a separate procedure. Meals provided as part of this service do not constitute a full nutritional regimen. Personal ~~Care~~care service enhancement in ~~Adult Day Health Care~~adult day health care is assistance in bathing, ~~and/or~~ hair ~~washing~~care, or laundry service, authorized by the service plan ~~of care~~ and billed as ~~a~~ separate ~~procedure~~procedures. Most assistance with activities of daily living (ADL), such as eating, mobility, toileting, and nail care~~,~~ are ~~services that are~~ integral services to ~~the Adult Day Health Care~~adult day health care service and are covered by the ~~Adult Day Health Care~~adult day health care basic reimbursement rate. Assistance with bathing, hair care, or laundry service is not a usual and customary adult day health care service. Enhanced personal care in adult day health care for assistance with bathing, hair care, or laundry ~~will be~~service is authorized when an ADvantage ~~waiver~~Waiver member who uses adult day health care requires assistance with bathing, hair care, or laundry service to maintain his or her health and safety.

(B) Adult ~~Day Health Care~~day health care is a 15-minute unit of service. No more than ~~8~~eight hours, ~~(32 units)~~32 units, are authorized per day. The number of units of service a member may receive is limited to the number of units approved on the member's approved service plan ~~of care~~.

(C) Adult ~~Day Health Care Therapy Enhancement~~day health care therapy enhancement is a maximum of one session unit per day ~~unit~~ of service.

(D) Adult ~~Day Health Personal Care Enhancement~~day health personal care enhancement is a maximum of one unit per day ~~unit~~ of bathing, hair care, or laundry service.

(4) **Environmental ~~Modifications~~modifications.**

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

(B) All services require prior authorization.

(5) **Specialized ~~Medical Equipment~~medical equipment and ~~Supplies~~supplies.**

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

(B) Specialized ~~Medical Equipment~~medical equipment and ~~Supplies~~supplies are billed using the appropriate ~~HCPC procedure code~~HealthCare Common Procedure Code (HCPC). Reoccurring supplies ~~which are~~ shipped and delivered to the member are compensable only when the member remains eligible for ~~waiver~~Waiver services, continues to reside in the home, and is not institutionalized in a hospital, skilled nursing facility, or nursing home. It is the provider's responsibility to verify the member's status prior to shipping and delivering these items. Payment for medical supplies is limited to the the SoonerCare rate if

established, to the Medicare rate, or to actual acquisition cost, plus 30 percent. All services must ~~be~~have prior ~~authorized~~authorization.

(6)**~~Advanced~~~~Supportive/Restorative~~~~Assistance~~supportive/restorative assistance**.

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

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

(7) **Nursing.**

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

(B) Nursing services are services of a maintenance or ~~preventive~~preventative nature provided to members with stable, chronic conditions. These services are not intended to treat an acute health condition and may not include services ~~which would be~~ reimbursable under either Medicaid or ~~Medicare's~~the Medicare Home Health Program. This service primarily provides nurse supervision to the ~~Personal Care Assistant~~personal care assistant or to the ~~Advanced Supportive/Restorative Assistance Aide~~advanced supportive/restorative assistance aide and assesses the member's health and prescribed medical services to ensure ~~that~~ they meet the member's needs as specified in the service plan ~~of care~~. A nursing assessment/evaluation, on-site visit is made to each member for whom ~~Advanced Supportive/Restorative Assistance~~advanced

supportive/restorative assistance services are authorized to evaluate the condition of the member and medical appropriateness of services. An assessment/evaluation visit report ~~will be~~is made to the ADvantage Program case manager in accordance with review schedule determined ~~in consultation~~ between the ~~Case Manager~~case manager and ~~the Nurse~~nurse, to report the member's condition or other significant information concerning each advanced supportive/restorative care member.

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

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

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

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

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

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

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

(IV) ~~providing~~provide nail care for the ~~diabetic~~ member with diabetes or member ~~with~~who has circulatory or neurological compromise;

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

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

(8) **Skilled ~~Nursing Services~~nursing services.**

(A) Skilled ~~Nursing Services~~nursing services listed in the service plan ~~of carewhich~~that are within the scope of the ~~State's~~state's Nurse Practice Act and are ordered by a licensed ~~medical~~ physician, osteopathic physician, physician assistant, or an advanced practice nurse and are provided by ~~a registered professional nurse, or licensed~~

~~practical or vocational nurse~~an RN, or an LPN or LVN under the supervision of a registered nurse, licensed to practice in the ~~State~~state. Skilled ~~Nursing~~nursing services provided in the member's home or other community setting are services requiring the specialized skills of a licensed nurse. The scope and nature of these services are intended for treatment of a disease or a medical condition and are beyond the scope of ADvantage ~~Nursing Services~~nursing services. These intermittent nursing services are targeted toward a prescribed treatment or procedure that must be performed at a specific time or other predictable rate of occurrence. ~~It is the responsibility of the RN to contact~~The RN contacts the member's physician to obtain ~~any~~ necessary information or orders pertaining to the member's care ~~of the member~~. ~~If~~When the member has an ongoing need for service activities~~, which require~~requiring more or less units than authorized, the RN ~~shall~~must recommend, in writing, that the ~~Plan of Care~~service plan be revised.

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

(9) **Home ~~Delivered Meals~~ delivered meals.**

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

(B) Home ~~Delivered Meals~~delivered meals are billed per meal, with one meal equaling one unit of service. The limit of the number of units a member is allowed to receive is ~~limited on~~in accordance with the member's service plan ~~of care~~. The provider must obtain a signature from the member or the member's representative at the time the ~~meals are~~meal is delivered. In the event

~~that~~ the member is temporarily unavailable~~ (i.e., doctor's appointment, etc.)~~, such as at a doctor's appointment and the meal is left at the member's home, the provider must document the reason a signature ~~is~~was not obtained. The signature logs must be available for review.

(10) **Occupational ~~Therapy Services~~therapy services.**

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

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

(11) **Physical ~~Therapy Services~~therapy services.**

(A) Physical ~~Therapy~~therapy services are those services that ~~prevent~~maintain or improve physical disability through the evaluation and rehabilitation of members disabled by pain, disease, or injury. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Treatment involves the use

of physical therapeutic means, such as massage, manipulation, therapeutic exercise, cold and/or heat therapy, hydrotherapy, electrical stimulation, and light therapy. Under a physician's order, a licensed physical therapist evaluates the member's rehabilitation potential and develops an appropriate, written, therapeutic regimen. The regimen utilizes paraprofessional physical therapy assistant services, within the ~~limits~~limitations of ~~their~~his or her practice, working under the supervision of the licensed physical therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services~~, where~~when appropriate. The licensed physical therapist ~~will ensure~~ensures monitoring and documentation of the member's rehabilitative progress and ~~will report~~reports to the member's case manager and physician to coordinate the necessary addition ~~and/~~or deletion of services, based on the member's condition and ongoing rehabilitation potential.

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

(12) **Speech and ~~Language Therapy Services~~language therapy services.**

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

and documentation of the member's rehabilitative progress and ~~will report~~reports to the member's case manager and physician to coordinate the necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

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

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

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

(B) A hospice program offers palliative and supportive care to meet the special needs arising out of the physical, emotional, and spiritual stresses ~~which are~~ experienced during the final stages of illness~~and during dying~~, through the end of life, and bereavement. The member signs a statement choosing hospice care instead of routine medical care ~~that has~~with the objective to treat and cure the member's illness. Once the member has elected hospice care, the hospice medical team assumes responsibility for the member's medical care for the ~~terminal~~ illness in the home environment. Hospice care services include nursing care, physician services, medical equipment and supplies, drugs for symptom ~~control~~ and pain relief, home health aide and personal care services,

physical, occupational and~~/or~~ speech ~~therapy~~therapies, medical social services, dietary counseling, and grief and bereavement counseling to the member and/or the member's family. ~~A Hospice plan of care must be developed by the hospice team in conjunction with the member's ADvantage case manager before hospice services are provided. The hospice services must be related to the palliation or management of the member's terminal illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills. A member that is eligible for Medicare Hospice provided as a Medicare Part A benefit, is not eligible to receive ADvantage Hospice services.~~

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

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

(14) **ADvantage ~~Personal Care~~personal care**.

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

(B) ADvantage ~~Home Care Agency Skilled Nursing~~home care agency skilled nursing staff working in coordination with an ADvantage ~~Case Manager~~case manager are responsible for the development and monitoring of the member's ~~Personal Care plan~~personal care services.

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

(15) **Personal ~~Emergency Response System~~emergency response system.**

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

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

(ii) member lives alone and ~~has no~~without a regular caregiver, paid or unpaid, and therefore is left alone for long periods of time;

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

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

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

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

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

authorized in accordance with the ADvantage approved service plan ~~of care~~.

(16) **Consumer-Directed Personal Assistance Services and Support(CD-PASS).**

(A) ~~Consumer-Directed Personal Assistance Services and Supports~~CD-PASS are ~~Personal Services Assistance~~personal services assistance (PSA) and ~~Advanced Personal Services Assistance~~advanced personal services assistance (APSA) that enable ~~an individual~~a member in need of assistance to reside in their home and ~~in the~~ community of their choosing rather than in an institution; and to carry out functions of daily living, ~~self care~~self-care, and mobility. CD-PASS services are delivered as authorized on the service plan. The member becomes the employer of record and employs the ~~Personal Services Assistant (PSA)~~PSA and~~/or~~ the ~~Advanced Personal Services Assistant (APSA)~~APSA. ~~and~~The member is responsible, with assistance from ADvantage Program Administrative Financial Management Services (FMS), for ensuring ~~that~~ the employment complies with ~~State~~ state and ~~Federal Labor Law~~federal labor law requirements. The member/employer may designate an adult family member or friend, ~~an individual~~ who is not a PSA or APSA to the member, as an "authorized representative" to assist in executing ~~these~~the employer functions. The member/employer:

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

(ii) ~~provides~~is solely responsible to provide instruction and training to the PSA or APSA on tasks ~~to be done~~ and works with the ~~Consumer Directed Agent/Case Manager~~consumer directed agent/case manager (CDA) to obtain ADvantage skilled nursing services assistance with training, when necessary. Prior to performing an ~~Advanced Personal Services Assistance~~APSA task for the first time, the APSA must demonstrate competency in the tasks in an on-the-job training session conducted by the member and the member must document the attendant's competency in performing each task in the ~~ASPA's~~APSA's personnel file;

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

(iv) supervises and documents employee work time; and~~,~~

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

(B) The ~~service Personal Services Assistance~~services the PSA may provide include:

(i) assistance with mobility and ~~with transfer~~transferring in and out of bed, wheelchair, or motor vehicle, or ~~both~~all;

(ii) assistance with routine bodily functions that may include:

(I) bathing and personal hygiene;

(II) dressing and grooming; and

(III) eating, including meal preparation and cleanup;

(iii) assistance with ~~homemaker type~~home services that may include shopping, laundry service, cleaning, and seasonal chores;

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

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

~~Services Assistance~~APSA includes assistance with health maintenance activities that may include:

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

(ii) ~~remove~~removing external catheters, ~~inspect~~inspecting skin, and reapplication of same;

(iii) ~~administer~~administering prescribed bowel program, including use of suppositories and sphincter stimulation, and enemas ~~(Pre-packaged only) with members~~(pre-packaged only without contraindicating rectal or intestinal conditions;

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

(v) ~~use~~using a lift for transfers;

(vi) manually ~~assist~~assisting with oral medications;

(vii) ~~provide~~providing passive range of motion (non-resistive flexion of joint) therapy, delivered in accordance with the service plan ~~of care,~~ unless contraindicated by underlying joint pathology;

(viii) ~~apply~~applying non-sterile dressings to superficial skin breaks or abrasions; and

(ix) ~~use Universal~~using universal precautions as defined by the ~~Center~~Centers for Disease Control and Prevention.

(D) ~~The service FinancialManagement Services~~FMS are program administrative services provided to participating CD-PASS ~~employer/members~~members/employers by ~~the OKDHS/ASD~~DHS AS. ~~Financial Management Services~~FMS are ~~employer related~~employer-related assistance that provides Internal Revenue Service (IRS) fiscal reporting agent and other financial management tasks and functions including, but not limited to:

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

(ii) other employer related payment disbursements as agreed to with the member/employer and in accordance with the member/employer's~~Individual Budget Allocation~~individual budget allocation;

(iii) responsibility for obtaining criminal and abuse registry background checks~~, on behalf of the member,~~ on prospective hires for PSAs or APSAs on the member/employer's behalf;

(iv) ~~providing to the member, as needed, assistance with employer related cognitive tasks, decision-making and specialized skills that may include assistance with Individual Budget Allocation planning and support for making decisions including training and providing reference material and consultation regarding employee management tasks such as recruiting, hiring, training and supervising the member's Personal Services Assistant or Advanced Personal Services Assistant~~ providing orientation and training regarding employer responsibilities, as well employer information and management guidelines, materials, tools and staff consultant expertise to support and assist the member in successfully performing employer-related functions; and

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

(E) The ~~service of Personal Services Assistance~~PSA service is billed per 15-minute unit of service. The number of units of PSA a member may receive is limited to the number of units approved on the ~~Service Plan~~service plan.

(F) The ~~service of Advanced Personal Services Assistance~~APSA service is billed per 15-minute unit of service. The number of units of APSA a member may receive is limited to the number of units approved on the ~~Service Plan~~service plan.

(17) ~~**Institution Transition Services**~~ **Institutional transition services**.

(A) ~~Institution Transition Services~~Institutional transition services are those services ~~that are~~ necessary to enable ~~an individual~~a member to leave the institution and receive necessary support through ADvantage ~~waiver~~Waiver services in ~~their~~his or her home and~~/or in the~~ community.

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

(i) ~~Institution Transition Case Management~~Institutional transition case management services are prior authorized and billed per 15-minute unit of service using the appropriate HCPC procedure code and modifier associated with the location of residence of the member served ~~as described in~~per OAC 317:30-5-763(1)(C).

(ii) A unique modifier code is used to distinguish ~~Institution Transition Case Management~~transitional case management services from regular ~~Case Management~~case management services.

(C) Institutional ~~Transition Services~~transition services may be authorized and reimbursed ~~under the following~~per the conditions~~:~~in (i) through (iv).

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

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

(iii) Institutional ~~Transition Services~~transition services are provided to the ~~individual~~member within 180 calendar-days of discharge from the institution~~;~~.

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

(D) ~~If~~When the member ~~has received Institution Transition Services~~receives institutional transition services but fails to enter the ~~waiver~~Waiver, any ~~Institution Transition Services~~institutional transition services provided are not reimbursable.

(18) **Assisted ~~Living Services~~living services**.

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

to and from medical appointments. Services, except for planned programs for socialization, activities, and exercise, are to meet the member's specific needs ~~of the participant~~ as determined through the individualized assessment and documented on the ~~participant's~~member's service plan.

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

(C) ADvantage ~~Assisted Living~~ALS required policies for ~~Admission/Termination~~admission and termination of services and definitions.

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

(I) rental unit availability;

(II) the compatibility of the ~~participant~~member with other residents; ~~and~~

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

(IV) restrictions initiated by statutory limitations.

(ii) The ALC may specify the number of units the provider is making available to service ADvantage ~~participants~~members. The number of rental units available to service the ADvantage participants may be altered based upon written request from the provider and acceptance by the ADvantage Administration (AA).

(iii) Mild or moderate, cognitive impairment of the applicant is not a justifiable reason to deny ALC admission. Centers are required to specify whether

they are able to accommodate ~~individuals~~members who have behavior problems or wander. Denial of admission due to a determination of incompatibility must be approved by the case manager and the ADvantage Administration (AA). Appropriateness of placement is not a unilateral determination by the ALC. The ADvantage ~~Case Manager~~case manager, the member, ~~and/~~or member's designated representative, and the ALC in consultation determine the appropriateness of placement.

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

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

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

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

(III) Arrange or coordinate transportation to and from medical appointments. The ALC must assist the member with accessing transportation for integration into the community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, and control his

or her personal resources and receive services in the community to the same degree of access as residents not receiving ADvantage services.

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

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

(viii) ~~Under~~Per OAC 310:663-1-2, "personal care" is defined as "assistance with meals, dressing, movement, bathing or other personal needs or maintenance, or general supervision of the physical and mental well-being of a person~~.~~, and includes assistance with toileting." For ADvantage ~~Assisted Living Services~~ALS, assistance with "other personal needs" in this definition includes assistance with ~~toileting,~~ grooming and transferring. ~~and the~~The term "assistance" is clarified to mean hands-on help, in addition to supervision.

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

(x) ~~Definition of Inappropriate ALC Placement.~~ Placement, or continued placement of an ADvantage

member in an ALC is inappropriate if any one or more of the ~~following~~ conditions in (I) through (IV) exist~~:~~.

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

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

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

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

(xi) Termination of residence when inappropriately placed. Once a determination is made that a member is inappropriately placed, the ~~assisted living center~~ALC must inform the member and~~/or~~ the member's representative, if any, the AA and the member's ADvantage ~~Case Manager~~case manager. The ALC must develop a discharge plan in consultation with the member, the member's ~~support network~~representative, the ADvantage ~~Case Manager~~case manager, and the AA. The ALC and ~~Case Manager~~case manager must ensure ~~that~~ the discharge plan includes strategies for providing increased services, when appropriate, to minimize risk and meet the higher care needs of members ~~awaiting a move~~transitioning out of the ALC, ~~if~~when the reason for discharge is inability to meet member needs. If voluntary termination of residency is not arranged, the ALC must provide written notice to the member and to the member's representative, with a copy to the member's ADvantage ~~Case Manager~~case manager and the AA, giving the member 30 calendar-days, written notice of

the ALC's intent to terminate the residency agreement and move the member to ~~a more~~an appropriate care provider. The 30 calendar-day requirement ~~shall~~must not apply when emergency termination of the residency agreement is mandated by the member's immediate health needs or when the termination of the residency agreement is necessary for the physical safety of the member or other ALC residents ~~of the ALC~~. The written notice of involuntary termination of residency for reasons of inappropriate placement must include:

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

(II) the notice date ~~of the notice~~;

(III) the date notice was given to the member and the member's representative, the ADvantage Case Manager, and the AA;

(IV) the date ~~by which~~ the member must leave ~~the~~ ALC; and

(V) notification of appeal rights and the process for submitting appeal of termination of Medicaid ~~Assisted Living services~~ALS to ~~the~~ OHCA.

(D) ADvantage ~~Assisted Living Services~~ALS provider standards in addition to licensure standards.

(i) Physical environment.

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

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

~~(II)~~(III) The ALC must provide each rental unit with a means for each member ~~resident~~ to control the

temperature in the ~~individual living~~residential unit through the use of a damper, register, thermostat, or other reasonable means that is under the control of the ~~resident~~member and that preserves ~~resident~~ privacy, independence, and safety, provided that the Oklahoma State Department of Health may approve an alternate means based on documentation that the design of the temperature control is appropriate to the special needs of each member who has an alternate temperature control.

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

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

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

~~(VI)~~(VII) The member is responsible for furnishing ~~their~~the rental unit. If a member is unable to supply basic furnishings defined as a bed, dresser, nightstand, chairs, table, trash can, and lamp, or if ~~the~~ member supplied furnishings pose a health or safety risk, the member's ~~Case Manager~~ADvantage case manager in coordination with the ALC must assist the member in obtaining basic furnishings for the rental unit. The member must have the freedom to furnish and decorate the rental unit within the scope of the lease or residency agreement.

~~(VII)~~(VIII) The ALC must meet the requirements of all applicable federal and state laws and regulations including, but not limited to, ~~the~~ state and local sanitary codes, state building and fire

safety codes, and laws and regulations governing use and access by persons with disabilities.

~~(VIII)~~ (IX) The ALC must ensure the design of common areas accommodates the special needs of ~~their~~the resident population and that the rental unit accommodates the special needs of the ~~individual~~member in compliance with ~~ADA Accessibility Guidelines~~the Americans with Disabilities Act accessibility guidelines per~~(28 CFR Part 36 Appendix A)~~28 Code of Federal Regulations, Part 36, Appendix A, at no additional cost to the member.

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

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

(XII) The ALC must provide the member with the right to have visitors of his or her choosing at any time. Overnight visitation is allowed, but may be limited by the ALC to the extent to which a visitor may stay overnight.

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

(ii) Sanitation.

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

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

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

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

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

(iii) Health and Safety.

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

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

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

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

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

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

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

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

(IX) The ALC must adopt safe practices for the preparation and delivery of meals~~;~~.

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

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

(iv) Staff to resident ratios.

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

(II) The ALC must ensure ~~that~~ staffing is sufficient to meet the needs of the ADvantage Program ~~residents~~members in accordance with each ~~individual's~~member's ADvantage ~~Service Plan~~service plan.

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

(v) Staff training and qualifications.

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

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

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

(vi) Staff supervision.

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

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

(vii) Resident rights.

(I) The ALC must provide to each member and each member's representative, at the time of admission, a copy of the resident statutory rights listed in ~~O.S. 63-1-1918~~Section 1-1918 of Title 63 of the Oklahoma

Statutes (O.S. 63-1-1918) amended to include additional rights and the clarification of rights as listed in the ADvantage ~~assisted living~~ Member Assurances. A copy of ~~the~~ resident rights must be posted in an easily accessible, conspicuous place in the facility. The facility must ensure that ~~its~~ staff is familiar with~~,~~ and observes, the resident rights.

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

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

(viii) Incident reporting.

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

(II) Incidents requiring report by licensed ~~Assisted Living Centers~~ALC are those defined by ~~the Oklahoma State Department of Health (OSDH) in~~OSDH per OAC 310:663-19-1 and listed on the AA Critical Incident Reporting Form.

(III) Reports of incidents must be made to the member's ADvantage ~~Case Manager~~case manager and to the AA via facsimile or mail within one business day of the reportable incident's discovery utilizing the

AA Critical Incident Reporting form. If required, a follow-up report of the incident must ~~will~~ be submitted via facsimile or mail to the member's ADvantage ~~Case Manager~~case manager and to the AA.~~,~~ The follow up report must be submitted within five business days ~~after~~of the incident. The final report must be filed with the member's ADvantage ~~Case Manager~~case manager and ~~to~~ the ~~ADvantage Administration~~AA when the ~~full~~ investigation is complete, not to exceed ~~ten~~10 business days after the incident.

(IV) Each ALC having reasonable cause to believe that a member is suffering from abuse, neglect, exploitation, or misappropriation of member property must make a report to ~~either the Oklahoma Department of Human Services , the office of the district attorney in the county in which the suspected abuse, neglect, exploitation, or property misappropriation occurred, or the local municipal police department or sheriff's department~~DHS Adult Protective Services (APS) as soon as the person is aware of the situation~~, in accordance with Section 10-104.A of Title 43A of Oklahoma Statutes~~per O.S. 43A § 10-104.A. Reports ~~should~~are also ~~be~~ made to ~~the~~ OSDH, as appropriate, ~~in accordance with the ALC's~~per ALC licensure rules.

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

(ix) Provision of or arrangement for necessary health services.

(I) The ALC must arrange or coordinate transportation for members to and from medical appointments.

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

(E) ~~Assisted Living Services~~ALS are billed per diem of service for days covered by the ADvantage member's service plan and during which the ~~Assisted Living Services~~ALS provider is responsible for providing ~~Assisted Living servicedas needed by~~ ALS for the member. The per diem rate for ~~the~~ ADvantage assisted living services for a member ~~will be~~is one of three per diem rate levels based ~~upon individual~~on a member's need for ~~service-~~type of, intensity of, and frequency of service to address member ~~ADL/IADL~~ADLs, IADLs, and health care needs. The rate level is based ~~upon (UCAT)~~on the Universal Comprehensive Assessment Tool (UCAT) assessment by the member's ADvantage ~~Case Manager~~case manager employed by a ~~Case Management~~case management agency ~~that is~~ independent of the ~~Assisted Living Services~~ALS provider. The determination of the appropriate per diem rate is made by the AA clinical review staff.

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 16, 2015

The proposed policy is an Emergency Rule. This proposal is scheduled to be presented to the Medical Advisory Committee (MAC) on November 19, 2015 and the OHCA Board of Directors on December 10, 2015.

Reference: APA WF # 15-14B

SUMMARY:
ADvantage Policy is revised to comply with 42 CFR 441.301 regarding conflict of interest provisions for case management services. These policy revisions are necessary as the regulation states providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual, must not provide case management services or develop the person centered service plan. The State is currently out of compliance. Without the recommended changes, the State may be in risk of losing federal funding.

LEGAL AUTHORITY
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, 42 CFR 441.301, 441710, and 441.730.

RULE IMPACT STATEMENT:
TO: Tywanda Cox
Health Policy

FROM: Princiss Rockmore
Health Policy

SUBJECT: Rule Impact Statement
APA WF # 15-14B

A. Brief description of the purpose of the rule:

ADvantage Policy is revised to comply with 42 CFR 441.301 regarding conflict of interest provisions for case management services. These policy revisions are necessary as the regulation

states providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual, must not provide case management services or develop the person centered service plan. The State is currently out of compliance. Without the recommended changes, the State may be in risk of losing federal funding.

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:

Persons affected by the proposed rule change include ADvantage Home and Community Based (HCBS) waiver members whom receive case management and other HBCS services through the same contracted provider. Additionally, providers of HCBS who provide both case management and other HCBS for the same member will also be affected. The member must exercise their freedom of choice to comply with the final rule.

Providers will potentially experience a decline in revenue as members may choose to receive Home and Community Based Services from another contracted provider.

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

Providers may benefit by receiving additional members. Members may benefit from the proposed change as the rule is designed to ensure conflict-free case management.

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:

Providers may receive additional revenue due to an increase in member participation. However, some providers may see a decline in revenue due to members choosing to receive Home and Community Based Services from other contracted providers.

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 Agency has determined that there are no expected costs to OHCA or other agencies as a result of the proposed rules nor is there an anticipated effect on current State revenues.

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 will require separation of case management and other Home and Community Based Services; however, access is still available to all waiver members who wish to continue utilizing Home and Community Based Services. Therefore, the

proposed rule should have no effects on 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 State is currently out of compliance with the Center for Medicare and Medicaid Services (CMS) and may be in risk of losing federal funding.

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

The rule impact statement was prepared August 12, 2015.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. ADVANTAGE PROGRAM MEDICAL ELIGIBILITY DETERMINATION
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 85. ADVANTAGE PROGRAM WAIVER SERVICES

317:30-5-763. Description of services

Services included in the ADvantage Program are ~~as follows~~:

(1) Case ~~Management~~management.

(A) Case ~~Management~~management services ~~are services that~~ assist a member in gaining access to medical, social, educational, or other services, regardless of payment source ~~of services,~~ that may benefit the member in maintaining health and safety. Case managers initiate and oversee necessary assessments and reassessments to establish or reestablish ~~waiver~~ Waiver program eligibility. Case managers develop the member's comprehensive service plan ~~of care~~, listing only services ~~which are~~ necessary to prevent institutionalization of the member, as determined through the assessments. Case managers initiate the addition of necessary services or deletion of unnecessary services, as dictated by the member's condition and available support. Case managers monitor the member's condition to ensure delivery and appropriateness of services and initiate service plan ~~of care~~ reviews. Case managers submit an individualized Form 02CB014, Services Backup Plan, on all initial service plans, annually at reassessment, and on updates as appropriate throughout the year, reflecting risk factors and measures in place to minimize risks. ~~If~~When a member requires hospital or

nursing facility services, the case manager assists the member in accessing institutional care and, as appropriate, periodically monitors the member's progress during the institutional stay, and helps the member transition from institution to home by updating the service plan, and preparing services to start on the date the member is discharged from the institution. Case Managersmanagers must meet ADvantage Program minimum requirements for qualification and training prior to providing services to ADvantage members. Providers of ADvantage services for the member, or for those who have an interest in, or are employed by an ADvantage provider for the member must not provide case management or develop the person-centered service plan, except when the AA demonstrates the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area, also provides other ADvantage services. Prior to providing services to members receiving Consumer-Directed Personal Assistance Services and Supports (CD-PASS), Case Managerscase manager supervisors and case managers are required to receive training and demonstrate knowledge regarding the CD-PASS service delivery model, "Independent Living Philosophy," and demonstrate competency in Person-centered planning person-centered planning competency.

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

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

(ii) Ancillaryancillary activities, such as clerical tasks likeincluding, but not limited to, mailing, copying, filing, faxing, drivedriving time, or supervisory/and administrative activities that are not billable case management activities, . and although the The administrative cost of these activities and other normal and customary business overhead costs have beenare included in the reimbursement rate for billable activities.

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

(i) Standard Raterate: Case Managementmanagement services are billed using a Standardstandard rate for reimbursement for billable service activities provided

to a member who resides in a county with a population density greater than 25 persons per square mile.

(ii) Very ~~Rural/Difficult Service Area Rate~~rural/difficult service area rate: Case ~~Management~~management services are billed using a ~~Very Rural/Difficult Service Area~~very rural/difficult service area rate for billable service activities provided to a member who resides in a county with a population density equal to, or less than 25 persons per square mile. ~~An exception would be~~Exceptions are services to members ~~that~~who reside in Oklahoma Department of Human Services~~/~~ Aging Services ~~Division (OKDHS/ASD)~~(DHS AS) identified zip codes in Osage County adjacent to the metropolitan areas of Tulsa and Washington Counties. Services to these members are prior authorized and billed using the ~~Standard~~standard rate.

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

(2) Respite.

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

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

(C) ~~Facility-Based Extended Respite~~Facility-based extended respite is filed for a per diem rate ~~if~~when provided in ~~Nursing Facility~~a nursing facility. Extended ~~Respite~~respite must be at least eight hours in duration.

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

(3) Adult ~~Day Health Care~~ day health care.

(A) Adult ~~Day Health Care~~day health care is furnished on a regularly scheduled basis for one or more days per week in an outpatient setting. It provides both health and social services ~~which are~~ necessary to ensure the member's optimal functioning ~~of the member~~. Physical, occupational, and~~/or~~ speech therapies ~~may~~are only ~~be~~ provided as an enhancement to the basic ~~Adult Day Health Care~~adult day health care service when authorized by the service plan ~~of care~~ and are billed as a separate procedure. Meals provided as part of this service do not constitute a full nutritional regimen. Personal ~~Care~~care service enhancement in ~~Adult Day Health Care~~adult day health care is assistance in bathing, ~~and/or~~ hair ~~washing~~care, or laundry service, authorized by the service plan ~~of care~~ and billed as ~~a~~ separate ~~procedure~~procedures. Most assistance with activities of daily living (ADL), such as eating, mobility, toileting, and nail care~~,~~ are ~~services that are~~ integral services to ~~the Adult Day Health Care~~adult day health care service and are covered by the ~~Adult Day Health Care~~adult day health care basic reimbursement rate. Assistance with bathing, hair care, or laundry service is not a usual and customary adult day health care service. Enhanced personal care in adult day health care for assistance with bathing, hair care, or laundry ~~will be~~service is authorized when an ADvantage ~~waiver~~Waiver member who uses adult day health care requires assistance with bathing, hair care, or laundry service to maintain his or her health and safety.

(B) Adult ~~Day Health Care~~day health care is a 15-minute unit of service. No more than ~~8~~eight hours, ~~(~~32 units~~)~~, are authorized per day. The number of units of service a member may receive is limited to the number of units approved on the member's approved service plan ~~of care~~.

(C) Adult ~~Day Health Care Therapy Enhancement~~day health care therapy enhancement is a maximum of one session unit per day ~~unit~~ of service.

(D) Adult ~~Day Health Personal Care Enhancement~~day health personal care enhancement is a maximum of one unit per day ~~unit~~ of bathing, hair care, or laundry service.

(4) Environmental ~~Modifications~~modifications.

(A) Environmental ~~Modifications~~modifications are physical adaptations to the home, required by the member's service plan ~~of care, which~~that are necessary to ensure the

health, welfare, and safety of the ~~individual~~member~~,~~ or ~~which~~ enable the ~~individual~~member to function with greater independence in the home and that without ~~which~~such, the member would require institutionalization. Adaptations or improvements to the home ~~which are~~ not of direct medical or remedial benefit to the ~~waiver~~Waiver member are excluded.

(B) All services require prior authorization.

(5) Specialized ~~Medical Equipment~~medical equipment and ~~Supplies~~supplies.

(A) Specialized ~~Medical Equipment~~medical equipment and ~~Supplies~~supplies are devices, controls, or appliances specified in the service plan ~~of care, which~~that enable members to increase ~~their abilities~~his or her ability to perform ~~activities of daily living~~ADLs, or to perceive, control, or communicate with the environment in which they live. ~~Also included, are items necessary~~Necessary items for life support, ancillary supplies, and equipment necessary ~~to~~for the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid state plan are also included. This service excludes any equipment and/or supply items ~~which that are~~ not of direct medical or remedial benefit to the ~~waiver~~Waiver member. This service is necessary to prevent institutionalization.

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

(6)Advanced ~~Supportive/Restorative Assistance~~supportive/restorative assistance.

(A) Advanced ~~Supportive/Restorative Assistance~~supportive/restorative assistance services are maintenance services used to assist a member who has a chronic, yet stable~~,~~ condition. These services assist with ~~activities of daily living which~~ADLs that require devices and procedures related to altered body functions. ~~This service is~~These services are for

maintenance only and ~~is~~are not utilized as ~~a~~ treatment ~~service~~services.

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

(7) Nursing.

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

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

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

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

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

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

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

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

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

(IV) ~~providing~~provide nail care for the ~~diabetic~~ member with diabetes or member ~~with~~who has circulatory or neurological compromise;

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

(C) Nursing service ~~can be billed for~~includes interdisciplinary team planning and recommendations for the member's service plan development and/or assessment/evaluation ~~services~~, or~~,~~ for other services

within the scope of the Oklahoma Nursing Practice Act, including private duty nursing. Nursing services are billed per 15-minute unit of service. A specific procedure code is used to bill for interdisciplinary team planning and recommendations for the member's service plan and for performing assessment/evaluations, ~~assessment/evaluation/service plan development nursing services and other~~another procedure ~~codes are~~code is used to bill for all other authorized nursing services. A maximum of eight units per day of nursing for ~~assessment / evaluation and/or~~ service plan development and assessment evaluation are allowed. An agreement by a provider to perform a nurse evaluation is also an agreement~~,~~ to provide ~~the nurse assessment identified in~~ the Medicaid in-home care services for which the provider is certified and contracted. Reimbursement for a nurse evaluation is denied ~~if~~when the provider that produced the nurse evaluation fails to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted.

(8) Skilled ~~Nursing Services~~nursing services.

(A) Skilled ~~Nursing Services~~nursing services listed in the service plan ~~of care which~~that are within the scope of the ~~State's~~state's Nurse Practice Act and are ordered by a licensed ~~medical~~ physician, osteopathic physician, physician assistant, or an advanced practice nurse and are provided by ~~a registered professional nurse, or licensed practical or vocational nurse~~an RN, or an LPN or LVN under the supervision of a registered nurse, licensed to practice in the ~~State~~state. Skilled ~~Nursing~~nursing services provided in the member's home or other community setting are services requiring the specialized skills of a licensed nurse. The scope and nature of these services are intended for treatment of a disease or a medical condition and are beyond the scope of ADvantage ~~Nursing Services~~nursing services. These intermittent nursing services are targeted toward a prescribed treatment or procedure that must be performed at a specific time or other predictable rate of occurrence. ~~It is the responsibility of the RN to contact~~The RN contacts the member's physician to obtain ~~any~~ necessary information or orders pertaining to the member's care ~~of the member~~. ~~If~~When the member has an ongoing need for service activities~~, which require~~requiring more or less units than authorized, the RN ~~shall~~must recommend, in writing, that the ~~Plan of Care~~service plan be revised.

(B) Skilled ~~Nursing~~nursing services are provided on an intermittent or part-time basis, and billed ~~in units of~~ per15-minute ~~increments~~units of service. ~~ADvantage~~ Skilled ~~Nursing~~nursing services are provided when nursing services are not available through Medicare or other sources or when SoonerCare plan nursing services ~~furnished under SoonerCare plan limits~~ are exhausted. Amount, frequency, and duration of services are prior-authorized in accordance with the member's service plan.

(9) Home ~~Delivered Meals~~ delivered meals.

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

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

(10) Occupational ~~Therapy Services~~therapy services.

(A) Occupational ~~Therapy~~therapy services are ~~those~~ services that increase functional independence by enhancing the development of adaptive skills and performance capacities of members with physical disabilities and related psychological and cognitive impairments. Services are provided in the member's home and are intended to help the member achieve greater independence enabling him or her to reside and participate in the community. Treatment involves the therapeutic use of self-care, work, ~~and~~ play activities, and may include modification of the tasks or environment to enable the member to achieve maximum independence, prevent further disability, and maintain health. Under a physician's order, a licensed occupational therapist evaluates the member's rehabilitation potential and develops an appropriate written, therapeutic regimen. The regimen

utilizes paraprofessional occupational therapy assistant services, within the ~~limits~~limitations of ~~their~~his or her practice, working under the supervision of ~~the~~a licensed occupational therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services~~, where~~when appropriate. The occupational therapist ~~will ensure~~ensures monitoring and documentation of the member's rehabilitative progress and ~~will report~~reports to the member's case manager and physician to coordinate the necessary addition ~~and/~~or deletion of services, based on the member's condition and ongoing rehabilitation potential.

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

(11) Physical ~~Therapy Services~~therapy services.

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

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

(12) Speech and ~~Language Therapy Services~~language therapy services.

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

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

(13) Hospice ~~Services~~services.

(A) Hospice ~~is~~services are palliative and~~/or~~ comfort care provided to the member and ~~his/her~~his or her family when a physician certifies ~~that~~ the member has a terminal illness, ~~and has six months or less to live~~with a life expectancy of six months or less, and orders hospice care. ADvantage ~~Hospice Care~~hospice care is authorized for a six-month period, and requires ~~a~~ physician certification of a terminal illness and orders of hospice care. ~~If~~When the member requires more than six months of hospice care, a physician or nurse practitioner must have a face-to-face visit with the member ~~thirty~~30-calendar days prior to the initial hospice authorization end date, and re-certify that the member has a terminal illness, ~~and~~ has six months or less to live, and orders additional hospice care. After the initial authorization period, additional periods of ADvantage ~~Hospice~~hospice may be authorized for a

maximum of 60-calendar day increments with physician certification that the member has a terminal illness and ~~has~~ six months or less to live. A member's service plan that includes hospice care must comply with ~~waiver~~Waiver requirements to be within total service plan cost limits.

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

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

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

(14) ADvantage ~~Personal Care~~ personal care.

(A) ADvantage ~~Personal Care~~ personal care is assistance to a member in carrying out ~~activities of daily living~~ ADLs, such as bathing, grooming, and toileting~~,~~ or in carrying out instrumental activities of daily living (IADLs), such

as preparing meals and ~~doing~~ laundry service, to ~~assure personal health and safety of the individual~~ ensure the member's personal health and safety, or to prevent or minimize physical health regression or deterioration. Personal ~~Care~~ care services do not include service provision of a technical nature, ~~i.e.~~ such as tracheal suctioning, bladder catheterization, colostomy irrigation, ~~and~~ or the ~~operation/maintenance~~operation and maintenance of equipment of a technical nature.

(B) ADvantage ~~Home Care Agency Skilled Nursing~~home care agency skilled nursing staff working in coordination with an ADvantage ~~Case Manager~~case manager are responsible for the development and monitoring of the member's ~~Personal Care plan~~personal care services.

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

(15) Personal ~~Emergency Response System~~ emergency response system.

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

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

(ii) member lives alone and ~~has no~~without a regular caregiver, paid or unpaid, and therefore is left alone for long periods of time;

(iii) member demonstrates the capability to comprehend the purpose of~~,~~ and activate the PERS;

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

(v) member has a disease management plan to implement medical and health interventions that reduce the

possibility of falls by managing the member's underlying medical condition causing the falls; and~~,~~

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

(B) PERS services are billed using the appropriate HCPC procedure code for installation, monthly service, or PERS purchase ~~of PERS~~. All services are prior-authorized in accordance with the ADvantage approved service plan ~~of care~~.

(16) Consumer-Directed Personal Assistance Services and Support (CD-PASS).

(A) ~~Consumer-Directed Personal Assistance Services and Supports~~ CD-PASS are ~~Personal Services Assistance~~personal services assistance (PSA) and ~~Advanced Personal Services Assistance~~advanced personal services assistance (APSA) that enable ~~an individual~~a member in need of assistance to reside in their home and ~~in the~~ community of their choosing rather than in an institution; and to carry out functions of daily living, self-care, and mobility. CD-PASS services are delivered as authorized on the service plan. The member becomes the employer of record and employs the ~~Personal Services Assistant (~~PSA~~)~~ and~~/or~~ the ~~Advanced Personal Services Assistant (~~APSA~~)~~. ~~and~~The member is responsible, with assistance from ADvantage Program Administrative Financial Management Services (FMS), for ensuring ~~that~~ the employment complies with ~~State~~ state and ~~Federal Labor Law~~federal labor law requirements. The member/employer may designate an adult family member or friend, ~~an individual~~ who is not a PSA or APSA to the member, as an "authorized representative" to assist in executing ~~these~~the employer functions. The member/employer:

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

(ii) ~~provides~~is solely responsible to provide instruction and training to the PSA or APSA on tasks ~~to be done~~ and works with the ~~Consumer Directed Agent/Case Manager~~consumer directed agent/case manager (CDA) to obtain ADvantage skilled nursing services assistance with training, when necessary. Prior to performing an ~~Advanced Personal Services Assistance~~APSA task for the first time, the APSA must demonstrate competency in the tasks in an on-the-job training session conducted by the member and the member must document the attendant's competency in performing each task in the ~~ASPA's~~APSA's personnel file;

(iii) determines where and how the PSA or APSA works, hours of work, what is to be accomplished and,

within ~~Individual Budget Allocation~~individual budget allocation limits, wages to be paid for the work;

(iv) supervises and documents employee work time; and~~,~~

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

(B) The ~~service~~services the ~~Personal Services Assistance~~PSA may provide include:

(i) assistance with mobility and ~~with transfer~~transferring in and out of bed, wheelchair, or motor vehicle, or ~~both~~all;

(ii) assistance with routine bodily functions that may include:

(I) bathing and personal hygiene;

(II) dressing and grooming; and

(III) eating, including meal preparation and cleanup;

(iii) assistance with ~~homemaker type~~home services that may include shopping, laundry service, cleaning, and seasonal chores;

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

(C) ~~Advanced Personal Services Assistance are maintenance services provided to assist~~An APSA provides assistance with ADLs to a member with a stable, chronic condition ~~with activities of daily living~~, when such assistance requires devices and procedures related to altered body function if such activities, in the opinion of the attending physician or licensed nurse, may be performed if the ~~individual~~member were physically capable, and the procedure may be safely performed in the home. ~~Advanced Personal Services Assistance is a~~Services provided by the APSA are maintenance ~~service~~services and ~~should~~are never ~~be~~ used as ~~a~~ therapeutic treatment. Members who develop medical complications requiring skilled nursing services while receiving ~~Advanced Personal Services Assistance~~APSA services ~~should be~~are referred to ~~their~~his or her attending physician, who ~~may, if~~when

appropriate, order home health services. ~~The service of Advanced Personal Services Assistance~~APSA includes assistance with health maintenance activities that may include:

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

(ii) ~~remove~~removing external catheters, inspect skin, and reapplication of same;

(iii) ~~administer~~administering prescribed bowel program, including use of suppositories and sphincter stimulation, and enemas (~~Pre~~pre-packaged only) ~~with members~~ without contraindicating rectal or intestinal conditions;

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

(v) ~~use~~using a lift for transfers;

(vi) manually ~~assist~~assisting with oral medications;

(vii) ~~provide~~providing passive range of motion (non-resistive flexion of joint) therapy, delivered in accordance with the service plan ~~of care,~~ unless contraindicated by underlying joint pathology;

(viii) ~~apply~~applying non-sterile dressings to superficial skin breaks or abrasions; and

(ix) ~~use Universal~~using universal precautions as defined by the ~~Center~~Centers for Disease Control and Prevention.

(D) ~~The service Financial Management Services~~FMS are program administrative services provided to participating CD-PASS ~~employer/~~member/employers by ~~the OKDHS/ASD~~DHS AS. ~~Financial Management Services~~FMS are employer-related assistance that provides Internal Revenue Service (IRS) fiscal reporting agent and other financial management tasks and functions including, but not limited to:

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

(ii) other employer related payment disbursements as agreed to with the member/employer and in accordance with the member/employer's ~~Individual Budget Allocation~~individual budget allocation;

(iii) responsibility for obtaining criminal and abuse registry background checks~~, on behalf of the member,~~ on prospective hires for PSAs or APSAs on the member/employer's behalf;

(iv) ~~providing to the member, as needed, assistance with employer related cognitive tasks, decision-making and specialized skills that may include assistance with Individual Budget Allocation planning and support for making decisions including training and providing reference material and consultation regarding employee management tasks such as recruiting, hiring, training and supervising the member's Personal Services Assistant or Advanced Personal Services Assistant~~ providing orientation and training regarding employer responsibilities, as well employer information and management guidelines, materials, tools and staff consultant expertise to support and assist the member in successfully performing employer-related functions; and

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

(E) The ~~service of Personal Services Assistance~~PSA service is billed per 15-minute unit of service. The number of units of PSA a member may receive is limited to the number of units approved on the ~~Service Plan~~service plan.

(F) The ~~service of Advanced Personal Services Assistance~~APSA service is billed per 15-minute unit of service. The number of units of APSA a member may receive is limited to the number of units approved on the ~~Service Plan~~service plan.

(17) ~~Institution Transition Services~~ Institutional transition services.

(A) ~~Institution Transition Services~~Institutional transition services are those services ~~that are~~ necessary to enable an ~~individual~~member to leave the institution and receive necessary support through ADvantage ~~waiver~~Waiver services in ~~their~~his or her home and~~/or~~ ~~in the~~ community.

(B) ~~Institution Transition Case Management Services~~Transitional case management services are services ~~as described in~~per OAC 317:30-5-763(1) required by the ~~individual's plan of care~~member and included on the member's service plan~~, which~~that are necessary to ensure the health, welfare, and safety of the ~~individual~~member, or to enable the ~~individual~~member to function with greater independence in the home, and without which, the ~~individual~~member would continue to require

institutionalization. ADvantage ~~Transition Case Management Services~~transitional case management services assist institutionalized ~~individuals~~members ~~that~~who are eligible to receive ADvantage services in gaining access to needed ~~waiver~~Waiver and other State plan services, as well as needed medical, social, educational, and other services to assist in the transition, regardless of the funding source for the services to which access is gained. ~~Transition Case Management Services~~Transitional case management services may be authorized for periodic monitoring of an ADvantage member's progress during an institutional stay~~,~~ and for assisting the member transition from institution to home by updating the service plan, including necessary ~~Institution Transition Services~~institutional transition services to prepare services and supports to be in place or to start on the date the member is discharged from the institution. ~~Transition Case Management Services~~Transitional case management services may be authorized to assist individuals that have not previously received ADvantage services, but ~~have been~~were referred by ~~the OKDHS/ASD~~ DHS AS to the ~~Case Management Provider~~case management provider for assistance in transitioning from the institution to the community with ADvantage services support.

(i) ~~Institution Transition Case Management~~Institutional transition case management services are prior authorized and billed per 15-minute unit of service using the appropriate HCPC procedure code and modifier associated with the location of residence of the member served ~~as described in~~per OAC 317:30-5-763(1)(C).

(ii) A unique modifier code is used to distinguish ~~Institution Transition Case Management~~transitional case management services from regular ~~Case Management~~case management services.

(C) Institutional ~~Transition Services~~transition services may be authorized and reimbursed ~~under the following~~per the conditions in (i) through (iv)~~:~~.

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

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

(iii) Institutional ~~Transition Services~~transition services are provided to the ~~individual~~member within 180 calendar-days of discharge from the institution~~;~~.

(iv) ~~Transition Services~~services provided while the ~~individual~~member is in the institution are ~~to be~~ claimed as delivered on the day of discharge from the institution.

(D) ~~If~~When the member ~~has received~~receives ~~Institution Transition Services~~institutional transition services but fails to enter the ~~waiver~~Waiver, any ~~Institution Transition Services~~institutional transition services provided are not reimbursable.

(18) Assisted ~~Living Services~~living services.

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

(B) The ADvantage ~~Assisted Living Services~~ALS philosophy of service delivery promotes ~~service~~ member choice, and to the greatest extent possible, ~~service~~ member control. ~~Members have~~A member has control over ~~their~~his or her living space and his or her choice of personal amenities, ~~furnishing~~furnishings, and activities in ~~their~~the residence. The ADvantage member must have the freedom to control his or her schedule and activities. The ~~Assisted Living Service~~ALS provider's documented

operating philosophy, including policies and procedures, must reflect and support the principles and values associated with the ADvantage assisted living philosophy and approach to service delivery ~~that emphasizes~~emphasizing member dignity, privacy, individuality, and independence.

(C) ADvantage ~~Assisted Living~~ALS required policies for ~~Admission/Termination~~admission and termination of services and definitions.

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

(I) rental unit availability;

(II) the compatibility of the ~~participant~~ member with other residents; ~~and~~

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

(IV) restrictions initiated by statutory limitations.

(ii) The ALC may specify the number of units the provider is making available to service ADvantage ~~participants~~members. The number of rental units available to service the ADvantage participants may be altered based upon written request from the provider and acceptance by the ADvantage Administration (AA).

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

(iv) The ALC is responsible for meeting the member's needs for privacy, ~~and~~ dignity, respect, and freedom from coercion and restraint. The ALC must optimize member's initiative, autonomy and independence in making life choices. The ALC must facilitate member choices regarding services and supports, and who

provides them. Inability to meet those needs ~~will~~ is not ~~be~~ recognized as a reason for determining ~~that~~ an ADvantage ~~participant's~~member's placement is inappropriate. The ALC agrees to provide or arrange and coordinate all of the services listed ~~in the description of assisted living center services~~ in the Oklahoma State Department of Health regulations (OAC 310:663-3-3), except for specialized services.

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

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

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

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

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

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

(viii) ~~Under~~Per OAC 310:663-1-2, "personal care" is defined as "assistance with meals, dressing, movement, bathing or other personal needs or maintenance, or general supervision of the physical and mental well-being of a person, and includes assistance with toileting." ~~.~~ For ADvantage ~~Assisted Living Services~~ALS, assistance with "other personal needs" in this definition includes assistance with ~~toileting,~~ grooming and transferring. ~~and the~~The term "assistance" is clarified to mean hands-on help, in addition to supervision.

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

(x) ~~Definition of Inappropriate ALC Placement.~~ Placement, or continued placement of an ADvantage member in an ALC is inappropriate if any one or more of the ~~following~~ conditions in (I) through (IV) exist~~:~~.

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

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

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

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

(xi) Termination of residence when inappropriately placed. Once a determination is made that a member is inappropriately placed, the ~~assisted living center~~ALC must inform the member and~~/or~~ the member's representative, if any, the AA and the member's ADvantage ~~Case Manager~~case manager. The ALC must develop a discharge plan in consultation with the member, the member's ~~support network~~representative, the ADvantage ~~Case Manager~~case manager, and the AA. The ALC and ~~Case Manager~~case manager must ensure ~~that~~ the discharge plan includes strategies for providing increased services, when appropriate, to minimize risk and meet the higher care needs of members ~~awaiting a move~~transitioning out of the ALC, ~~if~~when the reason for discharge is inability to meet member needs. If voluntary termination of residency is not arranged, the ALC must provide written notice to the member and to the member's representative, with a copy to the member's ADvantage ~~Case Manager~~case manager and the AA, giving the member 30 calendar-days, written notice of the ALC's intent to terminate the residency agreement and move the member to ~~a more~~an appropriate care provider. The 30 calendar-day requirement ~~shall~~must not apply when emergency termination of the residency agreement is mandated by the member's immediate health needs or when the termination of the residency agreement is necessary for the physical safety of the member or other ALC residents ~~of the ALC~~. The written notice of involuntary termination of residency for reasons of inappropriate placement must include:

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

(II) the notice date ~~of the notice~~;

(III) the date notice was given to the member and the member's representative, the ADvantage Case Manager, and the AA;

(IV) the date ~~by which~~ the member must leave ~~the~~ ALC; and

(V) notification of appeal rights and the process for submitting appeal of termination of Medicaid ~~Assisted Living services~~ALS to ~~the~~ OHCA.

(D) ADvantage ~~Assisted Living Services~~ALS provider standards in addition to licensure standards.

(i) Physical environment.

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

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

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

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

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

~~(V)~~(VI) The ALC must provide at a minimum, a kitchenette, defined as a space containing a refrigerator, adequate storage space for utensils, and a cooking appliance, ~~(~~a microwave is

acceptable~~),~~. ~~and adequate storage space for utensils.~~

~~(VI)~~(VII) The member is responsible for furnishing ~~their~~ the rental unit. If a member is unable to supply basic furnishings defined as a bed, dresser, nightstand, chairs, table, trash can, and lamp, or if ~~the~~ member supplied furnishings pose a health or safety risk, the member's ~~Case Manager~~ADvantage case manager in coordination with the ALC must assist the member in obtaining basic furnishings for the rental unit. The member must have the freedom to furnish and decorate the rental unit within the scope of the lease or residency agreement.

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

~~(VIII)~~(IX) The ALC must ensure the design of common areas accommodates the special needs of ~~their~~the resident population and that the rental unit accommodates the special needs of the ~~individual~~member in compliance with ~~ADA Accessibility Guidelines~~the Americans with Disabilities Act accessibility guidelines per ~~(~~28 ~~CFR~~Code of Federal Regulations, Part 36, Appendix A~~),~~ at no additional cost to the member.

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

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

(XII) The ALC must provide the member with the right to have visitors of his or her choosing at any time. Overnight visitation is allowed, but may be limited by the ALC to the extent to which a visitor may stay overnight.

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

(ii) Sanitation.

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

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

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

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

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

(iii) Health and Safety.

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

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

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

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

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

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

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

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

(IX) The ALC must adopt safe practices for the preparation and delivery of meals~~;~~.

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

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

(iv) Staff to resident ratios.

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

(II) The ALC must ensure ~~that~~ staffing is sufficient to meet the needs of the ADvantage Program ~~residents~~members in accordance with each ~~individual's~~member's ADvantage ~~Service Plan~~service plan.

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

(v) Staff training and qualifications.

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

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

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

(vi) Staff supervision.

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

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

(vii) Resident rights.

(I) The ALC must provide to each member and each member's representative, at the time of admission, a copy of the resident statutory rights listed in ~~O.S. 63-1-1918~~Section 1-1918 of Title 63 of the Oklahoma Statutes (O.S. 63 § 1-1918) amended to include additional rights and the clarification of rights as listed in the ADvantage ~~assisted living~~ Member Assurances. A copy of ~~the~~ resident rights must be posted in an easily accessible, conspicuous place in the facility. The facility must ensure that ~~its~~ staff is familiar with~~,~~ and observes, the resident rights.

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

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

(viii) Incident reporting.

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

(II) Incidents requiring report by licensed ~~Assisted Living Centers~~ALC are those defined by ~~the Oklahoma State Department of Health (~~OSDH~~) in~~per OAC 310:663-19-1 and listed on the AA Critical Incident Reporting Form.

(III) Reports of incidents must be made to the member's ADvantage ~~Case Manager~~case manager and to the AA via facsimile or mail within one business day

of the reportable incident's discovery utilizing the AA Critical Incident Reporting form. If required, a follow-up report of the incident must ~~will~~ be submitted via facsimile or mail to the member's ADvantage ~~Case Manager~~case manager and to the AA.~~,~~ The follow up report must be submitted within five business days ~~after~~ of the incident. The final report must be filed with the member's ADvantage ~~Case Manager~~case manager and ~~to~~ the ~~ADvantage Administration~~AA when the ~~full~~ investigation is complete, not to exceed ~~ten~~10 business days after the incident.

(IV) Each ALC having reasonable cause to believe that a member is suffering from abuse, neglect, exploitation, or misappropriation of member property must make a report to either ~~the Oklahoma Department of Human Services , the office of the district attorney in the county in which the suspected abuse, neglect, exploitation, or property misappropriation occurred~~DHS Adult Protective Services (APS) ~~or the local municipal police department or sheriff's department~~, as soon as the person is aware of the situation~~, in accordance with Section~~per ~~10-104.A of Title 43A of Oklahoma Statutes~~O.S. 43A § 10-104.A. Reports ~~should~~are also ~~be~~ made to ~~the~~ OSDH, as appropriate, ~~in accordance with the ALC's~~per ALC licensure rules.

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

(ix) Provision of or arrangement for necessary health services.

(I) The ALC must arrange or coordinate transportation for members to and from medical appointments.

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

(E) ~~Assisted Living Services~~ALS are billed per diem of service for days covered by the ADvantage member's service plan and during which the ~~Assisted Living Services~~ALS provider is responsible for providing ~~Assisted Living serviced~~ALS ~~as needed by~~for the member. The per diem rate for ~~the~~ ADvantage assisted living services for a member ~~will be~~is one of three per diem rate levels based ~~upon individual~~on a member's need for ~~service-~~type of, intensity of, and frequency of service to address member ~~ADL/IADL~~ADLs, ~~/~~IADLs~~)~~, and health care needs. The rate level is based ~~upon~~ on the Universal Comprehensive Assessment Tool (UCAT) assessment by the member's ADvantage ~~Case Manager~~case manager employed by a ~~Case Management~~case management agency ~~that is~~ independent of the ~~Assisted Living Services~~ALS provider. The determination of the appropriate per diem rate is made by the AA clinical review staff.

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 15, 2016

The proposed policy is a Permanent Rule. The proposed policy is scheduled to be presented to the Medical Advisory Committee (MAC) on January 21, 2016 and the (OHCA) Board of Directors on February 11, 2016.
Reference: APA WF 15-15

SUMMARY:
Drug Benefit — Proposed pharmacy policy changes will reflect guidance in federal law regarding included and excluded prescription drug coverage and to update the list of covered over-the-counter drugs.

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 State Plan Attachment 3.1-A, Page 5a-1.1; 42 U.S.C. 1396r-8(d)(2)

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

TO: Tywanda Cox
Health Policy

FROM: Sandra Manzo de Puebla
Health Policy

SUBJECT: Rule Impact Statement
APA WF # 15-15

A. Brief description of the purpose of the rule:

Proposed pharmacy policy changes will reflect guidance in

federal law regarding included and excluded prescription drug coverage and to update the list of covered over-the-counter drugs. This proposal will also update items within the State Plan to reflect most recent federal guidance.

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:

Pharmacies or prescribers of drugs that are not part of the covered drug benefit program will be affected by the proposed rule since the entities will not be able to prescribe non-covered drugs.

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

No classes of persons will benefit by the proposed rule. This rule should not place any cost burden on private or public entities.

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 not a probable economic impact for this proposed rule.

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:

This rule is budget neutral and will not have an impact on the OHCA budget.

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 September 18, 2015.

RULE TEXT

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 5. PHARMACIES

317:30-5-72.1. Drug benefit

OHCA administers and maintains an Open Formulary subject to the provisions of Title 42, United States Code (U.S.C.), Section 1396r-8. The OHCA covers a drug that has been approved by the Food and Drug Administration (FDA) and whose manufacturers have entered into a drug rebate agreement with the Centers for Medicare and Medicaid Services (CMS), subject to the following exclusions and limitations.

(1) The following drugs, classes of drugs, or their medical uses are excluded from coverage:

(A) Agents used to promote fertility.

(B) Agents primarily used to promote hair growth.

(C) Agents used for cosmetic purposes.

(D) Agents used primarily for the treatment of anorexia or weight gain. Drugs used primarily for the treatment of obesity, such as appetite suppressants are not covered. Drugs used primarily to increase weight are not covered unless otherwise specified.

(E) Agents that are experimental or whose side effects make usage controversial.

(F) Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or designee.

(G) Agents when used for the treatment of sexual or erectile dysfunction, unless such agents are used to treat a condition, other than sexual or erectile dysfunction, for which the agents have been approved by the Food and Drug Administration.

(2) The drug categories listed in (A) through (E) of this paragraph are covered at the option of the state and are subject to restrictions and limitations. An updated list of products in each of these drug categories is included on the OHCA's public website.

(A) Agents used for the systematic relief of cough and colds. Antihistamines for allergies or antihistamine use associated with asthmatic conditions may be covered when medically necessary and prior authorized.

(B) Vitamins and Minerals. Vitamins and minerals are not

covered except under the following conditions:

(i) prenatal vitamins are covered for pregnant women up to age 50;

(ii) fluoride preparations are covered for persons under 16 years of age or pregnant;

(iii) vitamin D, metabolites, and analogs when used to treat end stage renal disease are covered;

(iv) iron supplements may be covered for pregnant women if determined to be medically necessary;

(v) vitamin preparations may be covered for children less than 21 years of age when medically necessary and furnished pursuant to EPSDT protocol; and

(vi) some vitamins are covered for a specific diagnosis when the FDA has approved the use of that vitamin for a specific indication.

(C) Agents used for smoking cessation. A limited smoking cessation benefit is available.

(D) Coverage of non-prescription or over the counter drugs is limited to:

~~(i) Insulin, PKU formula and amino acid bars, other certain nutritional formulas and bars for children diagnosed with certain rare metabolic conditions;~~

(i) Insulin, PKU formula and amino acid bars, other certain nutritional formulas and bars for children diagnosed with certain rare metabolic conditions;

(ii) certain smoking cessation products;

(iii) family planning products;

(iv) OTC products may be covered if the particular product is both cost-effective and clinically appropriate; and

(v) prescription and non-prescription products which do not meet the definition of outpatient covered drugs, but are determined to be medically necessary.

(E) Coverage of food supplements is limited to PKU formula and amino acid bars for members diagnosed with PKU, other certain nutritional formulas and bars for children diagnosed with certain rare metabolic conditions when medically necessary and prior authorized.

(3) All covered outpatient drugs are subject to prior authorization as provided in OAC 317-30-5-77.2 and 317:30-5-77.3.

(4) All covered drugs may be excluded or coverage limited if:

(A) the prescribed use is not for a medically accepted indication as provided under 42 U.S.C. § 1396r-8; or

(B) the drug is subject to such restriction pursuant to the rebate agreement between the manufacturer and CMS.

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: February 16, 2016

The proposed policy is a Permanent Rule. This proposal is scheduled to be presented to the Medical Advisory Committee (MAC) on March 10, 2016 and the (OHCA) Board of Directors on March 26, 2016.
Reference: APA WF 15-17

SUMMARY:
Policy Revision to Modify Reimbursement Structure for Eyeglasses – Proposed policy changes will modify the reimbursement structure for eyeglasses and clarify other requirements and provisions for SoonerCare coverage of eyeglasses frames and lenses.

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:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

TO: Tywanda Cox
Health Policy

FROM: Harvey Reynolds
Health Policy

SUBJECT: Rule Impact Statement
APA WF # 15-17

A. Brief description of the purpose of the rule:

Proposed policy changes will modify the reimbursement structure of all eyeglasses frames and lenses. In addition, proposed policy changes clarify that eyeglasses meant as a backup are not covered, clarify that high-index lenses

require prior authorization and other language only changes for clarity. Proposed policy changes clarify that members can select eyeglasses with special features that exceed the SoonerCare allowable fee as long as the provider obtains signed consent from the member. The member will be responsible for the excess cost and the provider must be able to dispense standard eyeglasses for which SoonerCare would fully reimburse.

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 who currently provide and are reimbursed for eyeglasses frames and lenses will be affected by the proposed rule if a lower reimbursement rate is negotiated with the current eyeglass providers in order to achieve savings comparable to what would be achieved under a single contracted vendor.

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

SoonerCare providers will benefit from the proposed rule inasmuch as it allows members to select deluxe eyeglasses and pay the difference above what SoonerCare reimburses out of pocket. Oklahoma taxpayers will benefit from the proposed rule if a lower reimbursement rate is negotiated with the current eyeglass providers in order to achieve savings comparable to what would be achieved under a single contracted vendor, thereby spreading around scarce state dollars in a tight budget situation helping to avoid cuts to other 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:

The proposed rule may have an adverse economic impact on providers who provide eyeglasses frames and lenses if OHCA pays a lower reimbursement rate; however, the proposed rule will save state dollars in a tight budget situation helping to

avoid cuts to other services, thus having a positive impact on Oklahoma taxpayers.

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 will create a budget savings that will depend upon the terms of the contract or the reimbursement structure put in place. If the provision of eyeglasses is kept with the current providers at a lower reimbursement rate comparable to what would be achieved under a single contracted vendor, the OHCA budget savings would be between $6,500,000 and $7,000,000 per year.

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 may have an adverse effect on provider reimbursements for the providers who provide eyeglasses frames and lenses, including independent optical supply businesses which are small Oklahoma businesses, if the provision of eyeglasses is at a lower reimbursement rate.

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 are no other legal methods to achieve the purpose of the proposed

rule. Measures include multiple meetings with the Oklahoma Association of Optometric Physicians as well as a formal public comment period and tribal consultation.

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, safety or environment if the proposed rule is not implemented; however, if the proposed rule is not passed it will negatively impact the scarce OHCA budget.

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

Prepared date: December 3, 2015
Modified date: January 28, 2016; February 9, 2016

RULE TEXT

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 45. OPTOMETRISTS

317:30-5-432.1. Corrective lenses and optical supplies

(a) ~~Payment will be made for children for lenses, frames, low vision aids and certain tints when medically necessary including to protect children with monocular vision. Coverage includes one set of lenses and frames per year. Payment is limited to two glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.~~When medically necessary, payment will be made for lenses, frames, low vision aids and certain tints for children. Coverage

includes lenses and frames to protect children with monocular vision. Coverage includes two sets of non-high-index lenses and frames per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary. Payment is limited to two frames per year.

(b) Corrective lenses must be based on medical need. Medical need includes a significant change in prescription or replacement due to normal lens wear.

(c) SoonerCare provides frames when medically necessary. Frames are expected to last at least one year and must be reusable. If a lens prescription changes, the same frame must be used if possible. Payment for frames includes the dispensing fee.

(d) ~~SoonerCare reimbursement for frames or lenses represents payment in full. No difference can be collected from the patient, family or guardians.~~Providers must accept SoonerCare's payment as payment in full for services rendered, except when authorized by SoonerCare (e.g., copayments, other cost sharing arrangements authorized by the State).

(1) Providers must be able to dispense standard eyeglasses which SoonerCare would fully reimburse with no cost to the eligible member.

(2) If the member wishes to select eyeglasses with special features which exceed the SoonerCare allowable fee, the member may be billed the excess cost. The provider must obtain signed consent from the member acknowledging that they are selecting eyeglasses that will not be covered in full by SoonerCare and that they will be responsible to pay the excess cost. The signed consent must be included in the member's medical record.

(e) Replacement of or additional lenses and frames are allowed when medically necessary. The OHCA does not cover lenses or frames meant as a backup for the initial lenses/frames. Prior authorization is not required unless the number of glasses exceeds two per year. The provider must always document in the patient record the reason for the replacement or additional eyeglasses. The OHCA or its designated agent will conduct ongoing monitoring of replacement frequencies to ensure ~~guidelines are~~OHCA policy is followed. Payment adjustments will be made on claims not meeting these requirements.

(f) Bifocal lenses for the treatment of accommodative esotropia are a covered benefit. Progressive lenses, trifocals, photochromic lenses and tints for children require prior authorization and must satisfy the medical necessity standard. Polycarbonate lenses are covered for children when medically necessary. Payment is limited to two glasses per year. Any

glasses beyond this limit must be prior authorized and determined to be medically necessary.
(g) Progressive lenses, aspheric lenses, tints, coatings and photochromic lenses for adults are not compensable and may be billed to the patient.
(h) Replacement of lenses and frames due to abuse and neglect by the member is not covered.
(i) Bandage contact lenses are a covered benefit for adults and children. Contact lenses for medically necessary treatment of conditions such as aphakia, keratoconus, following keratoplasty, aniseikonia/anisometropia or albinism are a covered benefit for adults and children. Other contact lenses for children require prior authorization and must satisfy the medical necessity standard.

PART 47. OPTICAL ~~COMPANIES~~SUPPLIERS

317:30-5-450. Eligible providers

Payment can be made to optical suppliers who have a current ~~Memorandum of Agreement~~SoonerCare contract with ~~this Authority~~the OHCA.

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: February 16, 2016

The proposed policy is a Permanent Rule. This proposal is scheduled to be presented to the Medical Advisory Committee (MAC) on March 10, 2016 and the (OHCA) Board of Directors on March 24, 2016.
Reference: APA WF 15-18

SUMMARY:
Complex Rehabilitation Technology – Proposed DME policy is amended to comply with Senate Bill 494. The revisions establish focused regulations and policies for Complex Rehabilitation Technology products and services for people with complex physical disabilities.

LEGAL AUTHORITY
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; OK Senate Bill 494

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

TO: Tywanda Cox
Health Policy

FROM: Harvey Reynolds
Health Policy

SUBJECT: Rule Impact Statement
APA WF # 15-18

A. Brief description of the purpose of the rule:

Proposed DME revisions establish focused regulations and policies for Complex Rehabilitation Technology (CRT) products and services in order to comply with Senate Bill 494. The proposed revisions designate specific HCPCS billing codes as CRT, establish specific supplier standards for companies that provide CRT, restrict the provision of CRT to only qualified CRT

suppliers, and establish other requirements for the provision of CRT.

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 DMEPOS providers who supply CRT products and services, who must meet specific supplier and quality standards to provide CRT, including employing as a W-2 employee at least one qualified CRT professional, will be impacted by this proposed rule change.

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

SoonerCare members who need quality CRT products and services, training in how to use these products as well as repair of these products will benefit from this proposed 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 and there are no fee changes associated with the rule change for any 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:

There is no estimated budget impact for this rule because SoonerCare will not be adding any new billing codes nor paying for any additional services or products.

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:

The agency has taken measures to determine that there are no other legal methods to minimize compliance cost and that there are no less costly or non-regulatory method or less intrusive method to achieve the purpose of the proposed rule. Opportunities for public input are provided throughout the rulemaking process, in addition to formal public comment periods and tribal consultations.

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 benefits the public health and safety by considering the unique medical and functional needs of SoonerCare members with complex physical disabilities, thus reducing risks to the public health and safety.

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

The agency anticipates detrimental effects on the public health and safety if the proposed rule is not implemented because the unique medical and functional needs of SoonerCare members with complex physical disabilities will not be considered.

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

Prepared date: November 3, 2015
Modified date: January 28, 2016

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

317:30-5-210. Eligible providers

All eligible medical suppliers must have a current contract with the Oklahoma Health Care Authority. The supplier must comply with all applicable State and Federal laws. Effective January 1, 2011, all suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) must be accredited by a Medicare deemed accreditation organization for quality standards for DMEPOS suppliers in order to bill the SoonerCare program. OHCA may make exceptions to this standard based on the exemptions provided by the Centers for Medicare and Medicaid Services (CMS) for Medicare accreditation, if the provider is a government-owned entity, or at a provider's request and at the discretion of OHCA based on access issues and/or agency needs for SoonerCare members. Additionally, unless an exception is granted from the OHCA, all DMEPOS providers must meet the following criteria:

(1) DMEPOS providers are required to have a physical location in the State of Oklahoma, or within a designated range of the Oklahoma State border, as determined by the OHCA. The OHCA may make exceptions to this requirement if a DMEPOS provider provides a specialty item, product, or service, which is not otherwise available to SoonerCare members within the State of Oklahoma. Provider contracts for out-of-state DMEPOS providers will be reviewed on a case-by-case basis for specialty items only. The OHCA has discretion and the final authority to approve or deny any provider contract.

(2) DMEPOS providers are required to comply with Medicare DMEPOS Supplier Standards for DMEPOS provided to SoonerCare members, except the requirement to meet surety bond requirements, as specified in 42 C.F.R. 424.57(c).

(3) Complex Rehabilitation Technology (CRT) suppliers are considered DMEPOS providers. Only CRT suppliers may bill CRT procedure codes. A CRT supplier means a company or entity that:

(A) Is accredited by a recognized accrediting organization as a supplier of CRT;

(B) Is an enrolled Medicare supplier and meets the supplier and quality standards established for DME suppliers, including those for CRT, under the Medicare program;

(C) Employs as a W-2 employee at least one qualified CRT professional for each location to:

(i) Analyze the needs and capacities of complex-needs patients in consultation with qualified health care professionals;
(ii) Participate in selecting appropriate CRT items for such needs and capacities; and
(iii) Provide the complex-needs patient technology related training in the proper use and maintenance of the CRT items.
(D) Requires a qualified CRT professional be physically present for the evaluation and determination of the appropriate CRT;
(E) Has the capability to provide service and repair by qualified technicians for all CRT items it sells; and
(F) Provides written information to the complex-needs patient prior to ordering CRT as to how to access service and repair.

317:30-5-211.1. Definitions

The following words and terms, when used in this Part, have the following meaning, unless the context clearly indicates otherwise.

"**Adaptive equipment**" means devices, aids, controls, appliances or supplies of either a communication or adaptive type, determined necessary to enable the person to increase his or her ability to function in a home and community based setting or private Intermediate Care Facilities for Individuals with Intellectual Disabilities (IFC/IID) with independence and safety.

"**Basic activities of daily living**" means a series of activities performed on a day-to-day basis that are necessary to care for oneself (e.g., personal hygiene, dressing, eating, maintaining continence and transferring).

"**Capped rental**" means monthly payments for the use of the Durable Medical Equipment (DME) for a limited period of time not to exceed 13 months. Items are considered purchased after 13 months of continuous rental.

"**Certificate of medical necessity (CMN)**" means a certificate required to help document the medical necessity and other coverage criteria for selected items. Those items are defined in this Chapter. The physician's certification must include the member's diagnosis, the reason the equipment is required, and the physician's estimate, in months, of the duration of its need.

"**Complex-needs patient**" means an individual with a diagnosis or medical condition that results in significant physical or functional needs and capacities.

"**Complex rehabilitation technology**" means medically necessary durable medical equipment and items that are individually configured to meet specific and unique medical, physical, and functional needs and capacities for basic activities of daily living and instrumental activities of daily living of a complex needs patient. Such equipment and items include, but are not limited to, individually configured power wheelchairs and accessories, individually configured manual wheelchairs and accessories, adaptive seating and positioning systems and

accessories, and other specialized equipment such as standing frames and gait trainers.

"**Customized DME**" means items of DME which have been uniquely constructed or substantially modified for a specific member according to the description and orders of the member's treating physician or other qualified medical professional. For instance, a wheelchair would be considered "customized" if it has been:

(A) measured, fitted, or adapted in consideration of ~~the member's~~the member's body size, disability, period of need, or intended use;

(B) assembled by a supplier or ordered from a manufacturer who makes available customized features, modifications, or components for wheelchairs; and

(C) intended for an individual member's use in accordance with instructions from the member's physician.

"**Durable medical equipment (DME)**" means equipment that can withstand repeated use (e.g. a type of item that could normally be rented), is used to serve a medical purpose, is not useful to a person in the absence of an illness or injury, and is used in the most appropriate setting, including the home or workplace.

"**Instrumental activities of daily living**" means activities that are not necessarily required on a daily basis, but are important to being able to live independently (e.g., basic communication skills, transportation, meal preparation, shopping, housework, managing medication and managing personal finances).

"**Invoice**" means a document that provides the following information when applicable: the description of product, quantity, quantity in box, purchase price, NDC, strength, dosage, provider, seller's name and address, purchaser's name and address, and date of purchase. At times, visit notes will be required to determine how much of the supply was expended. When possible, the provider should identify the SoonerCare member receiving the equipment or supply on the invoice.

"**Medical supplies**" means an article used in the cure, mitigation, treatment, prevention, or diagnosis of illnesses. Disposable medical supplies are medical supplies consumed in a single usage and do not include skin care creams or cleansers. Medical supplies do not include surgical supplies or medical or surgical equipment.

"**OHCA CMN**" means a certificate required to help document the medical necessity and other coverage criteria for selected items. Those items are defined in this chapter. The physician's certification must include the member's diagnosis, the reason equipment is required, and the physician's estimate, in months, of the duration of its need. This certificate is used when the OHCA requires a CMN and one has not been established by CMS.

"**Orthotics**" means an item used for the correction or prevention of skeletal deformities.

"**Prosthetic devices**" means a replacement, corrective, or supportive device (including repair and replacement parts of the same) worn on or in the body to artificially replace a missing portion of the body, prevent or correct physical deformity or malfunction, or support a weak or deformed portion of the body.

"**Qualified complex rehabilitation technology professional**" means an individual who is certified as an Assistive Technology Professional (ATP) by the Rehabilitation Engineering and Assistive Technology Society of North America (RESNA).

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: February 16, 2016

The proposed policy is a Permanent Rule. This proposal is scheduled to be presented to the Medical Advisory Committee (MAC) on March 10, 2016 and the (OHCA) Board of Directors on March 24, 2016.
Reference: APA WF 15-21

SUMMARY:
Diagnostic Testing Facilities- The proposed Diagnostic Testing Facility policy is amended to define services that fall within the scope of authority for independent diagnostic testing facilities (IDTF). The proposed changes clarify reimbursement for rendered services and physician oversight.

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 410.32; 42 CFR 410.33

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

TO: Tywanda Cox
Federal and State Policy

From: Likita Gunn

SUBJECT: Rule Impact Statement
APA WF # 15-21

A. Brief description of the purpose of the rule:

The proposed Diagnostic Testing Facility policy is amended to define services that fall within the scope of authority for independent diagnostic testing facilities (IDTF). The proposed changes clarify reimbursement for the professional and technical components for rendered services and physician oversight. The language requires that IDTF supervising

physicians must: oversee non-physician personnel, monitor the quality of the testing performed, and monitor the operation and calibration of equipment.

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 contracted diagnostic testing facilities will be affected by the proposed change.

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

The OHCA will benefit from the proposed rule change as it will make the audit process more efficient.

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 change amends agency rules to mirror guidelines within federal regulation for Independent Diagnostic Testing Facilities and streamlines the audit process for the OHCA Program Integrity Division. Therefore, there is no anticipated economic impact and no fee changes.

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:

Agency staff has determined that the proposed rule is budget neutral.

F. 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.

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 costs.

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 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. Opportunities for public input are provided throughout the rulemaking process, in addition to formal public comment periods and tribal consultations.

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

The proposed change amends agency rules to mirror guidelines within federal regulation for Independent Diagnostic Testing Facilities and streamlines the audit process for the OHCA Program Integrity Division. Therefore, the agency does not anticipate any detrimental effects on the public health, safety, or environment.

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

This rule impact statement was prepared on November 30, 2015. This rule impact statement was amended on January 21, 2016.

RULE TEXT

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 90. DIAGNOSTIC TESTING ENTITIES

317:30-5-907. ~~Eligible providers~~ Provider requirements

~~Diagnostic testing entities must be Medicare certified as Mobile X-ray or Independent Diagnostic Testing Facilities (IDTF). Providers must have a current contract on file with the Oklahoma Health Care Authority.~~

(a) An Independent Diagnostic Testing Facility (IDTF) is either a fixed location or mobile entity independent of a hospital or physician's office where diagnostic services are performed by licensed certified non-physician personnel under appropriate physician supervision. Diagnostic testing entities must be Medicare certified as Mobile X-ray or an IDTF and have a current contract on file with the Oklahoma Health Care Authority.

(b) An IDTF must have one or more supervising physicians who are responsible for the direct and ongoing oversight of the quality of the testing performed, the proper operation and calibration of the equipment used to perform tests and the qualifications of non-physician personnel who use the equipment.

(c) An IDTF enrolled in the SoonerCare program must comply with all applicable federal regulations, including applicable provisions of 42 CFR 410.32 and 410.33.

317:30-5-907.1. ~~Coverage by category~~ Coverage and limitations

(a) **Adults.** ~~Payment is made for the technical component on outpatient diagnostic procedures in accordance with the guidelines set forth in OAC 317:30-5-24.~~ For IDTF services to be covered:

(1) Services must be medically necessary;

(2) The treating physician's order must specify the procedures to be performed and the reason for the service; and

(3) The IDTF may not add any procedures based on internal protocols without a written order by the treating physician.

(b) **Children.** Coverage is the same as adults.

317:30-5-907.3. Reimbursement

~~Reimbursement will be based on the current allowed charge for radiological procedures.~~

(a) Diagnostic procedure are reimbursable if the services were rendered to a non-hospital patient and the IDTF provided all services (professional and technical) associated with the total procedure as defined in the Current Procedural Terminology (CPT). When separate CPT codes itemize a service by its professional and technical components, the IDTF may bill and be reimbursed for the components of the procedure it actually performed.

(b) Payment is made for the technical component on outpatient diagnostic procedures in accordance with the guidelines set forth in OAC 317:30-5-24.

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 15, 2016

The proposed policy is a Permanent Rule. This proposal is scheduled to be presented to the Medical Advisory Committee (MAC) on January 21, 2016 and the (OHCA) Board of Directors on February 11, 2016.
Reference: APA WF 15-22

SUMMARY:
Health Record Signature Requirements - The proposed rules are revised clarify when a medical record must be authenticated. Current rules only address signature requirements for edits of a medical record.

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 482.24

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

TO: Tywanda Cox
Federal and State Policy

From: Likita Gunn

SUBJECT: Rule Impact Statement
APA WF # 15-22

A. Brief description of the purpose of the rule:

The proposed rules are revised to specify electronic and paper based medical records must be authenticated on the same day the record is completed or, if completed by someone else, the record must be signed within three business days. Current rules only address signature requirements for edits of a medical record.

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 contracted providers will be affected by the proposed change.

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:

The proposed rule involves no economic impact and no fee changes.

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:

Agency staff has determined that the proposed rule is budget neutral.

F. 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.

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 costs.

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 effects on the public health, safety, or environment.

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

This rule impact statement was prepared on November 16, 2015.

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

317:30-3-4.1. Uniform Electronic Transaction Act

The Oklahoma Health Care Authority enacts the provisions of the Uniform Electronic Transaction Act as provided in this Section with the exception to the act as provided in this Section.

(1) **Scope of Act.** The Electronic Transaction Act applies to an electronic record and an electronic signature created with a record that is generated, sent, communicated, received or stored by the Oklahoma Health Care Authority.

(2) **Use of electronic records and electronic signatures.** The rules regarding electronic records and electronic signatures

apply when both parties agree to conduct business electronically. Nothing in these regulations requires parties to conduct business electronically. However, should a party have the capability and desire to conduct business electronically with the Oklahoma Health Care Authority, then the following guidelines must be adhered to:

(A) Only employees designated by the provider's agency may make entries in the member's medical record. All entries in the member's medical record must be dated and authenticated with a method established to identify the author. The identification method may include computer keys, Private/Public Key Infrastructure (PKIs), voice authentication systems that utilize a personal identification number (PIN) and voice authentication, or other codes. Providers must have a process in place to deactivate an employee's access to records upon termination of employment of the designated employee.

(B) When PKIs, computer key/code(s), voice authentication systems or other codes are used, a signed statement must be completed by the agency's employee documenting that the chosen method is under the sole control of the person using it and further demonstrate that:

(i) A list of PKIs, computer key/code(s), voice authentication systems or other codes can be verified;

(ii) All adequate safeguards are maintained to protect against improper or unauthorized use of PKIs, computer keys, or other codes for electronic signatures; and

(iii) Sanctions are in place for improper or unauthorized use of computer key/code(s), PKIs, voice authentication systems or other code types of electronic signatures.

(C) There must be a specific action by the author to indicate that the entry is verified and accurate. Systems requiring an authentication process include but are not limited to:

(i) Computerized systems that require the provider's employee to review the document on-line and indicate that it has been approved by entering a unique computer key/code capable of verification;

(ii) A system in which the provider's employee signs off against a list of entries that must be verified in the member's records;

(iii) A mail system that sends transcripts to the provider's employee for review;

(iv) A postcard identifying and verifying the accuracy of the record(s) signed and returned by the provider's employee; or

(v) A voice authentication system that clearly

identifies author by a designated personal identification number or security code.

(D) Auto-authentication systems that authenticate a report prior to the transcription process do not meet the stated requirements and will not be an acceptable method for the authentication process.

(E) The authentication of an electronic medical record (signature and date entry) is expected on the day the record is completed. If the electronic medical record is transcribed by someone other than the provider, the signature of the rendering provider and date entry is expected within three business days from the day the record is completed.

~~(E)~~ (F) Records may be edited by designated administrators within the provider's facility ~~but must be authenticated by the original author~~. Edits must be in the form of a correcting entry which preserves entries from the original record. Edits must be completed prior to claims submission or no later than 45 days after the date of service, whichever is later.

~~(F)~~ (G) Use of the electronic signature, for clinical documentation, shall be deemed to constitute a signature and will have the same effect as a written signature on the clinical documentation. The section of the electronic record documenting the service provided must be authenticated by the employee or individual who provided the described service.

~~(G)~~ (H) Any authentication method for electronic signatures must:

(i) be unique to the person using it;

(ii) identify the individual signing the document by name and title;

(iii) be capable of verification, assuring that the documentation cannot be altered after the signature has been affixed;

(iv) be under the sole control of the person using it;

(v) be linked to the data in such a manner that if the data is changed, the signature is invalidated; and

(vi) provide strong and substantial evidence that will make it difficult for the signer to claim that the electronic representation is not valid.

~~(H)~~ (I) Failure to properly maintain or authenticate medical records (i.e., signature and date entry) may result in the denial or recoupment of SoonerCare payments.

(3) **Record retention for provider medical records.** Providers must retain electronic medical records and have access to the records in accordance with guidelines found at OAC 317:30-3-15.

(4) **Record retention for documents submitted to OHCA electronically.**

(A) The Oklahoma Health Care Authority's system provides that receivers of electronic information may both print and store the electronic information they receive. The Oklahoma Health Care Authority is the custodian of the original electronic record and will retain that record in accordance with a disposition schedule as referenced by the Records Destruction Act. The Oklahoma Health Care Authority will retain an authoritative copy of the transferable record as described in the Electronic Transaction Act that is unique, identifiable and unalterable.

(i) **Manner and format of electronic signature.** The manner and format required by the Oklahoma Health Care Authority will vary dependant upon whether the sender of the document is a member or a provider. In the limited case where a provider is a client, the manner and format is dependent upon the function served by the receipt of the record. In the case the function served is a request for services, then the format required is that required by a recipient. In the case the function served is related to payment for services, then the format required is that required by a provider.

(ii) **Recipient format requirements.** The Oklahoma Health Care Authority will allow members to request SoonerCare services electronically. An electronic signature will be authenticated after a validation of the data on the form by another database or databases.

(iii) **Provider format requirements.** The Oklahoma Health Care Authority will permit providers to contract with the Oklahoma Health Care Authority, check and amend claims filed with the Oklahoma Health Care Authority, and file prior authorization requests with the Oklahoma Health Care Authority. Providers with a social security number or federal employer's identification number will be given a personal identification number (PIN). After using the PIN to access the database, a PIN will be required to transact business electronically.

(B) Providers with the assistance of the Oklahoma Health Care Authority will be required to produce and enforce a security policy that outlines who has access to their data and what transaction employees are permitted to complete as outlined in the policy rules for electronic records and electronic signatures contained in paragraph (2) of this section.

(C) Third Party billers for providers will be permitted to perform electronic transaction as stated in paragraph (2)

only after the provider authorizes access to the provider's PIN and a power of attorney by the provider is executed.

(5) **Time and place of sending and receipt.** The provisions of the Electronic Transaction Act apply to the time and place of receipt with the exception of a power failure, Internet interruption or Internet virus. Should any of the exceptions in this paragraph occur, confirmation is required by the receiving party.

(6) **Illegal representations of electronic transaction.** Any person who fraudulently represents facts in an electronic transaction, acts without authority, or exceeds their authority to perform an electronic transaction may be prosecuted under all applicable criminal and civil laws.

317:30-3-15. Record retention

Federal regulations and rules promulgated by the Oklahoma Health Care Authority Board require that the provider retain, for a period of six years, any records necessary to disclose the extent of services the provider, wholly owned supplier, or subcontractor, furnishes to recipients and, upon request, furnish such records to the Secretary of the Department of Health and Human Services. Records in a provider's office must contain adequate documentation of services rendered. ~~Documentation must include the provider's signature and credentials.~~ Documentation must include the dated provider's signature and credentials. The provider's signature must be handwritten or electronically submitted if the provider and the Oklahoma Health Care Authority have agreed to conduct transactions by electronic means pursuant to the Uniform Electronic Act. Electronic records and electronic signatures must be in accordance with guidelines found at OAC 317:30-3-4.1. Where reimbursement is based on units of time, it will be necessary that documentation be placed in the member's record as to the beginning and ending times for the service claimed. All records must be legible. Failure to maintain legible records may result in denial of payment or recoupment of payment for services provided when attempts to obtain transcription of illegible records is unsuccessful or the transcription of illegible records appears to misrepresent the services documented. The provider may, after one year from the date of service(s), microfilm or microfiche the records for the remaining five years, as long as the microfilm or microfiche is of a quality that assures that the records remain legible. Electronic records are acceptable as long as they have a secured signature. Provider (other than individual practitioner) agrees to disclose, upon request, information relating to ownership or control, business transactions and criminal offenses involving

any program under Title V of the Child Health Act or Titles, XVIII, XIX, XX, or XXI of the Federal Social Security Act.

317:30-3-30. Signature requirements

(a) For medical review purposes, the Oklahoma Health Care Authority (OHCA) requires that all services provided and/or ordered be authenticated by the author. The method used shall be a hand written signature, electronic signature, or signature attestation statement. Stamped signatures are not acceptable. Pursuant to federal and/or state law, there are some circumstances for which an order does not need to be signed.

(1) Facsimile of original written or electronic signatures are acceptable for the certifications of terminal illness for hospice.

(2) Orders for clinical diagnostic tests are not required to be signed. If the order for the clinical diagnostic test is unsigned, there must be medical documentation by the treating physician that he/she intended the clinical diagnostic test be performed. This documentation showing the intent that the test be performed must be authenticated by the author via a hand written or electronic signature.

(3) Orders for outpatient prescription drugs are not required to be signed. If the order for a prescription drug is unsigned, there must be medical documentation by the treating physician that he/she intended that the prescription drug be ordered. This documentation showing the intent that the prescription drug be ordered must be authenticated by the author via a hand written or electronic signature.

(b) A hand written signature is a mark or sign by an individual on a document to signify knowledge, approval, acceptance, or obligation. The authentication of a medical record (signature and date entry) is expected on the day the record is completed. If the medical record is transcribed by someone other than the provider, the signature of the rendering provider and date entry is expected within three business days from the day the record is completed.

(1) If a signature is illegible, the OHCA will consider evidence in a signature log or attestation statement to determine the identity of the author of a medical record entry.

(2) If the signature is missing from an order, the OHCA will disregard the order during the review of the claim.

(3) If the signature is missing from any other medical documentation, the OHCA will accept a signature attestation from the author of the medical record entry.

(c) Providers may include in the documentation they submit a signature log that lists the typed or printed name of the author associated with initials or an illegible signature.

(1) The signature log may be included on the actual page where the initials or illegible signature are used or may be a separate document.

(2) The OHCA will not deny a claim for a signature log that is missing credentials.

(3) The OHCA will consider all submitted signature logs regardless of the date they were created.

(d) Providers may include in the documentation they submit a signature attestation statement. In order to be considered valid for medical review purposes, an attestation statement must be signed and dated by the author of the medical record entry and must contain sufficient information to identify the member.

(1) The OHCA will not consider signature attestation statements where there is no associated medical record entry.

(2) The OHCA will not consider signature attestation statements from someone other than the author of the medical record entry in question.

(3) The OHCA will consider all signature attestation statements that meet the above requirements regardless of the date the attestation was created, except in those cases where the regulations or rules indicate that a signature must be in place prior to a given event or a given date.

(e) Providers may use electronic signatures as an alternate signature method.

(1) Providers must use a system and software products which are protected against modification and must apply administrative procedures which are adequate and correspond to recognized standards and laws.

(2) Providers utilizing electronic signatures bear the responsibility for the authenticity of the information being attested to.

(3) Providers utilizing electronic signatures must comply with OAC 317:30-3-4.1.

(f) Nothing in this section is intended to absolve the provider of their obligations in accordance with the conditions set forth in their SoonerCare contract and the rules delineated in OAC 317:30.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 1. PHYSICIANS

317:30-5-3. Documentation of services

(a) Records in a physician's office or a medical institution (hospital, nursing home or other medical facility), must contain adequate documentation of services rendered. Such documentation must include the physician's signature or identifiable initials in relation to every patient visit, every prescription, or treatment.

In verifying the accuracy of claims for procedures which are reimbursed on a time frame basis, it will be necessary that documentation be placed in the patient's chart as to the beginning and ending times for the service claimed.

(b) Providers must adhere to signature requirements found at OAC 317:30-3-30.

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: February 16, 2016

The proposed policy is a Permanent Rule. This proposal is scheduled to be presented to the Medical Advisory Committee (MAC) on March 10, 2016 and the (OHCA) Board of Directors on March 24, 2016.
Reference: APA WF 15-24

SUMMARY:
Dental Oversight Requirements for Supervision of Anesthetists and General Clean-up of Terms- The proposed Dental policy is amended to mirror new terminology from the Code on Dental Procedures and Nomenclature (CDT), to clean up outdated language, and to add oversight requirements for the supervision of certified registered nurse anesthetists.

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 440.100

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

TO: Tywanda Cox
Federal and State Policy

From: Likita Gunn

SUBJECT: Rule Impact Statement
APA WF # 15-24

A. Brief description of the purpose of the rule:

The proposed Dental policy is amended to mirror new terminology from the Code on Dental Procedures and Nomenclature (CDT), to clean-up outdated terms, and to add oversight requirements for dentist who supervise certified registered nurse anesthetist during the administration of

anesthesia to members. The oversight requirement would align OHCA policy with requirements set forth by the Oklahoma Board of Dentistry. In addition, revisions include updating policy to reflect that diagnosis codes must appear on the dental form when requesting a prior authorization and the removal of language for the recoupment of restoration services. The removal of recoupment language will mirror other policy sections concerning dental services that are silent to the recoupment process. Recoupment for inappropriate restorations will still occur as deemed appropriate by the agency's Program Integrity Division.

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 contracted dentist who oversee nurse anesthetist will be affected by the proposed change. Additionally, all SoonerCare contracted dental providers will be affected by the proposed clean-up of dental policy language, and the addition of language to rules to mirror the new terminology found in the Code on Dental Procedures and Nomenclature (CDT).

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

The OHCA will benefit from the proposed rule as the change will alleviate the administrative burden on agency staff. The proposed change will also improve quality of care for SoonerCare members.

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 mirrors Oklahoma Dental Board language on oversight requirements, updates language to include new terminology from the Code on Dental Procedures and Nomenclature (CDT), and other general clean-up of dental policy. Therefore, there is no anticipated economic impact and no fee changes.

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:

Agency staff has determined that the proposed rule is budget neutral.

F. 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.

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 costs.

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 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. Opportunities for public input are provided throughout the rulemaking process, in addition to formal public comment periods and tribal consultations. Additionally, OHCA presented the proposed changes during the OHCA Dental Focus Group Quarterly Meeting.

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

The proposed rule mirrors Oklahoma Dental Board language on oversight requirements, updates language to include new terminology from the Code on Dental Procedures and Nomenclature (CDT), and other general clean-up of dental policy. Therefore, the agency does not anticipate any detrimental effects on the public health, safety, or environment.

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

This rule impact statement was prepared on November 13, 2015.
This rule impact statement was modified on January 22, 2016.

RULE TEXT

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 79. DENTISTS

317:30-5-695. Eligible dental providers and definitions

(a) Eligible dental providers in Oklahoma's SoonerCare program are:

(1) individuals licensed as dentists under 59 Oklahoma Statutes §§ 328.21, 328.22, and 328.23 (licensed dentists, specialty dentists and out of state dentists);

(2) individuals issued permits as dental interns under 59 Oklahoma Statute § 328.26;

(3) individuals who are third and fourth year dental students at an accredited Oklahoma dental college; and

(4) any individual issued a license in another state as a dentist.

(b) All eligible providers must be in good standing with regard to their license. Any revocation or suspension status of a provider referenced in subsection (a) above renders the provider ineligible for payment or subject to recoupment under SoonerCare.

(c) Eligible providers must document and sign records of services rendered in accordance with guidelines found at OAC 317:30-3-15.

(d) The American Dental Association's version of ~~Current Dental Terminology (CDT)~~Code on Dental Procedures and Nomenclature (CDT) is used by the OHCA to communicate information related to codes, and procedures for administration. Definitions, nomenclature, and descriptors as listed in the CDT will apply, with the exception of more specific definitions or limitations set forth.

(1) "Decay" means carious lesions in a tooth; decomposition and/or dissolution of the calcified and organic components of the tooth structure.

(2) "Emergency Dental Care" includes, but is not limited to, the immediate service that must be provided to relieve the

member from pain due to an acute infection, swelling, trismus or trauma.

(3) "Palliative Treatment" means action that relieves pain but is not curative. Palliative Treatment is an ~~all inclusive~~all-inclusive service. No other codes are reimbursable on the same date of service.

(4) "Radiographic Caries" means dissolution of the calcified and organic components of tooth tissue that has penetrated the enamel and is approaching the dentinoenamel junction.

(5) "Upcoding" means reporting a more complex and/or higher cost procedure than actually performed.

(6) "Unbinding" means billing separately for several individual procedures that are included within one Current Dental Terminology or Current Procedural Terminology (CPT) code.

317:30-5-696.1. ~~Conscious Sedation~~Anesthesia

Payment is made for 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. Payment is made to Dentists who have received appropriate formal education in conscious ~~(moderate)~~ sedation~~, deep sedation,~~ and general anesthesia. ~~and are qualified to use these modalities in practice.~~

(1) Training to competency in conscious ~~(moderate)~~ sedation techniques may be acquired at the predoctoral, postgraduate, graduate, or continuing education level. Dentists who wish to utilize conscious ~~(moderate)~~ sedation are expected to successfully complete formal training which is structured in accordance with the American Dental Association's educational guidelines as well as the board of Dentistry for the State in which they practice.

(2) The knowledge and skills required for the administration of deep sedation and general anesthesia are beyond the scope of pre-doctoral and continuing education. Only dentists who have successfully completed an accredited/approved residency program in anesthesiology, for the administration of anesthetic agents will be permitted to provide and bill for this service.

(3) All anesthesia services must be provided in accordance with OAC 317:30-5-7.

(A) Dentists who provide or supervise deep sedation or general anesthesia are required to have training in anesthesiology, oral surgery or pediatric dentistry, such as in a residency curriculum.

(B) To be considered qualified to supervise the administration of general anesthesia or deep sedation,

OHCA requires a minimum of eighteen (18) hours of courses related to the administration of anesthesia, deep sedation or medical emergencies in the dental office every three (3) years.

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)~~[See OAC 317:30-5-695(d)(2)]. Requests for dental services requiring prior authorization must be accompanied by sufficient documentation. Images with an indication of the left side of member, six point periodontal charting and copy of the comprehensive treatment plans are required. Study models are usually not required, but 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/IID residents. Minimum required records to be submitted with each request are right and left mounted ~~bitewing~~bitewings ~~x-rays or images~~ and periapical films or images of tooth/teeth involved or the edentulous areas if not visible in the bitewings. ~~X-rays~~Images must be submitted with film mounts and each film or print must be of diagnostic quality. ~~X-rays and/or images~~Images must be identified by the tooth number and include date of exposure, member name, member ID, provider name, and provider ID. All ~~x-rays or~~ images, regardless of the media, must be submitted together with a completed and signed comprehensive treatment plan that details all needed treatment at the time of examination, and a completed current ADA form requesting all treatments requiring prior authorization. The ~~film~~images, digital media, photographs, or ~~printout~~printouts must be of sufficient quality to clearly demonstrate for the reviewer, the

pathology which is the basis for the authorization request. If radiographs are not taken, provider must include in narrative sufficient information to confirm diagnosis and treatment plan.

(1) **Endodontics.** Root canal therapy is not considered an emergency procedure unless due to trauma to an anterior tooth. The provider must document the member's oral hygiene and flossing ability ~~over a minimum of two months,~~ in the member's records.Pulpal debridement may be performed for the relief of pain while waiting for the decision from the OHCA on request for endodontics.

(A) Prior authorization is required for members who have a treatment plan requiring more than two ~~anterior and/or two posterior~~ root canals. All rampant, active caries must be removed prior to requesting anterior endodontics. Payment is made for services provided in accordance with the following:

(i) Permanent teeth only.

(ii) Accepted ADA materials must be used.

(iii) Pre and post-operative periapical ~~x-rays~~images 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.

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

(i) The provider must document the member's oral hygiene and flossing ability ~~over a minimum of two months,~~ in the member's records.

(ii) Teeth that require pre-fabricated post and cores to retain a restoration due to lack of natural tooth structure should not be treatment planned for root canal therapy.

(iii) Pre and post-operative periapical ~~x-rays~~images 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 may not be approved if the tooth requires a post and core in order to present adequate structure to retain a crown.

(viii) Endodontics will not be considered if:

(I) an opposing tooth has super erupted;

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

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

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

(V) all rampant, active caries must be removed prior to requesting posterior endodontics.

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

(2) **Crowns for permanent teeth.** Crowns are compensable for restoration of natural teeth for members who are 16 years of age or older and adults residing in private Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) and who have been approved for (ICF/IID) level of care. Certain criteria and limitations apply.

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

(i) ~~all~~All rampant, active caries must be removed prior to requesting any type of crown.

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

(iii) The clinical crown is fractured or destroyed by one-half or more.

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

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

(C) Routine build-up(s) for authorized crowns are included in the fee for the crown. Non authorized restorative codes may be used if available.

(D) A crown will not be approved if adequate tooth structure does not remain to establish cleanable margins,

there is invasion of the biologic width, poor crown to root ratio, or the tooth appears to retain insufficient amounts of natural tooth structure. Cast dowel cores are not allowed for molar or pre-molar teeth.

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

(F) Provider is responsible for replacement or repair of all crowns if 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 missing anterior permanent teeth or two or more missing posterior teeth in the same arch for members 16 through 20 years of age. Provider must indicate which teeth will be replaced. ~~Members must have excellent oral hygiene documented for at least 18 months in the requesting provider's records and submitted with prior authorization request to be considered.~~ Members must have improved oral hygiene documented for at least 12 months in the provider's records and submitted with prior authorization request to be considered. Provider is responsible for any needed follow up for a period of two years post insertion.

(4) **Acrylic partial.** This appliance is the treatment of choice for replacement of three or more missing teeth in the same arch for members 12 through 16 years of age. Provider must indicate tooth numbers to be replaced. This appliance includes all necessary clasps and rests.

(5) **Occlusal guard.** Narrative of medical necessity must be sent with prior authorization. Model should not be made or sent unless requested.

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

(7) **Periodontal scaling and root planing.** Procedure is designed for the removal of calculus or tissue that is contaminated and requires anesthesia and some soft tissue removal. This procedure requires that each tooth have ~~3~~three or more of the six point measurements ~~5~~five millimeters or greater, or have multiple areas of ~~radiographic~~image supported bone loss ~~and~~, subgingival calculus and must involve two or more teeth per quadrant for consideration.

This procedure is not allowed on members under the age ~~10~~12. This procedure is not allowed in conjunction with any other periodontal surgery.

317:30-5-699. Restorations

(a) **Utilization parameters.** The Oklahoma Health Care Authority utilization parameters allow only one permanent restorative service to be provided per tooth per 24 months. Additional restorations may be authorized upon approval of OHCA in cases of trauma. Teeth receiving a restoration are eligible within three months for consideration of single crown if endodontically treated. Providers must document type of isolation used in treatment progress notes. The provider is responsible for follow-up or any required replacement of a failed restoration, if the member is currently SoonerCare eligible. ~~Fees paid for the original restorative services may be recouped if any additional treatments are required on the same tooth by a different provider within 12 months due to defective restoration or recurrent decay. If it is determined by the Dental Director that a member has received poorly rendered or insufficient treatment from a provider, the Dental Director may prior authorize corrective procedures by a second provider.~~

(b)**Coverage for dental restorations.** Restoration of incipient lesions is not considered medically necessary treatment. Any diagnosis not supported by ~~radiographs~~images requires documentation of the medical need on which the diagnosis was made. Services for dental restorations are covered as follows:

(1) If the mesial occlusal pit and the distal occlusal pit on an upper molar tooth are restored at the same appointment, this is a one surface restoration.

(2) If any two separate surfaces on a posterior tooth are restored at the same appointment, it is a two surface restoration.

(3) If any three separate surfaces on a posterior tooth are restored at the same appointment, it is a three surface restoration.

(4) If the mesial, distal, facial and/or lingual of an upper anterior tooth is restored at the same appointment, this is a four surface restoration.

(5) If any two separate surfaces on an anterior tooth are restored at the same appointment, it is a two surface restoration.

(6) If any three separate surfaces on an anterior tooth are restored at the same appointment, it is a three surface restoration.

(7) An incisal angle restoration is defined as one of the angles formed by the junction of the incisal and the mesial or distal surface of an anterior tooth. If any of these

surfaces are restored at the same appointment, even if separate, it is considered as a single incisal angle restoration.

(8) When four or more separate surfaces on a posterior tooth are restored at the same appointment it is a four surface restoration.

(9) Wide embrasure cavity preparations do not become extra surfaces unless at least one half of cusp or surface is involved in the restoration. An MODFL restoration would have to include the mesial-occlusal-distal surfaces as well as either the buccal groove pit or buccal surface or at least one half the surface of one of the buccal cusps. The same logic applies for the lingual surface.

317:30-5-700. Orthodontic services

(a) In order to be eligible for SoonerCare Orthodontic services, members must be referred through a primary care dentist; a member can receive a referral from a primary care dentist to the orthodontist only after meeting the following:

(1) the member has had a caries free initial visit; or

(2) has all decayed areas restored and has remained caries free for 12 months; and

(3) has demonstrated competency in maintaining an appropriate level of oral hygiene.

(b) Member with cleft palate can be referred directly by their treating physician without a dental referral and are exempt from above requirements.

(c) The Oklahoma SoonerCare Orthodontic Program limits orthodontic services to handicapping malocclusions determined to be severe enough to warrant medically necessary treatment. The orthodontic provider has the ability to determine if members may qualify with a visual screening. Diagnostic record accumulation and/or submission should only occur for members with high potential for acceptance. These orthodontic services include the following:

(1) a handicapping malocclusion, as measured on the Handicapping Labio-Lingual Deviation Index (HLD) with a minimum score of 30;

(2) any classification secondary to cleft palate or other maxillofacial deformity;

(3) if a single tooth or anterior crossbite is the only medical need finding, service will be limited to interceptive treatment;

(4) fixed appliances only; and

(5) permanent dentition with the exception of cleft defects.

(d) Reimbursement for Orthodontic services is limited to:

(1) Orthodontists, or

(2) General or Pediatric dental practitioners who have completed at least 200 certified hours of continuing education in the field of orthodontics practice and submit for review at least 25 successfully completed comprehensive cases. Of these 25 comprehensive cases, ten or more must be extraction cases. An applicant for this certification must practice in an OHCA deemed ~~under served~~under-served area. The comprehensive cases submitted should be of a complexity consistent with type of handicapping ~~Malocclusion~~malocclusion likely to be treated in the SoonerCare program.

(A) Cases submitted must include at least one of each of the following types:

(i) deep overbite where multiple teeth are impinging upon the soft tissue of the palate;

(ii) impacted canine or molar requiring surgical exposure;

(iii) bilateral posterior crossbite requiring fixed rapid palatal expansion; and

(iv) skeletal class II or III requiring orthognathic surgery.

(B) As with all dental or orthodontia treatment performed and reimbursed by SoonerCare, all pre and post orthodontic records must be available for review.

(C) The ~~Oklahoma Health Care Authority~~OHCA requires all ~~General~~general dentists providing comprehensive orthodontic care to submit a copy of the Oklahoma Board of Dentistry continuing education report and verification that at least 20 continuing education hours in the field of orthodontics has been completed per reporting period. All verification reports must be submitted to OHCA Dental unit every three years, no later than August 30. In addition, verification of adequate progress for all active orthodontic cases will be reviewed by the OHCA Dental Unit upon completion of 24 months of therapy.

(e) The following limitations apply to orthodontic services:

(1) Cosmetic orthodontic services are not a covered benefit of the SoonerCare Program and no requests should be submitted;

(2) All orthodontic procedures require prior authorization for payment;

(3) Prior authorization for orthodontic treatment is not a notification of the member's eligibility and does not guarantee payment. Payment for authorized services depends on the member's eligibility at the beginning of each treatment year. Treatment year is determined by date of banding;

(4) The member must be SoonerCare-eligible and under 18 years of age at the time the request for prior authorization for treatment is received by the OHCA. Services cannot be added

or approved after eligibility has expired. It is the orthodontist's responsibility to verify that the member has current SoonerCare eligibility and the date of birth indicates the member is under age 18.

(f) Orthodontic services are an elective procedure. The orthodontist must interview the prospective member as to his/her understanding of and willingness to cooperate fully in a lengthy treatment program.

(g) The interview information is unavailable to OHCA except through the provider's recommendation of treatment. The interview process for OHCA members is equivalent to that of private pay patients.

(h) Providers are not obligated to accept a member when it appears that the member will not cooperate in the orthodontic hygiene treatment program, does not return to the general dentist for preventive visits or is not willing to keep eligibility for SoonerCare current.

317:30-5-700.1. Orthodontic prior authorization

(a) The following records and documentation, plainly labeled with the member's full name, recipient identification number (RID), and the orthodontist's name are required for prior authorization of orthodontic services and must be submitted to the Dental Unit of the OHCA when the member has a total score of not less than 30 points or meets other eligibility criteria in paragraph (d).

(1) Completed currently approved ADA dental claim form;

(2) Complete and scored Handicapping Labio-Lingual Deviations Index with Diagnosis of Angle's classification;

(3) Detailed description of any oral maxillofacial anomaly;

(4) Estimated length of treatment;

(5) Intraoral photographs showing teeth in centric occlusion and/or photographs of trimmed anatomically occluded diagnostic casts. A lingual view of casts may be included to verify impinging overbites;

(6) Cephalometric ~~x-rays~~images with tracing, and panoramic film, with a request for prior authorization of comprehensive orthodontic treatment;

(7) If diagnosed as a surgical case, submit an oral surgeon's written opinion that orthognathic surgery is indicated and the surgeon is willing to provide this service;

(8) Additional pertinent information as determined necessary by the orthodontist or as requested by the OHCA.

(b) All images~~, x-rays,~~ and required documentation must be submitted in one package. OHCA is not responsible for lost or damaged materials.

(c) All records and documentation submitted in a request for prior authorization for orthodontic treatment are reviewed by

the OHCA Orthodontic Consultant for compensability and length of treatment. Any documentation on which a decision is made will not be returned.

(d) Some children not receiving a minimum score of 30 on the Handicapping Labio-Lingual Deviation Index (HLD) may have other conditions to be considered. In the event an orthodontist believes there are other medical, social, or emotional conditions impacting the general health of the child, he/she refers to the conditions listed on the EPSDT exception section found on the HLD. The following guidelines and restrictions apply to other conditions:

(1) Other medical, social, or emotional conditions are limited to those conditions that affect the medical, social or emotional function of the child.

(2) Other medical, social, or emotional conditions are not scored if the sole condition sought to be improved is the cosmetic appearance of the child.

(3) Such other medical, social, or emotional conditions must be demonstrated by objective evidence such as supported documentation outside the child's immediate family (i.e., a child's teacher, primary care physician, behavioral health provider, school counselor).

(4) Objective evidence must be submitted with the HLD.

(5) When such other medical, social, or emotional conditions are reflected on the HLD, the OHCA Orthodontic Consultant must review the data and use his or her professional judgment to score the value of the conditions.

(6) The OHCA Orthodontic Consultant may consult with and utilize the opinion of the orthodontist who completes the form.

(e) If it is determined that the malocclusion is not severe enough to warrant medically necessary orthodontic services or the member's age precludes approval, a computer generated notice is issued to the provider and member with notice of the denial, the reason for the denial, and appeal rights (see OAC 317:2-1 for grievance procedures and process).

(f) Orthodontic treatment and payment for the services are approved within the scope of SoonerCare. If orthodontic treatment is approved, a computer generated notice is issued authorizing the first year of treatment.

(1) Approval of orthodontic treatment is given in accordance with the following:

(A) Authorization for the first year begins on the date of banding and includes the placement of appliances, arch wires, and a minimum of six adjustments. It is expected that orthodontic members be seen every four to eight weeks for the duration of active treatment.

(B) Subsequent adjustments will be authorized in one year

intervals and the treating orthodontist must provide a comprehensive progress report at the 24 month interval.

(C) All approved treatment is included on the original prior authorization and will include the total payment for that treatment year.

(2) Claim and payment are made as follows:

(A) Payment for comprehensive treatment includes the banding, wires, ~~and~~ adjustments as well as all ancillary services, including the removal of appliances, and the construction and placing of retainers.

(B) Payment is not made for comprehensive treatment beyond 36 months.

(g) If the member moves from the geographic area or shows a need to change their provider, then the provider who received the yearly payment is financially responsible until completion of that member's orthodontic treatment for the current year.

(h) If the provider who received yearly payment does not agree to be financially responsible, then the Oklahoma Health Care Authority will recoup funds paid for the member's orthodontic treatment.

(i) All orthodontic services are subject to post-utilization review. This review may include a request by the OHCA to submit medical documentation necessary to complete the review. After review is completed, these materials are returned to the orthodontist.

(j) Study models must be diagnostic and meet the following requirements:

(1) Study models must be properly poured and adequately trimmed without large voids or positive bubbles present.

(2) Centric occlusion must be clearly indicated by pencil lines on the study models, making it possible to occlude the teeth on the models in centric occlusion.

(3) 3-D model images are preferred.

(4) Study models not in compliance with the above described diagnostic guidelines are not accepted. The provider may send new images that meet these requirements. If the provider does not respond, the request for treatment is denied.

(5) All measurements are made or judged on the basis of greater than or more than the minimal criteria. Measurement, counting, recording, or consideration is performed only on teeth that have erupted and may be seen on the study models.

317:30-5-704. Billing instructions

(a) **HCPCS Codes.** The Oklahoma Health Care Authority utilizes the Medicare Level II HCPCS Codes. All claim submissions must be in compliance with this coding system.

(b) **Prior authorization.** Where applicable, the appropriate <u>arch, quadrant, or tooth</u> surface and tooth number must be included on

the claim. Diagnosis codes are requested to be listed in box 34 of ADA form 2012.
(c) ~~**X-rays.**~~**Images.** Any type of film or prints submitted will not be returned. All ~~x-rays~~images must be dated, mounted and have patient's name, recipient identification number (RID), provider name and provider number.

317:30-5-705. Billing

Billing for dental services may be submitted on the currently approved version of the American Dental Association (ADA) claim form. Diagnosis codes are requested to be listed in box 34 of ADA form 2012. Electronic submission must be made on the HIPPA compliant Form 837D.

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 15, 2016

The proposed policy is a Permanent Rule. This proposal is scheduled to be presented to the Medical Advisory Committee (MAC) on January 21, 2016 and the (OHCA) Board of Directors on February 11, 2016.
Reference: APA WF 15-27A

SUMMARY:
SoonerCare Primary Care Providers- OHCA proposes policy changes that would clarify inconsistent and conflicting language authorizing medical residents as Primary Care Physicians (PCP) under SoonerCare. Language cleanup will reflect current OHCA practices.

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 431.10

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

TO: Tywanda Cox
Federal and State Policy

From: William Baker

SUBJECT: Rule Impact Statement
APA WF # 15-27A

A. Brief description of the purpose of the rule:

The proposed policy changes would clarify inconsistent and conflicting language authorizing medical residents as Primary Care Physicians (PCP) under SoonerCare. Language cleanup will reflect current OHCA practices.

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 this proposed rule since the language changes merely reflect longstanding SoonerCare practices.

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

No classes of persons will benefit from the language cleanup.

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 involves no economic impact and no fee changes.

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:

Agency staff has determined that the proposed rule is budget neutral.

F. 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.

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 costs.

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 effects on the public health, safety, or environment.

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

This rule impact statement was prepared on October 22, 2015.

RULE TEXT

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 25. SOONERCARE CHOICE

SUBCHAPTER 7. SOONERCARE

PART 1. GENERAL PROVISIONS

317:25-7-5. Primary care providers

For provision of health care services, the OHCA contracts with qualified Primary Care Providers. All providers serving as PCPs must have a valid SoonerCare Fee-for-Service contract as well as an exercised SoonerCare Choice addendum. Additionally, all PCPs, excluding Provider or Physician Groups, must agree to accept a minimum capacity of patients, however this does not guarantee PCPs a minimum patient volume. Primary Care Providers are limited to:

(1) **Physicians.** Any physician licensed to practice medicine

in the state in which he or she practices who is engaged in a general practice or in family medicine, general internal medicine or general pediatrics may serve as a PCP. The Chief Executive Officer (CEO) of the OHCA may designate physicians to serve as PCPs who are licensed to practice medicine in the state in which they practice who are specialized in areas other than those described above. In making this determination, the CEO may consider such factors as the percentage of primary care services delivered in the physician's practice, the availability of primary care providers in the geographic area of the state in which the physician's practice is located, the extent to which the physician has historically provided services to SoonerCare members, and the physician's medical education and training.

(A) For physicians serving as SoonerCare Choice PCPs, the State caps the number of members per physician at 2,500. However, the CEO in his/her discretion may increase this number in under served areas based on a determination that this higher cap is in conformance with usual and customary standards for the community. If a physician practices at multiple sites, the capacity at each site is determined based on the number of hours per week the physician holds office hours, not to exceed one FTE. Thus, the physician cannot exceed a maximum total capacity of 2500 members.

(B) In areas of the State where cross-state utilization patterns have developed because of limited provider capacity in the State, the CEO may authorize contracts with out-of-state providers for PCP services. Out-of-State PCPs are required to comply with all access standards imposed on Oklahoma physicians.

(2) **Advanced Practice Nurses.** Advanced Practice Nurses who have prescriptive authority may serve as PCPs for the Primary Care Case Management delivery system if licensed to practice in the state in which he or she practices. Advanced Practice Nurses who have prescriptive authority may serve as PCPs for a maximum number of 1,250 members. However, the CEO in his/her discretion may increase this number.

(3) **Physician Assistants.** Physician Assistants may serve as PCPs if licensed to practice in the state in which he or she practices. Physician Assistants may serve as PCPs for a maximum number of 1,250 members. However, the CEO in his/her discretion may increase this number.

~~(4) **Medical Residents.**~~

~~(A) Medical residents may serve as PCPs when the following conditions are met:~~

~~(i) The resident is licensed to practice in the state in which he or she practices.~~

~~(ii) The resident is at least at the Post-Graduate 2~~

~~(PG-2) level.~~

~~(iii) The resident serves as a PCP only within his or her continuity clinic setting (for example, Family Practice residents may only serve as the PCP within the Family Practice Residency clinic setting).~~

~~(iv) The resident works under the supervision of a licensed attending physician.~~

~~(v) The resident specifies the residency program or clinic to which payment will be made.~~

~~(B) Medical residents practicing as a PCP may not exceed a capacity of more than 875 members. However, the CEO in his/her discretion may increase this number.~~

~~(5)~~(4) **Indian Health Service (IHS) Facilities and Federally Qualified Health Center (FQHC) provider groups.**

(A) Indian Health Service facilities whose professional staff meet the general requirements in paragraphs (1) through (3) of this Section and the provider participation requirements at OAC 317:30-5-1088 may serve as PCPs.

(B) Federally Qualified Health Centers whose professional staff meet the general requirements in paragraphs (1) through (3) of this Section and the provider participation requirements in OAC 317:30-5-660.2 may serve as PCPs.

~~(6)~~(5) **Provider or physician group capacity and enrollment.**

(A) Provider or physician groups must agree to accept a minimum enrollment capacity and may not exceed 2,500 members per physician participating in the provider group.

(B) If licensed physician assistants or advanced practice nurses are members of a group, the capacity may be increased by 1,250 members if the provider is available full-time.

(C) Provider or physician groups must designate a medical director to serve as the primary contact with OHCA.

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 15, 2016

The proposed policy is a Permanent Rule. This proposal is scheduled to be presented to the Medical Advisory Committee (MAC) on January 21, 2016 and the (OHCA) Board of Directors on February 11, 2016.
Reference: APA WF 15-27B

SUMMARY:
SoonerCare Primary Care Providers - OHCA proposes policy changes that would clarify inconsistent and conflicting references to language authorizing medical residents as Primary Care Physicians (PCP) under SoonerCare. Cleanup of language would accurately reflect OHCA practices and requirements for payment under SoonerCare.

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 431.10

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

TO: Tywanda Cox
Federal and State Policy

From: William Baker

SUBJECT: Rule Impact Statement
APA WF # 15-27B

A. Brief description of the purpose of the rule:

The proposed policy changes would remove language on medical residents that refers to stricken language in

OAC 317:25-7-5(4). Cleanup of language would accurately reflect OHCA practices and requirements for payment under SoonerCare.

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 this proposed rule since the language changes merely reflect longstanding SoonerCare practices.

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

No classes of persons will benefit from the language cleanup.

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 involves no economic impact and no fee changes.

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:

Agency staff has determined that the proposed rule is budget neutral.

F. 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.

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 costs.

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 effects on the public health, safety, or environment.

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

This rule impact statement was prepared on October 22, 2015.

RULE TEXT

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 75. FEDERALLY QUALIFIED HEALTH CENTERS

317:30-5-660.5. Health Center service definitions

The following words and terms, when used in this Subchapter,

shall have the following meaning, unless the context clearly indicates otherwise:

"Core Services" means outpatient services that may be covered when furnished to a patient at the Center or other location, including the patient's place of residence.

"Encounter or Visit" means a face-to-face contact between an approved health care professional as authorized in the FQHC state plan pages and an eligible SoonerCare member for the provision of defined services through a Health Center within a 24-hour period ending at midnight, as documented in the patient's medical record.

"Licensed Behavioral Health Professional (LBHP)" means licensed psychologists, licensed clinical social workers (LCSWs), licensed marital and family therapists (LMFTs), licensed professional counselors (LPCs), licensed behavioral practitioners (LBPs), and licensed alcohol and drug counselors (LADCs).

"Other ambulatory services" means other health services covered under the State plan other than core services.

"Physician" means:

(A) a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which the function is performed or who is a licensed physician employed by the Public Health Service;

(B) within limitations as to the specific services furnished, a doctor of dentistry or dental or oral surgery, a doctor of optometry, or a doctor of podiatry;

~~(C) a resident as defined in OAC 317:25-7-5(4) who meet the requirements for payment under SoonerCare;~~

"Physicians' services" means professional services that are performed by a physician at the Health Center (or are performed away from the Center, excluding inpatient hospital services) whose agreement with the Center provides that he or she will be paid by the Health Center for such services.

"PPS" means prospective payment system all-inclusive per visit rate method specified in the State plan.

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: February 16, 2016

The proposed policy is a Permanent Rule. This proposal is scheduled to be presented to the Medical Advisory Committee (MAC) on March 10, 2016 and the OHCA Board of Directors on March 24, 2016.
Reference: APA WF 15-28

SUMMARY:
I/T/U Language Update – Proposed Indian Health Services, Tribal Programs and Urban Indian Clinics (I/T/U) policy is revised for clarity and consistency with other sections of Chapter 30.

LEGAL AUTHORITY
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; Article 10, Section 23 of the Oklahoma Constitution; 42 CFR Part 136

RULE IMPACT STATEMENT

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

TO: Tywanda Cox
Federal and State Policy

FROM: William Baker
State Policy

SUBJECT: Rule Impact Statement
APA WF # 15-28

A. Brief description of the purpose of the rule:

Proposed Indian Health Services, Tribal Programs and Urban Indian Clinics (I/T/U) policy is revised for clarity and consistency with other sections of Chapter 30. Proposed revisions update professional staff titles, clarify requirements for providers to contract with OHCA and appear on the IHS listing of tribal facilities, update language to

include the use of OHCA's EPE system and clarify professional staff recognized by OHCA. Additional revisions would remove language on telemedicine originating fees, define homebound individuals, require documentation of treatment and add requirements for licensure candidates. Proposed revisions include clean-up to remove outdated policy to align with current practice and to clarify I/T/U encounters and outpatient encounters, inpatient practitioner services and prior authorizations.

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 I/T/U facilities in Oklahoma and providers working at those facilities. I/T/U facilities will also be required to utilize the OHCA EPE system. I/T/U facilities are now responsible to petition IHS for placement on the list of facilities operating under a 638 agreement. Contracted psychosocial rehabilitation service providers are responsible for obtaining all necessary prior authorizations.

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

No classes of person will benefit from this rule change as it is cleanup to reflect current practice of both ITUs and OHCA.

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 involves no economic impact and no fee changes.

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:

Agency staff has determined that the proposed rule 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:

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:

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. Opportunities for public input are provided throughout the rulemaking process, in addition to formal public comment periods and tribal consultations.

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 3, 2015.
This rule impact statement was modified on January 21, 2016.

RULE TEXT

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 110. INDIAN HEALTH SERVICES, TRIBAL PROGRAMS, AND URBAN INDIAN CLINICS (I/T/Us)

317:30-5-1085. General provisions

(a) Indian Health Services (IHS) provide health care to Certificate of Degree of Indian Blood (CDIB) eligible American Indian and Alaska Natives (AI/AN). The IHS is a division of the Department of Health and Human Services that administers a system of hospitals and Indian health outpatient services. Urban Indian Clinics are considered facilities of the IHS. Under the Indian Self-Determination Act, Public Law 93-638, as amended, Tribes may also provide health care to ~~CDIB~~IHS eligible AI/ANs.

(b) The rules at OAC 317:30-3 apply to IHS, Tribal, and Urban Indian facilities. Additionally, unless otherwise stated, all other SoonerCare rules apply to IHS, Tribal, and Urban Indian facilities.

317:30-5-1086. Eligible I/T/U providers

~~Indian Health Services, Tribal Programs, and Urban Indian Clinics (I/T/Us) are considered eligible for participation in the SoonerCare Program. To receive SoonerCare reimbursement, an I/T/U must have a current contract on file with the Oklahoma Health Care Authority (OHCA). OHCA recognizes that I/T/Us are the payer of last resort, and are not considered creditable health insurance.~~

Indian Health Services, Tribal Programs, and Urban Indian Clinics (I/T/Us) are considered eligible for participation in the SoonerCare Program. To receive SoonerCare reimbursement, an I/T/U must be contracted as a provider with the Oklahoma Health Care Authority and appear on the IHS maintained listing of IHS-operated and Indian health care facilities under a 638 agreement. OHCA recognizes that I/T/Us are the payer of last resort, and are not considered creditable health insurance. It is the sole responsibility of the facility to petition IHS for

placement on the list of facilities operating under a 638 agreement.

317:30-5-1087. Terms and definitions

The following words and terms, when used in this Part, have the following meaning, 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) **"Behavioral Health services"** means professional medical services for the treatment of a mental health and/or addiction disorder(s).

(3) **"CFR"** means the Code of Federal Regulations.

(4) **"CMS"** means the Centers for Medicare and Medicaid Services.

(5) **"Encounter"** means a face to face contact between a health care professional and ~~a CDIB card~~an IHS eligible SoonerCare member for the provision of medically necessary Title XIX or Title XXI covered services through an IHS or Tribal 638 facility or an urban Indian clinic within a 24-hour period ending at midnight, as documented in the patient's record.

(6) **"Licensed Behavioral Health Professional (LBHP)"** means a licensed psychologist, licensed clinical social worker ~~(LSW-C)~~(LCSW), licensed marital and family therapist (LMFT), licensed professional counselor (LPC), licensed behavioral practitioner (LBP) or licensed alcohol and drug counselor (LADC).

(7) **"OHCA"** means the Oklahoma Health Care Authority.

(8) **"OMB rate"** means the Medicaid reimbursement rate negotiated between CMS and IHS. Inpatient and outpatient Medicaid reimbursement rates for I/T/Us are published annually in the Federal Register or Federal Register Notices. The outpatient rate is also known as the I/T/U encounter rate. The encounter rate is available only to I/T/U facilities that appear on the IHS maintained listing of IHS-operated and Indian health care facilities operating under a 638 agreement. It is the sole responsibility of the facility to petition IHS for placement on this list.

(9) **"Physician"** means a doctor of medicine or osteopathy legally authorized to practice medicine and surgery or who is a licensed physician employed by the Federal Government in an IHS facility or who provides services in a 638 Tribal Facility.

(10) **"State Administering Agency (SAA)"** is the Oklahoma Health Care Authority.

(11) **"638 Tribal Facility"** is a facility that is operated by a tribe or tribal organization and funded by Title I or Title

III of the Indian Self Determination and Education Assistance Act (Public Law 93-638).

317:30-5-1088. I/T/U provider participation requirements

(a) I/T/Us must ~~either~~ directly employ ~~or contract~~ the services of legally credentialed professional staff that are authorized within their scope of practice under state law to provide the services for which claims are submitted to SoonerCare; or I/T/U Physicians may meet all requirements for employment by the Federal Government as a physician and be employed by the Federal Government in an IHS facility or affiliated with a 638 Tribal Facility.

~~(b) The facility is required to report professional staff contracted or employed by the I/T/U to the OHCA. Participating I/T/Us are required to submit a list of names of all practitioners working within the facility and a list of all individual OHCA provider and National Provider Identifier (NPI) numbers. The reimbursement for the services rendered at or on behalf of the I/T/U will be made to the facility.~~

(b) The facility is required to contract with OHCA all professional staff employed by the I/T/U. Participating I/T/Us are required to submit contracts for all practitioners working within the facility via Oklahoma's Electronic Provider Enrollment (EPE) web-based system. The reimbursement for services rendered at or on behalf of the I/T/U will be made to the facility.

~~(c) The following professional staff are recognized by OHCA:~~

~~(1) Physicians;~~

~~(2) Licensed Physician Assistants;~~

~~(3) Dentists;~~

~~(4) Pharmacists;~~

~~(5) Advanced Practice Nurses (APNs) which include:~~

~~(A) Advanced Registered Nurse Practitioners (ARNPs);~~

~~(B) Certified Nurse Midwives (CNMs);~~

~~(C) Certified Registered Nurse Anesthetists (CRNAs); and~~

~~(D) Clinical Nurse Specialists (CNSs);~~

~~(6) Registered nurses under the supervision of a licensed physician; and~~

~~(7) Practitioners who are actively and regularly receiving board approved supervision, or those receiving extended supervision by a fully licensed clinician if board's supervision requirement is met but the individual is not yet fully licensed for the services that are within the practitioner's scope of practice. This includes but is not limited to:~~

~~(A) licensed clinical social workers (LSW-C);~~

~~(B) marital and family therapists (LMFT);~~

~~(C) licensed professional counselors (LPC);~~

~~(D) licensed behavioral practitioners (LBP); and~~
~~(E) licensed alcohol and drug counselors (LADC).~~

(c) Only professional staff listed as eligible providers in OAC 317:30-5 are recognized by OHCA.

317:30-5-1089. I/T/U multiple sites

(a) I/T/Us may contract as a PCP/CM under SoonerCare Choice (See OAC 317:25-7-5).

~~(b) I/T/Us are required to submit a list of all clinics affiliated or owned by the facility including any clinics that do not have I/T/U status, along with all OHCA provider numbers assigned to these clinics.~~

(b) I/T/Us are required to contract with all facilities affiliated or owned by the I/T/U to be eligible for SoonerCare reimbursement.

317:30-5-1090. Provision of other health services outside of the I/T/U encounter

~~(a) An I/T/U outpatient facility may provide other items and services which are not part of an encounter. If covered, these services are separately billable to the SoonerCare program. Coverage of services will be based upon medical necessity and the scope of coverage under the SoonerCare program and subject to any limitations, restrictions or prior authorization requirements.~~

~~(b)~~(a) Medically necessary SoonerCare covered services that are not included in the I/T/U outpatient encounter rate may be billed outside the encounter rate within the scope of the SoonerCare fee-for-service ~~rate~~contract. The services will be reimbursed at the fee-for-service rate, and will be subject to any limitations, restrictions or prior authorization requirements. Examples of these services include but are not limited to:

(1) pharmaceuticals/drugs;
(2) durable medical equipment;
(3) glasses;
(4) ambulance;
(5) home health;
(6) inpatient practitioner services;
(7) non-emergency transportation [refer to OAC 317:35-3-2];
(8) behavioral health case management [refer to ~~OAC 317:30-5-585 through 317:30-5-589 and OAC 317:30-5-595 through 317:30-5-599~~OAC 317:30-5-240 through 317:30-5-249];
(9) psychosocial rehabilitative services [refer to OAC 317:30-5-240 through ~~317:30-5-248~~317:30-5-249]; and
(10) psychiatric residential treatment facility services [refer to OAC 317:30-5-96.3].

~~(c)~~(b) If the I/T/U facility chooses to provide other SoonerCare State Plan covered health services which are not included in the I/T/U encounter definition, those service providers must be contracted with OHCA and bill for those services under their assigned provider number consistent with program coverage limitations and billing procedures described by the OHCA.
~~(d) The originating site facility fee for telemedicine services is not an I/T/U service. When an I/T/U serves as the originating site, the originating site facility fee is paid separately from the clinic's all-inclusive rate.~~

317:30-5-1091. Definition of I/T/U services
(a) As described in ~~Title 42 of the Code of Federal Regulations (CFR) 136.11(a)~~42 CFR 136.11(a), the I/T/U services may include hospital and medical care, dental care, public health nursing, ~~and~~ preventive care (including immunizations)~~, and health examination of special groups such as school children~~.
(b) Further, ~~Title~~ 42 CFR 136.11(c) allows that the scope and availability of I/T/U services will depend upon the resources of the facility.
(c) I/T/U services may be covered when furnished to a patient at the clinic or other location, including a mobile clinic, or the patient's place of residence. Provider contracts must meet the provider participation requirements found at OAC 317:30-5-1096.
(d) I/T/U outpatient encounters include but are not limited to:
(1) Physicians' services and supplies incidental to a physician's services;
(2) Within limitations as to the specific services furnished, a doctor of dentistry or oral surgery, a doctor of optometry, or a doctor of podiatry [Refer to Section 1861(r) of the Act for specific limitations];
~~(3) The services of a resident as defined in OAC 317:25-7-5(4) who meets the requirements for payment under SoonerCare and the supplies incidental to a resident's services;~~
~~(4)~~(3) Services of advanced practice nurses (APNs), physician assistants (PAs), certified nurse midwives (CNMs), or specialized advanced practice nurse practitioners;
~~(5)~~(4) Services and supplies incidental to the services of APNs and PAs (including services furnished by certified nurse midwives);
~~(6)~~(5) Public health nursing services, within the scope of their licensure, include but are not limited to services in the following areas:
(A) Phlebotomy;
(B) Wound care;
(C) Public health education;
(D) Administration of immunizations;
(E) Administration of medication;

(F) Child health screenings meeting EPSDT criteria;
(G) Smoking and Tobacco Use Cessation Counseling;
(H) Prenatal, newborn and postpartum assessments, including case management services for first time mothers; and
(I) General health assessments and management of conditions such as tuberculosis, diabetes and hypertension.

~~(7)~~(6) Visiting nurse services to the homebound;

~~(8)~~(7) Behavioral health professional services and services and supplies incidental to the services of LBHPs; and

~~(9)~~(8) Dental services.

317:30-5-1093. I/T/U visiting nurses services

(a) Visiting nurse services may be covered if:

(1) The services are rendered to a homebound individual~~,~~ who is permanently or temporarily confined to his or her place of residence because of a medical or health condition. The individual may be considered homebound if he or she leaves the place of residence infrequently. For this purpose, place of residence does not include a hospital or long term care facility; and

(2) The services are furnished by a registered nurse, licensed practical nurse, or licensed vocational nurse who is employed by, ~~or~~and receives compensation for the services from the I/T/U; and

(3) The services are furnished under a written plan of treatment that is:

(A) established and reviewed at least every 60 days by a supervising physician of the I/T/U or established by a nurse practitioner, physician assistant, nurse midwife, or specialized nurse practitioner and reviewed at least every 60 days by a supervising physician; and

(B) signed by the nurse practitioner, physician assistant, nurse midwife, specialized nurse practitioner, or the supervising physician of the clinic.

(b) The nursing care covered in this Section includes:

(1) Services that must be performed by a registered nurse, licensed practical nurse, or licensed vocational nurse if the safety of the patient ~~is to be assured~~can be assured in the home and the medically desired results achieved; and

(2) Personal care services, to the extent covered under Medicare as home health services. These services include helping the patient to bathe, to get in and out of bed, to exercise and to take medications.

(c) This benefit does not cover household and housekeeping services or other services that would constitute custodial care.

~~(d) For purposes of this Section, homebound means an individual who is permanently or temporarily confined to his or her place of residence because of a medical or health condition. The individual may be considered homebound if he or she leaves the place of residence infrequently. For this purpose, place of residence does not include a hospital or long term care facility.~~

317:30-5-1094. Behavioral health services provided at I/T/Us

(a) Behavioral health services that are primary, preventive, and therapeutic and would be covered if provided in another setting may be provided by I/T/U providers. Services provided by an I/T/U (refer to OAC 317:30-5-241 for a description of services) must meet the same requirements as services provided by another provider. Services include:

(1) Mental Health Assessment/Evaluation Testing;

(2) Alcohol and/or Substance Abuse Services Assessment and Treatment Plan Development;

(3) Crisis Intervention Services;

(4) Medication Training and Support;

(5) Individual/interactive Psychotherapy;

(6) Group Psychotherapy; and

(7) Family Psychotherapy.

(b) Behavioral health professional therapy services are covered when provided in accordance with a documented individualized treatment plan, developed to treat the identified mental health and/or substance abuse disorder(s). A minimum of a 45 to 50 minute standard clinical session must be completed by an I/T/U in order to bill an encounter for the session. Treatment must be documented in accordance with OAC 317:30-5-248.

(c) In order to support access to mental health services, these services may be provided in settings outside of the I/T/U. Offsite services must take place in a confidential setting.

(d) The outpatient behavioral health services' provider enrollment and reimbursement process in no way changes the OHCA's policy with regard to reimbursement of practitioners. Licensed clinical social workers ~~(LSW-C)~~(LCSW), licensed marital and family therapists (LMFT), licensed professional counselors (LPC), licensed behavioral practitioners (LBP), ~~and~~ licensed alcohol and drug counselors (LADC), and licensure candidates are not eligible for direct reimbursement as practitioners. Their services are compensable only when billed by their employers and when provided in those clinical settings in which they are currently approved to render services. Licensure candidates must meet the requirements contained in OAC 317:30-5-240.3.

(e) For the provision of behavioral health related case management services, I/T/U providers must meet the requirements found at OAC ~~317:30-5-585 through 317:30-5-589 and OAC 317:30-5-~~

~~595 through 317:30-5-599~~317:30-5-240 through 317:30-5-249, and be contracted as such. The provision of these services is considered to be outside of the I/T/U encounter. Contracted behavioral health case management providers are responsible for obtaining all necessary prior authorizations, if needed, and will be paid at the current fee-for-service rate.

(f) For the provision of psychosocial rehabilitation services, I/T/U facilities meet the requirements found at OAC 317:30-5-240 through ~~317:30-5-248~~317:30-5-249, and must contract as an outpatient behavioral health agency. The provision of these services is considered to be outside of the I/T/U encounter. Contracted psychosocial rehabilitation service providers are responsible for obtaining all necessary prior authorizations, if needed, and will be paid at the current fee-for-service rate.

317:30-5-1095. I/T/U services not compensable under outpatient encounters

~~(a)~~ I/T/U services that are not compensable under outpatient encounters include:

(1) group or mass information programs, health education classes, or group education activities, including media productions and publications;

(2) vaccines covered by the Vaccines for Children program [refer to OAC 317:30-5-14(a)(1)];

(3) group or sports physicals and medical reports;

(4) drug samples or other prescription drugs provided to the clinic free of charge;

(5) administrative medical examinations and report services; and

(6) gauze, band-aids, or other disposable products used during an office visit.

~~(b) Exclusions from the definition of I/T/U encounters include but are not limited to:~~

~~(1) Durable medical equipment or medical supplies not generally provided during the course of a clinic visit such as diabetic supplies;~~

~~(2) Pharmaceutical or biologicals not generally provided during the clinic visit. For example, sample medications are part of the encounter but dispensing a prescription is billed separately under the fee-for-service pharmacy program;~~

~~(3) Other services that are not defined in this rule or the State Plan under Title XIX or Title XXI of the Social Security Act.~~

~~(4) Eyeglasses (refer to OAC 317:30-5-450);~~

~~(5) Emergency ambulance transportation (refer to OAC 317:30-5-335);~~

~~(6) Non-emergency transportation;~~

~~(7) Prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags) and supplies directly related to colostomy care and the replacement of such devices;~~
~~(8) Behavioral health rehabilitative services [see OAC 317:30-5-241];~~
~~(9) hearing aids; and~~
~~(10) Behavioral health case management service [refer to OAC 317:30-585 through 317:30-589 and OAC 317:30-5-595 through 317:30-5-599].~~

317:30-5-1096. I/T/U off-site services

I/T/U covered services provided off-site or outside of the I/T/U setting, including mobile clinics or places of residence, are compensable when billed by the I/T/U. ~~The I/T/U must have a written contract with the physician and other practitioners that specifies that the I/T/U will bill SoonerCare for services provided off-site and how such providers will be compensated.~~ The I/T/U must meet provider participation requirements listed in 317:30-5-1088. I/T/U off-site services may be covered if the services rendered were within the provider's scope of practice and are of the same integrity of services rendered at the I/T/U facility.

317:30-5-1098. I/T/U outpatient encounters

(a) I/T/U outpatient encounters that are billed to the OHCA must meet the definition in this Section and are limited to services covered by the OHCA. These services include health services included in the State Plan under Title XIX or Title XXI of the Social Security Act.

(b) The following words and terms have the following meaning unless the context clearly indicates otherwise:

~~(1) An I/T/U outpatient encounter is a face-to-face contact between a health care professional and a CDIB card eligible SoonerCare member for the provision of Title XIX and Title XXI covered outpatient services in an I/T/U facility within a 24-hour period ending at midnight, as documented in the patient's medical record.~~

(1) An I/T/U encounter means a face to face or telemedicine contact between a health care professional and an IHS eligible SoonerCare member for the provision of medically necessary Title XIX or Title XXI covered services through an IHS or Tribal 638 facility or an urban Indian clinic within a 24-hour period ending at midnight, as documented in the patient's record.

~~(2) An I/T/U encounter means outpatient services that may be covered when furnished to a patient by employees of the I/T/U~~

~~facility at the I/T/U facility or other location, including the patient's place of residence.~~

(2) An I/T/U outpatient encounter means outpatient services that may be covered when furnished to a patient by a contracted SoonerCare provider employed by the I/T/U facility and rendered at the I/T/U facility or other location, including the patient's place of residence.

(c) The following services may be considered reimbursable encounters subject to the limitations of the Oklahoma State Plan and include any related medical supplies provided during the course of the encounter:

(1) Medical;
(2) Diagnostic;
(3) Behavioral Health services [refer to OAC 317:30-5-1094];
(4) Dental, Medical and Mental Health Screenings;
(5) Vision;
(6) Physical Therapy;
(7) Occupational Therapy;
(8) Podiatry;
(9) Speech;
(10) Hearing;
(11) Visiting Nurse Service [refer to OAC 317:30-5-1093];
(12) Smoking and Tobacco Use Cessation Counseling
(13) Other Title XIX or XXI services as allowed under OHCA's SoonerCare State Plan and OHCA Administrative Rules;
(14) Drugs or medication treatments provided during a clinic visit are part of the encounter rate. For example, a member has come into the clinic with high blood pressure and is treated at the clinic with a hypertensive drug or drug sample. Drug samples are included in the encounter rate. Prescriptions are not included in the encounter rate and must be billed through the pharmacy program by a qualified enrolled pharmacy;
(15) Encounters with a registered professional nurse or a licensed practical nurse and related medical supplies (other than drugs and biologicals) furnished on a part-time or intermittent basis to home-bound members; and
(16) I/T/U Multiple Outpatient Encounters.

(A) OHCA will cover one medically necessary outpatient medical encounter per member per day unless if due to an emergency, the same member returns on the same day for a second visit with a different diagnosis. Then, a second encounter is allowed.

(B) OHCA will cover one dental encounter per member per day regardless of how many procedures are done or how many providers are seen unless if due to an emergency, the same member returns on the same day for a second visit and has

a different diagnosis. Then, a second encounter is allowed.

(C) OHCA will cover one behavioral health professional outpatient encounter per member per day unless if due to an emergency, the same member returns on the same day for a second visit and has a different diagnosis. Then, a second encounter is allowed.

(D) Each service must have distinctly different diagnoses in order to meet the criteria for multiple I/T/U outpatient encounters. ~~For example, a medical visit and a dental visit on the same day are considered different services with distinctly different diagnoses.~~

~~(E) Similar services, even when provided by two different I/T/U health care practitioners, are not considered multiple encounters. Situations that would not be considered multiple encounters provided on the same date of service include, but are not limited to:~~

~~(i) A well child check and an immunization;~~

~~(ii) A preventive dental screen and fluoride varnish application in a single setting;~~

~~(iii) A medical encounter with a mental health or addiction diagnosis on the same day as a mental health or addiction encounter;~~

~~(iv) A mental health and addiction encounter with similar diagnosis;~~

~~(v) Any time a member receives only a partial service with one provider and partial service from another provider. This would be considered a single encounter.~~

~~(d) More than one outpatient visit with a medical professional within a 24-hour period for distinctly different diagnoses may be reported as two encounters. This does not imply that if a member is seen at a single office visit with multiple problems that multiple encounters can be billed. For example, a member comes to the clinic in the morning for an immunization, and in the afternoon, the member falls and breaks an arm. This would be considered multiple medical encounters and can be billed as two encounters. However, a member who comes to the I/T/U facility for a prenatal visit in the morning and delivers in the afternoon would not be considered a distinctly different diagnosis and can only be billed as a single encounter.~~

(d) More than one outpatient visit with a medical professional within a 24-hour period for distinctly different diagnoses may be reported as two encounters. This does not imply that if a member is seen at a single office visit with multiple problems that multiple encounters can be billed. For example, a member comes to the clinic in the morning for an immunization, and in the afternoon, the member falls and breaks an arm. This would be considered multiple medical encounters and can be billed as

two encounters. However, a member who comes to the I/T/U facility for a diabetic wellness screening and is then referred to a podiatrist within the clinic for diabetes-related follow-up on the same date of service would not be considered a distinctly different diagnosis and can only be billed as a single encounter.

(e) The following services may be considered as separate or multiple encounters when two or more services are provided on the same date of service with distinctly different diagnoses:

(1) Medical Services;

(2) Dental Services;

(3) Mental Health and addiction services with similar diagnoses can only be billed as one encounter. In addition, if the member is also seen for a medical office visit with a mental health or addiction diagnosis, then it is considered a single encounter;

(4) Physical or occupational therapy (PT/OT). If this service is also performed on the same date of service as the medical encounter that determined the need for PT/OT (initial referral), then it is considered a single encounter;

(5) Administration of immunizations. If no other medical office visit occurs on the same date of services; and

(6) Tobacco cessation limited to state plan services. If no other medical or addiction encounter occurs on the same date of service.

(f) I/T/U outpatient encounters for ~~CDIB~~IHS eligible SoonerCare members whether medical, dental, or behavioral health, are not subject to prior authorization. Other State Plan covered services that the I/T/U facility chooses to provide but which are not part of the I/T/U encounter are subject to all applicable SoonerCare regulations which govern the provision and coverage for that service.

317:30-5-1099. I/T/U service limitations

Service limitations governing the provision of all Oklahoma SoonerCare services will apply pursuant to Chapter 30 of the OHCA rules. In addition, the following limitations and requirements apply to services provided by I/T/U facilities:

(1) **Multiple encounters.** An I/T/U facility may bill for more than one encounter per 24 hour period under certain conditions.

(2) **Behavioral Health services.** Behavioral Health Services are limited to those services furnished to members at or on behalf of the I/T/U facility.

(3) **Laboratory procedures.** Laboratory procedures performed by an I/T/U outpatient facility (not an independently certified enrolled laboratory) on the same date of service

are considered part of the health care practitioner's service and are included in the I/T/U encounter.

317:30-5-1100. Inpatient care provided by IHS facilities

Inpatient practitioner services are separately contracted and paid at a fee-for-service rate. Each individual inpatient practitioner must be contracted with SoorerCare and attached to a SoonerCare contracted medical group. The Inpatient hospital per diem rate for inpatient medical care provided by IHS facilities is published annually in the Federal Register or Federal Register Notices. In order to receive the inpatient hospital per diem rate, the IHS or Tribal 638 facility must:

(1) be contracted as a provider with the Oklahoma Health Care Authority; and

(2) appear on the IHS maintained listing of IHS-operated and Indian health care facilities operating under a 638 agreement. It is the sole responsibility of the facility to petition IHS for placement on this list.

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 15, 2016

The proposed policy is a Permanent Rule. This proposal is scheduled to be presented to the Medical Advisory Committee (MAC) on January 21, 2016 and the (OHCA) Board of Directors on February 11, 2016.
Reference: APA WF 15-29

SUMMARY:
Behavioral Health Case Management — Proposed Behavioral Health Case Management policy changes will transfer coverage guidelines and provider requirements for case management services to another Part of rules addressing guidelines for services provided by Outpatient Behavioral Health Agencies.

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 Part 431,440, and 441

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

TO: Tywanda Cox
Health Policy

FROM: Traylor Rains-Sims
Oklahoma Department of Mental Health & Substance Abuse Services

SUBJECT: Rule Impact Statement
APA WF # 15-29

A. Brief description of the purpose of the rule:

The Agency is proposing rule revisions to its Behavioral

Health Case Management policy in order to transfer coverage guidelines and provider requirements for case management services to another Part of rules addressing guidelines for services provided by Outpatient Behavioral Health Agencies. This change is being made to reduce provider confusion and to organize outpatient behavioral health agency service rules in a way that is more comprehensive and easily understood by SoonerCare providers and 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:

No classes of persons will be affected from this proposed rule.

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

Outpatient behavioral health agencies may benefit from the proposed rule in that they will be able to access rules in a more organized, transparent manner.

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 the affected classes of persons or political subdivisions. There are no fee changes 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 effect on state revenues, including a projected net loss or gain in such revenues if it can be projected by the agency:

The Agency has determined that there are no probable net costs to OHCA or other agencies expected as a result of the

proposed rules nor is there an anticipated effect on State revenues.

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:

The Agency has determined that there is no potential adverse effect on small business as a result of the proposed rule change.

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:

Throughout the year Agency staff gather relevant information through stakeholder involvement and public forums in order to communicate the planned actions of the Agency concerning rulemaking, as well as other issues. While it is difficult to balance the needs of SoonerCare members with those of the various providers, the Agency proposes rules with each of these issues and interests considered.

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:

The Agency has determined that the proposed rules will have no detrimental effect on the public health, safety and environment if they are not implemented.

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

The rule impact statement was prepared December 7, 2015.

RULE TEXT

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 21. OUTPATIENT BEHAVIORAL HEALTH AGENCY SERVICES

317:30-5-240.3 Staff Credentials

(a) **Licensed Behavioral Health Professional (LBHPs).** LBHPs are defined as follows:

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

(2) Practitioners with a license to practice in the state in which services are provided, issued by one of the licensing boards listed in (A) through (F). The exemptions from licensure under 59 § 1353(4) (Supp. 2000) and (5), 59 § 1903(C) and (D) (Supp. 2000), 59 § 1925.3(B) (Supp. 2000) and (C), and 59 § 1932(C) (Supp. 2000) and (D) do not apply to Outpatient Behavioral Health Services.

(A) Psychology,
(B) Social Work (clinical specialty only),
(C) Professional Counselor,
(D) Marriage and Family Therapist,
(E) Behavioral Practitioner, or
(F) Alcohol and Drug Counselor.

(3) 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.

(4) A Physician 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.

(b) **Licensure Candidates.** Licensure candidates are practitioners actively and regularly receiving board approved supervision, and extended supervision by a fully licensed clinician if board's supervision requirement is met but the individual is not yet licensed, to become licensed by one of the licensing boards listed in (2)(A) through (F) above. The supervising LBHP responsible for the member's care must:

(1) staff the member's case with the candidate,

(2) be personally available, or ensure the availability of an LBHP to the candidate for consultation while they are providing services,

(3) agree with the current plan for the member, and

(4) confirm that the service provided by the candidate was appropriate; and

(5) The member's medical record must show that the requirements for reimbursement were met and the LBHP responsible for the member's care has reviewed, countersigned, and dated the service plan and any updates thereto so that it is documented that the licensed professional is responsible for the member's care.

(c) **Certified Alcohol and Drug Counselors (CADCs).** CADCs are defined as having a current certification as a CADC in the state in which services are provided.

(d) **Multi-Systemic Therapy (MST) Provider.** Masters level therapist who works on a team established by OJA which may include Bachelor level staff.

(e) **Peer Recovery Support Specialist (PRSS).** The Peer Recovery Support Specialist must be certified by ODMHSAS pursuant to requirements found in OAC 450:53.

(f) **Family Support and Training Provider (FSP).** FSPs are defined as follows:

(1) Have a high school diploma or equivalent;

(2) be 21 years of age and have successful experience as a family member of a child or youth with serious emotional disturbance, or a minimum of 2 years' experience working with children with serious emotional disturbance or be equivalently qualified by education in the human services field or a combination of work experience and education with one year of education substituting for one year of experience (preference is given to parents or care givers of child with SED);

(3) successful completion of ODMHSAS Family Support Training;

(4) pass background checks; and

(5) service plans must be overseen and approved by an LBHP or Licensure Candidate; and

(6) must function under the general direction of an LBHP, or Licensure Candidate or systems of care team, with an LBHP or Licensure Candidate available at all times to provide back up, support, and/or consultation.

(g) **Behavioral Health Aide (BHA).** BHAs are defined as follows:

(1) Behavioral Health Aides must have completed 60 hours or equivalent of college credit; or

(2) may substitute one year of relevant employment and/or responsibility in the care of children with complex emotional needs for up to two years of college experience; and

(3) must have successfully completed the specialized training and education curriculum provided by the ODMHSAS; and

(4) must be supervised by a bachelor's level individual with a minimum of two years case management or care coordination experience; and

(5) service plans must be overseen and approved by an LBHP or Licensure Candidate; and

(6) must function under the general direction of an LBHP, or Licensure Candidate and/or systems of care team, with an LBHP or Licensure Candidate available at all times to provide back up, support, and/or consultation.

(h) **Behavioral Health Case Manager.** For behavioral health case management services to be compensable by SoonerCare, the provider performing the services must be an LBHP, Licensure Candidate, CADC or have and maintain a current certification as a Case Manager II (CM II) or Case Manager I (CM I) from ODMHSAS. The requirements for obtaining these certifications are as follows:

(1) Certified Behavioral Health Case Manager II (CM II) must meet the requirements in (A), (B), (C) or (D) below:

(A) Possess a Bachelor's or Master's degree in a behavioral health related field earned from a regionally accredited college or university recognized by the United States Department of Education (USDE) or a Bachelor's or Master's degree in education; and complete web-based training for behavioral health case management and behavioral health rehabilitation as specified by ODMHSAS; and complete one day of face-to-face behavioral health case management training and two days of face-to-face behavioral health rehabilitation training as specified by ODMHSAS; and pass web-based competency exams in behavioral health case management and behavioral health rehabilitation.

(B) Possess a current license as a registered nurse in the State of Oklahoma with experience in behavioral health care; complete web-based training for behavioral health case management and behavioral health rehabilitation as specified by ODMHSAS; complete one day of face-to-face behavioral health case management training and two days of face-to-face behavioral health rehabilitation training as specified by ODMHSAS; and pass web-based competency exams for behavioral health case management and behavioral health rehabilitation.

(C) Possess a Bachelor's or Master's degree in any field earned from a regionally accredited college or university recognized by the USDE and a current certification or Children's Certificate in Psychiatric Rehabilitation from the US Psychiatric Rehabilitation Association (USPRA);

complete the behavioral health case management web-based training as specified by ODMHSAS; complete one day of face-to-face behavioral health case management training; and pass web-based competency exams for behavioral health case management. Applicants who have not received a certificate in children's psychiatric rehabilitation from the US Psychiatric Association (USPRA) must also complete the behavioral health rehabilitation web-based training as specified by ODMHSAS.

(D) Possess a Bachelor's or Master's degree in any field and proof of active progression toward obtaining a clinical licensure Master's or Doctoral degree at a regionally accredited college or university recognized by the USDE and complete web-based training for behavioral health case management and behavioral health rehabilitation as specified by ODMHSAS; complete one day of face-to-face behavioral health case management training and two days of face-to-face behavioral health rehabilitation training as specified by ODMHSAS; and pass web-based competency exams in behavioral health case management and behavioral health rehabilitation.

(2) Certified Behavioral Health Case Manager I meets the requirements in either (A) or (B) and (C):

(A) completed 60 college credit hours; or

(B) has a high school diploma with 36 total months of experience working with persons who have a mental illness and/or substance abuse. Documentation of experience on file with ODMHSAS; and

(C)completes two days of ODMHSAS specified behavioral health case management training and passes a web-based competency exam for behavioral health case management.

(3) **Wraparound Facilitator Case Manager.** LBHP, Licensure Candidate, CADC, or meets the qualifications for CM II and has the following:

(A) successful completion of the ODMHSAS training for wraparound facilitation within six months of employment; and

(B) participate in ongoing coaching provided by ODMHSAS and employing agency; and

(C) successfully complete wraparound credentialing process within nine months of beginning process; and

(D) direct supervision or immediate access and a minimum of one hour weekly clinical consultation with a Qualified Mental Health Professional, as required by ODMHSAS.

(4) **Intensive Case Manager.** LBHP, Licensure Candidate, CADC or meets the provider qualifications of a Case Manager II and has the following:

(A) A minimum of two years Behavioral Health Case Management experience, crisis diversion experience, and

(B) must have attended the ODMHSAS six hours Intensive case management training.

317:30-5-241.6 Behavioral Health Case Management [NEW]

Payment is made for behavioral health case management services as set forth in this Section.

(1) Payment is made for services rendered to SoonerCare members as follows:

(A) **Description of behavioral health case management services.** Services under behavioral health case management are not comparable in amount, duration and scope. The target group for behavioral health case management services are persons under age 21 who are in imminent risk of out-of-home placement for psychiatric or substance abuse reasons or are in out-of-home placement due to psychiatric or substance abuse reasons and chronically and/or severely mentally ill adults who are institutionalized or are at risk of institutionalization. All behavioral health case management services will be subject to medical necessity criteria.

(i) Behavioral health case management services are provided to assist eligible individuals in gaining access to needed medical, social, educational and other services essential to meeting basic human needs. The behavioral health case manager provides assessment of case management needs, development of a case management care plan, referral, linkage, monitoring and advocacy on behalf of the member to gain access to appropriate community resources. The behavioral health case manager must monitor the progress in gaining access to services and continued appropriate utilization of necessary community resources. Behavioral case management is designed to promote recovery, maintain community tenure, and to assist individuals in accessing services for themselves following the case management guidelines established by ODMHSAS. In order to be compensable, the service must be performed utilizing the Strengths Based model of case management. This model of case management assists individuals in identifying and securing the range of resources, both environmental and personal, needed to live in a normally interdependent way in the community. The focus for the helping process is on strengths, interests, abilities, knowledge and capacities of each person, not on their diagnosis, weakness or deficits. The relationship between the service member and the behavioral health case manager

is characterized by mutuality, collaboration, and partnership. Assistive activities are designed to occur primarily in the community, but may take place in the behavioral health case manager's office, if more appropriate. The provider will coordinate with the member and family (if applicable) by phone or face-to-face, to identify immediate needs for return to home/community no more than 72 hours after notification that the member/family requests case management services. For members discharging from a higher level of care than outpatient, the higher level of care facility is responsible for scheduling an appointment with a case management agency for transition and post discharge services. The case manager will make contact with the member and family (if applicable) for transition from the higher level of care than outpatient back to the community, within 72 hours of discharge, and then conduct a follow-up appointment/contact within seven days. The case manager will provide linkage/referral to physicians/medication services, psychotherapy services, rehabilitation and/or support services as described in the case management service plan. Case Managers may also provide crisis diversion (unanticipated, unscheduled situation requiring supportive assistance, face-to-face or telephone, to resolve immediate problems before they become overwhelming and severely impair the individual's ability to function or maintain in the community) to assist member(s) from progression to a higher level of care. During the follow-up phase of these referrals or links, the behavioral health case manager will provide aggressive outreach if appointments or contacts are missed within two business days of the missed appointments. Community/home based case management to assess the needs for services will be scheduled as reflected in the case management service plan, but not less than one time per month. The member/parent/guardian has the right to refuse behavioral health case management and cannot be restricted from other services because of a refusal of behavioral health case management services.

(ii) An eligible member/parent/guardian will not be restricted and will have the freedom to choose a behavioral health case management provider as well as providers of other medical care.

(iii) In order to ensure that behavioral health case management services appropriately meet the needs of the member and family and are not duplicated, behavioral

health case management activities will be provided in accordance with an individualized plan of care.

(iv) The individual plan of care must include general goals and objectives pertinent to the overall recovery of the member's (and family, if applicable) needs. Progress notes must relate to the individual plan of care and describe the specific activities to be performed. The individual plan of care must be developed with participation by, as well as, reviewed and signed by the member, the parent or guardian (if the member is under 18), the behavioral health case manager, and a Licensed Behavioral Health Professional or Licensure Candidate as defined in OAC 317:30-5-240.3(a) and (b).

(v) SoonerCare reimbursable behavioral health case management services include the following:

(I) Gathering necessary psychological, educational, medical, and social information for the purpose of individual plan of care development.

(II) Face-to-face meetings with the member and/or the parent/guardian/family member for the implementation of activities delineated in the individual plan of care.

(III) Face-to-face meetings with treatment or service providers, necessary for the implementation of activities delineated in the individual plan of care.

(IV) Supportive activities such as non-face-to-face communication with the member and/or parent/guardian/family member.

(V) Non face-to-face communication with treatment or service providers necessary for the implementation of activities delineated in the individual plan of care.

(VI)Monitoring of the individual plan of care to reassess goals and objectives and assess progress and or barriers to progress.

(VII) Crisis diversion (unanticipated, unscheduled situation requiring supportive assistance, face-to-face or telephone, to resolve immediate problems before they become overwhelming and severely impair the individual's ability to function or maintain in the community) to assist member(s) from progression to a higher level of care.

(VIII) Transitioning from institutions to the community. Behavioral Health Case Management is available to individuals transitioning from institutions to the community (except individuals

ages 22 to 64 who reside in an institution for mental diseases (IMD) or individuals who are inmates of public institutions). Individuals are considered to be transitioning to the community during the last 30 consecutive days of a covered institutional stay. This time is to distinguish case management services that are not within the scope of the institution's discharge planning activities from case management required for transitioning individuals with complex, chronic, medical needs to the community. Transition services provided while the individual is in the institution are to be claimed as delivered on the day of discharge from the institution.

(B) **Levels of Case Management.**

(i) Basic Case Management/Resource Coordination. Resource coordination services are targeted to adults with serious mental illness and children and adolescents with mental illness or serious emotional disturbance, and their families, who need assistance in accessing, coordination, and monitoring of resources and services. Services are provided to assess an individual's strengths and meet needs in order to achieve stability in the community. Standard managers have caseloads of 30 - 35 members. Basic case management/resource coordination is limited to 25 units per member per month.

(ii) Intensive Case Management (ICM)/Wraparound Facilitation Case Management (WFCM). Intensive Case Management is targeted to adults with serious and persistent mental illness (including members in PACT programs) and Wraparound Facilitation Case Management is targeted to children with serious mental illness and emotional disorders (including members in a System of Care Network) who are deemed high risk and in need of more intensive CM services. It is designed to ensure access to community agencies, services, and people whose functions are to provide the support, training and assistance required for a stable, safe, and healthy community life, and decreased need for higher levels of care. To produce a high fidelity wraparound process, a facilitator can facilitate between 8 and 10 families. To ensure that these intense needs are met, case manager caseloads are limited between 10-15 caseloads. The ICM shall be a Certified Behavioral Health Case Manager, have a minimum of 2 years Behavioral Health Case Management experience, crisis diversion experience, must have attended the ODMHSAS 6 hours ICM training, and 24 hour availability is required.

ICM/WFCM is limited to 54 units per member per month.

(C) **Excluded Services.** SoonerCare reimbursable behavioral health case management does not include the following activities:

(i) physically escorting or transporting a member or family to scheduled appointments or staying with the member during an appointment; or

(ii) managing finances; or

(iii) providing specific services such as shopping or paying bills; or

(iv) Delivering bus tickets, food stamps, money, etc.; or

(v) counseling, rehabilitative services, psychiatric assessment, or discharge planning; or

(vi) filling out forms, applications, etc., on behalf of the member when the member is not present; or

(vii) filling out SoonerCare forms, applications, etc.;

(viii) mentoring or tutoring;

(ix) provision of behavioral health case management services to the same family by two separate behavioral health case management agencies;

(x) non-face-to-face time spent preparing the assessment document and the service plan paperwork;

(xi) monitoring financial goals;

(xii) services to nursing home residents;

(xiii) psychotherapeutic or rehabilitative services, psychiatric assessment, or discharge; or

(xix) services to members residing in ICF/IID facilities.

(D) **Excluded Individuals.** The following SoonerCare members are not eligible for behavioral health case management services:

(i) children/families for whom behavioral health case management services are available through OKDHS/OJA staff without special arrangements with OKDHS, OJA, and OHCA;

(ii) members receiving Residential Behavior Management Services (RBMS) in a foster care or group home setting unless transitioning into the community;

(iii) residents of ICF/IID and nursing facilities unless transitioning into the community;

(iv) members receiving services under a Home and Community Based services (HCBS) waiver program.

(E) Case management services provided to Medicare eligible members should be filed directly with the fiscal agent.

(F) **Documentation requirements.** The service plan must include general goals and objectives pertinent to the overall recovery needs of the member. Progress notes must

relate to the service plan and describe the specific activities performed. Behavioral health case management service plan development is compensable time if the time is spent communicating with the member and it must be reviewed and signed by the member, the behavioral health case manager, and a licensed behavioral health professional or licensure candidate as defined at OAC 317:30-5-240.3(a) and (b). All behavioral health case management services rendered must be reflected by documentation in the records. In addition to a complete behavioral health case management service, plan documentation of each session must include but is not limited to:

(i) date;

(ii) person(s) to whom services are rendered;

(iii) start and stop times for each service;

(iv) original signature or the service provider (original signatures for faxed items must be added to the clinical file within 30 days);

(v) credentials of the service provider;

(vi) specific service plan needs, goals and/or objectives addressed;

(vii) specific activities performed by the behavioral health case manager on behalf of the child related to advocacy, linkage, referral, or monitoring used to address needs, goals and/or objectives;

(viii) progress and barriers made towards goals, and/or objectives;

(ix) member (family when applicable) response to the service;

(x) any new service plan needs, goals, and/or objectives identified during the service; and

(xi) member satisfaction with staff intervention.

(G) **Case Management Travel Time.** The rate for case management services assumes that the case manager will spend some amount of time traveling to the member for the face-to-face service. The case manager must only bill for the actual face-to-face time that they spend with the member and not bill for travel time. This would be considered duplicative billing since the rate assumes the travel component already.

317:30-5-249. Non-covered services

In addition to the general program exclusions [OAC 317:30-5-2(a)(2)] the following are excluded from coverage. Work and education services:

(1) Talking about the past and current and future employment

goals, going to various work sites to explore the world of work, and assisting client in identifying the pros and cons of working.

(2) Development of an ongoing educational and employment rehabilitation plan to help each individual establish job specific skills and credentials necessary to achieve ongoing employment. Psycho-social skills training however would be covered.

(3) Work/school specific supportive services, such as assistance with securing of appropriate clothing, wake-up calls, addressing transportation issues, etc. These would be billed as Case Management following ~~317:30-5-595 through 317:30-5-599~~317:30-5-241.6.

(4) Job specific supports such as teaching/coaching a job task.

PART 67. BEHAVIORAL HEALTH CASE MANAGEMENT SERVICES

317:30-5-595. Eligible providers [REVOKED]

~~Services are provided by outpatient behavioral health agencies established for the purpose of providing behavioral health outpatient and case management services.~~

~~(1) **Provider agency requirements.** Services are provided by outpatient behavioral health agencies contracted with OHCA that meet the requirements under OAC 317:30-5-240. The agency must demonstrate its capacity to deliver behavioral health case management services in terms of the following items:~~

~~(A) OHCA reserves the right to obtain a copy of any accreditation audit and/or site visit reports from the provider and/or the accreditation agency.~~

~~(B) Agencies that are eligible to contract with OHCA to provide behavioral health case management services to eligible individuals must be community based.~~

~~(C) The agency must be able to demonstrate the ability to develop and maintain appropriate patient records including but not limited to assessments, service plans, and progress notes.~~

~~(D) An agency must agree to follow the Oklahoma Department of Mental Health and Substance Abuse Services established behavioral health case management rules found in OAC 450:50.~~

~~(E) An agency's behavioral health case management staff must serve the target group on a 24 hour on call basis.~~

~~(F) Each site operated by a behavioral health outpatient and case management facility must have a separate provider number, per OAC 317:30-5-240.2.~~

(2) **Provider Qualifications.** For behavioral health case management services to be compensable by SoonerCare, the provider performing the service must be an LBHP, Licensure Candidate, CADC, or have and maintain a current certification as a Case Manager II (CM II) or Case Manager I (CM I) from the ODMHSAS. The requirements for obtaining these certifications are as follows:

(A) Certified Behavioral Health Case Manager II (CM II) must meet the requirements in (i), (ii), (iii) or (iv) below:

(i) Possess a Bachelor's or Master's degree in a behavioral health related field earned from a regionally accredited college or university recognized by the United States Department of Education (USDE) or a Bachelor's or Master's degree in education; and complete web-based training for behavioral health case management and behavioral health rehabilitation as specified by ODMHSAS; and complete one day of face-to-face behavioral health case management training and two days of face-to-face behavioral health rehabilitation training as specified by ODMHSAS; and pass web-based competency exams in behavioral health case management and behavioral health rehabilitation.

(ii) Possess a current license as a registered nurse in the State of Oklahoma with experience in behavioral health care; complete web-based training for behavioral health case management and behavioral health rehabilitation as specified by ODMHSAS; complete one day of face-to-face behavioral health case management training and two days of face-to-face behavioral health rehabilitation training as specified by ODMHSAS; and pass web-based competency exams for behavioral health case management and behavioral health rehabilitation.

(iii) Possess a Bachelor's or Master's degree in any field earned from a regionally accredited college or university recognized by the USDE and a current certification or Children's Certificate in Psychiatric Rehabilitation from the US Psychiatric Rehabilitation Association (USPRA); complete the behavioral health case management web-based training as specified by ODMHSAS; complete one day of face-to-face behavioral health case management training; and pass web-based competency exams for behavioral health case management. Applicants who have not received a certificate in children's psychiatric rehabilitation from the US Psychiatric Association (USPRA) must also complete the

behavioral health rehabilitation web-based training as specified by ODMHSAS.

(iv) Possess a Bachelor's or Master's degree in any field and proof of active progression toward obtaining a clinical licensure Master's or Doctoral degree at a regionally accredited college or university recognized by the USDE and complete web-based training for behavioral health case management and behavioral health rehabilitation as specified by ODMHSAS; complete one day of face-to-face behavioral health case management training and two days of face-to-face behavioral health rehabilitation training as specified by ODMHSAS; and pass web-based competency exams in behavioral health case management and behavioral health rehabilitation.

(B) Certified Behavioral Health Case Manager I meets the requirements in either (i) or (ii), and (iii):

(i) completed 60 college credit hours; or

(ii) has a high school diploma with 36 total months of experience working with persons who have a mental illness and/or substance abuse. Documentation of experience on file with ODMHSAS; and

(iii)Completes two days of ODMHSAS specified behavioral health case management training and passes a web-based competency exam for behavioral health case management.

(C) **Wraparound Facilitator Case Manager.** LBHP, Licensure Candidate, CADC, or meets the qualifications for CM II and has the following:

(i) Successful completion of the ODMHSAS training for wraparound facilitation within six months of employment; and

(ii) Participate in ongoing coaching provided by ODMHSAS and employing agency; and

(iii) Successfully complete wraparound credentialing process within nine months of beginning process; and

(iv) Direct supervision or immediate access and a minimum of one hour weekly clinical consultation with a Qualified Mental Health Professional, as required by ODMHSAS.

(D) **Intensive Case Manager.** LBHP, Licensure Candidate, CADC or meets the provider qualifications of a Case Manager II and has the following:

(i) A minimum of two years Behavioral Health Case Management experience, crisis diversion experience, and

(ii) must have attended the ODMHSAS six hours Intensive case management training.

(E) All certified case managers must fulfill the continuing education requirements as outlined under OAC

~~450:50-5-4.~~

317:30-5-596. Coverage by category [REVOKED]

~~Payment is made for behavioral health case management services as set forth in this Section.~~

~~(1) Payment is made for services rendered to SoonerCare members as follows:~~

~~(A) **Description of behavioral health case management services**. Services under behavioral health case management are not comparable in amount, duration and scope. The target group for behavioral health case management services are persons under age 21 who are in imminent risk of out-of-home placement for psychiatric or substance abuse reasons or are in out-of-home placement due to psychiatric or substance abuse reasons and chronically and/or severely mentally ill adults who are institutionalized or are at risk of institutionalization. All behavioral health case management services will be subject to medical necessity criteria.~~

~~(i) Behavioral health case management services are provided to assist eligible individuals in gaining access to needed medical, social, educational and other services essential to meeting basic human needs. The behavioral health case manager provides assessment of case management needs, development of a case management care plan, referral, linkage, monitoring and advocacy on behalf of the member to gain access to appropriate community resources. The behavioral health case manager must monitor the progress in gaining access to services and continued appropriate utilization of necessary community resources. Behavioral case management is designed to promote recovery, maintain community tenure, and to assist individuals in accessing services for themselves following the case management guidelines established by ODMHSAS. In order to be compensable, the service must be performed utilizing the Strengths Based model of case management. This model of case management assists individuals in identifying and securing the range of resources, both environmental and personal, needed to live in a normally interdependent way in the community. The focus for the helping process is on strengths, interests, abilities, knowledge and capacities of each person, not on their diagnosis, weakness or deficits. The relationship between the service member and the behavioral health case manager is characterized by mutuality, collaboration, and partnership. Assistive activities are designed to occur~~

~~primarily in the community, but may take place in the behavioral health case manager's office, if more appropriate. The community based behavioral health case management agency will coordinate with the member and family (if applicable) by phone or face-to-face, to identify immediate needs for return to home/community no more than 72 hours after notification that the member/family requests case management services. For member's discharging from a higher level of care than outpatient, the higher level of care facility is responsible for scheduling an appointment with a case management agency for transition and post discharge services. The case manager will make contact with the member and family (if applicable) for transition from the higher level of care than outpatient back to the community, within 72 hours of discharge, and then conduct a follow-up appointment/contact within seven days. The case manager will provide linkage/referral to physicians/medication services, counseling services, rehabilitation and/or support services as described in the case management service plan. Case Managers may also provide crisis diversion (unanticipated, unscheduled situation requiring supportive assistance, face-to-face or telephone, to resolve immediate problems before they become overwhelming and severely impair the individual's ability to function or maintain in the community) to assist member(s) from progression to a higher level of care. During the follow-up phase of these referrals or links, the behavioral health case manager will provide aggressive outreach if appointments or contacts are missed within two business days of the missed appointments. Community/home based case management to assess the needs for services will be scheduled as reflected in the case management service plan, but not less than one time per month. The member/parent/guardian has the right to refuse behavioral health case management and cannot be restricted from other services because of a refusal of behavioral health case management services.~~

~~(ii) An eligible member/parent/guardian will not be restricted and will have the freedom to choose a behavioral health case management provider as well as providers of other medical care.~~

~~(iii) In order to ensure that behavioral health case management services appropriately meet the needs of the member and family and are not duplicated, behavioral~~

~~health case management activities will be provided in accordance with an individualized plan of care.~~

~~(iv) The individual plan of care must include general goals and objectives pertinent to the overall recovery of the member's (and family, if applicable) needs. Progress notes must relate to the individual plan of care and describe the specific activities to be performed. The individual plan of care must be developed with participation by, as well as, reviewed and signed by the member, the parent or guardian (if the member is under 18), the behavioral health case manager, and a Licensed Behavioral Health Professional or Licensure Candidate as defined in OAC 317:30-5-240.3(a) and (b).~~

~~(v) SoonerCare reimbursable behavioral health case management services include the following:~~

~~(I) Gathering necessary psychological, educational, medical, and social information for the purpose of individual plan of care development.~~

~~(II) Face-to-face meetings with the member and/or the parent/guardian/family member for the implementation of activities delineated in the individual plan of care.~~

~~(III) Face-to-face meetings with treatment or service providers, necessary for the implementation of activities delineated in the individual plan of care.~~

~~(IV) Supportive activities such as non face-to-face communication with the member and/or parent/guardian/family member.~~

~~(V) Non face-to-face communication with treatment or service providers necessary for the implementation of activities delineated in the individual plan of care.~~

~~(VI)Monitoring of the individual plan of care to reassess goals and objectives and assess progress and or barriers to progress.~~

~~(VII) Crisis diversion (unanticipated, unscheduled situation requiring supportive assistance, face-to-face or telephone, to resolve immediate problems before they become overwhelming and severely impair the individual's ability to function or maintain in the community) to assist member(s) from progression to a higher level of care.~~

~~(VIII) Transitioning from institutions to the community. Behavioral Health Case Management is available to individuals transitioning from~~

~~institutions to the community (except individuals ages 22 to 64 who reside in an institution for mental diseases (IMD) or individuals who are inmates of public institutions). Individuals are considered to be transitioning to the community during the last 30 consecutive days of a covered institutional stay. This time is to distinguish case management services that are not within the scope of the institution's discharge planning activities from case management required for transitioning individuals with complex, chronic, medical needs to the community. Transition services provided while the individual is in the institution are to be claimed as delivered on the day of discharge from the institution.~~

~~(B)~~ **~~Levels of Case Management.~~**

~~(i) Basic Case Management/Resource Coordination. Resource coordination services are targeted to adults with serious and persistent mental illness and children and adolescents with mental illness or serious emotional disturbance, and their families, who need assistance in accessing, coordination, and monitoring of resources and services. Services are provided to assess an individual's strengths and meet needs in order to achieve stability in the community. Standard managers have caseloads of 30 - 35 members. Basic case management/resource coordination is limited to 25 units per member per month.~~

~~(ii) Intensive Case Management (ICM)/Wraparound Facilitation Case Management (WFCM). Intensive Case Management is targeted to adults with serious and persistent mental illness (including members in PACT programs) and Wraparound Facilitation Case Management is targeted to children with serious mental illness and emotional disorders (including members in a System of Care Network) who are deemed high risk and in need of more intensive CM services. It is designed to ensure access to community agencies, services, and people whose functions are to provide the support, training and assistance required for a stable, safe, and healthy community life, and decreased need for higher levels of care. To produce a high fidelity wraparound process, a facilitator can facilitate between 8 and 10 families. To ensure that these intense needs are met, case manager caseloads are limited between 10-15 caseloads. The ICM shall be a Certified Behavioral Health Case Manager, have a minimum of 2 years Behavioral Health Case Management experience, crisis diversion~~

~~experience, must have attended the ODMHSAS 6 hours ICM training, and 24 hour availability is required. ICM/WFCM is limited to 54 units per member per month.~~

~~(C) **Excluded Services.** SoonerCare reimbursable behavioral health case management does not include the following activities:~~

~~(i) Physically escorting or transporting a member or family to scheduled appointments or staying with the member during an appointment; or~~

~~(ii) Managing finances; or~~

~~(iii) Providing specific services such as shopping or paying bills; or~~

~~(iv) Delivering bus tickets, food stamps, money, etc.; or~~

~~(v) Counseling, rehabilitative services, psychiatric assessment, or discharge planning; or~~

~~(vi) Filling out forms, applications, etc., on behalf of the member when the member is not present; or~~

~~(vii) Filling out SoonerCare forms, applications, etc.;~~

~~(viii) Mentoring or tutoring;~~

~~(ix) Provision of behavioral health case management services to the same family by two separate behavioral health case management agencies;~~

~~(x) Non face-to-face time spent preparing the assessment document and the service plan paperwork;~~

~~(xi) monitoring financial goals;~~

~~(xii) services to nursing home residents;~~

~~(xiii) psychotherapeutic or rehabilitative services, psychiatric assessment, or discharge; or~~

~~(xix) services to members residing in ICF/IID facilities.~~

~~(D) **Excluded Individuals.** The following SoonerCare members are not eligible for behavioral health case management services:~~

~~(i) Children/families for whom behavioral health case management services are available through OKDHS/OJA staff without special arrangements with OKDHS, OJA, and OHCA;~~

~~(ii) Members receiving Residential Behavior Management Services (RBMS) in a foster care or group home setting unless transitioning into the community;~~

~~(iii) Residents of ICF/IID and nursing facilities unless transitioning into the community;~~

~~(iv) Members receiving services under a Home and Community Based services (HCBS) waiver program.~~

~~(E) Case management services provided to Medicare eligible members should be filed directly with the fiscal agent.~~

(F) **Documentation requirements**. The service plan must include general goals and objectives pertinent to the overall recovery needs of the member. Progress notes must relate to the service plan and describe the specific activities performed. Behavioral health case management service plan development is compensable time if the time is spent communicating with the participation by, as well as, reviewed and signed by the member, the behavioral health case manager, and a licensed behavioral health professional or licensure candidate as defined at OAC 317:30-5-240.3(a) and (b). All behavioral health case management services rendered must be reflected by documentation in the records. In addition to a complete behavioral health case management service, plan documentation of each session must include but is not limited to:

(i) date;

(ii) person(s) to whom services are rendered;

(iii) start and stop times for each service;

(iv) original signature or the service provider (original signatures for faxed items must be added to the clinical file within 30 days);

(v) credentials of the service provider;

(vi) specific service plan needs, goals and/or objectives addressed;

(vii) specific activities performed by the behavioral health case manager on behalf of the child related to advocacy, linkage, referral, or monitoring used to address needs, goals and/or objectives;

(viii) progress and barriers made towards goals, and/or objectives;

(ix) member (family when applicable) response to the service;

(x) any new service plan needs, goals, and/or objectives identified during the service; and

(xi) member satisfaction with staff intervention.

(G) **Case Management Travel Time**. The rate for case management services assumes that the case manager will spend some amount of time traveling to the member for the face-to-face service. The case manager must only bill for the actual face-to-face time that they spend with the member and not bill for travel time. This would be considered duplicative billing since the rate assumes the travel component already.

317:30-5-599. Documentation of records [REVOKED]

All behavioral health case management services rendered must

~~be reflected by documentation in the records. In addition to a complete behavioral health case management individual plan of service, documentation of each session must include but is not limited to:~~

~~(1) date;~~
~~(2) person(s) to whom services were rendered;~~
~~(3) start and stop time for each service;~~
~~(4) original signature of the service provider (in circumstances where it is necessary to fax a service plan to someone for review and then have them fax back their signature, this is acceptable; however, the provider needs to obtain the original signature for the clinical file within 30 days. No stamped or Xeroxed signatures are allowed);~~
~~(5) credentials of service provider;~~
~~(6) specific service plan need(s), goals and/or objectives addressed;~~
~~(7) specific activities performed by the behavioral health case manager on behalf of the child related to advocacy, linkage, referral, or monitoring used to address problem(s), goals and/or objectives;~~
~~(8) progress or barriers made towards goals and/or objectives;~~
~~(9) client (and family, when applicable) response to the services;~~
~~(10) any new individual plan of service need(s), goals and/or objectives identified during the service; and~~
~~(11) member satisfaction with staff intervention(s).~~

PART 75. FEDERALLY QUALIFIED HEALTH CENTERS

317:30-5-660.3. Health Center enrollment requirements for specialty behavioral health services

~~(a) For the provision of behavioral health related case management services, Health Centers must meet the requirements found at OAC 317:30-5-595 through 317:30-5-599.~~

~~(b)~~(a) For the provision of behavioral health related case management services and psychosocial rehabilitation services, Health Centers must contract as an outpatient behavioral health agency and meet the requirements found at OAC 317:30-5-240 through ~~30-5-249~~317:30-5-249.

~~(c)~~(b) Health Centers which provide substance abuse treatment services must also be certified by the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS).

317:30-5-661.4. Behavioral health professional services provided at Health Centers and other settings

(a) Medically necessary behavioral health services that are

primary, preventive, and therapeutic and that would be covered if provided in another setting may be provided by Health Centers. Services provided by a Health Center (refer to OAC 317:30-5-240.3 for a description of services) must meet the same requirements as services provided by other behavioral health providers. Rendering providers must be eligible to individually enroll or meet the requirements as an agency/organization provider specified in OAC 317:30-5-240.2~~,~~and 317:30-5-280~~ and 317:30-5-595~~.

(1) Behavioral Health services include:

(A) Assessment/Evaluation;

(B) Crisis Intervention Services;

(C) Individual/Interactive Psychotherapy;

(D) Group Psychotherapy;

(E) Family Psychotherapy;

(F) Psychological Testing; and

(G) Case Management (as an integral component of services 1-6 above).

(b) Medically necessary behavioral health professional therapy services are covered when provided in accordance with a documented individualized treatment plan, developed to treat the identified behavioral health disorder(s). A minimum of a 45 to 50 minute one-on-one standard clinical session must be completed by an health care professional authorized in the approved FQHC State Plan pages in order to bill the PPS encounter rate for the session. Services rendered by providers not authorized under the approved FQHC state plan pages to bill the PPS encounter rate will be reimbursed pursuant to the SoonerCare fee-for-service fee schedule and must comply with rules found at OAC 317:30-5-280 through 317:30-5-283.

(c) Centers are reimbursed the PPS rate for services when rendered by approved health care professionals, as authorized under FQHC state plan pages, if the Health Center receives funding pursuant to Section 330 or is otherwise funded under Public Law to provide primary health care services at locations off-site (not including satellite or mobile locations) to Health Center patients on a temporary or intermittent basis, unless otherwise limited by Federal law.

(d) Health Centers that operate day treatment programs in school settings must meet the requirements found at OAC ~~317:30-5-240.2(7)~~317:30-5-240.2(b)(7).

(e) In order to support the member's access to behavioral health services, these services may take place in settings away from the Health Center. Off-site behavioral health services must take place in a confidential setting.

317:30-5-664.1. Provision of other health services outside of

the Health Center core services

(a) If the Center chooses to provide other SoonerCare State Plan covered health services which are not included in the Health Center core service definition in OAC 317:30-5-661.1, the practitioners of those services are subject to the same program coverage limitations, enrollment and billing procedures described by the OHCA, and these services (e.g., home health services) are not included in the PPS settlement methodology in OAC 317:30-5-664.12.

(b) Other health services include, but are not limited to:

(1) dental services (refer to OAC 317:30-5-696) except for primary preventive dental services;

(2) eyeglasses (refer to OAC 317:30-5-450);

(3) clinical lab tests performed in the Center lab (other than the specific laboratory tests set out for Health Centers' certification and covered as Health Center services);

(4) technical component of diagnostic tests such as x-rays and EKGs (interpretation of the test provided by the Center physician is included as physician professional services);

(5) durable medical equipment (refer to OAC 317:30-5-210);

(6) emergency ambulance transportation (refer to OAC 317:30-5-335);

(7) prescribed drugs (refer to OAC 317:30-5-70);

(8) prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags) and supplies directly related to colostomy care and the replacement of such devices;

(9) specialized laboratory services furnished away from the clinic;

(10) Psychosocial Rehabilitation Services [refer to OAC 317:30-5-241(a)(7)]; and

(11) Behavioral health related case management services (refer to OAC ~~317:30-5-585 through 317:30-5-589 and OAC 317:30-5-595 through 317:30-5-599~~317:30-5-240 through 317:30-5-249).

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) SoonerPlan family planning services;

(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 105. RESIDENTIAL BEHAVIORAL MANAGEMENT SERVICES IN GROUP SETTINGS AND NON-SECURE DIAGNOSTIC AND EVALUATION CENTERS

317:30-5-1043. Coverage by category

(a) **Adults.** Residential Behavioral Management Services in Group Settings and Non-Secure Diagnostic and Evaluation Center Services are not covered for adults.

(b) **Children.** Residential Behavioral Management Services (RBMS) in Group Settings and Non-Secure Diagnostic and Evaluation Centers are covered for children as set forth in this subsection.

(1) **Description.** Residential Behavior Management Services are provided by Organized Health Care Delivery Systems (OHCDS) for children in the care and custody of the State who have special psychological, behavioral, emotional and social needs that require more intensive care than can be provided in a family or foster home setting. The behavior management services are provided in the least restrictive environment and within a therapeutic milieu. The group setting is restorative in nature, allowing children with emotional and psychological problems to develop the necessary control to function in a less restrictive setting. Residential Behavior Management Services are reimbursed in accordance with the intensity of supervision and treatment required for the group setting in which the child is placed. Members residing in a Level E and Intensive Treatment Services (ITS) Group Homes receive maximum supervision and treatment. In addition, ITS group homes provide crisis and stabilization intervention and treatment. Members residing in a Level D+ Group Home receive highly intensive supervision and treatment. Members residing in a Level D Group home or in a wilderness camp receive close supervision and moderate treatment. Members residing in a Level C Group Home receive minimum supervision and treatment. Members residing in Residential Diagnostic and Evaluation Centers receive intensive supervision and a 20 day comprehensive assessment. Members residing in a Sanctions Home receive highly intensive supervision and treatment. Members residing in an Independent Living Group Home receive intensive supervision and treatment. It is expected that RBMS in group settings are an all-inclusive array of treatment services provided in one day. In the case of a child who needs additional specialized services, under the Rehabilitation Option or by a psychologist, prior authorization by the OHCA or designated agent is required. Only specialized rehabilitation or psychological treatment services to address unique, unusual or severe symptoms or disorders will be authorized. If additional services are approved, the OHCDS collaborates with the provider of such services as directed by the OHCA or its agent. Any additional specialized behavioral health services provided to children in state custody are funded in the normal manner. The OHCDS must provide concurrent documentation that these services are not duplicative. The OHCDS determines the need for RBMS.

(2) **Medical necessity criteria.** The following medical

necessity criteria must be met for residential behavior Management Services.

(A) Any DSM~~-IV AXIS I~~ primary diagnosis, with the exception of V codes, with a detailed description of the symptoms supporting the diagnosis. A detailed description of the child's emotional, behavioral and psychological condition must be on file. A diagnosis is not required for behavior management services provided in Diagnostic and Evaluation centers.

(B) The child is medically stable and not actively suicidal or homicidal and not in need of substance abuse detoxification services.

(C) It has been determined by the OHCDS that the current disabling symptoms could not have been or have not been manageable in a less intensive treatment program.

(D) Documentation that the child's presenting emotional and/or behavioral problems prevent the child from living in a traditional family home. The child requires the availability of 24 hour crisis response/behavior management and intensive clinical interventions from professional staff.

(E) The Agency which has permanent or temporary custody of the child agrees to active participation in the child's treatment needs and planning.

(F) All of the medical necessity criteria must also be met for continued stay in residential group settings.

(3) **Treatment components.**

(A) **Individual plan of care development.** A comprehensive individualized plan of care for each resident shall be formulated by the provider agency staff within 30 days of admission, for ITS level within 72 hours, with documented input from the agency which has permanent or temporary custody of the child and when possible, the parent. This plan must be revised and updated at least every three months, every seven days for ITS, with documented involvement of the agency which has permanent or temporary custody of the child. Documented involvement can be written approval of the individual plan of care by the agency which has permanent or temporary custody of the child and indicated by the signature of the agency case worker or liaison on the individual plan of care. It is acceptable in circumstances where it is necessary to fax a service plan to someone for review and then have them fax back their signature; however, the provider obtains the original signature for the clinical file within 30 days. No stamped or Xeroxed signatures are allowed. An individual plan of care is considered inherent in the

provision of therapy and is not covered as a separate item of behavior management services. The individual plan of care is individualized taking into account the child's age, history, diagnosis, functional levels, and culture. It includes appropriate goals and time limited and measurable objectives. Each member's individual plan of care must also address the provider agency's plans with regard to the provision of services in each of the following areas:

(i) group therapy;
(ii) individual therapy;
(iii) family therapy;
(iv) alcohol and other drug counseling;
(v) basic living skills redevelopment;
(vi) social skills redevelopment;
(vii) behavior redirection; and
(viii) the provider agency's plan to access appropriate educational placement services. (Any educational costs are excluded from calculation of the daily rate for behavior management services.)

(B) **Individual therapy.** The provider agency must provide individual therapy on a weekly basis with a minimum of one or more sessions totaling one hour or more of treatment per week to children and youth receiving RBMS in Wilderness Camps, Level D, Level D+ homes, Level E Homes, Independent Living Homes, and Sanctions Homes. ITS Level residents will receive a minimum of five or more sessions totaling a minimum of five or more hours of individual therapy per week. Members residing in Diagnostic and Evaluation Centers and Level C Group Homes receive Individual Therapy on an as needed basis. Individual therapy must be age appropriate and the techniques and modalities employed relevant to the goals and objectives of the individual's plan of care. Individual counseling is a face to face, one to one service, and must be provided in a confidential setting.

(C) **Group therapy.** The provider agency must provide group therapy to children and youth receiving residential behavioral management services. Group therapy must be a face to face interaction, age appropriate and the techniques and modalities employed relevant to the goals and objectives of the individual's plan of care. The minimum expected occurrence would be one hour per week in Level D, Level C, Wilderness Camps and Independent Living. Two hours per week are required in Levels D+ and E. Ten hours per week are required in Sanctions Homes, Intensive Treatment Service Level. Group therapy is not required for

Diagnostic and Evaluation Centers. Group size should not exceed six members and group therapy sessions must be provided in a confidential setting. One half hour of individual therapy may be substituted for one hour of group therapy.

(D) **Family therapy.** Family therapy is a face to face interaction between the therapist/counselor and family, to facilitate emotional, psychological or behavioral changes and promote successful communication and understanding. The provider agency must provide family therapy as indicated by the resident's individual plan of care. The agency must work with the caretaker to whom the resident will be discharged, as identified by the OHCDS custody worker. The agency must seek to support and enhance the child's relationships with family members (nuclear and appropriate extended), if the custody plan for the child indicates family reunification. The RBMS provider must also seek to involve the child's parents in treatment team meetings, plans and decisions and to keep them informed of the child's progress in the program. Any service provided to the family must have the child as the focus.

(E) **Alcohol and other drug abuse treatment education, prevention, therapy.** The provider agency must provide alcohol and other drug abuse treatment for residents who have emotional or behavioral problems related to substance abuse/chemical dependency, to begin, maintain and enhance recovery from alcoholism, problem drinking, drug abuse, drug dependency addiction or nicotine use and addiction. This service is considered ancillary to any other formal treatment program in which the child participates for treatment and rehabilitation. For residents who have no identifiable alcohol or other drug use, abuse, or dependency, age appropriate education and prevention activities are appropriate. These may include ~~self esteem~~self-esteem enhancement, violence alternatives, communication skills or other skill development curriculums.

(F) **Basic living skills redevelopment.** The provider agency must provide goal directed activities designed for each resident to restore, retain, and improve those basic skills necessary to independently function in a family or community. Basic living skills redevelopment is age appropriate and relevant to the goals and objectives of the individual plan of care. This many include, but is not limited to food planning and preparation, maintenance of personal hygiene and living environment, household management, personal and household shopping, community

awareness and familiarization with community resources, mobility skills, job application and retention skills.

(G) **Social skills redevelopment.** The provider agency must provide goal directed activities designed for each resident to restore, retain and improve the self help, communication, socialization, and adaptive skills necessary to reside successfully in home and community based settings. These are age appropriate, culturally sensitive and relevant to the goals of the individual plan of care. For ITS level of care, the minimum skill redevelopment per day is three hours. Any combination of basic living skills and social skills redevelopment that is appropriate to the need and developmental abilities of the child is acceptable.

(H) **Behavior redirection.** The provider agency must be able to provide behavior redirection management by agency staff as needed 24 hours a day, 7 days per week. The agency must ensure staff availability to respond in a crisis to stabilize residents' behavior and prevent placement disruption. In addition, ITS group homes will be required to provide crisis stabilization interaction and treatment for new residents 24 hours a day, seven days a week.

(4) **Providers.** For eligible RBMS agencies to bill the Oklahoma Health Care Authority for services of their providers, the providers of individual, group and family therapies must:

(A) be a licensed psychologist, social worker (clinical specialty only), professional counselor, marriage and family therapist, or behavioral practitioner, or under Board Supervision to be licensed in one of the above stated areas; or

(B) have one year of experience in a behavioral health treatment program and a master's degree in a mental health treatment field licensable in Oklahoma by one of the following licensing boards:

(i) Psychology,

(ii) Social work (clinical specialty only),

(iii) Licensed professional counselor,

(iv) Licensed marriage and family therapist, or

(v) Licensed behavioral practitioner; or

(C) have a baccalaureate degree in a mental health field in one of the stated areas listed in (B) of this paragraph AND three or more years post-baccalaureate experience in providing direct patient care in a behavioral health treatment setting and be provided a minimum of weekly supervision by a staff member licensed as listed in (A) of

this paragraph; or

(D) be a registered psychiatric nurse; AND

(E) demonstrate a general professional or educational background in the following areas:

(i) case management, assessment and treatment planning;

(ii) treatment of victims of physical, emotional, and sexual abuse;

(iii) treatment of children with attachment disorders;

(iv) treatment of children with hyperactivity or attention deficit disorders;

(v) treatment methodologies for emotional disturbed children and youth;

(vi) normal childhood development and the effect of abuse and/or neglect on childhood development;

(vii) treatment of children and families with substance abuse and chemical dependency disorders;

(viii) anger management; and

(ix) crisis intervention.

(5) For eligible RBMS agencies to bill the Oklahoma Health Care Authority for services provided by their staff for behavior management therapies (Individual, Group, Family) as of July 1, 2007, providers must have the following qualifications:

(A) be licensed in the state in which the services are delivered as a licensed psychologist, social worker (clinical specialty only), professional counselor, marriage and family therapist, or behavioral practitioner, alcohol and drug counselor or under Board approved Supervision to be licensed in one of the above stated areas; or

(B) be licensed as an 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, AND

(C) demonstrate a general professional or educational background in the following areas:

(i) case management, assessment and treatment planning;

(ii) treatment of victims of physical, emotional, and sexual abuse;

(iii) treatment of children with attachment disorders;

(iv) treatment of children with hyperactivity or attention deficit disorders;

(v) treatment methodologies for emotionally disturbed children and youth;

(vi) normal childhood development and the effect of abuse and/or neglect on childhood development;

(vii) treatment of children and families with substance abuse and chemical dependency disorders;

(viii) anger management; and

(ix) crisis intervention.

(D) Staff providing basic living skills redevelopment, social skills redevelopment, and alcohol and other substance abuse treatment, must meet one of the following areas:

(i) Bachelor's or Master's degree in a behavioral health related field including but not limited to, psychology, sociology, criminal justice, school guidance and counseling, social work, occupational therapy, family studies, alcohol and drug; or

(ii) a current license as a registered nurse in Oklahoma; or

(iii) certification as an Alcohol and Drug Counselor to provide substance abuse rehabilitative treatment to those with alcohol and/or other drug dependencies or addictions as a primary or secondary DSM~~IV Axis I~~ diagnosis; or

(iv) current certification as a Behavioral Health Case Manager from DMHSAS and meets OHCA requirements to perform case management services, as described in OAC ~~317:30-5-595~~317:30-5-240 through 317:30-5-249.

(E) Staff providing behavior redirection services must have current certification and required updates in nationally recognized behavior management techniques, such as Controlling Aggressive Patient Environment (CAPE) or MANDT. Additionally, staff providing these services must receive initial and ongoing training in at least one of the following areas:

(i) trauma informed methodology,

(ii) anger management,

(iii) crisis intervention,

(iv) normal child and adolescent development and the effect of abuse,

(v) neglect and/or violence on such development,

(vi) grief and loss issues for children in out of home placement,

(vii) interventions with victims of physical, emotional and sexual abuse,

(viii) care and treatment of children with attachment disorders,

(ix) care and treatment of children with hyperactive, or attention deficit, or conduct disorders,

(x) care and treatment of children, youth and families with substance abuse and chemical dependency disorders,

(xi) passive physical restraint procedures,

(xii) procedures for working with delinquents or the Inpatient Mental Health and Substance Abuse Treatment of Minors Act.

(F) In addition, Behavioral Management staff must have access to consultation with an appropriately licensed mental health professional.

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 15, 2016

The proposed policy is a Permanent Rule. This proposal is scheduled to be presented to the Medical Advisory Committee (MAC) on January 21, 2016 and the (OHCA) Board of Directors on February 11, 2016.
Reference: APA WF 15-30

SUMMARY:
Biopsychosocial Requirements — Proposed outpatient Behavioral Health Agency policy changes will allow providers more flexibility in conducting biopsychosocial assessments by removing specific required elements. Furthermore, outpatient behavioral health agency rules are revised to remove specific minimum time requirements for behavioral health assessment services. By removing the time requirements from rules, there will be more flexibility in allowing providers to bill in alternative ways that may be different based upon the type of assessment conducted.

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:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

TO: Tywanda Cox
Health Policy

FROM: Traylor Rains-Sims
Oklahoma Department of Mental Health & Substance Abuse Services

SUBJECT: Rule Impact Statement
APA WF #15-30

A. Brief description of the purpose of the rule:

The Agency is proposing rule revisions to its outpatient behavioral health agency rules in order to allow providers more flexibility in conducting biopsychosocial assessments by removing specific required elements. Further, the agency is also proposing rule revision to remove specific minimum time requirements for behavioral health assessment services. Current rules require at least 1.5 hours in order to bill a low complexity assessment and over 2 hours to bill a moderate complexity assessment. By removing the time requirements from rules, there will be more flexibility in allowing providers to bill in alternative ways that may be different based upon the type of assessment conducted.

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 person will receive benefit from this proposed rule.

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

Licensed behavioral health professionals within outpatient behavioral health agencies may benefit from the proposed rule in that they will now have more flexibility in conducting biopsychosocial assessments on SoonerCare clients. LBHP within outpatient behavioral health agencies will also have more flexibility in allowing providers to bill in alternative ways that may be different based upon the type of assessment conducted.

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 the affected classes of persons or political subdivisions. There are no fee changes 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 Agency has determined that there are no probable net costs to OHCA or other agencies expected as a result of the proposed rules nor is there an anticipated effect on State revenues.

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:

The Agency has determined that there is no potential adverse effect on small business as a result of the proposed rule change.

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:

Throughout the year Agency staff gather relevant information through stakeholder involvement and public forums in order to communicate the planned actions of the Agency concerning rulemaking, as well as other issues. While it is difficult to balance the needs of SoonerCare members with those of the various providers, the Agency proposes rules with each of these issues and interests considered.

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:

The Agency has determined that the proposed rules will have no detrimental effect on the public health, safety and environment if they are not implemented.

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

Prepared date: October 16, 2015.
Modified date: November 19, 2015

RULE TEXT

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 21. OUTPATIENT BEHAVIORAL HEALTH AGENCY SERVICES

317:30-5-241.1. Screening, assessment and service plan

All providers must comply with the requirements as set forth in this Section.

(1) **Screening.**

(A) **Definition.** Screening is for the purpose of determining whether the member meets basic medical necessity and need for further BH assessment and possible treatment services.

(B) **Qualified professional.** Screenings can be performed by any credentialed staff members as listed under OAC 317:30-5-240.3.

(C) **Target population and limitations.** Screening is compensable on behalf of a member who is seeking services for the first time from the contracted agency. This service is not compensable if the member has previously received or is currently receiving services from the agency, unless there has been a gap in service of more than six months. To qualify for reimbursement, the screening tools used must be evidence based or otherwise approved by OHCA and ODMHSAS and appropriate for the age and/or developmental stage of the member.

(2) **Assessment.**

(A) **Definition.** Gathering and assessment of historical and current bio-psycho-social information which includes face-to-face contact with the person and/or the person's family or other informants, or group of persons resulting in a written summary report, diagnosis and recommendations. All agencies must assess the medical necessity of each individual to determine the appropriate level of care.

(B) **Qualified practitioners.** This service is performed by an LBHP or Licensure Candidate.

~~(C) **Time requirements.** The minimum face-to-face time spent in assessment session(s) with the member and others as identified previously in paragraph (1) of this subsection for a low complexity Behavioral Health Assessment by a Non-Physician is one and one half hours. For a moderate complexity, it is two hours or more.~~

~~(D)~~ (C) **Target population and limitations.** The Behavioral Health Assessment by a Non-Physician, moderate complexity, is compensable on behalf of a member who is seeking services for the first time from the contracted agency. This service is not compensable if the member has previously received or is

currently receiving services from the agency, unless there has been a gap in service of more than six months and it has been more than one year since the previous assessment.

~~(E)~~(D) **Documentation requirements**. The assessment must include all elements and tools required by the OHCA. In the case of children under the age of 18, it is performed with the direct, active face-to-face participation of the parent or guardian. The child's level of participation is based on age, developmental and clinical appropriateness. The assessment must include at least one DSM diagnosis from the most recent DSM edition. The information in the assessment must contain but is not limited to the following:

~~(i) Date, to include month, day and year of the assessment session(s);~~

~~(ii) Source of information;~~

~~(iii) Member's first name, middle initial and last name;~~

~~(iv) Gender;~~

~~(v) Birth Date;~~

~~(vi) Home address;~~

~~(vii) Telephone number;~~

~~(viii) Referral source;~~

~~(ix) Reason for referral;~~

~~(x) Person to be notified in case of emergency;~~

~~(xi) Presenting reason for seeking services;~~

~~(xii) Start and stop time for each unit billed;~~

~~(xiii) Signature of parent or guardian participating in face-to-face assessment. Signature required for members over the age of 14;~~

~~(xiv) Bio-Psychosocial information which must include:~~

~~(I) Identification of the member's strengths, needs, abilities and preferences;~~

~~(II) History of the presenting problem;~~

~~(III) Previous psychiatric treatment history, include treatment for psychiatric; substance abuse; drug and alcohol addiction; and other addictions;~~

~~(IV) Health history and current biomedical conditions and complications;~~

~~(V) Alcohol, Drug, and/or other addictions history;~~

~~(VI) Trauma, abuse, neglect, violence, and/or sexual assault history of self and/or others, include Department of Human Services involvement;~~

~~(VII) Family and social history, include MH, SA, Addictions, Trauma/Abuse/Neglect;~~

~~(VIII) Educational attainment, difficulties and history;~~

~~(IX) Cultural and religious orientation;~~

~~(X) Vocational, occupational and military history;~~

~~(XI) Sexual history, including HIV, AIDS, and STD at-risk behaviors;~~
~~(XII) Marital or significant other relationship history;~~
~~(XIII) Recreation and leisure history;~~
~~(XIV) Legal or criminal record, including the identification of key contacts, (e.g., attorneys, probation officers, etc.);~~
~~(XV) Present living arrangements;~~
~~(XVI) Economic resources;~~
~~(XVII) Current support system including peer and other recovery supports.~~
~~(xv) Mental status and Level of Functioning information, including questions regarding:~~
~~(I) Physical presentation, such as general appearance, motor activity, attention and alertness, etc.;~~
~~(II) Affective process, such as mood, affect, manner and attitude, etc.;~~
~~(III) Cognitive process, such as intellectual ability, social-adaptive behavior, thought processes, thought content, and memory, etc.; and~~
~~(IV) Full DSM diagnosis.~~
~~(xvi) Pharmaceutical information to include the following for both current and past medications;~~
~~(I) Name of medication;~~
~~(II) Strength and dosage of medication;~~
~~(III) Length of time on the medication; and~~
~~(IV) Benefit(s) and side effects of medication.~~
~~(xvii) Practitioner's interpretation of findings and diagnosis;~~
~~(xviii) Signature and credentials of the practitioner who performed the face-to-face behavioral assessment;~~
~~(xix) Client Data Core Elements reported into designated OHCA representative.~~
(i) Behavioral, including substance use, abuse, and dependence;
(ii) Emotional, including issues related to past or current trauma;
(iii) Physical;
(iv) Social and recreational;
(v) Vocational;
(vi) Date of the assessment sessions as well as start and stop times;
(vii) Signature of parent or guardian participating in face-to-face assessment. Signature required for members over the age of 14; and
(viii) Signature and credentials of the practitioner who

performed the face-to-face behavioral assessment

(3) **Behavioral Health Services Plan Development.**

(A) **Definition.** The Behavioral Health Service Plan is developed based on information obtained in the assessment and includes the evaluation of all pertinent information by the practitioners and the member. It includes a discharge plan. It is a process whereby an individualized plan is developed that addresses the member's strengths, functional assets, weaknesses or liabilities, treatment goals, objectives and methodologies that are specific and time limited, and defines the services to be performed by the practitioners and others who comprise the treatment team. Behavioral Health Service Plan Development is performed with the direct active participation of the member and a member support person or advocate if requested by the member. In the case of children under the age of 18, it is performed with the participation of the parent or guardian and the child as age and developmentally appropriate, and must address school and educational concerns and assisting the family in caring for the child in the least restrictive level of care. For adults, it is focused on recovery and achieving maximum community interaction and involvement including goals for employment, independent living, volunteer work, or training. A Service Plan Development, Low Complexity is required every 6 months and must include an update to the bio-psychosocial assessment and re-evaluation of diagnosis.

(B) **Qualified practitioners.** This service is performed by an LBHP or Licensure Candidate.

(C) **Time requirements.** Service Plan updates must be conducted face-to-face and are required every six months during active treatment. Updates can be conducted whenever it is clinically needed as determined by the qualified practitioner and member.

(D) **Documentation requirements.** Comprehensive and integrated service plan content must address the following:

(i) member strengths, needs, abilities, and preferences(SNAP);

(ii) identified presenting challenges, problems, needs and diagnosis;

(iii) specific goals for the member;

(iv) objectives that are specific, attainable, realistic, and time-limited;

(v) each type of service and estimated frequency to be received;

(vi) the practitioner(s) name and credentials that will be providing and responsible for each service;

(vii) any needed referrals for service;

(viii) specific discharge criteria;

(ix) description of the member's involvement in, and responses to, the service plan, and his/her signature and date;
(x) service plans are not valid until all signatures are present (signatures are required from the member, if 14 or over), the parent/guardian (if younger than 18 or otherwise applicable), and the primary LBHP or Licensure Candidate; and
(xi) all changes in service plan must be documented in a service plan update (low complexity) or within the service plan until time for the update (low complexity). Any changes to the existing service plan must be signed and dated by the member (if 14 or over), the parent/guardian (if younger than 18 or otherwise applicable), and the lead LBHP or Licensure Candidate.
(xii) Updates to goals, objectives, service provider, services, and service frequency, must be documented within the service plan until the six month review/update is due.
(xiii) Service plan updates must address the following:
(I) update to the bio-psychosocial assessment, re-evaluation of diagnosis service plan goals and/ or objectives;
(II) progress, or lack of, on previous service plan goals and/or objectives;
(III) a statement documenting a review of the current service plan and an explanation if no changes are to be made to the service plan;
(IV) change in goals and/or objectives (including target dates) based upon member's progress or identification of new need, challenges and problems;
(V) change in frequency and/or type of services provided;
(VI) change in practitioner(s) who will be responsible for providing services on the plan;
(VII) change in discharge criteria;
(VIII) description of the member's involvement in, and responses to, the service plan, and his/her signature and date; and
(IX) service plans are not valid until all signatures are present. The required signatures are: from the member (if 14 or over), the parent/guardian (if younger than 18 or otherwise applicable), and the primary LBHP or Licensure Candidate.

(E) **Service limitations:**
(i) Behavioral Health Service Plan Development, Moderate complexity (i.e., pre-admission procedure code group) are limited to 1 per member, per provider, unless more than a

year has passed between services, then another one can be requested and may be authorized by OHCA or its designated agent.

(ii) Behavioral Health Service Plan Development, Low Complexity: Service Plan updates are required every six months during active treatment. Updates can be conducted whenever needed as determined by the provider and member. The date of service is when the service plan is complete and the date the last required signature is obtained. Services should always be age, developmentally, and clinically appropriate.

(4) **Assessment/Evaluation testing.**

(A) **Definition.** Assessment/Evaluation testing is provided by a clinician utilizing tests selected from currently accepted assessment test batteries. Test results must be reflected in the Service Plan. The medical record must clearly document the need for the testing and what the testing is expected to achieve.

(B) **Qualified practitioners.** Assessment/Evaluation testing will be provided by a psychologist, certified psychometrist, psychological technician of a psychologist, an LBHP or Licensure Candidate. For assessments conducted in a school setting, the Oklahoma State Department of Education requires that a licensed supervisor sign the assessment. Each qualified professional must have a current contract with the Oklahoma Health Care Authority.

(C) **Documentation requirements.** All psychological services must be reflected by documentation in the member's record. All assessment, testing, and treatment services/units billed must include the following:

(i) date;

(ii) start and stop time for each session/unit billed and physical location where service was provided;

(iii) signature of the provider;

(iv) credentials of provider;

(v) specific problem(s), goals and/or objectives addressed;

(vi) methods used to address problem(s), goals and objectives;

(vii) progress made toward goals and objectives;

(viii) patient response to the session or intervention; and

(ix) any new problem(s), goals and/or objectives identified during the session.

(D) **Service Limitations.** Testing for a child younger than three must be medically necessary and meet established Child (0-36 months of Age) criteria as set forth in the Behavioral Health Provider Manual. Evaluation and testing is clinically

appropriate and allowable when an accurate diagnosis and determination of treatment needs is needed. Eight hours/units of testing per patient over the age of three, per provider is allowed every 12 months. There may be instances when further testing is appropriate based on established medical necessity criteria found in the Behavioral Health Provider Manual. Justification for additional testing beyond allowed amount as specified in this section must be clearly explained and documented in the medical record. Testing units must be billed on the date the actual testing, interpretation, scoring, and reporting are performed. A maximum of 12 hours of therapy and testing, per day per rendering provider are allowed. A child who is being treated in an acute inpatient setting can receive separate psychological services by a physician or psychologist as the inpatient per diem is for "non-physician" services only. A child receiving Residential level treatment in either a therapeutic foster care home, or group home may not receive additional individual, group or family counseling or psychological testing unless allowed by the OHCA or its designated agent. Psychologists employed in State and Federal Agencies, who are not permitted to engage in private practice, cannot be reimbursed for services as an individually contracted provider. For assessment conducted in a school setting the Oklahoma State Department of Education requires that a licensed supervisor sign the assessment. Individuals who qualify for Part B of Medicare: Payment is made utilizing the SoonerCare allowable for comparable services. Payment is made to physicians, LBHPs or psychologists with a license to practice in the state where the services is performed or to practitioners who have completed education requirements and are under current board approved supervision to become licensed.

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 15, 2016

The proposed policy is a Permanent Rule. This proposal is scheduled to be presented to the Medical Advisory Committee (MAC) on January 21, 2016 and the (OHCA) Board of Directors on February 11, 2016.
Reference: APA WF 15-32

SUMMARY:
HEALTH HOME — Department of Mental Health & Substance Abuse Services proposes language clean up to clarify inconsistencies between OHCA rules and Health Home Certification.

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:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

TO: Tywanda Cox
Health Policy

FROM: Traylor Rains-Sims
Oklahoma Department of Mental Health & Substance Abuse Services

SUBJECT: Rule Impact Statement
APA WF # 15-32

A. Brief description of the purpose of the rule:

SoonerCare Health Homes for adults with Serious Mental Illness (SMI) and Children with Serious Emotional Disturbances (SED) were implemented in February, 2015. Since implementation, some inconsistencies between OHCA rules and

Health Home Certification rules administered by the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) have been identified that need to be cleaned up. Some examples are specifics regarding provider requirements and which providers are allowed to provide specific Health Home 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:

No particular class of persons will likely be affected by the proposed rule. There have been no cost impacts received by the agency from any private or public entities.

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

No classes of person will receive benefit from this 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 probable economic impact of the proposed rule upon the affected classes of persons or political subdivisions. There are no fee changes 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 Agency has determined that there are no probable net costs to OHCA or other agencies expected as a result of the proposed rules nor is there an anticipated effect on State revenues.

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:

The Agency has determined that there is no potential adverse effect on small business as a result of the proposed rule change.

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:

Throughout the year Agency staff gather relevant information through stakeholder involvement and public forums in order to communicate the planned actions of the Agency concerning rulemaking, as well as other issues. While it is difficult to balance the needs of SoonerCare members with those of the various providers, the Agency proposes rules with each of these issues and interests considered.

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:

The Agency has determined that the proposed rules will have no detrimental effect on the public health, safety and environment if they are not implemented.

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

The rule impact statement was prepared November 18, 2015.

RULE TEXT

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 22. HEALTH HOMES

317:30-5-251. Eligible providers

(a) **Agency requirements.** Providers of Health Home (HH) services are responsible for providing HH services to qualifying individuals within the provider's specified service area. Qualifying providers must be:

(1) Certified by the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) as a Community Mental Health Center under OAC 450:17; or

(2) Accredited as a provider of outpatient behavioral health services from one of the national accrediting bodies; or

(3) Certified by ODMHSAS as a Mental Illness Service Program pursuant to OAC 450:27; or

(4) Certified by ODMHSAS as a Program of Assertive Community Treatment (PACT) pursuant to OAC 450:55.

(5) In addition to the accreditation/certification requirements in (1) – (4), providers must also have provider specific credentials from ODMHSAS for Health Home Services (OAC 450:17; OAC 450:27; OAC 450:55).

(b) **Health Home team.** Health Homes will utilize an interdisciplinary team of professionals and paraprofessionals to identify an individual's strengths and needs, create a unified plan to empower persons toward self-management and coordinate the individual's varied healthcare needs. HH teams will vary in size depending on the size of the member panel and acuity of members. HH team composition will vary slightly between providers working with adults and children.

(1) Health Homes working with adults with Serious Mental Illness (SMI) will utilize a multidisciplinary team consisting of the following:

(A) Health Home Director;

(B) Nurse Care Manager (RN or LPN);

(C) Consulting Primary Care Practitioner (PCP);

(D) Psychiatric Consultant (317:30-5-11);

(E) Certified Behavioral Health Case Manager (CM) (OAC 450:50; 317:30-5-595);

(F) Wellness Coach~~/Peer Support Specialist (OAC 450:53; 317:30-5-240.3)~~ credentialed through ODMHSAS; and

(G) Administrative support.

(2) In addition to the individuals listed in (1) (A) through (G) above, teams working with adults with SMI (PACT teams only) will also have at least one of the following team members:

(A) Licensed Behavioral Health Professional or Licensure Candidate (317:30-5-240.3);

(B) Substance abuse treatment specialist (Licensed Alcohol and Drug Counselor (LADC) or Certified Alcohol and Drug Counselor (CADC); or

(C) Employment specialist.

(3) Health Homes working with children with Serious Emotional Disturbance (SED) will utilize a multidisciplinary team consisting of the following:

(A) ~~Project~~ Health Home Director;

(B) Nurse Care Manager (RN or LPN);

(C) Consulting Primary Care Practitioner (PCP);

(D) Psychiatric Consultant (317:30-5-11);

(E) Care Coordinator (CM II Wraparound Facilitator as defined in 317:30-5-595(2) (C);

(F) Family Support Provider (317:30-5-240.3);

(G) Youth/Peer Support Specialist (OAC 450:53; 317:30-5-240.3);

(H) Children's Health Home Specialist (Behavioral Health Aide or higher, with additional training in WellPower or credentialed as a Wellness Coach through ODMHSAS); and

(I) Administrative Support.

317:30-5-252. Covered Services

Health Home services are covered for adults with Serious Mental Illness (SMI) and children with Serious Emotional Disturbance (SED) as set forth in this Section unless specified otherwise, and when provided in accordance with a documented care plan. The care plan must be client directed, integrated, and reflect the input of the team (including the involvement of the consulting primary care physician or APRN in managing the medical component of the plan), as well as others the client chooses to involve. Coverage includes the following services:

(1) **Comprehensive Care Management.**

(A) **Definition.** Comprehensive care management services consist of developing a Comprehensive Care Plan to address needs of the whole person and involves the active participation of the Nurse Care Manager, certified Behavioral Health Case Manager, Primary Care Practitioner, the Health Home clinical support staff with participation of other team members, family and caregivers.

(B) **Service requirements.** Comprehensive care management services include the following, but are not limited to:

(i) Identifying high-risk members and utilizing member information to determine level of participation in care management services;

(ii) Assessing preliminary service needs; participating in comprehensive person-centered service plan development; responsible for member physical health goals, preferences and optimal clinical outcomes;

(iii) Developing treatment guidelines that establish clinical pathways for health teams to follow across risk levels or health conditions;

(iv) Monitoring individual and population health status and service use to determine adherence to or variance from best practice guidelines; and

(v) Developing and disseminating reports that indicate progress toward meeting outcomes for member satisfaction, health status, service delivery and cost.

(C) **Qualified professionals.** Comprehensive care management services are provided by a health care team with participation from the client, family and caregivers~~, consisting of the following required professionals and paraprofessionals~~. The following team members are eligible to provide comprehensive care management:

(i) Nurse Care Manager (RN or LPN within scope of practice);

(ii) Certified Behavioral Health Case Manager; and

(iii) Primary Care Practitioner.

(iv) Psychiatric consultant; and

(v) Licensed Behavioral Health Professional (LBHP).

(2) **Care coordination.**

(A) **Definition.** Care coordination is the implementation of the Comprehensive Care Plan with active member involvement through appropriate linkages, referrals, coordination, and follow-up to needed services and supports.

(B) **Service requirements.** Care coordination services include the following, but are not limited to:

(i) Care coordination for primary health care, specialty health care, and transitional care from emergency departments, hospitals and Psychiatric Residential Treatment Facilities (PRTFs);

(ii) Ensuring integration and compatibility of mental health and physical health activities;

(iii) Providing on-going service coordination and link members to resources;

(iv) Tracking completion of mental and physical health goals in member's Comprehensive Care Plan;

(v) Coordinating with all team members to ensure all objectives of the Comprehensive Care Plan are progressing;

(vi) Appointment scheduling;

(vii) Conducting referrals and follow-up monitoring;

(viii) Participating in hospital discharge processes; and

(ix) Communicating with other providers and members/family.

(C) **Qualified professionals.** Team members are responsible to ensure implementation of the Comprehensive Care Plan, which includes mental health goals, physical health goals, and other life domain goals for achievement of clinical outcomes. Care coordination services are provided by a primary care practitioner-led team which includes the following professionals and paraprofessionals:

(i) Nurse Care Manager (RN or LPN); ~~and~~

(ii) Certified Behavioral Health Case Managers~~.~~;

(iv) Health Home Director;

(v) Family Support Provider;

(vi) Youth/Peer Support Specialist; and

(vi) Health Home Specialist/Hospital Liaison.

(3) **Health promotion.**

(A) **Definition.** Health promotion consists of providing health education specific to the member's chronic condition.

(B) **Service requirements.** Health promotion will minimally consist of the following, but is not limited to:

(i) Providing health education specific to member's condition;

(ii) Developing self-management plans with the member;

(iii) Providing support for improving social networks and providing health promoting lifestyle interventions including:

(I) Substance use prevention;

(II) Smoking prevention and cessation;

(III) Obesity reduction and prevention;

(IV) Nutritional counseling; and

(V) Increasing physical activity.

(C) **Qualified professionals.** Health promotion services must be provided by the Primary Care Practitioner, Registered Nurse Care Manager (or LPN within full scope of practice) and the Wellness Coach or Health Home Specialist at the direction of the Health Home Director.

(4) **Comprehensive transitional care.**

(A) **Definition.** Care coordination services for comprehensive transitional care are designed to streamline

plans of care, reduce hospital admissions and interrupt patterns of frequent hospital emergency department use.

(B) **Service requirements.** ~~In conducting comprehensive transitional care, the Nurse Care Manager and the case manager will work as co-leads.~~ The duties of the ~~Nurse Care Manager or the case manager~~ qualified team members providing transitional care services include, but are not limited to the following:

(i) Developing contracts or Memorandums of Understanding (MOUs) with regional hospitals or system(s) to ensure a formalized structure for transitional care planning, to include communication of inpatient admissions and discharges of Health Home members;

(ii) Maintaining a mutual awareness and collaboration to identify individuals seeking emergency department services that may benefit from connection with a Health Home site; and

(iii) Motivate hospital staff to notify the Health Home staff of such opportunities.

(C) **Qualified individuals.** Comprehensive transitional care services can be provided by the following team members:

(i) Nurse Care Manager;

(ii) Certified behavioral health case manager; and

(iii) Family Support provider.

(5) **Individual and family support services.**

(A) **Definition.** Individual and family support services assist individuals in accessing services that will reduce barriers and improve health outcomes, with a primary focus on increasing health literacy, the ability of the member to self- manage their care, and facilitate participation in the ongoing revision of their Comprehensive Care Plan.

(B) **Service requirements.** Individual and family support services include, but are not limited to:

(i) Teaching individuals and families self-advocacy skills;

(ii) Providing peer support groups;

(iii) Modeling and teaching how to access community resources;

(iv) Assisting with obtaining and adhering to medications and other prescribed treatments; and

(v) Identifying resources to support the member in attaining their highest level of health and functioning in their families and in the community, including transportation to medically necessary services.

(C) **Qualified individuals.** Individual and family support service activities must be provided by one of the following:

(i) Wellness Coaches, Recovery support specialist, Children's Health Home specialist; or
(ii) Care coordinators; or
(iii) Family Support Providers.; or
(iv) Nurse Care Manager.

(6) **Referral to community and social support services.**

(A) **Definition.** Provide members with referrals to community and social support services in the community.

(B) **Service requirements.** Providing assistance for members to obtain and maintain eligibility for the following services as applicable, including but not limited to:
(i) Healthcare;
(ii) Disability benefits;
(iii) Housing;
(iv) Transportation;
(v) Personal needs; and
(vi) Legal services.

(C) **Limitations.** For members with Developmental Disabilities, the Health Home will refer to and coordinate with the approved Developmental Disabilities case management entity for these services.

(D) **Qualified individuals.** Referral to community and social support services may be provided by a certified behavioral health case manager, Family Support Provider or a nurse care manager.

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: February 16, 2016

The proposed policy is a Permanent Rule. This proposal is scheduled to be presented to the Medical Advisory Committee (MAC) on March 10, 2016 and the (OHCA) Board of Directors on March 24, 2016.
Reference: APA WF 15-36

SUMMARY:
Policy Revision to Remove Specific Limits on Diabetic Testing Supplies — Proposed supplies rules are revised to remove specific limits on the quantity of diabetic testing supplies.

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:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

TO: Tywanda Cox
Health Policy

FROM: Harvey Reynolds
Health Policy

SUBJECT: Rule Impact Statement
APA WF # 15-36

A. Brief description of the purpose of the rule:

Proposed revisions remove specific quantity limits to diabetic testing supplies and replaces it with more general language about testing supplies being based on insulin use or type of diabetes so that a rule change is not necessary when quantities should be changed according to evidence-based guidelines. Revisions will also specify that a prior

authorization may be required for supplies beyond the standard allowance.

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:

Persons affected by the proposed rule include SoonerCare members with diabetes who use diabetic testing supplies, providers who prescribe diabetic testing supplies for diabetics and providers who supply diabetic testing supplies to SoonerCare members with diabetes.

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

There is a potential benefit to members as guidelines are revised to allow more flexibility because current guidelines set specific limits to the quantity of diabetic supplies covered. Revised guidelines allow testing supplies to be based on type of diabetes or insulin use and supplies beyond the standard allowance can be approved through the prior authorization process.

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 and there are no fee changes associated with the rule change for any 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:

There is no estimated budget impact for this rule as no change to diabetic testing supply quantities are planned.

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:

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. Opportunities for public input are provided throughout the rulemaking process, in addition to formal public comment periods and tribal consultations.

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. The proposed rule provides more flexibility in providing diabetic supplies based on insulin use or type of diabetes instead of the current hard and fast quantity limits. It also allows for quantities beyond the standard allowance through the prior authorization process.

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

If the proposed rule is not implemented SoonerCare members with diabetes will be limited to hard and fast quantity limits on diabetic supplies.

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

Prepared date: December 14, 2015
Modified date: January 28, 2016

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 medically necessary 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.** Glucose test strips and lancets are covered when medically necessary and prescribed by a physician, physician assistant, or an advanced practice nurse. ~~A maximum of 100 glucose test strips and 100 lancets per month are covered items for insulin dependent members and a maximum of 100 glucose test strips and 100 lancets per 90 days are covered for non-insulin dependent members. Members diagnosed with gestational diabetes may receive a maximum of 150 glucose test strips and 150 lancets per month when the appropriate diagnostic classification for gestational diabetes is used. Diabetic supplies in excess of these parameters must be prior authorized.~~Testing supplies may be limited based on insulin use or type of diabetes. Prior authorization may be required for supplies beyond the standard allowance.

(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.
(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: February 16, 2016

The proposed policy is a Permanent Rule. The proposed policy is scheduled to be presented to Tribal Consultation on January 5, 2016, Medical Advisory Committee (MAC) on March 10, 2016 and the (OHCA) Board of Directors on March 24, 2016.

Reference: APA WF # 15-38

SUMMARY:
Quality of Care Fund Reports – Proposed Quality of Care (QOC) policy revisions clean up existing language to reflect the modernization of OHCA business practices.

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 1925.1 of Title 63 of Oklahoma Statutes.

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

TO: Tywanda Cox
Federal and State Policy

FROM: William Baker
State Policy

SUBJECT: Rule Impact Statement
APA WF # 15-38

A. Brief description of the purpose of the rule:

Proposed Quality of Care (QOC) policy revisions clarify procedures for the completion and submission of the QOC Report. Policy is amended to correctly list the types of employee positions that are counted in staffing ratios and

outline procedures for counting non-direct care workers when those employees are rendering direct care. Revisions eliminate references to outdated submission methods such as certified mail, diskettes and electronic mail, while adding a requirement to submit QOC reports via the provider portal. Proposed policy revisions clarify the types of information required in the QOC report and update staff unit terminology.

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:

Providers will be affected by the elimination of USPS mail or diskettes for the submission of monthly reports. Reports are only accepted through the OHCA Provider Portal. Providers are also required to report additional information on the Quality of Care Report. No information on cost impacts was received from any entity.

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

Providers will benefit from reduced administrative burden from the elimination of faxed and mailed documents. All providers will be allowed to submit reports online. We believe this change allows for a more streamlined process for submissions.

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:

Reduced printing and mailing costs will result in a positive economic impact on providers.

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:

This rule is budget neutral and will not have an impact on

the OHCA budget. Language cleanup only.

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. Opportunities for public input are provided throughout the rulemaking process, in addition to formal public comment periods and tribal consultations.

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 25, 2015.
The rule impact statement was modified January 21, 2016.

RULE TEXT

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 9. LONG TERM CARE FACILITIES

317:30-5-131.2. Quality of care fund requirements and report

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

(1) **"Nursing Facility and Intermediate Care Facility for Individuals with Intellectual Disabilities"** means any home, establishment, or institution or any portion thereof, licensed by the State Department of Health as defined in Section 1-1902 of Title 63 of the Oklahoma Statutes.

(2) **"Quality of Care Fee"** means the fee assessment created for the purpose of quality care enhancements pursuant to Section 2002 of Title 56 of the Oklahoma Statutes upon each nursing facility and intermediate care facility for individuals with intellectual disabilities licensed in this State.

(3) **"Quality of Care Fund"** means a revolving fund established in the State Treasury pursuant to Section 2002 of Title 56 of the Oklahoma Statutes.

(4) **"Quality of Care Report"** means the monthly report developed by the Oklahoma Health Care Authority to document the staffing ratios, total patient gross receipts, total patient days, and minimum wage compliance for specified staff for each nursing facility and intermediate care facility for individuals with intellectual disabilities licensed in the State.

(5) **"Staffing ratios"** means the minimum direct-care-staff-to-resident ratios pursuant to Section 1-1925.2 of Title 63 of the Oklahoma Statutes and pursuant to OAC 310:675-1 et seq.

(6) **"Peak In-House Resident Count"** means the maximum number of in-house residents at any point in time during the applicable shift.

(7) **"Staff Hours worked by Shift"** means the number of hours worked during the applicable shift by direct-care staff.

(8) **"Direct-Care Staff"** means any nursing or therapy staff who provides direct, hands-on care to residents in a nursing facility and intermediate care facility for individuals with intellectual disabilities pursuant to Section 1-1925.2 of Title 63 of the Oklahoma Statues, pursuant to OAC 310:675-1 et seq., and as defined in subsection (c) of this Section.

(9) **"Major Fraction Thereof"** is defined as an additional threshold for direct-care-staff-to-resident ratios at which another direct-care staff person(s) is required due to the peak in-house resident count exceeding one-half of the minimum direct-care-staff-to-resident ratio pursuant to Section 1-1925.2 of Title 63 of the Oklahoma Statutes.

(10) **"Minimum wage"** means the amount paid per hour to specified staff pursuant to Section 5022.1 of Title 63 of the Oklahoma Statutes.

(11) **"Specified staff"** means the employee positions listed in the Oklahoma Statutes under Section 5022.1 of Title 63 and as defined in subsection (d) of this Section.

(12) **"Total Patient Days"** means the monthly patient days that are compensable for the current monthly Quality of Care Report.

(13) **"Total Gross Receipts"** means all cash received in the current Quality of Care Report month for services rendered to all residents in the facility. Receipts should include all Medicaid, Medicare, Private Pay and Insurance including receipts for items not in the normal per diem rate. Charitable contributions received by the nursing facility are not included.

(14) **"Service rate"** means the minimum direct-care-staff-to-resident rate pursuant to Section 1-1925.2 of Title 63 of Oklahoma Statutes and pursuant to OAC 310:675-1 et seq.

(b) **Quality of care fund assessments.**

(1) The Oklahoma Health Care Authority (OHCA) was mandated by the Oklahoma Legislature to assess a monthly service fee to each Licensed Nursing Facility in the State. The fee is assessed on a per patient day basis. The amount of the fee is uniform for each facility type. The fee is determined as six percent (6%) of the average total gross receipts divided by the total days for each facility type.

(2) In determination of the fee for the time period beginning October 1, 2000, a survey was mailed to each licensed nursing facility requesting calendar year 1999 Total Patient Days, Gross Revenues and Contractual Allowances and Discounts. This data is used to determine the amount of the fee to be assessed for the period of 10-01-00 through 06-30-01. The fee is determined by totaling the "annualized" gross revenue and dividing by the "annualized" total days of service. "Annualized" means that the surveys received that do not

cover the whole year of 1999 are divided by the total number of days that are covered and multiplied by 365.

(3) The fee for subsequent State Fiscal Years is determined by using the monthly gross receipts and census reports for the six month period October 1 through March 31 of the prior fiscal year, annualizing those figures, and then determining the fee as defined above. As per 56 O.S. Section 2002, as amended, the fees are frozen at the amount in effect at July 1, 2004. Also, the fee will be monitored to never surpass the federal maximum.

(4) The fee is authorized through the Medicaid State Plan and by the Centers for Medicare and Medicaid Services (CMS) regarding waiver of uniformity requirements related to the fee.

(5) Monthly reports of Gross Receipts and Census are included in the monthly Quality of Care Report. The data required includes, but is not limited to, the Total Gross Receipts and Total Patient Days for the current monthly report.

(6) The method of collection is as follows:

(A) The Oklahoma Health Care Authority assesses each facility monthly based on the reported patient days from the Quality of Care Report filed two months prior to the month of the fee assessment billing. As defined in this subsection, the total assessment is the fee times the total days of service. The Oklahoma Health Care Authority notifies the facility of its assessment by the end of the month of the Quality of Care Report submission date.

(B) Payment is due to the Oklahoma Health Care Authority by the 15th of the following month. 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 10% of the amount and interest of 1.25% per month. The Quality of Care Fee must be submitted no later than the 15th of the month. If the 15th falls upon a holiday or weekend (Saturday-Sunday), the fee is due by 5 p.m. (Central Standard Time) of the following business day (Monday-Friday).

(C) The monthly 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 Authority the assessment within the time frames noted on the second 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. Adjustments to prior months' reported amounts for gross receipts or patient days may be made by filing an amended part C of the Quality of Care Report.

(D) The Quality of Care fee assessments excluding penalties and interest are an allowable cost for Oklahoma Health Care Authority Cost Reporting purposes.

(E) The Quality of Care fund which contains assessments collected excluding penalties and interest as described in this subsection and any interest attributable to investment of any money in the fund must be deposited in a revolving fund established in the State Treasury. The funds will be used pursuant to Section 2002 of Title 56 of the Oklahoma Statutes.

(c) **Quality of care direct-care-staff-to resident-ratios.**

(1) Effective September 1, 2000, all nursing facilities and intermediate care facilities for individuals with intellectual disabilities (ICFs/IID) subject to the Nursing Home Care Act, in addition to other state and federal staffing requirements, must maintain the minimum direct-care-staff-to-resident ratios or direct-care service rates as cited in Section 1-1925.2 of Title 63 of the Oklahoma Statutes and pursuant to OAC 310:675-1 et seq.

(2) For purposes of staff-to-resident ratios, direct-care staff are limited to the following employee positions:

(A) Registered Nurse
(B) Licensed Practical Nurse
(C) Nurse Aide
(D) Certified Medication Aide
(E) Qualified Intellectual Disability Professional (ICFs/IID only)
(F) Physical Therapist
(G) Occupational Therapist
(H) Respiratory Therapist
(I) Speech Therapist
(J) Therapy Aide/Assistant
~~(K) Social Services Director/Social Worker~~
~~(L) Other Social Services Staff~~
~~(M) Activities Director~~
~~(N) Other Activities Staff~~
~~(O) Combined Social Services/Activities~~

(3) ~~Prior to September 1, 2003, activity and social services staff who did not provide direct, hands-on care may be included in the direct-care-staff-to-resident ratio in any shift or direct-care service rates. On and after September 1, 2003, such persons are not included in the direct-care-staff-to-resident ratio or direct-care service rates.~~The hours of direct care rendered by persons filling non-direct care positions may be used when those persons are certified and

rendering direct care in the positions listed in OAC 317:30-5-131.2(c)(2) when documented in the records and time sheets of the facility.

(4) In any shift when the direct-care-staff-to-resident ratio computation results in a major fraction thereof, direct-care staff is rounded to the next higher whole number.

(5) To document and report compliance with the provisions of this subsection, nursing facilities and intermediate care facilities for individuals with intellectual disabilities must submit the monthly Quality of Care Report pursuant to subsection (e) of this Section.

(d) **Quality of care minimum wage for specified staff.** Effective November 1, 2000, all nursing facilities and private intermediate care facilities for individuals with intellectual disabilities receiving Medicaid payments, in addition to other federal and state regulations, must pay specified staff not less than in the amount of $6.65 per hour. Employee positions included for purposes of minimum wage for specified staff are as follows:

(1) Registered Nurse
(2) Licensed Practical Nurse
(3) Nurse Aide
(4) Certified Medication Aide
(5) Other Social Service Staff
(6) Other Activities Staff
(7) Combined Social Services/Activities
(8) Other Dietary Staff
(9) Housekeeping Supervisor and Staff
(10) Maintenance Supervisor and Staff
(11) Laundry Supervisor and Staff

(e) **Quality of care reports.** Effective September 1, 2000, all nursing facilities and intermediate care facilities for individuals with intellectual disabilities must submit a monthly report developed by the Oklahoma Health Care Authority, the Quality of Care Report, for the purposes of documenting the extent to which such facilities are compliant with the minimum direct-care-staff-to-resident ratios or direct-care service rates.

(1) The monthly report 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 benefit or payment...shall (i) in the case of such statement, representation, concealment, failure, or conversion by any person in connection with furnishing (by that person) of items or services for which payment is or may be made 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) The Quality of Care Report must be submitted by 5 p.m. (CST) on the 15th of the following month. If the 15th falls upon a holiday or a weekend (Saturday-Sunday), the report is due by 5 p.m. (CST) of the following business day (Monday - Friday).

(5) The Quality of Care Report will be made available in an electronic version for uniform submission of the required data elements.

(6) Facilities must submit the monthly report ~~either through electronic mail to the Opportunities for Living Life Division, Long Term Care Quality Initiatives Unit or send the monthly report in disk or paper format by certified mail and pursuant to subsection (e)(14) of this section. The submission date is determined by the date and time recorded through electronic mail or the postmark date and the date recorded on the certified mail receipt~~through the OHCA Provider Portal.

(7) Should a facility discover an error in its submitted report for the previous month only, the facility must provide to the ~~Opportunities for Living Life Division, Long Term Care Quality Initiatives Unit~~Long Term Care Financial Management Unit written notification with adequate, objective and substantive documentation within five business days following the submission deadline. Any documentation received after the five business day period will not be considered in determining compliance and for reporting purposes by the Oklahoma Health Care Authority.

(8) An initial administrative penalty of $150.00 is imposed upon the facility for incomplete, unauthorized, or non-timely filing of the Quality of Care Report. Additionally, a daily administrative penalty will begin upon the Authority notifying the facility in writing that the report was not complete or not timely submitted as required. The $150.00 daily administrative penalty accrues for each calendar day

after the date the notification is received. The penalties are deducted from the Medicaid facility's payment. For 100% private pay facilities, the penalty amount(s) is included and collected in the fee assessment billings process. Imposed penalties for incomplete reports or non-timely filing are not considered for Oklahoma Health Care Authority Cost Reporting purposes.

(9) The Quality of Care Report includes, but is not limited to, information pertaining to the necessary reporting requirements in order to determine the facility's compliance with subsections (b) and (c) of this Section. Such reported information includes, but is not limited to: ~~staffing ratios; peak in-house resident count; staff hours worked by shift; total patient days; available bed days; Medicare bed days; Medicaid bed days; and total gross receipts~~total gross receipts, patient days, available bed days, direct care hours, Medicare days, Medicaid days, number of employees, monthly resident census, and tenure of Certified Nursing Assistants, nurses, directors of nursing, and administrators.

(10) Audits may be performed to determine compliance pursuant to subsections (b), (c) and (d) of this Section. Announced/unannounced on-site audits of reported information may also be performed.

(11) Direct-care-staff-to-resident information and on-site audit findings pursuant to subsection (c), will be reported to the Oklahoma State Department of Health for their review in order to determine "willful" non-compliance and assess penalties accordingly pursuant to Title 63 Section 1-1912 through Section 1-1917 of the Oklahoma Statutes. The Oklahoma State Department of Health informs the Oklahoma Health Care Authority of all final penalties as required in order to deduct from the Medicaid facility's payment. Imposed penalties are not considered for Oklahoma Health Care Authority Cost Reporting purposes.

(12) If a Medicaid provider is found non-compliant pursuant to subsection (d) based upon a desk audit and/or an on-site audit, for each hour paid to specified staff that does not meet the regulatory minimum wage of $6.65, the facility must reimburse the employee(s) retroactively to meet the regulatory wage for hours worked. Additionally, an administrative penalty of $25.00 is imposed for each non-compliant staff hour worked. For Medicaid facilities, a deduction is made to their payment. Imposed penalties for non-compliance with minimum wage requirements are not considered for Oklahoma Health Care Authority Cost Reporting purposes.

(13) Under OAC 317:2-1-2, Long Term Care facility providers may appeal the administrative penalty described in (b)(5)(B) and (e)(8) and (e)(12) of this section.
(14) Facilities that have been authorized by the Oklahoma State Department of Health (OSDH) to implement flexible staff scheduling must comply with OAC 310:675-1 et seq. The authorized facility is required to complete the flexible staff scheduling section of Part A of the Quality of Care Report. The Owner, authorized Corporate Officer or Administrator of the facility must complete the flexible staff scheduling signature block, acknowledging their OSDH authorization for Flexible Staff Scheduling.

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 15, 2016

The proposed policy is a Permanent Rule. The proposed policy is scheduled to be presented to the Medical Advisory Committee (MAC) on January 21, 2016 and the (OHCA) Board of Directors on February 11, 2016.

Reference: APA WF # 15-40

SUMMARY:
Hospital Leave Payments — Proposed policy change would clean up existing language to reflect the elimination of hospital leave payments implemented in 2014. Hospital leave payments are no longer made to long term care facilities. Payments will continue for therapeutic leave.

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 483.12

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

TO: Tywanda Cox
Federal and State Policy

FROM: William Baker
Health Policy

SUBJECT: Rule Impact Statement
APA WF # 15-40

A. Brief description of the purpose of the rule:

Proposed policy would clean up language in Chapter 35 to match 2014 changes to Chapter 30 that eliminated hospital

leave payments to long term care facilities. Proposed changes to Chapter 35 would remove existing references to reimbursement for hospital leave and reflect current OHCA practices. Payments will continue for therapeutic leave.

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. This rule should not place any cost burden on private or public entities.

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

No classes of persons will receive benefit from this 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 not a probable economic impact for this proposed rule.

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:

This rule is budget neutral and will not have an impact on the OHCA budget. Changes to these payments were made in 2014 and are not altered by this proposed 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:

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 October 9, 2015.

RULE TEXT

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

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

PART 11. PAYMENT, BILLING, AND OTHER ADMINISTRATIVE PROCEDURES

317:35-9-95. Payment to ICF/~~MR~~IID (public and private)

The Oklahoma Health Care Authority may execute agreements to provide care only with facilities which are properly licensed by the state licensing agency. The agreement is initiated by application from the facility and expires on a specified date, or with termination of the facility license, or shall be automatically terminated on notice to OHCA that the facility is not in compliance with Medicaid (or other federal long-term care) requirements.

(1) In the event that a facility changes ownership, the agreement with the previous owner may be extended to the new owner, pending certification of the new owner to provide care to individuals during the change of ownership. In the event that the new owner is not showing good faith in pursuit of certification, the OHCA will begin planning for alternate placement of Medicaid patients. The county office is immediately notified of any relevant change in facility status.

(2) Payment for long-term care is made only for those individuals who have been approved by the DHS for such care. The amount of payment is based on the actual time the individual received care (including therapeutic/hospital leave) from a nursing facility during any given month. Payment for nursing care cannot be made for any period during which the care has been temporarily interrupted for reasons other than therapeutic leave. Therapeutic leave is any planned leave other than hospitalization that is for the benefit of the patient. Therapeutic leave must be clearly documented in the patient's plan of care before payment for a reserved bed can be made by the OHCA. Hospital leave is planned or unplanned leave when the patient is admitted to a licensed hospital.

(3) A nursing facility may receive payment for up to 7 days per calendar year for each eligible individual in order to reserve a bed when the patient is on therapeutic leave.

(4) The ICF/~~MR~~IID may receive payment for a maximum of 60 days of therapeutic leave per calendar year for each recipient to reserve a bed. No more than 14 consecutive days of therapeutic leave may be claimed per absence. Recipients approved for ICF/~~MR~~IID on or after July 1 of the year will only be eligible for 30 days of therapeutic leave during the remainder of that year.

(5) The Statement of Compensable Therapeutic Leave Only form is used by the facility to record use of therapeutic leave. This form is to be made available by the local office to the nursing facility upon request.

(6) ~~Effective August 1, 1995, a nursing facility may receive payment for a maximum of three (3) days of hospital leave per calendar year for each recipient to reserve a bed when the patient is admitted to a licensed hospital, if the facility has an occupancy rate of at least 90 percent at the time of hospital admission. Claims for hospital leave are submitted on Form Adm-41 (Long Term Care Claim Form).~~No payment shall be made for hospital leave.

~~(7) Effective January 1, 1996, the nursing facility may receive payment for a maximum of five (5) days of hospital leave per calendar year for each recipient to reserve the bed when the patient is admitted to a licensed hospital.~~

SUBCHAPTER 19. NURSING FACILITY SERVICES

317:35-19-26. Payment to NF

The OHCA may execute agreements to provide care only with facilities which are properly licensed by the state licensing agency. The agreement is initiated by application from the facility and expires on a specified date, or with termination of the facility license, or shall be automatically terminated on notice to this Authority that the facility is not in compliance with Medicaid (or other federal long-term care) requirements.

(1) In the event that a facility changes ownership, the agreement with the previous owner may be extended to the new owner, pending certification of the new owner to provide care to individuals during the change of ownership. In the event that the new owner is not showing good faith in pursuit of certification, the OHCA will begin planning for alternate placement of Medicaid patients. The county office is immediately notified of any relevant change in facility status.

(2) Payment for long-term care is made only for those individuals who have been approved by the Department of Human Services for such care. The amount of payment is based on the actual time the individual received care (including

therapeutic leave) from a nursing facility during any given month. Payment for nursing care cannot be made for any period during which the care has been temporarily interrupted for reasons other than therapeutic leave. Therapeutic leave is any planned leave other than hospitalization that is for the benefit of the patient. Therapeutic leave must be clearly documented in the patient's plan of care before payment for a reserved bed can be made by the OHCA.

(3) Effective July 1, 1994, the nursing facility may receive payment for a maximum of seven days of therapeutic leave per calendar year for each eligible individual to reserve the bed.

(4) The Statement of Compensable Therapeutic Leave Only form is used by the facility to record use of therapeutic leave. This form is to be made available by the local office to the nursing facility upon request.

(5) ~~Effective August 1, 1995, a nursing facility may receive payment for a maximum of three (3) days of hospital leave per calendar year for each recipient to reserve a bed when the patient is admitted to a licensed hospital, if the facility has an occupancy rate of at least 90 percent at the time of hospital admission. Claims for hospital leave are submitted on Form Adm-41 (Long Term Care Claim Form).~~No payment shall be made for hospital leave.

~~(6) Effective January 1, 1996, the nursing facility may receive payment for a maximum of five (5) days of hospital leave per calendar year for each recipient to reserve the bed when the patient is admitted to a licensed hospital.~~

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: February 16, 2016

The proposed policy is a Permanent Rule. The proposed policy is scheduled to be presented to the Medical Advisory Committee (MAC) on March 10, 2016 and the (OHCA) Board of Directors on March 24, 2016.
Reference: APA WF 15-41

SUMMARY:
Third Party Liability – Proposed revisions to policy clarify the payer of last resort provisions when third party liability claims are involved.

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:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

TO: Tywanda Cox
Federal and State Policy

FROM: William Baker
State Policy

SUBJECT: Rule Impact Statement
APA WF # 15-41

A. Brief description of the purpose of the rule:

Proposed revisions to policy clarify the payer of last resort provisions when third party liability claims are involved. Revisions include adding exceptions to policy for medical expenses incurred in relation to a claim or lawsuit for which

third party responsibility is involved. Language will be added to prohibit billing more than the SoonerCare rate for a covered service and that the payments made by OHCA represent payment in full.

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:

Providers for members whose expenses are in relation to a claim or lawsuit for which a third party may be responsible are affected by this rule. The providers can elect to directly bill the third party liability carrier. Medical providers are prohibited from recovering an amount exceeding the SoonerCare rate. No information was received on cost impacts from any entity.

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

Members, providers and private insurers will benefit from clarification of third party liability rules. Members are protected from paying more than the SoonerCare rate for covered 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 not a probable economic impact for this proposed rule on any classes of persons or political subdivisions. There are no fee changes in this proposed rule.

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:

This rule is budget neutral and will not have an impact on

the OHCA budget.

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 and will not require cooperation from any political subdivision.

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. Opportunities for public input are provided throughout the rulemaking process, in addition to formal public comment periods and tribal consultations.

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, 2015.
The rule impact statement was modified January 21, 2016.

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

317:30-3-24. Third party liability

~~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. Guidance for third party liability under the Insure Oklahoma program is found in OAC 317:45, Insure Oklahoma.~~

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 include, but are not limited to, those receiving medical treatment through Indian Health Services, those eligible for the Crime Victims Compensation Act, and those medical expenses incurred in relation to a claim or lawsuit for which a third party may be responsible and for which the OHCA will have a right to subrogation of medical expense payments. Guidance for third party liability under the Insure Oklahoma program is found in OAC 317:45, Insure Oklahoma.

(1) If a member has healthcare coverage by an absent parent's insurance program or any other policy holder, that insurance resource must be used prior to filing a SoonerCare claim. This includes Health Maintenance Organizations (HMO), Preferred Provider Organizations (PPO) and any other insuring arrangements that provide a member access to healthcare. Members must comply with all requirements of their primary insurance as well as SoonerCare requirements in order to take advantage of both coverages. ~~For example, a member must comply with the network restrictions of both the primary and SoonerCare plans as well as prior authorization requirements.~~For example, a member must comply with all healthcare network restrictions, as well as prior authorization requirements. If the member does not comply

with the requirements of the primary plan, he/she will be responsible for the charges incurred. Denials by private insurance companies because the member did not secure a ~~preauthorization~~necessary prior authorization or use a network or participating provider is not a sufficient reason for SoonerCare to make payment. If the provider is aware of private healthcare insurance or healthcare liability, a claim must first be filed with that source. When private insurance information is known to the OHCA, the eligibility verification system will reflect that information. If payment is denied by the primary insurance, except as stated above, the provider must attach the Explanation of Benefits (EOB), stating the reason for the denial, to the claim submitted to the Fiscal Agent. When payment is received from another source, that payment amount must be reflected on the claim form.

(2) It is possible that other resources are available but are unknown to OHCA. Providers will routinely question SoonerCare members to determine whether any other resources are available. In some instances, coverage may not be obvious, for example, the member may be covered by a policy on which he/she is not the subscriber (e.g., a child whose absent parent maintains medical and hospital coverage).

(3) If the provider receives payment from another source after OHCA has made payment, it is necessary that the provider reimburse OHCA for the SoonerCare payment. The provider may retain the primary insurance payment, if any, that represents payment for services that are not covered services under SoonerCare. By accepting the OHCA's payment, the provider agrees to accept it as payment in full and, therefore, cannot retain any portion of other resource money as payment for reduced charges on covered services. Other than SoonerCare copayments, a provider cannot bill a member for any unpaid portion of the bill or for a claim that is not paid because of provider administrative error. If, after reimbursing OHCA and retaining a portion of the other payment in satisfaction of any non-covered services there is money remaining, it must be refunded to the member.

(4) If a member is covered by a private health insurance policy or plan, he/she is required to inform medical providers of the coverage, including:

(A) provision of applicable policy numbers;

(B) assignment payments to medical providers;

(C) provision of information to OHCA of any coverage changes; and

(D) release of money received from a health insurance plan to the provider if the provider has not already received payment or to the OHCA if the provider has already been paid by the OHCA.

(5) Members are responsible for notifying their providers of the intent to make application for SoonerCare coverage and of any retroactive eligibility determinations. Members may be

responsible for any financial liability if they fail to notify the provider of the eligibility determinations and as a result, the provider is unable to secure payment from OHCA.
(6) Members must present evidence of SoonerCare and any other health insurance coverage to a medical provider each time services are requested. Members may be responsible for any financial liability if they fail to furnish the necessary information before the receipt of services and as a result, the provider is unable to secure payment from OHCA.
(7) Regarding SoonerCare compensable services, when there is a third party (whether an individual, entity or insurance carrier) who may be liable for the medical expenses incurred by a member (based upon injury and/or damages, whether or not a claim for damages or a lawsuit have been pursued by the member), the medical provider rendering the medical services can elect to bill the third party liability carrier directly or to bill SoonerCare directly. However, the provider cannot bill more than the SoonerCare rate for that covered service. Otherwise, the subrogation rights of the OHCA against that third party may be adversely affected. Those having Provider Agreements with the OHCA are prohibited from recovering more than the SoonerCare rate. See 42 CFR 447.15. The Medical providers are prohibited from recovering an amount exceeding the SoonerCare rate for SoonerCare compensable services even when the provider does not seek payment from the OHCA. As a result of the claimant/member utilizing SoonerCare for healthcare, medical providers who contract with the OHCA are paid significantly less than they ordinarily bill and prohibited by state and federal law from pursuing additional payments from the claimant/member. Regarding SoonerCare compensable services, providers who seek to collect an amount greater than the SoonerCare allowable from a member may be subjected to penalties pursuant to 42 CFR 447.21. Penalties can be a reduction in SoonerCare payments due the provider, which is equal to three times the amount the provider sought to collect. Pursuant to 42 CFR 447.15, payments made by the OHCA shall be considered payment in full for all covered services provided to a SoonerCare member. Medical Providers shall not bill a SoonerCare member for such service and shall not be relieved of this provision by electing not to bill OHCA for the service. This provision shall not apply to co-payments allowed by OHCA.

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: February 16, 2016

The proposed policy is a Permanent Rule. The proposed policy is scheduled to be presented to the Medical Advisory Committee (MAC) on March 10, 2016 and the (OHCA) Board of Directors on March 24, 2016.
Reference: APA WF 15-42

SUMMARY:
Audit Procedures – Proposed program integrity audit and review policy is revised to clarify OHCA audit procedures and address issues such as extrapolation, reconsideration and audits.

LEGAL AUTHORITY
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes, and Section 1011.9 of Title 56 of Oklahoma Statutes.

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

TO: Tywanda Cox
Federal and State Policy

FROM: William Baker
State Policy

SUBJECT: Rule Impact Statement
APA WF # 15-42

A. Brief description of the purpose of the rule:

Proposed program integrity audit and review policy is revised to clarify OHCA audit procedures and address issues such as extrapolation, reconsideration and audits. Definitions will

be expanded to include universe, sample and error rate. Language will be amended to clarify those items included in the audit/review process, the provider's options after an initial audit/review, and the process for selecting sample claims in a probability sample audit.

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 information on cost impacts were received from any entity. Providers will be required to provide documentation when requesting an informal reconsideration or formal appeal. Providers must now identify each claim being contested. Providers must request reconsideration or formal appeal within the specified timeframe.

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

Providers will benefit from clarification of methods used to reduce error rates and options available to providers after an initial audit/review.

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 not a probable economic impact for this proposed rule.

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:

This rule is budget neutral and will not have an impact on the OHCA budget.

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. Opportunities for public input are provided throughout the rulemaking process, in addition to formal public comment periods and tribal consultations.

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 10, 2015.
The rule impact statement was modified January 20, 2016.

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

317:30-3-2.1. Program Integrity Audits/Reviews

(a) This section applies to all contractors/providers:

(1) **"Contractor/provider"** means any person or organization that has signed a provider agreement with the Oklahoma Health Care Authority (OHCA).

(2) **"Extrapolation"** means the methodology of estimating an unknown value by projecting, with a calculated precision (i.e., margin of error), the results of a probability sample to the universe from which the sample was drawn.

(3) **"Probability sample"** means the standard statistical methodology in which a sample is selected based on the theory of probability (a mathematical theory used to study the occurrence of random events).

(4) "**Universe"** means all paid claims or types of paid claims audited/reviewed during a specified timeframe.

(5) "**Sample"** means a statistically valid number of claims obtained from the universe of claims audited/reviewed.

(6) "**Error Rate"** means the percentage of dollars of audited claims found to be billed in error.

(b) An OHCA audit/review includes the following:

~~(1) An examination of provider records, by either an on-site or desk audit. Claims may be examined for compliance with relevant federal and state laws and regulations, written provider billing instructions, numbered memoranda, and/or medical necessity.~~

(1) An examination of provider records, by either an on-site or desk audit. Claims may be examined for compliance with provider contracts, relevant federal and state laws and regulations, including but not limited to the Oklahoma Administrative Code.

~~(2) A draft audit/initial review report, which contains preliminary findings.~~

(2) An initial audit/review report contains preliminary findings. Upon receipt of the findings, a provider may elect to:

(A) Remit the identified overpayment to OHCA;

(B) Request informal reconsideration of the initial report per OAC 317:30-3-2.1(b)(3); or

(C) Request a formal appeal of the initial report per OAC 317:30-3-2.1(b)(4).

~~(3) An informal reconsideration period in which the provider may supply relevant information to clear any misunderstandings and/or findings.~~

(3) An informal reconsideration period. If a provider requests an informal reconsideration, the provider shall provide any and all documentation or relevant information to clear any misunderstandings and/or findings identified in the initial report. Only claims identified by the provider for reconsideration will be reviewed by the OHCA. Any claims or findings not identified by the provider for reconsideration will be deemed waived by the provider if the provider chooses to later appeal the reconsideration finding. The reconsideration findings will replace the initial findings and be identified as the final report.

~~(4) The right to a formal appeal, if the contractor/provider requests it.~~

(4) The right to a formal appeal, if requested by the provider. A request for reconsideration does not limit a provider's right to a formal appeal. However, all claims not specifically identified by the provider for further audit/review at reconsideration will be deemed waived by the provider for purposes of a formal audit appeal. Additionally, the provider must specifically identify each claim to be contested on appeal and any claim not identified in the appeal will be deemed waived on appeal.

~~(5) A final audit/review report.~~

(5) If the provider does not request either a reconsideration or a formal appeal within the specified timeframe, the initial report will become the final report and the provider will be obligated to reimburse OHCA for any identified overpayment, which amount shall be immediately due and payable to OHCA.

~~(c) When OHCA conducts a probability sample audit, the sample claims are selected on the basis of recognized and generally accepted sampling methods. If audit reveals patterns of inappropriate coding, failure to adhere to SoonerCare policies,~~

~~issues related to medical necessity, consistent patterns of overcharging, lack of appropriate documentation, or other fiscal abuse of the SoonerCare program, with an error rate of more than 10%, the provider may be required to reimburse OHCA the extrapolated amount.~~

(c) When OHCA conducts a probability sample audit, the sample claims are selected on the basis of recognized and generally accepted sampling methods. If an audit reveals an error rate exceeding 10%, OHCA shall extrapolate the error rate to the universe of the dollar amount of the audited paid claims.

~~(1) When projecting the overpayment, using statistical sampling, OHCA uses a sample that is sufficient to ensure a minimum 95% confidence level.~~

(1) When using statistical sampling, OHCA uses a sample that is sufficient to ensure a minimum confidence level of 95%.

(2) When calculating the amount to be recovered, OHCA ensures that all overpayments and underpayments reflected in the probability sample are totaled and extrapolated to the universe from which the sample was drawn.

(3) OHCA does not consider non-billed services or supplies when calculating underpayments and overpayments.

~~(d) If sampling reveals an error rate of 10% or less, the provider will be required to reimburse OHCA for any overpayments noted during the review.~~

(d) If a probability sample audit reveals an error rate of 10% or less, the provider will be required to reimburse OHCA for any overpayments noted during the audit/review.

~~(e) In those instances when the probability sample results in an error rate in excess of 10%, the results of a probability sample may be used by OHCA to extrapolate the amount to be recovered.~~

~~(f) SoonerCare contracted providers shall have the option of requesting OHCA perform a full-scope audit or utilize an extrapolation method to determine overpayments, if during a review a statistical sample indicates an error rate greater than 10% of paid claims.~~

~~(1) The provider must select the overpayment determination method, full-scope audit or extrapolation, within the time constraints of the designated appeal.~~

~~(A) The additional labor cost to perform a full-scope audit will be carried by the OHCA if the review produces an error rate less than the initial error rate.~~

~~(B) The provider will be charged the cost of the full-scope audit if the review produces an error rate equal to or greater than the initial error rate.~~

~~(C) Cost will be determined through OHCA billable time plus all applicable overhead and/or the cost of contracted services.~~

~~(D) The provider must choose an independent contactor from an OHCA approved list of qualified contractors to perform the full-scope audit.~~

~~(2) The provider will be responsible for repayment of any identified overpayment resulting from the review method chosen.~~

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: February 16, 2016

The proposed policy is a Permanent Rule. The proposed policy is scheduled to be presented to the Medical Advisory Committee (MAC) on March 10, 2016 and the (OHCA) Board of Directors on March 24, 2016.
Reference: APA WF 15-43

SUMMARY:
Appeal Procedures – Proposed policy revisions clarify and make corrections to instructions for the submission of claim inquiries by providers, and language cleanup.

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:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

TO: Tywanda Cox
Federal and State Policy

FROM: William Baker
State Policy

SUBJECT: Rule Impact Statement
APA WF # 15-43

A. Brief description of the purpose of the rule:

Proposed policy revisions clarify and make corrections to instructions for the submission of claim inquiries by providers. Proposed changes include title change to section, removal of incorrect references to revoked policy, and

updated guidance on proper form used for claim inquiries. Proposed policy changes should result in decreased confusion for providers inquiring about payment for services provided to 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:

No classes of persons will be affected by the proposed rule. This rule should not place any cost burden on private or public entities.

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

Providers inquiring about payments for services will benefit from clarified language and corrected references to instructions.

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 not a probable economic impact for this proposed rule.

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:

This rule is budget neutral and will not have an impact on the OHCA budget.

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. Opportunities for public input are provided throughout the rulemaking process, in addition to formal public comment periods and tribal consultations.

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 13, 2015.
The rule impact statement was modified January 21, 2016.

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

317:30-3-20. ~~Appeals~~Claim inquiry procedures (excluding nursing homes and hospitals)

~~OHCA has established administrative procedures whereby a~~A medical provider may request a review of the decision of the amount paid or the non-payment of medical services provided an eligible ~~recipient~~member. If the medical provider does not agree with the original payment from the Fiscal Agent, he/she may submit a written explanation on HCA-17 (Claim Inquiry Form) as to why the adjustment is being requested and what action is to be taken, a copy of the paid remittance statement and/or detailed explanation of the paid information and a copy of the original claim with the corrections to be made for consideration of additional payment. The claim should be ~~filed~~submitted in accordance with the instructions in the ~~OAC 317:30-7 for the type of medical provider involved~~OHCA Provider Billing and Procedures Manual.

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: February 16, 2016

The proposed policy is a Permanent Rule. This proposal is scheduled to be presented to the Medical Advisory Committee (MAC) on March 10, 2016 and the (OHCA) Board of Directors on March 24, 2016.
Reference: APA WF 15-48

SUMMARY:
Service Quality Review/ TPS Employment Relationship with TFC – Proposed policy replace Inspection of Care language with the more appropriate Service Quality Review language to mirror practice and other policy changes. In addition, minor cleanup changes were made and the term outpatient was removed where referenced regarding behavioral health services to minimize confusion for Therapeutic Foster Care providers. In addition, rules are also revised to broaden the definition of employment to align with Therapeutic Foster Care (TFC) agencies' employment practices with Treatment Parent Specialist (TPS).

LEGAL AUTHORITY
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; OAC 340:75-8-6; OAC 340:75-8-8; Section 1-9-119 of Title 10A of the Oklahoma Statutes

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

TO: Tywanda Cox
Health Policy

FROM: Tatiana Reed
Health Policy

SUBJECT: Rule Impact Statement
APA WF # 15-48

A. Brief description of the purpose of the rule:

Proposed policy revisions replace Inspection of Care language with the more appropriate Service Quality Review language to mirror practice and other policy changes. In addition, minor cleanup changes were made and the term outpatient was removed where referenced regarding behavioral health services to minimize confusion for Therapeutic Foster Care providers. Rules also revised to broaden the definition of employment to align with Therapeutic Foster Care (TFC) agencies' employment practices with Treatment Parent Specialist (TPS). Current policy language regarding employment status of TPS in a TFC is problematic for TFC agencies as there are different variations of “employment” among the agencies. Changing policy language from “employment” to “employment relationship” will create more inclusive terminology which will reflect the various arrangements TFC agencies have with TPS (i.e. full-time employment, contractual employment, etc.).

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:

Treatment Parent Specialists without an employment relationship with the Therapeutic Foster Care for which the TPS performs services will be affected by the proposed rule.

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

Therapeutic Foster Care agencies may benefit from the broadening of the meaning of “employment relationship” with the Treatment Parent Specialist.

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:

This proposed rule change consists of language clean up to mirror current practice and Part 6 Inpatient Psychiatric Hospitals policy at OAC 317:30-5-95-42. Therefore, 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. The cleanup to update the references from Inspection of Care (IOC) to Service Quality Review Team is required Mirror current practice and policy.

The request to remove the term "outpatient" from outpatient behavioral health services is to reduce confusion since the Therapeutic Foster Care (TFC) agency provides the behavioral health services to the member.

TFC agencies hire clinical staff to provide a set of behavioral health services—the same type of services you might find if you went to an outpatient behavioral health agency. The TFC agency has to get prior authorization and if approved has a certain dollar amount from which to provide an

array of behavioral health services. Sometimes children have a special issue that is out of the scope of the providers at the TFC agency, and it is determined additional services are needed for the child. These additional services would be provided by an outpatient behavioral health provider to address those specific needs. That requires a separate PA and is a separate process. This is a higher level of care than those receiving services in an outpatient behavioral health setting. The requested change will reduce confusion between TFC and outpatient behavioral health services.

OHCA does not contract with TPS directly; rather, OHCA contracts with Residential Behavioral Management Services (RBMS) agencies. The TPS receives reimbursement through the TFC agency, not directly from OHCA. OHCA's special provisions for RBMS agencies do mention that the provider agrees that appropriate licensing is required for their employed mental health professionals and foster parents. However, DHS rules and policies dictate requirements of TFC agencies in regard to recruitment of and training for TPS providers. Further, policy was informed that most TPS are contracted employees of the TFC agency not a "benefit-receiving" employee. Confusion has increased in regard to employment status of TPS (e.g. whether "contracted" fits the definition, TFCs stating that they cannot employ TPS and provide benefits for them, etc.) when SQR performs an audit.

The intent of changing this rule is to give back the responsibility of employment status/practices of TPSs back to the TFC agencies. It is believed that "employment relationship" may be more open to interpretation (contracted employee, payroll employee, other).

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 change consists of language clean up to language clean up to mirror current practice and consistency throughout Part 6 OAC 317:30-5-95-42 of policy. Therefore, the 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 11, 2015.
The rule impact statement was modified January 22, 2016.

TEXT

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 83. RESIDENTIAL BEHAVIOR MANAGEMENT SERVICES IN FOSTER CARE SETTINGS

317:30-5-740. Eligible providers

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

(1) **Therapeutic foster care (TFC) agencies**. A foster care agency is an agency that provides foster care as defined in the Code of Federal Regulations (CFR) as "24-hour substitute care for children outside their own homes." Therapeutic foster care settings are foster family homes.

(2) **Therapeutic foster care homes**. Agency-supervised private family homes in which foster parents have been trained to provide individualized, structured services in a safe, nurturing family living environment for children and adolescents with significant emotional or behavioral problems who require a higher level of care than is found in a conventional foster home but do not require placement in a more restrictive setting. Therapeutic foster care homes are considered the least restrictive out-of-home placement for children with severe emotional disorders.

(b) **TFC Agency Requirements.** Eligible TFC agencies must have:

(1) current certification from the Oklahoma Department of Human services (OKDHS) as a child placing agency;

(2) a contract with the Division of Children and Family Services of the Oklahoma Department of Human Services, or OJA;

(3) a contract with the Oklahoma Health Care Authority; and

(4) a current accreditation status appropriate to provide ~~outpatient~~ behavioral health services in a foster care setting from:

(A) The Joint Commission formerly the Joint Commission on Accreditation (JCAHO), or

(B) the Rehabilitation Accreditation Commission (CARF), or

(C) the Council on Accreditation (COA), or

(D) the American Osteopathic Association (AOA).

317:30-5-740.1. Provider qualifications and requirements

(a) **Therapeutic foster care model**. Children in the TFC environment receive intensive individualized behavioral health and other support services from qualified staff. Because TFC children require exceptional levels of skill, time and supervision, the number of unrelated children placed per home is limited; no more than two TFC children in a home at any one time unless additional cases are specifically authorized by OKDHS, Division of Children and Family Services or OJA.

(b) **Treatment team.** TFC agencies are primarily responsible for treatment planning and coordination of the child's treatment team. This team is typically composed of an OKDHS or OJA caseworker, the child, the child's parents, others closely involved with the child and family. It also includes the following:

(1) **Certified Behavioral Health Case Manager II (CM).** A bachelors level team member that may provide support services and case management. In addition to the minimum requirements at OAC 317:30-5-240.3 (c), the CM must have:

(A) a minimum of one year of experience in providing direct care and/or treatment to children and/or families, and

(B) have access to weekly consultation with a licensed behavioral health professional or Licensure Candidate.

(C) CM must also follow requirements at OAC 317:30-5-241.3 for providing psychosocial rehabilitation services.

(2) **Licensed Behavioral Health Professional (LBHP)**. A masters level professional that provides treatment and supervision for the treatment staff to maintain clinical standards of care and provide direct clinical services. In addition to the requirements at OAC 317:30-5-240.3(a) and (b), the LBHP or Licensure Candidate in a TFC setting must demonstrate a general professional or educational background in the following areas:

(A) case management, assessment and treatment planning;

(B) treatment of victims of physical, emotional, and sexual abuse;

(C) treatment of children with attachment disorders;

(D) treatment of children with hyperactivity or attention deficit disorders;
(E) treatment methodologies for emotionally disturbed children and youth;
(F) normal childhood development and the effect of abuse and/or neglect on childhood development;
(G) anger management;
(H) crisis intervention; and
(I) trauma informed methodology.

(3) **Licensed Psychiatrist and/or psychologist**. TFC agencies must provide staff with access to professional psychiatric or psychological consultation as deemed necessary for the planning, implementation and appropriate management of the resident's treatment. See OAC 317:30-5-240.3(a) and OAC 317:25-275.

(4) **Treatment Parent Specialist (TPS)**. The TPS serve as integral members of the team of professionals providing services for the child. The TPS receives special training in mental health issues, behavior management and parenting techniques; and implements the in-home portion of the treatment plan with close supervision and support. They provide services for the child, get the child to therapy and other treatment appointments, write daily notes about interventions and attend treatment team meetings. The TPS must be under the supervision of a licensed behavioral health professional of the foster care agency and meet the following criteria:

(A) have a high school diploma or equivalent;
~~(B) be employed by the foster care agency as a foster parent complete with OSBI and OKDHS background screening;~~
(B) have an employment relationship with the foster care agency as a foster parent complete with OSBI and OKDHS background screening;
(C) completion of therapeutic foster parent training outlined in this section;
(D) have a minimum of twice monthly face to face supervision with the licensed, or under-supervision for licensure, LBHP, independent of the child's family therapy;
(E) have weekly contact with the foster care agency professional staff; and
(F) complete required annual trainings.

(c) **Agency assurances.** The TFC agency must ensure that each individual that renders treatment services (whether employed by or contracted by the agency) meets the minimum provider qualifications for the service. Individuals eligible for direct enrollment must have a contract on file with the Oklahoma Health Care Authority.

(d) **Policies and Procedures.** Eligible TFC agency providers that are defined in section OAC 317:30-5-740(a) shall have written policies and procedures for the orientation of new staff and foster parents which is reviewed and updated annually, for the following:

(1) pre-service training of foster parents in treatment methodologies and service needs of emotionally and behaviorally disturbed children;

(2) treatment of victims of physical, emotional, and sexual abuse;

(3) treatment of children with attachment disorders;

(4) treatment of children with hyperactive or attention deficit disorders;

(5) normal childhood development and the effect of abuse and/or neglect on childhood development;

(6) treatment of children and families with substance use disorders;

(7) the Inpatient Mental Health and Substance Abuse Treatment of Minors Act;

(8) anger management;

(9) inpatient authorization procedures;

(10) crisis intervention;

(11) grief and loss issues for children in foster care;

(12) the significance/value of birth families to children receiving ~~outpatient~~ behavioral health services in a foster care setting; and

(13) trauma informed methodology.

317:30-5-741. Coverage by category

(a) **Adults.** ~~Outpatient Behavioral Health Services~~Behavioral health services in Therapeutic Foster settings are not covered for adults.

(b) **Children.** ~~Outpatient behavioral~~Behavioral health services are allowed in therapeutic foster care settings for certain children and youth as medically necessary. The children and youth receiving services in this setting have special psychological, social and emotional needs, requiring more intensive, therapeutic care than can be found in the traditional foster care setting. The designated children and youth must continually meet medical necessity criteria to be eligible for coverage in this setting.

(c) **Medical necessity criteria**. Medical necessity criteria is delineated as follows:

(1) A diagnosis from the most recent edition of "The Diagnostic and Statistical Manual of Mental Disorders" (DSM), with the exception of V codes and adjustment disorders, with a detailed description of the symptoms supporting the diagnosis. Children with a provisional diagnosis may be

admitted for a maximum of 30 days. An assessment must be completed by a Licensed Behavioral Health Professional (LBHP) or Licensure Candidate as defined in OAC 317:30-5-240.3(a) and (b) within the 30 day period resulting in a diagnosis from the most recent edition of "the Diagnostic and Statistical Manual of Mental Disorders"(DSM) with the exception of V codes and adjustments disorders, with a detailed description of the symptoms supporting the diagnosis to continue RBMS in a foster care setting.

(2) Conditions are directly attributed to a mental illness/serious emotional disturbance as the primary need for professional attention.

(3) It has been determined by the inpatient authorization reviewer that the current disabling symptoms could not have been or have not been manageable in a less intensive treatment program.

(4) Evidence that the child's presenting emotional and/or behavioral problems prohibit full integration in a family/home setting without the availability of 24 hour crisis response/behavior management and intensive clinical interventions from professional staff, preventing the child from living in a traditional family home.

(5) The child is medically stable and not actively suicidal or homicidal and not in need of substance abuse detoxification services.

(6) The legal guardian/parent of the child (OKDHS/OJA if custody child) agrees to actively participate in the child's treatment needs and planning.

317:30-5-742. Description of services

(a) Treatment services must be provided in the least restrictive, non-institutional therapeutic milieu. The foster care setting is restorative in nature, allowing children with emotional and psychological problems to develop the necessary control to function in a less restrictive setting.

(b) ~~Outpatient behavioral~~Behavioral health services must include an individual plan of care for each member served. The individual plan of care requirements are set out in OAC 317:30-5-742.2(b)(1). Treatment services in a therapeutic foster care setting may include an array of services listed in (1) - (6) of this subsection as provided in the individual plan of care. Services include, but may not be limited to:

(1) Individual, family and group therapy;

(2) Substance abuse/chemical dependency education, prevention, and therapy;

(3) Psychosocial rehabilitation and support services;

(4) Behavior management

(5) Crisis intervention; and

(6) Case Management.

317:30-5-742.2. Individual plan of care and prior authorization of services

(a) All ~~outpatient~~ behavioral health services must be prior authorized by the designated agent of the Oklahoma Health Care Authority before the service is rendered by an eligible service provider. Without prior authorization, payment is not authorized.

(b) All ~~outpatient~~ behavioral health services in a foster care setting are provided as a result of an individual assessment of the members needs and documented in the individual plan of care.

(1)**Assessment**.

(A) **Definition.** Gathering and assessment of historical and current bio-psycho-social information which includes face-to-face contact with the person and/or the person's family or other informants, or group of persons resulting in a written summary report, diagnosis and recommendations. All agencies must assess the medical necessity of each individual to determine the appropriate level of care.

(B) **Qualified professional.** This service is performed by an LBHP or Licensure Candidate.

(C) **Time requirements.** The minimum face-to-face time spent in assessment session(s) with the member and others for a low complexity Behavioral Health Assessment by a Non-Physician is one and one half hours.

(D) **Documentation requirements.** The assessment must include all elements and tools required by the OHCA. In the case of children under the age of 18, it is performed with the direct, active face-to-face participation of the child and parent or guardian. The child's level of participation is based on age, developmental and clinical appropriateness. The assessment must include all related diagnoses from the most recent DSM edition. The assessment must contain but is not limited to the following:

(i) Date, to include month, day and year of the assessment session(s);

(ii) Source of information;

(iii) Member's first name, middle initial and last name;

(iv) Gender;

(v) Birth Date;

(vi) Home address;

(vii) Telephone number;

(viii) Referral source;

(ix) Reason for referral;

(x) Person to be notified in case of emergency;

(xi) Presenting reason for seeking services;
(xii) Start and stop time for each unit billed;
(xiii) Signature of parent or guardian participating in face-to-face assessment. Signature required for members over the age of 14;
(xiv) Bio-Psychosocial information which must include:
(I) Identification of the member's strengths, needs, abilities and preferences;
(II) History of the presenting problem;
(III) Previous psychiatric treatment history, include treatment for psychiatric; substance use; drug and alcohol addiction; and other addictions;
(IV) Health history and current biomedical conditions and complications;
(V) Alcohol, Drug, and/or other addictions history;
(VI) Trauma, abuse, neglect, violence, and/or sexual assault history of self and/or others, including Department of Human Services involvement;
(VII) Family and social history, include MH, SA, Addictions, Trauma/Abuse/Neglect;
(VIII) Educational attainment, difficulties and history;
(IX) Cultural and religious orientation;
(X) Vocational, occupational and military history;
(XI) Sexual history, including HIV, AIDS, and STD at-risk behaviors;
(XII) Marital or significant other relationship history;
(XIII) Recreation and leisure history;
(XIV) Legal or criminal record, including the identification of key contacts, (e.g. attorneys, probation officers~~, etc.)~~;
(XV) Present living arrangements;
(XVI) Economic resources;
(XVII) Current support system including peer and other recovery supports.
(xv) Mental status and Level of Functioning information, including questions regarding but not limited to the following:
(I) Physical presentation, such as general appearance, motor activity, attention and alertness~~, etc.~~;
(II) Affective process, such as mood, affect, manner and attitude~~, etc.~~;
(III) Cognitive process, such as intellectual ability, social-adaptive behavior, thought processes, thought content, and memory~~, etc.~~; and
(IV)All related diagnoses from the most recent

addition of the DSM.

(xvi) Pharmaceutical information to include the following for both current and past medications;

(I) Name of medication;

(II) Strength and dosage of medication;

(III) Length of time on the medication; and

(IV) Benefit(s) and side effects of medication.

(xvii) LBHP's interpretation of findings and diagnosis;

(xviii) Signature and credentials of the qualified practitioner who performed the face-to-face behavioral assessment.

(2) **Individual plan of care requirement.**

(A) A written individual plan of care following a comprehensive evaluation for each member must be formulated by the provider agency staff within 30 days of admission with documented input from the member, legal guardian (OKDHS/OJA) staff, the foster parent (when applicable) and the treatment provider(s). It is acceptable in circumstances where it is necessary to fax a service plan to someone for review and have them fax back their signature; however, the provider must obtain the original signature for the clinical file within 30 days. No stamped or photocopied signatures are allowed. This plan must be revised and updated ~~each 90 days~~every three months with documented involvement of the legal guardian and resident.

(B) The individual plan of care must be individualized and take into account the member's age, history, diagnosis, assessed functional levels, culture, and the effect of past and current traumatic experiences in the life of the member. It includes the member's documented diagnosis, appropriate goals, and corresponding reasonable and attainable objectives and action steps within the expected time lines. Each member's individual plan of care is to also address the provider agency's plans with regard to the provision of services. Each plan of care must clearly identify the type of services required to meet the child's treatment needs and frequency over a given period of time.

(C) Requests for ~~outpatient~~ behavioral health services in a foster care setting will be approved for a maximum of three months.

(D) **Qualified professional**. This service is performed by an LBHP or Licensure Candidate.

(E) **Time requirements**. Individual plan of care updates must be conducted face-to-face and are required every three months during active treatment. Updates can be conducted whenever it is clinically needed as determined by the qualified practitioner and member.

(F)**Documentation requirements.** Comprehensive and integrated service plan content must address the following:

(i) member strengths, needs, abilities, and preferences(SNAP);

(ii) identified presenting challenges, problems, needs and diagnosis;

(iii) specific goals for the member;

(iv) objectives that are specific, attainable, realistic, and time-limited;

(v) each type of service and estimated frequency to be received;

(vi) the practitioner(s) name and credentials that will be providing and responsible for each service;

(vii) any needed referrals for service;

(viii) specific discharge criteria;

(ix) description of the member's involvement in, and responses to, the treatment plan, and his/her signature and date;

(x) updates to goals, objectives, service provider, services, and service frequency, must be documented within the individual plan of care until the review/update is due.

(xi) individual plan of care updates must address the following:

(I) update to the bio-psychosocial assessment, re-evaluation of diagnosis, individual plan of care goals and/ or objectives;

(II) progress, or lack of, on previous individual plan of care goals and/or objectives;

(III) a statement documenting a review of the current individual plan of care and an explanation if no changes are to be made to the individual plan of care and a statement addressing the status of identified problem behaviors that lead to placement must be included;

(IV) change in goals and/or objectives (including target dates) based upon member's progress or identification of new need, challenges and problems;

(V) change in frequency and/or type of services provided;

(VI) change in practitioner(s) who will be responsible for providing services on the plan;

(VII) change in discharge criteria;

(VIII) description of the member's involvement in, and responses to, the treatment plan, and his/her signature and date.

(3) **Description of Services.** Agency services include:

(A) **Individual, family and group therapy**. See OAC 317:30-5-241.2(a), (b), and (c).
(B) **Crisis/behavior management and redirection**. The provider agency must provide crisis/behavior redirection by agency staff as needed 24 hours per day, 7 days per week. The agency must ensure staff availability to respond to the residential foster parents in a crisis to stabilize members' behavior and prevent placement disruption. This service is to be provided to the member by an LBHP.
(C) **Discharge planning.** The provider agency must develop a discharge plan for each member. The discharge plan must be individualized, child-specific and include an after care plan that is appropriate to the member's needs, identifies the member's needs, includes specific recommendations for follow-up care and outlines plans that are in place at the time of discharge. The plan for children in parental custody must include, when appropriate, reunification plans with the parent(s)/legal guardian. The plan for children who remain in the custody of the Oklahoma Department of Human Services or the Office of Juvenile Affairs must be developed in collaboration with the case worker and in place at the time of discharge. The discharge plan is to include at a minimum, recommendations for continued treatment services, educational services, and other appropriate community resources. Discharge planning provides a transition from foster care placement into a lesser restrictive setting within the community.
(D) **Substance use/chemical dependency use therapy.** Substance use/chemical dependency therapy can be provided if a member is identified by diagnosis or documented social history as having emotional or behavioral problems directly related to substance use and/or chemical dependency. The modalities employed are provided in order to begin, maintain and enhance recovery from alcoholism, problem drinking, addiction or nicotine use and addiction. This service is to be provided to the member by an LBHP or Licensure Candidate.
(E) **Substance Use Rehabilitation Services**.
~~Definition.~~ Covered ~~outpatient~~ substance use rehabilitation services are provided in non-residential settings in regularly scheduled sessions intended for individuals not requiring a more intensive level of care or those who require continuing services following more intensive treatment regimes. The purpose of substance use rehabilitation services is to begin, maintain, and/or enhance recovery from alcoholism, problem drinking, drug use, drug dependency addiction or nicotine use and

addiction. Rehabilitation services may be provided individually or in group sessions, and they take the format of an agency approved curriculum based education and skills training. This service is to be provided to the member by a CM II.

(F) **Psychosocial rehabilitation (PSR).**

(i) ~~Definition.~~ PSR services are face-to-face Behavioral Health Rehabilitation services which are necessary to improve the member's ability to function in the community. They are performed to improve the skills and abilities of members to live interdependently in the community, improve self-care and social skills, and promote lifestyle change and recovery practices. Rehabilitation services may be provided individually or in group sessions, and they take the format of an agency approved curriculum based education and skills training.

(ii) ~~Clinical restrictions.~~ This service is generally performed with only the members and the qualified provider, but may include a member and the member's family/support system group that focuses on the member's diagnosis, symptom management, and recovery based curriculum. A member who at the time of service is not able to cognitively benefit from the treatment due to active hallucinations, substance use, or other impairments is not suitable for this service. Family involvement is allowed for support of the member and education regarding his/her recovery, but does not constitute family therapy, which requires a licensed provider.

(iii) ~~Qualified providers.~~ CM II, LBHP or a Licensure Candidate and LBHP may perform PSR, following development of an individual plan of care curriculum approved by an LBHP or Licensure Candidate. PSR staff must be appropriately and currently trained in a recognized behavioral/ management intervention program such as MANDT or CAPE or trauma informed methodology. The CM II must have immediate access to an LBHP who can provide clinical oversight of the CM II and collaborate with the CM II in the provision of services. A minimum of one monthly face-to-face consultation with an LBHP is required.

(iv) ~~Group sizes.~~ The maximum staffing ratio is eight to one for children under the age of eighteen.

(v) Limitations.

(I) ~~Location.~~ In order to develop and improve the member's community and interpersonal functioning and self-care abilities, PSR services may take place in

settings away from the ~~outpatient~~ behavioral health agency site as long as the setting protects and assures confidentiality. When this occurs, the qualified provider must be present and interacting, teaching, or supporting the defined learning objectives of the member for the entire claimed time.

(II) ~~Eligibility for PSR services.~~ PSR services are intended for children with Serious Emotional Disturbance (SED), and children with other emotional or behavioral disorders. Children under age 6, unless a prior authorization for children ages 4 and 5 has been granted by OHCA or its designated agent based on a finding of medical necessity, are not eligible for PSR services.

(III) ~~Billing limits.~~ PSR services are time-limited services designed to be provided over the briefest and most effective period possible and as adjunct (enhancing) interventions to compliment more intensive behavioral health therapies. Service limits are based on the member's needs according to the CAR or other approved tool, the requested placement based on the level of functioning rating, medical necessity, and best practice. Service limitations are designed to help prevent rehabilitation diminishing return by remaining within reasonable age and developmentally appropriate daily limits.

(vi) ~~Progress Notes.~~ In accordance with OAC 317:30-5-241.1, the behavioral health individual plan of care developed by the LBHP must include the member's strengths, functional assets, weaknesses or liabilities, treatment goals, objectives and methodologies that are specific and time-limited, and defines the services to be performed by the practitioners and others who comprise the treatment team. When PSR services are prescribed, the plan must address objectives that are specific, attainable, realistic, measurable, and time-limited. The plan must include the appropriate treatment coordination to achieve the maximum reduction of the mental and/or behavioral health disability and to restore the member to their best possible functional level.

(I) Start and stop times for each day attended and the physical location in which the service was rendered;

(II) Specific goal(s) and objectives addressed during the session/group;

(III) Type of Skills Training provided each day and/or during the week including the specific curriculum used with member;
(IV) Member satisfaction with staff intervention(s);
(V) Progress, or barriers made towards goals, objectives;
(VI) New goal(s) or objective(s) identified;
(VII) Signature of the qualified provider; and
(VIII) Credentials of the qualified provider;

(vii) ~~Additional documentation requirements.~~ Documentation of ongoing consultation and/or collaboration with an LBHP or Licensure Candidate related to the provision of PSR services.

(viii) ~~Non-Covered Services.~~ The following services are not considered PSR and are not reimbursable:
(I) room and board;
(II) educational costs;
(III) supported employment; and
(IV) respite.

(G) ~~**Social skills redevelopment.**~~ Goal directed activities for each member to restore, retain and improve the self-help, communication, socialization, and adaptive skills necessary to reside successfully in home and community based settings. These will be daily activities that are age appropriate, culturally sensitive and relevant to the goals of the individual plan of care. These may include self-esteem enhancement, violence alternatives, communication skills or other related skill development. This service is to be provided to the member by the Treatment Parent Specialist (TPS). Services rendered by the TPS are limited to 1.5 hours daily.

317:30-5-743.1. ~~Inspection of Care~~Service Quality Review

There will be an ~~on site~~on-site ~~Inspection of Care~~ Service Quality Review (SQR) performed by the OHCA or its designated agent of each Therapeutic Foster Care (TFC) agency that provides care to members. ~~which will be performed by the OHCA or its designated agent.~~ The OHCA will designate the members of the ~~Inspection of Care~~ SQR Team. This team will consist of at least two team members and will be comprised of Licensed Behavioral Health Professionals and/or Registered Nurses. ~~The Inspection may include observation and contact with members.~~ The SQR ~~Inspection of Care (IOC) review~~ will consist of a survey of current members receiving services ~~present or listed as facility residents at the beginning of the Inspection of Care visit~~ SQR as well as members ~~on~~ for which claims have been filed with OHCA for TFC services. Observation and contact with members may be incorporated. The review includes validation of certain factors,

all of which must be met for the services to be compensable. Following the on-site inspection, the ~~Inspection of Care Team~~ SQR Team will report its findings to the agency. The agency will be provided with written notification if the findings of the ~~Inspection of Care~~ SQR have resulted in any deficiencies. A copy of the final report will be sent to the agency's accrediting ~~agency~~body. Deficiencies found during the ~~IOC~~ SQR may result in a recoupment of the compensation received for that service. The individual plan of care is considered to be critical to the integrity of care and treatment and must be completed within the time lines designated at OAC 317:30-5-742.2. If the individual plan of care is missing or it is found that the child did not meet medical necessity criteria at any time, all paid services will be recouped for each day the individual plan of care was missing from the date the plan of care was due for completion or the date from which medical necessity criteria was no longer met.

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: February 16, 2016

The proposed policy is a Permanent Rule. This proposal is scheduled to be presented to the Medical Advisory Committee (MAC) on March 10, 2016 and the (OHCA) Board of Directors on March 24, 2016.
Reference: APA WF 15-50

SUMMARY:
Policy Revision to Amend Policy Regarding Home Property in a Revocable Trust as a Countable Resource — Proposed policy revisions clarify home property revocable trust exemptions.

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 USC 1396p(d)(3)(A)(i);

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

TO: Tywanda Cox
Health Policy

FROM: Harvey Reynolds
Health Policy

SUBJECT: Rule Impact Statement
APA WF # 15-50

A. Brief description of the purpose of the rule:

Proposed policy changes amend countable resource rules regarding home property in a revocable trust. Current policy states that home property in a revocable trust retained certain exemptions. Those exemptions are not found in federal regulations. Federal regulations states that the sum of the trust shall be considered resources available to the individual.

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 place home property in a revocable trust and who claim an exemption referenced in policy so that the home property in a revocable trust in not counted as a countable resource would be affected because those exemptions are not allowed in federal regulations. The rule should not place any cost burden on private or public entities.

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

No classes of persons will receive benefit from this 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 a possible economic impact from this proposed rule for individuals applying for long-term care services who have over $500,000 equity in their home as they are not able to exempt that resource by placing it in a revocable trust and they will be over the resource limit and not eligible. However, this exemption was already not allowed under federal regulations.

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:

This rule is budget neutral and will not have an economic impact on the OHCA budget.

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. Opportunities for public input are provided throughout the rulemaking process, in addition to formal public comment periods and tribal consultations.

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 and due to federal regulations implementation of the proposed rule is not optional.

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

Prepared date: December 1, 2015
Modified date: January 28, 2016

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

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

(a) Home property is excluded from resources regardless of value unless the individual is applying for long-term care services. [See 317:35-5-41.8(a) (relating to eligibility for long-term care services)]

(b) For purposes of the home property resource exclusion, a home is defined as any shelter in which the individual has an ownership interest and which is used by the individual as his/her principal place of residence. The home may be either real or personal property, fixed or mobile. Home property includes all property which is adjacent to the home. ~~Home property in a revocable trust under the direct control of the individual, spouse, or legal representative retains the exemption as outlined in OAC 317:35-5-41.8(a)(2).~~ Property has a value regardless of whether there is an actual offer to purchase. Verification of home/real property value is established by collateral contacts with specialized individuals knowledgeable in the type and location of property being considered.

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

member at any time an extension is allowed. Detailed documentation in the case record is required.
(2) If the member fails or is unwilling to take steps necessary to convert the resource for use in meeting current needs, continuing eligibility cannot be established and the member is advised as to the effective date of closure and of the right to receive assistance when the resources are within the maximum allowable resources provided other conditions of eligibility continue to be met.
(3) When a member sells his/her home with the intention of purchasing another home or when an insurance payment for damage to the home is received, a reasonable period of time is given to reinvest the money in another home. A reasonable period of time is considered to be not in excess of a 90-day period. Extensions beyond the 90 days may be justified only after interviewing the member, determining that a good faith effort is still being made and that completion of the transaction is beyond his/her control. This must be documented in the case record.
(4) At the point a member decides not to reinvest the proceeds from the sale of his/her home in another home, the member's plan for use of the proceeds is evaluated in relation to rules on resources disposed of while receiving assistance.
(5) A home traded for another home of equal value does not affect the member's eligibility status. If the home is traded for a home of lesser value, the difference may be invested in improvement of the new home.
(6) Absences from home for up to 90 days for trips or visits or six months for medical care (other than nursing facilities) do not affect receipt of assistance or the home exclusion as long as the individual intends to return home. Such absences, if they extend beyond those limits, may indicate the home no longer serves as the principal place of residence.
(7) Mineral rights associated with the home property are considered along with the surface rights and are excluded as a resource. However, mineral rights which are not associated with the home property are considered as a resource. Since evaluation and scalability of mineral rights fluctuate, the establishment of the value of mineral rights are established based on the opinion of collateral sources. Actual offers of purchase are used when established as a legitimate offer through a collateral source. Mineral rights not associated with home property which are income producing are considered in the same way as income producing property. Refer to (11)(B) of this subsection for treatment of mineral rights as non-trade or non-business property.

(8) The market value of real estate other than home property owned by the member or legal dependent and encumbrances against such property are ascertained in determining the equity (including the cost to the member of a merchantable title to be determined when the resource approaches the maximum). The market value of real estate other than the home owned by the applicant is established on the basis of oral or written information which the applicant has on hand ~~and~~and counsel with persons who have specialized knowledge about this kind of resource. Refer to (11) of this subsection for exclusion of real estate that produces income.

(9) Land which is held by an enrolled member of an Indian tribe is excluded from resources as it cannot be sold or transferred without the permission of other individuals, the tribe, or a federal agency. If permission is needed, the land is excluded as a resource.

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

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

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

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

worker.

(11) Real and/or personal property which produces income is excluded if it meets the following conditions.

(A) **Trade or business property**. The existence of a trade or business may be established through business tax returns that would be used to compute self-employment earnings. If the current business tax return is unavailable, the existence of the business may be determined through other business forms, records, partnership, a detailed description of the business and its activities, etc. Once it is established that a trade or business exists, any property (real or personal) connected to it and in current use is excluded. This exclusion includes liquid assets, such as a bank account(s) necessary for the business operation. All property used by a trade or business and all property used by an employee in connection with employment is excluded as property essential to self support. The income from the trade or business is determined as any other self-employment income.

(B) **Non-trade or non-business property**. Property which produces income but is not used in a trade or business is excluded if the total equity value does not exceed $6000, and the net return equals at least 6% of the equity annually. An equity value in excess of $6000 is a countable resource. If the equity exceeds $6000 and 6% return is received on the total equity, only the amount in excess of $6000 is a countable resource. An annual return of less than 6% is acceptable if it is beyond the individual's control, and there is a reasonable expectation of a future 6% return. Liquid resources cannot be excluded as income producing property or meeting the $6000/6% rule (mortgages, including contract for deed, and notes which are income producing are considered as liquid resources). The $6000/6% rule applies to all resources in total, and not separately. Examples of non-business income producing property are rental property, timber rights, mineral rights, etc.

317:35-5-41.6. Trust accounts

Monies held in trust for an individual applying for or receiving SoonerCare must have the availability of the funds determined. Funds held in trust are considered available when they are under the direct control of the individual or his/her spouse, and disbursement is at their sole discretion. Funds may also be held in trust and under the control of someone other than the individual or his/her spouse, such as the courts,

agencies, other individuals, etc., or the Bureau of Indian Affairs (BIA).

(1) **Availability determinations.** The worker should be able to determine the availability of a trust using the definitions and explanations listed in (2) of this subsection. However, in some cases, the worker may wish to submit a trust to the OKDHS State Office for determination of availability. In these instances, all pertinent data is submitted to Family Support Services Division, Attention: Health Related and Medical Services Section, for a decision.

(2) **Definition of terms**. The following words and terms, when used in this paragraph, have the following meaning, unless the context clearly indicates otherwise:

(A) **Beneficiary**. Beneficiary means the person(s) who is to receive distributions of either income or principal, or on behalf of whom the trustee is to make payments.

(B) **Corpus/principal**. Corpus/principal means the body of the trust or the original asset used to establish the trust, such as a sum of money or real property.

(C) **Discretionary powers**. Discretionary powers means the grantor gives the trustee the power to make an independent determination whether to distribute income and/or principal to the beneficiary(ies) or to retain the income and add it to the principal of the trust.

(D) **Distributions**. Distributions means payments or allocations made from the trust from the principal or from the income produced by the principal (e.g., interest on a bank account).

(E) **Grantor (trustor/settlor)**. Grantor (trustor/settlor) means the individual who establishes the trust by transferring certain assets.

(F) **Irrevocable trust**. Irrevocable trust means a trust in which the grantor has expressly not retained the right to terminate or revoke the trust and reclaim the trust principal and income.

(G) **Pour over or open trust**. Pour over or open trust means a trust which may be expanded from time to time by the addition to the trust principal (e.g., a trust established to receive the monthly payment of an annuity, a workers' compensation settlement, a disability benefit or other periodic receivable). The principal may accumulate or grow depending upon whether the trustee distributes the receivable or permits it to accumulate. Generally, the terms of the trust will determine the availability of the income in the month of receipt and the availability of the principal in subsequent months.

(H) **Primary beneficiary**. Primary beneficiary means the

first person or class of persons to receive the benefits of the trust.

(I) **Revocable trust**. Revocable trust means a trust in which the grantor has retained the right to terminate or revoke the trust and reclaim the trust principal and income. Unless a trust is specifically made irrevocable, it is revocable. Even an irrevocable trust is revocable upon the written consent of all living persons with an interest in the trust.

(J) **Secondary beneficiary**. Secondary beneficiary means the person or class of persons who will receive the benefits of the trust after the primary beneficiary has died or is otherwise no longer entitled to benefits.

(K) **Testamentary trust**. Testamentary trust means a trust created by a will and effective upon the death of the individual making the will.

(L) **Trustee**. Trustee means an individual, individuals, a corporation, court, bank or combination thereof with responsibility for carrying out the terms of the trust.

(3) **Documents needed.** To determine the availability of a trust for an individual applying for or receiving SoonerCare, copies of the following documents are obtained:

(A) Trust document;

(B) When applicable, all relevant court documents including the Order establishing the trust, Settlement Agreement, Journal Entry, etc.; and

(C) Documentation reflecting prior disbursements (date, amount, purpose).

(4) **Trust accounts established on or before August 10, 1993**. The rules found in (A) - (C) of this paragraph apply to trust accounts established on or before August 10, 1993.

(A) **Support trust.** The purpose of a support trust is the provision of support or care of a beneficiary. A support trust will generally contain language such as "to provide for the care, support and maintenance of ...", "to provide as necessary for the support of ...", or "as my trustee may deem necessary for the support, maintenance, medical expenses, care, comfort and general welfare." Except as provided in (i)-(iii) of this subparagraph, the amount from a support trust deemed available to the beneficiary is the maximum amount of payments that may be permitted under the terms of the trust to be distributed to the beneficiary, assuming the full exercise of discretion by the trustee(s) for distribution of the maximum amount to the beneficiary. The beneficiary of a support trust, under which the distribution of payments to the beneficiary is determined by one or more trustees who are permitted to

exercise discretion with respect to distributions, may show that the amounts deemed available are not actually available by:

(i) Commencing proceedings against the trustee(s) in a court of competent jurisdiction;

(ii) Diligently and in good faith asserting in the proceedings that the trustee(s) is required to provide support out of the trust; and

(iii) Showing that the court has made a determination, not reasonably subject to appeal, that the trustee must pay some amount less than the amount deemed available. If the beneficiary makes the showing, the amount deemed available from the trust is the amount determined by the court. Any action by a beneficiary or the beneficiary's representative, or by the trustee or the trustee's representative, in attempting a showing to make the Agency or the State of Oklahoma a party to the proceeding, or to show to the court that SoonerCare benefits may be available if the court limits the amounts deemed available under the trust, precludes the showing of good faith required.

(B) **Medicaid Qualifying Trust (MQT).** A Medicaid Qualifying Trust is a trust, or similar legal device, established (other than by will) by an individual or an individual's spouse, under which the individual may be the beneficiary of all or part of the distributions from the trust and such distributions are determined by one or more trustees who are permitted to exercise any discretion with respect to distributions to the individual. A trust established by an individual or an individual's spouse includes trusts created or approved by a representative of the individual (parent, guardian or person holding power of attorney) or the court where the property placed in trust is intended to satisfy or settle a claim made by or on behalf of the individual or the individual's spouse. This includes trust accounts or similar devices established for a minor child pursuant to 12 O.S. 83. In addition, a trust established jointly by at least one of the individuals who can establish an MQT and another party or parties (who do not qualify as one of these individuals) is an MQT as long as it meets the other MQT criteria. The amount from an irrevocable MQT deemed available to the individual is the maximum amount of payments that may be permitted under the terms of the trust to be distributed to the individual assuming the full exercise of discretion by the trustee(s). The provisions regarding MQT apply even though an MQT is irrevocable or is established for purposes other

than enabling an individual to qualify for SoonerCare, and, whether or not discretion is actually exercised.

(i) **Similar legal device**. MQT rules listed in this subsection also apply to "similar legal devices" or arrangements having all the characteristics of an MQT except that there is no actual trust document. An example is the member petitioning the court to irrevocably assign all or part of his/her income to another party (usually the spouse). The determination whether a given document or arrangement constitutes a "similar legal device" should be made by the OKDHS Office of General Counsel, Legal Unit.

(ii) **MQT resource treatment**. For revocable MQTs, the entire principal is an available resource to the member. Resources comprising the principal are subject to the individual resource exclusions (e.g., the home property exclusion) since the member can access those resource items without the intervention of the trustee. For irrevocable MQTs, the countable amount of the principal is the maximum amount the trustee can disburse to (or for the benefit of) the member, using his/her full discretionary powers under the terms of the trust. If the trustee has unrestricted access to the principal and has discretionary power to disburse the entire principal to the member (or to use it for the member's benefit), the entire principal is an available resource to the member. Resources transferred to such a trust lose individual resource consideration (e.g., home property transferred to such a trust is no longer home property and the home property exclusions do not apply). The value of the property is included in the value of the principal. If the MQT permits a specified amount of trust income to be distributed periodically to the member (or to be used for his/her benefit), but those distributions are not made, the member's countable resources increase cumulatively by the undistributed amount.

(iii) **Income treatment.** Amounts of MQT income distributed to the member are countable income when distributed. Amounts of income distributed to third parties for the member's benefit are countable income when distributed.

(iv) **Transfer of resources**. If the MQT is irrevocable, a transfer of resources has occurred to the extent that the trustee's access to the principal (for purposes of distributing it to the member or using it for the member's benefit) is restricted (e.g., if the trust

stipulates that the trustee cannot access the principal but must distribute the income produced by that principal to the member, the principal is not an available resource and has, therefore, been transferred).

(C) **Special needs trusts**. Some trusts may provide that trust benefits are intended only for a beneficiary's "special needs" and require the trustee to take into consideration the availability of public benefits and resources, including SoonerCare benefits. Some trusts may provide that the trust is not to be used to supplant or replace public benefits, including SoonerCare benefits. If a trust contains such terms and is not an MQT, the trust is not an available resource.

(5) **Trust accounts established after August 10, 1993.** The rules found in (A) - (C) of this paragraph apply to trust accounts established after August 10, 1993.

(A) For purposes of this subparagraph, the term "trust" includes any legal document or device that is similar to a trust. An individual is considered to have established a trust if assets of the individual were used to form all or part of the principal of the trust and if the trust was established other than by will and by any of the following individuals:

(i) the individual;

(ii) the individual's spouse;

(iii) a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse; or

(iv) a person, including a court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

(B) Where trust principal includes assets of an individual described in this subparagraph and assets of any other person(s), the provisions of this subparagraph apply to the portion of the trust attributable to the assets of the individual. This subparagraph applies without regard to the purposes for which the trust is established, whether the trustees have or exercise any discretion under the trust, and restrictions on when or whether distributions may be made from the trust, or any restrictions on the use of the distribution from the trust.

(C) There are two types of trusts, revocable trusts and irrevocable trusts.

(i) In the case of a revocable trust, the principal is considered an available resource to the individual. ~~Home property in a revocable trust under~~

~~the direct control of the individual, spouse or legal representative retains the exemption as outlined in OAC 317:35-5-41.8(a)(2).~~ Payments from the trust to or for the benefit of the individual are considered income of the individual. Other payments from the trust are considered assets disposed of by the individual for purposes of the transfer of assets rule and are subject to the 60 months look back period.

(ii) In the case of an irrevocable trust, if there are any circumstances under which payments from the trust could be made to or for the benefit of the individual, the portion of the principal of the trust, or the in income on the principal, from which payment to the individual could be made is considered available resources. Payments from the principal or income of the trust is considered income of the individual. Payments for any other purpose are considered a transfer of assets by the individual and are subject to the 60 months look back period. Any portion of the trust from which, or any income on the principal from which no payment could under any circumstances be made to the individual is considered as of the date of establishment of the trust (or if later, the date on which payment to the individual was foreclosed) to be assets disposed by the individual for purposes of the asset transfer rules and are subject to the 60 months look back period.

(6) **Exempt trusts.** Paragraph (5) of this subsection does not apply to the following trusts:

(A) A trust containing the assets of a disabled individual under the age of 65 which was established for the benefit of such individual by the parent, grandparent, legal guardian of the individual or a court if the State receives all amounts remaining in the trust on the death of the individual up to an amount equal to the total medical assistance paid on behalf of the individual. This type of trust requires:

(i) The trust may only contain the assets of the disabled individual.

(ii) The trust must be irrevocable and cannot be amended or dissolved without the written agreement of the Oklahoma Department of Human Services or the Oklahoma Health Care Authority.

(iii) Trust records must be open at all reasonable times to inspection by an authorized representative of the OHCA or OKDHS.

(iv) The exception for the trust continues after the disabled individual reaches age 65. However, any addition or augmentation after age 65 involves assets that were not the assets of an individual under age 65; therefore, those assets are not subject to the exemption.
(v) Establishment of this type of trust does not constitute a transfer of assets for less than fair market value if the transfer is made into a trust established solely for the benefit of a disabled individual under the age of 65.
(vi) Payments from the trust are counted according to SSI rules. According to these rules, countable income is anything the individual receives in cash or in kind that can be used to meet the individual's needs for food, clothing and shelter. Accordingly, any payments made directly to the individual are counted as income to the individual because the payments could be used for food, clothing, or shelter for the individual. This rule applies whether or not the payments are actually used for these purposes, as long as there is no legal impediment which would prevent the individual from using the payments in this way. In addition, any payments made by the trustee to a third party to purchase food, clothing, or shelter for the individual can also count as income to the individual. For example, if the trustee makes a mortgage payment for the individual, that payment is a shelter expense and counts as income.
(vii) A corporate trustee may charge a reasonable fee for services in accordance with its published fee schedule.
(viii) The OKDHS Form 08MA018E, Supplemental Needs Trust, is an example of the trust. Workers may give the sample form to the member or his/her representative to use or for their attorney's use.
(ix) To terminate or dissolve a Supplemental Needs Trust, the worker sends a copy of the trust instrument and a memorandum to OKDHS Family Support Services Division, Attention: Health Related and Medical Services (HR&MS) explaining the reason for the requested termination or dissolution of the Supplemental Needs Trust, and giving the name and address of the trustee. The name and address of the financial institution and current balance are also required. Health Related and Medical Services notifies OHCA/TPL to initiate the recovery process.

(B) A trust (known as the Medicaid Income Pension Trust) established for the benefit of an individual if:

(i) The individual is in need of long-term care and has countable income above the categorically needy standard for long-term care (OKDHS Appendix C-1 Schedule VIII.B) but less than the average cost of nursing home care per month (OKDHS Appendix C-1 Schedule VIII.B).

(ii) The Trust is composed only of pension, social security, or other income of the individual along with accumulated income in the trust. Resources cannot be included in the trust.

(iii) All income is paid into the trust and the applicant is not eligible until the trust is established and the monthly income has been paid into the trust.

(iv) The trust must retain an amount equal to the member's gross monthly income less the current categorically needy standard of OKDHS Appendix C-1. The Trustee distributes the remainder.

(v) The income disbursed from the trust is considered as the monthly income to determine the cost of their care, and can be used in the computations for spousal diversion.

(vi) The trust must be irrevocable and cannot be amended or dissolved without the written agreement of the OHCA. Trust records must be open at all reasonable times to inspection by an authorized representative of the OHCA or OKDHS.

(vii) The State will receive all amounts remaining in the trust up to an amount equal to the total SoonerCare benefits paid on behalf of the individual subsequent to the date of establishment of the trust.

(viii) Accumulated funds in the trust may only be used for medically necessary items not covered by SoonerCare, or other health programs or health insurance and a reasonable cost of administrating the trust. Reimbursements cannot be made for any medical items to be furnished by the nursing facility. Use of the accumulated funds in the trust for any other reason will be considered as a transfer of assets and would be subject to a penalty period.

(ix) The trustee may claim a fee of up to 3% of the funds added to the trust that month as compensation.

(x) An example trust is included on OKDHS Form 08MA011E. Workers may give this to the member or his/her representative to use or for their attorney's use as a guide for the Medicaid Income Pension Trust.

(xi) To terminate or dissolve a Medicaid Income Pension Trust, the worker sends a memorandum with a copy of the trust to OKDHS Family Support Services Division, Attention: HR&MS, explaining the reason and effective date for the requested termination or dissolution of the Medicaid Income Pension Trust, and giving the name and address of the trustee. The name and address of the financial institution, account number, and current balance are also required. Health Related and Medical Services notifies OHCA/TPL to initiate the recovery process.

(C) A trust containing the assets of a disabled individual when all of the following are met:

(i) The trust is established and managed by a non-profit association;

(ii) The trust must be made irrevocable;

(iii) The trust must be approved by the Oklahoma Department of Human Services and may not be amended without the permission of the Oklahoma Department of Human Services;

(iv) The disabled person has no ability to control the spending in the trust;

(v) A separate account is maintained for each beneficiary of the trust but for the purposes of investment and management of funds, the trust pools these accounts;

(vi) The separate account on behalf of the disabled person may not be liquidated without payment to OHCA for the medical expenses incurred by the members;

(vii) Accounts in the trust are established by the parent, grandparent, legal guardian of the individual, the individual, or by a court;

(viii) To the extent that amounts remaining in the beneficiary's account on the death of the beneficiary are not retained by the trust, the trust pays to the State from such remaining amounts an amount equal to the total medical assistance paid on behalf of the individual. A maximum of 30% of the amount remaining in the beneficiary's account at the time of the beneficiary's death may be retained by the trust.

(7) **Funds held in trust by Bureau of Indian Affairs (BIA).** Interests of individual Indians in trust or restricted lands are not considered in determining eligibility for assistance under the Social Security Act or any other federal or federally assisted program.

(8) **Disbursement of trust.** At any point that disbursement occurs, the amount disbursed is counted as a non-recurring

lump sum payment in the month received. Some trusts generate income on a regular basis and the income is sent to the beneficiary. In those instances, the income is treated as unearned income in the month received.

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: February 16, 2016

The proposed policy is a Permanent Rule. This proposal is scheduled to be presented to the Medical Advisory Committee (MAC) on March 10, 2016 and the (OHCA) Board of Directors on March 24, 2016.
Reference: APA WF 15-52

SUMMARY:
Proposed policy revisions correct citations and references to state statutes, clarify the Administrative Law Judge's jurisdiction and clean up language for clarity and accuracy.

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 431.220

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

TO: Tywanda Cox
Health Policy

FROM: Harvey Reynolds
Health Policy

SUBJECT: Rule Impact Statement
APA WF # 15-52

A. Brief description of the purpose of the rule:

Proposed policy changes correct citations and references to state statutes, specify that policy addresses appeals and not grievances which are addressed in other policies, remove provisions related to the Administrative Law Judge's jurisdiction to match other rules or statutes and language clean-up for clarity and accuracy.

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:

Individuals and entities who are involved in various member or provider appeals would be affected. The rule should not place any cost burden on private or public entities.

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

No classes of persons will receive benefit from this 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 not a probable economic impact for this proposed rule.

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:

This rule is budget neutral and will not have an economic impact on the OHCA budget.

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. Opportunities for public input are provided throughout the rulemaking process, in addition to formal public comment periods and tribal consultations.

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:

Prepared date: December 9, 2015
Modified date: January 21, 2016

RULE TEXT

TITLE 317: OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 2. GRIEVANCE PROCEDURES AND PROCESS

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 by OHCA within ~~30 days of written notice sent by OHCA~~the timeframe ~~according~~ pursuant to Title 68 O.S. § 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~~or if necessary documentation is 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~~subsection

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~~an appeal) files an LD form requesting ~~a grievance~~an appeal 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~~appeals 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)~~(C) A decision will be rendered by the ALJ ordinarily within 45 days of the close of all evidence in the case.

~~(E)~~(D) 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~~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)~~(E) 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)~~(F) Appeals which relate to eligibility determinations made by OHCA;

~~(H)~~(G) 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)~~(D) ~~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;~~Appeals of Professional Service Contract awards and other matters related to the Central Purchasing Act pursuant to Title 74 O. S. § 85.1 *et seq.*;

~~(F)~~(E) Drug rebate appeals;

~~(G) Nursing home contracts which are terminated, denied, or non-renewed;~~

~~(H)~~(F) 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)~~(G) 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)~~(H) 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)~~(I) Supplemental Hospital Offset Payment Program (SHOPP) annual assessment, Supplemental Payment, fees or

penalties as specifically provided in OAC 317:2-1-15.

317:2-1-13. Appeal to the Chief Executive Officer

(a) The Oklahoma Health Care Authority offers approximately 40 different types of administrative appeals. Some of the appeals are appealable to the Chief Executive Officer~~,~~ and some are not. The following appeals may be heard by the Chief Executive Officer following the decision of an Administrative Law Judge:

(1) Appeals under 317:2-1-2(c)(1)(A) to (c)(1)~~(H)~~(G), with the exception of ~~Subsection~~subsection ~~(F)~~(c)(1)(E);

(2) Appeals under 317:2-1-2(c)(2)(A) to (c)(2)~~(K)~~(I), with the exceptions of ~~Subsections~~subsections ~~(H)~~(c)(2)(F) and ~~(J)~~(G); and

(3) Appeals under 317:2-1-8 and 317:2-1-10.

(b) Appeals to the Chief Executive Officer must be filed with the OHCA within ~~twenty (20)~~20 days of the date of the Order, or decision by OHCA.

(c) No new evidence may be presented to the Chief Executive Officer.

(d) Appeals to the Chief Executive Officer under (a) of this Section may be filed by the provider, member, or agency. The Chief Executive Officer will ordinarily render decisions within ~~sixty (60)~~60 days of the receipt of the appeal.

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: February 16, 2016

The proposed policy is a Permanent Rule. This proposal is scheduled to be presented to the Medical Advisory Committee (MAC) on March 10, 2016 and the (OHCA) Board of Directors on March 24, 2016.
Reference: APA WF 15-53

SUMMARY:
Proposed policy is revised to clarify the purpose of the Program Integrity audit appeal hearings, clarify which issues are appealable and streamline the process of audit appeal hearings. In addition, OHCA proposed revisions revoke the rules in nursing home provider contract appeals 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; Oklahoma Statute §56-1011.9; Oklahoma Statute §75-250.2; 42 CFR §447.202; 42 CFR §431.151; 42 CFR 431.153; 42 USC §1396a(a)(42)(B)(ii)(III)

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

TO: Tywanda Cox
Health Policy

FROM: Harvey Reynolds
Health Policy

SUBJECT: Rule Impact Statement
APA WF # 15-53

A. Brief description of the purpose of the rule:

The proposed rule clarifies the purpose of the Program Integrity audit appeal hearings, clarifies which issues are

appealable, and streamlines the process of audit appeal hearings. In addition, OHCA proposes to revoke the rules in nursing home provider contract appeals policy. Due to the fact that Oklahoma is not a right to contract state, there is not a requirement to have the rule in place.

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:

Individuals and entities who are involved in a Program Integrity audit appeal with the Oklahoma Health Care Authority will be impacted by the proposed rule changes.

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

No SoonerCare members or other classes of persons will benefit from the proposed rule changes.

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 and there are no fee changes associated with the rule changes for any 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 proposed rule changes will not have an impact on the budget.

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 due to these proposed rule changes.

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 these proposed rule changes.

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. Opportunities for public input are provided throughout the rulemaking process, in addition to formal public comment periods and tribal consultations.

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 changes 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 if the proposed rule changes are not implemented.

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

Prepared date: December 11, 2015
Modified date: January 28, 2016

RULE TEXT

TITLE 317: OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 2. GRIEVANCE PROCEDURES AND PROCESS

317:2-1-7. Program Integrity Audit Appeals

All appeals related to audits originating from Program Integrity resulting in overpayments are heard by an Administrative Law Judge (ALJ) ~~per~~pursuant to 56 ~~Okla. Stat.~~O.S. § 1011.9.

(1) ~~If a provider disagrees with a decision of an OHCA audit, which has determined that the provider has received an overpayment, the provider may appeal, within 20 days of the date of that decision by submitting an LD-2 form to OHCA's docket clerk.~~If the OHCA determines a provider received an overpayment based upon audit findings issued pursuant to OAC 317:30-3-2.1, the provider may appeal the audit findings. If a provider elects to appeal the audit findings, the provider must file its appeal with the OHCA's Legal Docket Clerk, using Form LD-2. The LD-2 must be received by the OHCA Legal Docket Clerk within 20 days of the date of the initial audit findings or within 20 days of the date of the audit findings following reconsideration. The computation of time shall be calculated in accordance with 12 O.S. § 2006.

(2) ~~The appeal will be commenced by the receipt of an LD-2 form from the appellant provider. The form must set out with specificity the overpayment finding to which the provider objects along with the grounds for the appeal. The provider shall explain in detail the factual and/or legal basis for disagreement with the alledged erroneous decision. The provider shall attach to the LD-2 form all relevant exhibits the provider believes necessary to decide the appeal, including the following:~~The provider must attach a statement to the LD-2 that specifies what findings and/or claims are being appealed, as well as all factual and legal bases for the appeal. The provider shall attach the following to the LD-2 form:

(A) Citations for any statute or rule that the provider contends has been violated;

(B) The provider's name, address, e-mail address, and telephone number;

(C) The name, address, e-mail address, and ~~phone~~telephone number of the provider's authorized representative, if any; and

(D) The LD-2 must be signed by the provider or provider's authorized representative.

(i) For purposes of this section, "provider" means the

person or entity against ~~which~~whom the overpayment is sought.

(ii) ~~If someone other than an individual provider or entity's authorized representative is representing the provider, he/she must be licensed to practice law within the State of Oklahoma.~~ Consistent with Oklahoma rules of practice, an individual provider may appear on his/her own behalf or may be represented by an attorney licensed to practice law within the State of Oklahoma. In the case of an entity, the provider entity must be represented by an attorney licensed to practice within the State of Oklahoma. Attorneys not licensed to practice in Oklahoma must comply with 5 ~~Okla. Stat.~~O.S. Art II, Sec. 5, and rules of the Oklahoma Bar Association.

(3) ~~The burden of proof during the hearing will be upon the provider and the Administrative Law Judge will decide the case based upon a preponderance of evidence standard as defined by the Oklahoma Supreme Court.~~A provider or the provider's authorized representative shall immediately report any change in contact information during the course of the appeal to the OHCA Legal Docket Clerk.

(4) ~~Within approximately 45 days of receiving the LD-2, the docket clerk will schedule a pre-hearing conference before an Administrative Law Judge. This period of time is intended to allow parties an opportunity to settle the dispute prior to the pre-hearing. Settlement or mediation of audit disputes is encouraged and can begin at any time of the audit process between the provider and OHCA's legal division. If settlement is reached, the terms shall be set out in writing and signed by both parties and/or their representatives. Upon the finalization and signature of the settlement agreement, the appeal(s) shall be dismissed with prejudice.~~The OHCA, on its own initiative or upon written request of a party, may consolidate or join appeals if to do so will expedite the processing of the appeals and not adversely affect the interest of the parties.

(5) ~~Any change in contact information during the course of the appeal should be immediately reported to the OHCA docket clerk.~~

The provider has the burden of proof to prove that the overpayment determination and the errors identified in the audit findings are inaccurate. The provider must prove the relief sought by a preponderance of the evidence standard, as defined by the Oklahoma Supreme Court. In adjudicating an appeal under the preponderance of the evidence standard, the ALJ will examine each piece of evidence for relevance,

probative value, and credibility, to determine whether the fact to be proven is proved by the greater weight of the evidence.

(6) ~~The OHCA, on its own initiative or upon written request of a party, may consolidate or join appeals if to do so will expedite the processing of the appeals and not adversely affect the interest of the parties.~~Within approximately 45 days of receiving the LD-2, the Legal Docket Clerk will schedule a prehearing conference before an ALJ. This period of time is intended to provide the parties an opportunity to settle the dispute prior to the prehearing. Settlement of audit appeals is encouraged and can begin at any time of the audit appeal process between the provider and OHCA's Legal Division. If a settlement is reached, the terms shall be set out in writing and signed by both parties and/or their authorized representatives. Unless otherwise warranted, an Agreed Order setting out the terms of the settlement shall be presented to the ALJ for approval. In limited situations, a settlement may be agreed to be a confidential settlement by the parties and will not be submitted as an Agreed Order to the ALJ. In the case of confidential settlements, the Appellant shall file a motion to dismiss the appeal with prejudice which informs the ALJ that the matter has been settled and that the audit appeal is moot.

(7) Audit appeals which are not settled will commence with a prehearing conference before the assigned ~~administrative law judge~~ALJ as follows:

(A) ~~At the conference the parties shall clarify and isolate the legal and factual issues involved in the audit appeal.~~The prehearing conference shall be informal, structured by the ALJ, and not open to the public. The ALJ shall record the prehearing conference by digital recording.

(i) Each party shall be notified of the date of the prehearing conference at least 30 calendar days prior to the scheduled prehearing conference.

(ii) Each party shall appear in person or through their authorized representative.

(iii) Witnesses, not including a named party, shall not appear at the prehearing conference. Nor shall any witness testimony be presented at the prehearing conference.

(B) ~~Each party shall be present, on time and prepared. Failure to do so may result in dismissal of the appeal or other sanctions unless good cause is shown.~~A request for continuance of a prehearing conference can be made up to three (3) business days prior to the scheduled prehearing

conference date. A lesser period of time may be permitted for good cause shown. The ALJ shall rule on the request and in no case shall a combination of continuance exceed a total of 30 calendar days except for good cause shown.

(C) Within ~~fifteen~~20 days prior to the prehearing conference, the Appellant provider shall file a prehearing conference statement with the ~~docket clerk~~Legal Docket Clerk and provide a copy to the other party; and within 10 days prior to the prehearing conference, the OHCA shall file a prehearing conference statement with the docket clerk and provide a copy to the other party. Each party's prehearing conference statement shall include:

(i) A brief statement of ~~his or her~~its case, ~~to include~~including a list of stipulations and legal and factual issues to be heard;

(ii) A list of any witnesses who have direct knowledge of the facts surrounding the issues of the appeal and who are expected to be called at the hearing. The list shall include a brief statement of the testimony each witness will offer;

(iii) A list of ~~any documents and exhibits and the original, or a copy, of each document or exhibit~~all exhibits, together with a copy thereof, which each party intends to ~~be offered~~offer into evidence ~~or presented~~ at the hearing; and

(iv) Any ~~requirements or~~ requests for discovery.

~~(D) The prehearing conference shall be informal, structured by the administrative law judge, and not open to the public. The administrative law judge shall record the prehearing conference by digital recording.~~

~~(i) Each party shall be notified of the date of the prehearing conference at least 20 calendar days prior to the scheduled prehearing conference.~~

~~(ii) Witnesses, not including a named party, shall not appear at the prehearing conference. Nor shall any witness testimony be presented at the prehearing conference.~~

(D) At the prehearing conference, the parties shall clarify and isolate the legal and factual issues involved in the audit appeal.

(E) ~~A request for continuance of a prehearing conference can be made up to three days prior to the scheduled prehearing conference date. A lesser period of time may be permitted for good cause shown. The administrative judge shall rule on the request and in no case shall a combination of continuances exceed a total of 30 calendar days except for good cause shown.~~

Each party shall be present, on time, and prepared. Failure to do so may result in dismissal of the appeal or other sanctions unless good cause is shown. A prehearing conference shall not be continued if a party fails to be prepared to identify issues, propose witnesses, or provide exhibits, unless the ALJ finds good cause is shown.

(F) Following the prehearing conference, the ~~administrative judge~~ALJ shall issue ~~an~~a Scheduling Order setting ~~out the witnesses, exhibits, documents, and issues to be presented at the hearing; the hearing date; the decisions reviewed and made during the prehearing conference; other scheduling deadlines as may be needed; and any stipulations agreed to by the parties. The administrative judge should attempt to issue the Order within two weeks of the prehearing conference.~~forth deadlines for parties to complete discovery, submit briefs as directed by the ALJ, submit prehearing motions, and other deadlines as may be needed. The ALJ should attempt to issue the Scheduling Order within two (2) weeks of the prehearing conference. Upon completion of discovery and the submission of any motions or briefs, the ALJ shall issue a Prehearing Order that shall identify all issues to be presented at the hearing; a final list of witnesses to be called by each party; a final list of exhibits to be used by each party; and the hearing date and anticipated duration of the hearing. The Prehearing Order should be filed by the ALJ no later than 10 days prior to the hearing.

(8) ~~Administrative Law Judge~~The ALJ shall:

(A) Limit all decisions, rulings, and orders to matters directly related to the contested overpayment determination resulting from the audit findings issued pursuant to OAC 317:30-3-2.1 and procedural matters set forth within OAC 317:2-1-7;

~~(A)~~(B) Hear and rule on pending requests or motions as expeditiously as possible. This includes setting filing and responsive deadlines in accordance with Title 12 of the Oklahoma Statutes and the Rules for District Courts of Oklahoma. To preserve judicial efficiency, a reply to a response to a motion shall not be filed by a party without leave of Court to do so and such permission shall not be routinely granted;

~~(B)~~(C) Rule on whether witnesses have knowledge of the facts at issue;

~~(C) Rule on whether a witness shall produce a report to detail proposed testimony as described in Rule 26 of the Federal Rules of Procedure;~~

(D) Rule on whether discovery requests and other motions and requests are relevant;

(E) Rule on whether to grant a party's request to depose a witness. To preserve judicial efficiency, depositions shall not be routinely permitted and shall only be permitted by order of the ALJ;

(F) Strike or deny witnesses, documents, exhibits, discovery requests, and other requests or motions which are cumulative, not relevant, not material, used as a means of harassment, unduly burdensome, or not timely filed; and

(G) Identify and rule on errors being appealed and issues to be heard at the administrative hearing.

(9) ~~The hearing shall be digitally recorded and closed to the public.~~As the purpose of the administrative process is to expedite a limited appellate review of the audit findings, the ALJ shall ensure a timely resolution of the appeal. The ALJ shall schedule a hearing within 90 days of the prehearing conference. A party may request a continuance of the hearing by motion, which shall only be permitted if the ALJ finds good cause exists and neither party shall be prejudiced by the continuation.

(10) At the hearing:

(A) Each party shall appear in person or through their authorized representative.

(B) All witnesses must appear in person to provide testimony.

(C) All relevant exhibits provided with each party's prehearing conference statement or final exhibit list, that have not been objected to or stricken by the ALJ, shall be deemed admissible at the hearing.

(D) Each party is responsible to provide a sufficient number of copies of its own exhibits at the hearing.

(E) The hearing will be limited to one (1) day. Each side will be allowed four (4) hours to present its case-in-chief, which is inclusive of any time needed for cross-examination of witnesses by the opposing party. For good cause shown, the ALJ may increase or decrease the time limit for each party to present its case-in-chief, taking into account the time limits of the entire appeal process.

~~(10)~~(11) The ~~administrative law judge~~ALJ should attempt to make the final hearing decision within ~~180~~90 days from the date of the ~~prehearing conference~~hearing. ~~The final order shall be the entire record of the appeal. Pursuant to Administrative Procedures Act, the Order does not need to contain findings of fact or conclusions of law. The final order is the final decision and is not appealable to the~~

~~CEO.~~Any appeal of the final order pursuant to 12 O.S. § 951 must be filed with the District Court of Oklahoma County within 30 days.

(A) The following items shall constitute the record on appeal:

(i) all motions and orders filed with the Legal Docket Clerk;

(ii) all exhibits admitted during the hearing; and

(iii) the transcripts of proceedings, if any.

(B) It shall be the duty of the Appellant in any District Court appeal to order a written transcript of proceedings to be used on appeal. The transcript must be ordered within 30 days of the filing of an appeal in the District Court and any costs associated with the preparation of the transcript shall be borne by the Appellant.

(12) All orders and settlements are non-precedential decisions.

(13) The prehearing conference, the hearing, and any supplementary hearings or conferences shall be digitally recorded and closed to the public.

(14) The record of the appeal, confidential settlements, and any audio recordings shall remain confidential.

317:2-1-8. Nursing home provider contract appeals [REVOKED]

~~This Section explains the appeal process to be accorded all nursing home providers whose contracts are terminated, denied or non-renewed. No procedure is afforded a nursing facility whose contract is limited in any other fashion.~~

~~(1) If a nursing home provider's contract is terminated, non-renewed or denied prior to the action's effective date, the provider will be afforded an informal reconsideration in accordance with 42 C.F.R. 421.153.~~

~~(2) The notice of termination, non-renewal or, denial of contract will include the findings it was based upon. The letter will be sent by certified mail to the provider.~~

~~(3) The provider will have 60 days to respond to the notice unless there is a finding of immediate jeopardy or a determination that the facility's SoonerCare certification has been cancelled prior to 60 days. The response should outline the reasons why the OHCA's decision to terminate, non-renew, or deny the contract is wrong. The response by the provider must include a detailed position addressing the findings set out in the OHCA's letter. In the event that less than a 60 day notice is provided for either reason stated above, the provider will be afforded a notice in as much time before decertification as possible.~~

~~(4) Based upon the provider's response, the OHCA will affirm~~

~~or deny the notice of non-renewal, termination or denial.~~

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: February 16, 2016

The proposed policy is a Permanent Rule. This proposal is scheduled to be presented to the Medical Advisory Committee (MAC) on March 10, 2016 and the (OHCA) Board of Directors on March 24, 2016.
Reference: APA WF 15-54

SUMMARY:
Proposed Insure Oklahoma policy revisions will clarify inconsistent and conflicting language. Language cleanup will reflect current OHCA practices. In addition, emergency transportation will be added to the Insure Oklahoma Individual Plan.

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 431.53; 1115 Waiver

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

TO: Tywanda Cox
Federal and State Policy

FROM: Carmen Johnson
Health Policy

SUBJECT: Rule Impact Statement
APA WF # 15-54

A. Brief description of the purpose of the rule:

Insure Oklahoma policy is being revised to better align with future business processes, Online Enrollment and the Affordable Care Act. Special Terms and Conditions (STCs) for the 1115 waiver does not speak to business process for Insure Oklahoma, so there will be no amendments or language changes to the waiver. In addition to language revisions, emergency transportation will be added to the Insure Oklahoma Individual

Plan.

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 this proposed rule since the language changes merely reflect longstanding Insure Oklahoma practices. The proposed rule to add emergency transportation will affect the adult population only due to Insure Oklahoma only covers adults.

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

No classes of persons will benefit from the language cleanup. Insure Oklahoma adult members will benefit from the rule, as emergency transportation services are opened.

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 language revisions involve no economic impact. To add emergency transportation the projected cost of $16,164,048.22 at an average cost of $40.67 per adult. The Insure Oklahoma program has a designated revenue source therefore the cost associated with this change will be deducted from the Tobacco Tax funds.

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:

Agency staff has determined that there will be no budget impact due to IO state share is covered by tobacco tax.

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 SoonerCare providers 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:

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 of adding emergency transportation may have a positive impact on public health, safety and environment as SoonerCare members will now have access to emergency transportation with no limitations.

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:
Prepared December 10, 2015.
Modified January 29, 2016.

RULE TEXT

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

SUBCHAPTER 1. GENERAL PROVISIONS

317:45-1-3. Definitions

The following words or terms, when used in this Chapter, will

have the following meanings unless the context clearly indicates otherwise:

"Carrier" means:

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

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

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

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

"Child Care Center" means a facility licensed by OKDHS which provides care and supervision of children and meets all the requirements in OAC 340:110-3-1 through OAC 340:110-3-33.3.

"College Student" means an Oklahoma resident between the age of 19 through 22 that is a full-time student at an Oklahoma accredited University or College.

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

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

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

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

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

~~**"EOB"** means an Explanation of Benefits.~~

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

"Full-time Employment" means a normal work week of 24 or more hours.

"Full-time Employer" means the employer who employs an employee for 24 hours or more per week to perform work in exchange for wages or salary.

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

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

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

~~**"Insure Oklahoma IP"** means the Individual Plan program.~~

~~**"Insure Oklahoma ESI"** means the Employer Sponsored Insurance program.~~

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

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

"OESC" means the Oklahoma Employment Security Commission.

"OHCA" means the Oklahoma Health Care Authority.

"OKDHS" means the Oklahoma Department of Human Services.

~~**"PCP"** means Primary Care Provider.~~

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

"Primary Care Provider (PCP)" means a provider under contract with the Oklahoma Health Care Authority to provide primary care services, including all medically necessary referrals.

"Premium" means a monthly payment to a carrier or a self-funded plan for ~~health~~benefit plan coverage.

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

"Qualifying Event" means the occurrence of an event that permits

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

"**Self-funded Plan"** means or meets the definition of an "employee welfare benefit plan" or "benefit plan" as authorized in 29 US Code, Section 1002. The term carrier can be replaced with self-funded plan if applicable in these rules.

"State" means the State of Oklahoma, acting by and through the Oklahoma Health Care Authority.

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

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

(b) For all eligible ~~medical~~ expenses as defined above in OAC 317:45-1-4(a), the member must submit the OHCA required form and all OHCA required documentation to support that the member incurred and paid the out-of-pocket ~~medical~~ expense. ~~The required documentation must be submitted no later than 90 days after the close of the member's eligibility period.~~ The OHCA required documentation must substantiate that the member actually incurred and paid the eligible out-of-pocket expense. The OHCA may request additional documentation at any time to support a member's request for reimbursement of eligible out-of-pocket ~~medical~~ expenses.

SUBCHAPTER 3. INSURE OKLAHOMA CARRIERS

317:45-3-1. Carrier eligibility

Carriers must be able to submit all required and requested information and documentation to OHCA for each ~~health~~benefit plan to be considered for qualification. Carriers must be able to supply specific claim payment scenarios as requested by OHCA. Carriers must also provide the name, address, telephone number, and, if available, email address of a contact individual who is able to verify employer enrollment status in a qualified ~~health~~benefit plan.

317:45-3-2. ~~Audits~~Reviews

Carriers are subject to ~~audits~~reviews related to ~~health~~benefit plan qualifications. These ~~audits~~reviews may be conducted periodically to determine if each qualified ~~health~~benefit plan continues to meet all requirements as defined in 317:45-5-1.

SUBCHAPTER 5. INSURE OKLAHOMA QUALIFIED ~~HEALTH~~BENEFIT PLANS

317:45-5-1. Qualified ~~Health~~Benefit Plan requirements

(a) Participating qualified ~~health~~benefit plans must offer, at a minimum, benefits that include:

(1) hospital services;
(2) physician services;
(3) clinical laboratory and radiology;
(4) pharmacy;
(5) office visits;
(6) well baby/well child exams;
(7) age appropriate immunizations as required by law; and
(8) emergency services as required by law.

(b) The ~~health~~benefit plan, if required, must be approved by the Oklahoma Insurance Department for participation in the Oklahoma market or a self-funded plan. All ~~health~~benefit plans must share in the cost of covered services and pharmacy products in addition to any negotiated discounts with network providers, pharmacies, or pharmaceutical manufacturers. If the ~~health~~benefit plan requires co-payments or deductibles, the co-payments or deductibles cannot exceed the limits described in this subsection.

(1) An annual in-network out-of-pocket maximum cannot exceed $3,000 per individual, excluding separate pharmacy deductibles.
(2) Office visits cannot require a co-payment exceeding $50 per visit.
(3) Annual in-network pharmacy deductibles cannot exceed $500 per individual.

(c) Qualified ~~health~~benefit plans will provide an EOB, an expense summary, or required documentation for paid and/or denied claims subject to member co-insurance or member deductible calculations. The required documentation must contain, at a minimum, the:

(1) provider's name;
(2) patient's name;
(3) date(s) of service;
(4) code(s) and/or description(s) indicating the service(s) rendered, the amount(s) paid or the denied status of the claim(s);
(5) reason code(s) and description(s) for any denied service(s);
(6) amount due and/or paid from the patient or responsible party; and
(7) provider network status (in-network or out-of-network provider).

317:45-5-2. Closure criteria for ~~health~~benefit plans

Eligibility for the carrier's ~~health~~benefit plans ends when:
(1) changes are made to the design ~~or benefits~~ of the ~~health~~benefit plan such that it no longer meets the requirements to be considered a qualified ~~health~~benefit plan. Carriers are required to report to OHCA any changes in health plans potentially affecting their qualification for participation in the program not less than 90 days prior to the effective date of such change(s).
(2) the carrier no longer meets the definition set forth in 317:45-1-3.
(3) the ~~health~~benefit plan is no longer an available product in the Oklahoma market.
(4) the ~~health~~benefit plan fails to meet or comply with all requirements for a qualified ~~health~~benefit plan as defined in 317 : 45-5-1.

SUBCHAPTER 7. INSURE OKLAHOMA ESI EMPLOYER ELIGIBILITY

317:45-7-1. Employer application and eligibility requirements for Insure Oklahoma ESI

(a) In order for an employer to be eligible to participate in the Insure Oklahoma program the employer must:
(1) have no more than a total of 250 employees on its payroll if the employer is a for-profit business entity. Not-for-profit businesses may participate if the employer has no more than a total of 500 employees on its payroll. The increase in the number of employees from ~~50~~250 to ~~250~~500 will be phased in over ~~a period of~~ time as determined by the Oklahoma Health Care Authority. The number of employees is determined based on the third month employee count of the most recently filed OES-3 form with the Oklahoma Employment Security Commission (OESC). Employers may provide additional documentation confirming terminated employees that will be excluded from the OESC employee count. If the employer is exempt from filing an OES-3 form or is contracted with a PEO or is a Child Care Center in accordance with OHCA rules, this determination is based on appropriate supporting documentation~~, such as the W-2 Summary Wage and Tax form~~ to verify employee count. Employers must be in compliance with all OESC requirements to be eligible for the program. As requested by the OHCA, employers that do not file with the OESC must submit documentation that proves compliance with state law;
(2) have a business that is physically located in Oklahoma;
(3) be currently offering, or at the contracting stage to offer a qualified ~~health~~benefit plan. The qualified ~~health~~benefit plan coverage must begin on the first day of the month and continue through the last day of the month;
(4) offer qualified ~~health~~benefit plan coverage to employees; and
(5) contribute a minimum 25 percent of the eligible employee

monthly ~~health~~benefit plan premium or an equivalent 40 percent of premiums for ~~covered~~ dependent children.

(b) An employer who meets all of the requirements listed in OAC 317:45-7-1(a) must complete and submit the OHCA required forms and application to be considered for participation in the program.

(c) The employer must provide its Federal Employee Identification Number (FEIN).

(d) It is the employer's responsibility to notify the OHCA of any changes that might impact eligibility in the program. Employers must notify the OHCA of any participating employee terminations, resignations, or new hires within five working days of the occurrence.

317:45-7-3. Employer cost sharing

Employers are responsible for a portion of the eligible employee's monthly ~~health~~benefit plan premium as defined in 317:45-7-1.

317:45-7-5. Reimbursement

In order to receive a premium subsidy, the employer must submit all pages of the current ~~health~~benefit plan invoice.

317:45-7-7. ~~Audits~~Reviews

Employers are subject to ~~audits~~reviews related to program eligibility requirements found at OAC 317:45-7-1 and subsidy payments. Eligibility may be revoked at any time if inconsistencies are found. Any monies paid in error are subject to recoupment.

317:45-7-8. Closure

Eligibility provided under the Insure Oklahoma ESI program may end during the eligibility period when:

(1) the employer no longer meets the eligibility requirements in 317:45-7-1;

(2) the employer fails to pay premiums to the carrier;

(3) the employer fails to provide an invoice verifying the monthly ~~health~~benefit plan premium has been paid; or

(4) ~~an audit~~a review indicates a discrepancy that makes the employer ineligible.

SUBCHAPTER 9. INSURE OKLAHOMA ESI EMPLOYEE ELIGIBILITY

317:45-9-1. Employee eligibility requirements

(a) Employees must complete and submit the OHCA required forms and application to be considered for participation in the program.

(b) The eligibility determination will be processed within 30 days from the date the application is received. The employee will be notified in writing of the eligibility decision.

(c) All eligible employees described in this section must be enrolled in their employer's qualified ~~health~~benefit plan. Eligible employees must:

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

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

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

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

(3) be Oklahoma residents;

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

(5) not be receiving benefits from SoonerCare or Medicare;

(6) be employed with a qualified employer at a business location in Oklahoma;

(7) be age 19 through age 64

(8) be eligible for enrollment in the employer's qualified ~~health~~benefit plan;

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

(10) select one of the qualified ~~health~~benefit plans the employer is offering; and

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

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

(1) the employer's ~~health~~benefit plan includes coverage for dependents;

(2) the employee is eligible;

(3) if employed, the spouse may not have full-time employment with any employer who does not meet the eligible employer guidelines listed in 317:45-7-1 (a) (1)-(2); and

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

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

(f) College students may enroll in the Insure Oklahoma ESI program as ~~covered~~ dependents. Effective January 1, 2016, financial eligibility for Insure Oklahoma ESI ~~health~~ benefits for college students is determined using the MAGI methodology. See OAC 317:35-6-39 through OAC 317:35-6-54 for the applicable MAGI rules for determining household composition and countable income.

(g) ~~Covered~~Dependent children must have countable income at the

appropriate standard according to the family size on the Insure Oklahoma ESI Income Limits Guidelines form. Effective January 1, 2016, financial eligibility for Insure Oklahoma ESI ~~health~~ benefits is determined using the MAGI methodology. See OAC 317:35-6-39 through OAC 317:35-6-54 for the applicable MAGI rules for determining household composition and countable income.

(1) Children found to be eligible for SoonerCare may not receive coverage through Insure Oklahoma.

(2) Children are not eligible for Insure Oklahoma if they are a member of a family eligible for employer-sponsored dependent ~~health~~ insurance coverage under any Oklahoma State Employee ~~Health~~ Insurance Plan.

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

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

317:45-9-4. Employee cost sharing

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

317:45-9-6. ~~Audits~~Reviews

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

317:45-9-7. Closure

(a) Employer and employee eligibility are tied together. If the employer is no longer eligible, then the associated employees enrolled under that employer are also ineligible. Employees are mailed a notice 10 days prior to closure of eligibility.

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

(1) termination of employment, either voluntary or involuntary, occurs;

(2) the employee moves out-of-state;

(3) the covered employee dies;

(4) the employer ends its contract with the qualified

~~health~~benefit plan;
(5) the employer's eligibility ends;
(6) ~~an audit~~a review indicates a discrepancy that makes the employee or employer ineligible;
(7) the employer is terminated from the program;
(8) the employer fails to pay the premium;
(9) the qualified ~~health~~benefit plan or carrier no longer meets the requirements set forth in this Chapter;
(10) the employee becomes eligible for SoonerCare or Medicare;
(11) the employee or employer reports any change affecting eligibility;
(12) the employee is no longer listed as a covered person on the employer's ~~health~~benefit plan invoice;
(13) the employee requests closure; or
(14) the employee no longer meets the eligibility criteria set forth in this Chapter.

317:45-9-8. Appeals

~~(a)~~ Employee appeal procedures based on denial of eligibility due to income are described at OAC 317:2-1-2.

~~(b) Employee appeals regarding out-of-pocket medical expense reimbursements may be made to the OHCA. The OHCA may request documentation to support the out-of-pocket appeal. The decision of the OHCA is final.~~

SUBCHAPTER 11. INSURE OKLAHOMA IP
PART 3. INSURE OKLAHOMA IP MEMBER HEALTH CARE BENEFITS

317:45-11-11. Insure Oklahoma IP non-covered services

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

(9) experimental procedures, drugs or treatments;
(10) dental services (preventive, basic, major, orthodontia, extractions or services related to dental accident) except for pregnant women and as covered in 317:30-5-696;
(11) vision care and services (including glasses), except services treating diseases or injuries to the eye;
(12) physical medicine including chiropractic and acupuncture therapy;
(13) hearing services;
(14) non-emergency and emergency air transportation ~~[emergency or non-emergency (air or ground)]~~;
(15) allergy testing and treatment;
(16) hospice regardless of location;
(17) Temporomandibular Joint Dysfunction (TMD) (TMJ);
(18) genetic counseling;
(19) fertility evaluation/treatment/and services;
(20) sterilization reversal;
(21) Christian Science Nurse;
(22) Christian Science Practitioner;
(23) skilled nursing facility;
(24) long-term care;
(25) stand by services;
(26) thermograms;
(27) abortions (for exceptions, refer to 317:30-5-6);
(28) services of a Lactation Consultant;
(29) services of a Maternal and Infant Health Licensed Clinical Social Worker;
(30) enhanced services for medically high risk pregnancies as found in 317:30-5-22.1;
(31) ultraviolet treatment-actinotherapy; ~~and~~
(32) private duty nursing~~.~~;
(33) Payment for removal of benign skin lesions; and
(34) Sleep studies.

PART 5. INSURE OKLAHOMA IP MEMBER ELIGIBILITY

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

(a) Oklahoma employed working adults not eligible to participate in an employer's qualified ~~health~~benefit plan, employees of non-participating employers, self-employed, unemployed seeking work, workers with a disability, and qualified college students may apply for the Individual Plan. Applicants cannot obtain IP coverage if they are eligible for ESI. Applicants, unless a qualified college student, must be engaged in employment as defined under state law, must be considered self-employed as defined under federal and/or state law, or must be considered unemployed as defined under state law.

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

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

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

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

(3) be an Oklahoma resident;

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

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

(6) be age 19 through 64;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

317:35-6-54 for the applicable MAGI rules for determining household composition and countable income.

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

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

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

317:45-11-21. Dependent eligibility

(a) If the spouse of an Insure Oklahoma IP approved individual is eligible for Insure Oklahoma ESI, they must apply for Insure Oklahoma ESI. Spouses cannot obtain Insure Oklahoma IP coverage if they are eligible for Insure Oklahoma ESI.

(b) The employed or self-employed spouse of an approved applicant must meet the guidelines listed in 317:45-11-20 (a) through (g) to be eligible for Insure Oklahoma IP.

(c) The ~~covered~~ dependent of an applicant approved according to the guidelines listed in 317:45-11-20(h) does not become automatically eligible for Insure Oklahoma IP.

(d) The applicant and the dependents' eligibility are tied together. If the applicant no longer meets the requirements for Insure Oklahoma IP, then the associated ~~covered~~ dependent enrolled under that applicant is also ineligible.

(e) College students may enroll in the Insure Oklahoma IP program. Effective January 1, 2016, financial eligibility for Insure Oklahoma IP ~~health~~ benefits for college ~~students is~~students' are determined using the MAGI methodology. See OAC 317:35-6-39 through OAC 317:35-6-54 for the applicable MAGI rules for determining household composition and countable income.

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

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

317:45-11-23. Employee eligibility period

(a) The rules in this subsection apply to applicants eligible according to 317:45-11-20(a) through (e).

(1) The employee’s coverage period begins only after receipt of the premium payment.

(A) If the application is received and approved before the 15th of the month, eligibility begins the first day of the

second consecutive month. If the application is not received or approved before the 15th of the month, eligibility begins the first day of the 3rd consecutive month. (Examples: An application is received and approved on January 14th and the premium is received before February 15th, eligibility begins March 1st; or an application is received and approved January 15th and the premium is received on March 15th, eligibility begins April 1st.)

(B) If premiums are paid early, eligibility ~~still begins as scheduled.~~will begin the first of the following month.

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

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

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

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

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

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

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

(A) If the application is received and approved before the 15th of the month, eligibility begins the first day of the second consecutive month. If the application is not received or approved before the 15th of the month, eligibility begins the first day of the 3rd consecutive month. (Examples: An application is approved on January 14th and the premium is received before February 15th, eligibility begins March 1st; or an application is approved January 15th and the premium is received on March 15th, eligibility begins April 1st.)

(B) If premiums are paid early, eligibility ~~still begins as scheduled.~~will begin the first of the following month.

317:45-11-24. Member cost sharing

(a) Members are given monthly invoices for ~~health~~their benefit 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 100 percent of the Federal Poverty Level.

(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~~returned payments.

317:45-11-25. Premium payment [REVOKED]

~~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.~~

317:45-11-26. ~~Audits~~Reviews

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

317:45-11-27. Closure

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

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

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

(1) the member requests closure;

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

(3) the covered member dies;

(4) the employer's eligibility ends;

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

(6) the employer is terminated from Insure Oklahoma;

(7) the member fails to pay ~~the amount due within 60 days of the date on the bill;~~their premium;

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

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

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

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

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

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

(1) the member requests closure;
(2) the member moves out-of-state;
(3) the covered member dies;
(4) the employer's eligibility ends;
(5) ~~an audit~~a review indicates a discrepancy that makes the member or employer ineligible;
(6) the member fails to pay ~~the amount due within 60 days of the date on the bill~~their premium;
(7) the member becomes eligible for SoonerCare or Medicare;
(8) the member begins receiving coverage by a private ~~health~~benefit ~~insurance~~ policy or plan;
(9) the member or employer reports any change affecting eligibility; or
(10) the member no longer meets the eligibility criteria set forth in this Chapter.

317:45-11-28. Appeals

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

~~(b) Member appeals regarding out-of-pocket medical expense reimbursements may be made to the OHCA. The OHCA may request documentation to support the out-of-pocket appeal. The decision of the OHCA is final.~~

SUBCHAPTER 13. INSURE OKLAHOMA DENTAL SERVICES

317:45-13-1. Dental services requirements and benefits [REVOKED]

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: February 16, 2016

The proposed policy is a Permanent Rule. This proposal is scheduled to be presented to the Medical Advisory Committee (MAC) on March 10, 2016 and the (OHCA) Board of Directors on March 11, 2016.
Reference: APA WF 15-55

SUMMARY:
Programs of the All-Inclusive Care for the Elderly (PACE) transfer guidelines — Policy is being revised to provide clarification on enrollment standards for members who voluntarily dis-enroll and wish to transfer from one PACE site to another PACE site to align with current business practices.

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, Part 460

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

TO: Tywanda Cox
Health Policy

FROM: Carmen Johnson
Health Policy

SUBJECT: Rule Impact Statement
APA WF # 15-55

A. Brief description of the purpose of the rule:

Proposed policy revisions will provide clarification on enrollment standards for members who voluntarily dis-enroll and wish to transfer from one PACE site to another PACE site and align with current business practices.

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 this proposed rule since the language additions merely clarify member disenrollment and transfer criteria.

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.

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 involves no economic impact and no fee changes.

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:

Agency staff has determined that there is no budget impact due to language clean up only.

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 the PACE participants. This will require cooperation from PACE site staff personnel 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:

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, or 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:
Prepared December 14, 2015.
Modified January 29, 2016.

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

317:35-18-5. Eligibility criteria

(a) To be eligible for participation in PACE, the applicant must:

(1) be age 55 years or older

(2) live in a PACE service area;

(3) be determined by the state to meet nursing facility level of care~~.~~; and

(4) be determined by the PACE Interdisciplinary team as able to be safely served in the community at the time of enrollment. If the PACE provider denies enrollment because the IDT determines that the applicant cannot be served safely in the community, the PACE provider must:

(A) notify the applicant in writing of the reason for the denial;

(B) refer the applicant to alternative services as appropriate;

(C) maintain supporting documentation for the denial and notify CMS and OHCA of the denial and make the supporting documentation available for review; and

(D) advise the applicant orally and in writing of the grievance and appeals process.

(b) To be eligible for SoonerCare capitated payments, the individual must:

(1) meet categorical relationship to disability (reference OAC 317:35-5-4).

(2)be eligible for Title XIX services if institutionalized as determined by the Oklahoma Department of Human Services;

(3) be eligible for SoonerCare State Plan services;

(4) meet the same financial eligibility criteria as set forth for the SoonerCare Advantage program per OAC 317:35-17-10 and 317:30-17-11;and

(5) meet appropriate medical eligibility criteria.

(c) Medical determination of ~~Eligibility~~eligibility. The nurse designee makes the medical determination utilizing professional judgment, the Uniform Comprehensive Assessment Tool (UCAT) I, Part III, and other available medical information.

(1) When PACE services are requested:

(A) The PACE nurse or OKDHS nurse is responsible for completing the UCAT assessment.

(B) The PACE intake staff is responsible for aiding the PACE enrollee in contacting OKDHS to initiate the financial eligibility application process.

(2) The nurse completes the UCAT, Part III visit with the PACE enrollee within 10 days of receipt of the referral for PACE services.

(3) The nurse sends the UCAT, Part III to the designated OHCA nurse staff member for review and level of care determination.

(4) A new medical level of care determination may be required when a member requests any of the following changes in service programs:

(A) From PACE to Advantage.

(B) From ~~Pace~~PACE to State Plan Personal Care Services.

(C) From Nursing Facility to PACE.

(D) From Advantage to PACE if previous UCAT was completed more than 6 months prior to member requesting PACE enrollment.

(E) From PACE site to PACE site.

(d) To obtain and maintain eligibility, the individual must agree to accept the PACE providers and its contractors as the individual's only service provider. The individual may be held financially liable for services received without prior authorization except for emergency medical care.

317:35-18-8. Enrollment

(a) The provider determines whether the applicant meets PACE enrollment requirements.

(b) The enrollment effective date is the first day of the month after the provider receives the signed enrollment form.

(c) Enrollment continues until the participant's death, regardless of changes in health status, unless either of the following actions occur:

(1) The participant voluntarily disenrolls and/or elects to transfer to other eligible PACE program.

(2) The participant is involuntarily disenrolled.

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: February 16, 2016

The proposed policy is a Permanent Rule. This proposal is scheduled to be presented to the Medical Advisory Committee (MAC) on March 10, 2016 and the (OHCA) Board of Directors on March 24, 2016.
Reference: APA WF 15-56

SUMMARY:
Pharmacy Lock-In - OHCA proposes revisions to the policy that would strengthen the consequences of not adhering to the lock-in restrictions by sanctioning members who have been locked in with a single prescriber and pharmacy.

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, Part 484.20

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

TO: Tywanda Cox
Health Policy

FROM: Carmen Johnson
Health Policy

SUBJECT: Rule Impact Statement
APA WF # 15-56

A. Brief description of the purpose of the rule:

The proposed revisions are to clarify and enhance lock-in procedures. Proposed revisions would strengthen the consequences of not adhering to the lock-in restrictions by sanctioning members who have been locked in with a single prescriber and pharmacy.

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:

All adult and children SoonerCare members enrolled in the lock-in program.

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

SoonerCare members enrolled in the lock-in program will benefit from the rule, as to cease abuse of the program and avoid drug addiction habits.

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 involves no economic impact and may be a cost savings.

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:

Agency staff has determined that the proposed language revisions have no budget impact and may be a cost savings.

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 nor will it 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:

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 agency had determined that the proposed rule should have no effect on the public health, safety, or environment. The proposed rule could possibly reduce abuse of the pharmacy program and also prevent drug abuse by a member.

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

OHCA does not anticipate any detrimental effects 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:
Prepared December 11, 2015
Modified Date: December 22, 2015

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

317:30-3-14. Freedom of choice

(a) **Any Qualified provider.** The Oklahoma Health Care Authority (OHCA) assures that any individual eligible for SoonerCare, may obtain services from any institution, agency, pharmacy, person, or organization that is contracted with OHCA and qualified to perform the services.

(b) **Member lock-in.** SoonerCare members who have demonstrated utilization above the statistical norm, during a 6-month period, may be "locked-in" to a prescriber and/or one pharmacy for medications classified as controlled dangerous substances in accordance with ~~Federal Regulation~~ 42 CFR 431.54.

(1) Over-utilization patterns by SoonerCare members may be identified either by referral or by OHCA automated computer systems. SoonerCare records, for a 6-month period, of those identified members are then reviewed. Medical and pharmacy claim histories are reviewed by OHCA pharmacy consultants to determine if ~~high usage is medically justified~~the member has unreasonably utilized SoonerCare provider and/or prescription services.

(2) If it is determined that SoonerCare has been over-utilized, the member may be notified, by letter, of the need to select a prescriber and/or pharmacy and of their opportunity for a fair hearing in accordance with OAC 317:2-1-2. If ~~they do~~the member does not select a prescriber or pharmacy, one ~~is~~will be selected for ~~them. In some cases, members may be sanctioned under OAC 317:35-13-7.~~the member.
(3) The prescriber and/or pharmacy of choice, unless the aforementioned providers have been identified as having problems with over-utilization, are notified by letter and given an opportunity to accept or decline to be the member's prescriber and/or pharmacy.
(4) When the provider accepts, a confirmation letter is sent to both member and provider showing the effective date of the arrangement.
(5) After the lock-in arrangement is made, the provider may file claims for services provided in accordance with OHCA guidelines.
(6) Locked-in members may obtain emergency services from an emergency room facility for an emergency medical condition or as part of an inpatient admission.
(7) If a claim for a controlled dangerous substance is filed by another pharmacy, the claim will be denied.
(8) ~~When a member is enrolled into the lock-in program, usage is monitored periodically and reviewed every 24 months. A provider may send a written request for member review. If review indicates utilization patterns meet lock-in removal criteria, the member may be removed from lock-in at the discretion of OHCA staff.~~A member placed in the lock-in program will remain in lock-in status for a minimum of 24 months. While in lock-in status, the member's usage shall be monitored periodically and shall be reviewed at the end of 24 months.
(9) ~~During~~Following a review, OHCA may elect to continue lock-in for an additional period of up to 24 months, remove the member from lock-in ~~because of~~based upon medical necessity, or remove ~~them because of decreased utilization, or impose sanctions under OAC 317:35-13-7.~~the member based upon program compliance. The member will be provided written notice of OHCA's decision and afforded an opportunity to appeal. OHCA retains the right at any time to impose sanctions in an appropriate case pursuant to OAC 317:35-13-7 or to take other appropriate action for abusive conduct.
(10) The member in the lock-in program may make a request to change providers after the initial three months; when the member moves to a different city or if the member feels irreconcilable differences will prevent necessary medical care. Change of providers based on irreconcilable differences must be approved by OHCA staff or contractor.
(11) OHCA may make a provider change when the provider makes a request for change or may initiate a change anytime it is determined necessary to meet program goals.

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: February 16, 2016

The proposed policy is a Permanent Rule. This proposal is scheduled to be presented to the Medical Advisory Committee (MAC) on March 10, 2016 and the (OHCA) Board of Directors on March 24, 2016.
Reference: APA WF 15-57

SUMMARY:
The purpose is to clean the different sections of the waiver to assure that the waiver and policy language are the same and to detail operation and procedural changes that have occurred since receiving the five year renewal.

LEGAL AUTHORITY
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 1915c Waiver

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

TO: Tywanda Cox
Health Policy

FROM: Carmen Johnson
Health Policy

SUBJECT: Rule Impact Statement
APA WF # 15-57

A. Brief description of the purpose of the rule:

The purpose is to clean the different sections of the waiver to assure that the waiver and policy language are the same and to detail operation and procedural changes that have occurred since receiving the five year renewal.

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 this proposed rule due to language cleanup only and to align policy with current business practices.

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

No classes of persons will benefit from this rule due to language clean up only.

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 involves no economic impact and no fee changes due to language cleanup only.

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:

Agency staff has determined that there is no budget expected pertaining to 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:

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:
Prepared December 17, 2015.
Modified January 29, 2016.

RULE TEXT

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

SUBCHAPTER 1. MEDICALLY FRAGILE WAIVER SERVICES

317:50-1-3. Medically Fragile Program overview
(a) The Medically Fragile Waiver program is a Medicaid Home and Community Based Services Waiver used to finance non-institutional long-term care services for a targeted group of physically disabled adults when there is a reasonable expectation that the person's health, due to disease process or disability, would, without appropriate services, deteriorate and require skilled nursing facility or hospital level of care to arrest the deterioration. Medically Fragile Waiver program members must be SoonerCare eligible and must not reside in an institution; room and board licensed residential care facility, 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~~DHS form 08AX001E, Schedule VIII. B. 1) and without such services would be institutionalized. Services provided through the Medically Fragile Waiver are approved based on medical necessity.

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

(1) case management;

(2) institutional transition services;

(3) respite;

(4) environmental modifications;

(5) specialized medical equipment and supplies;

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

(7) advanced supportive/restorative assistance;

(8) skilled nursing;

(9) home delivered meals;

(10) hospice care;

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

(12) Medically Fragile Waiver personal care;

(13) Personal Emergency Response System (PERS);

(14) Self Directed personal care, respite and advanced supportive/restorative assistance;

(15) Self Directed Goods and Services (SD-GS); ~~and~~

(16) ~~SoonerCare medical services within the scope of the State~~

~~Plan.~~Transitional Case Management Services; and

(17) SoonerCare medical services within the scope of the State Plan.

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

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

(2) the member is in the Medically Fragile Waiver targeted service group. The target group is an individual who is age 19 or older with a physical disability and may also have 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.~~Redetermination of program eligibility can be requested for the following reasons:

(1) if the member fails to comply with the community service plan;

(2) if the member's health and safety cannot be ensured;

(3) if the member is unable or unwilling to accept the negotiated risk of living in the community; or

(4) as deemed necessary by waiver review staff or the member's case manager.

(h) Individuals determined ineligible for Medically Fragile Waiver program services are notified in writing of the determination and of their right to appeal the decision.

317:50-1-4. Application for Medically Fragile Waiver services

(a) ~~If waiver slots are available, the~~The application process is initiated by the receipt of a UCAT, Part I or by ~~an oral request for services.~~receipt of the initial waiver referral form. A written financial application is not required for an individual who is a SoonerCare member at the time of application. A financial application for Medically Fragile Waiver services consists of the Medical Assistance Application form. The form is signed by the applicant, parent, spouse, guardian or someone else acting on the applicant's behalf.

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

(2) An individual residing in a NF or requesting waiver services, or the individual's community spouse may request an assessment of resources available to each spouse by using ~~OKDHS~~DHS form 08MA011E, Assessment of Assets, when SoonerCare application is not being made. The individual and/or spouse

must provide documentation of resources. The assessment reflects all countable resources of the couple (owned individually or as a couple) and establishes the spousal share to be protected when subsequent determination of SoonerCare long-term care eligibility is made.

(3) When SoonerCare application is being made, an assessment of resources must be completed if it was not completed when the individual entered the NF or began receiving waiver services. For applicants of the Medically Fragile waiver, those resources owned by the couple the month the application was made determines the spousal share of resources. If the individual applies for SoonerCare at the time of entry into the Medically Fragile Waiver, Form 08MA011E is not appropriate. However, the spousal share must be determined using the resource information provided on the SoonerCare application form and computed using ~~OKDHS~~DHS form 08MA12E, Title XIX Worksheet.

(b) **Date of application**. The date of application is the date the signed application is received or the date when the request for SoonerCare is made orally and the financial application form is signed later. The date of the oral request is noted above the date the form is signed.

(c) **Medically Fragile Waiver waiting list procedures.** Medically Fragile Waiver Program capacity is the number of members that may be enrolled in the Program without exceeding, on an annualized basis, the maximum number authorized by the waiver to be served in the waiver year. If available waiver capacity has been realized, requests for services are not processed as applications, but placed on a waiting list. As available capacity permits, the OHCA selects in chronological order (first on, first off) requests for services from the waiting list to forward for application processing. When waiver capacity exceeds the number on the waiting list and after all persons on the waiting list have been processed, waiting list procedures are suspended.

317:50-1-5. Medically Fragile Waiver program medical eligibility determination

A medical eligibility determination is made for Medically Fragile Waiver program services based on the Uniform Comprehensive Assessment Tool (UCAT) III assessment, professional judgment and the determination that the member has unmet care needs that require Medically Fragile Waiver Program, SNF or hospital services to assure member health and safety. Medically Fragile Waiver services are initiated to support the informal care that is being provided in the member's home, or, that based on the UCAT, can be expected to be provided in the member's home upon discharge of the member from a SNF or hospital. These services are not intended to take the place of regular care provided by family members and/or by significant others. When there is an informal (not paid) system of care available in the home, Medically Fragile Waiver service

provision will supplement the system within the limitations of Medically Fragile Waiver Program policy.

(1) Categorical relationship must be established for determination of eligibility for Medically Fragile Waiver services. If categorical relationship to disability has not already been established, the Level of Care Evaluation Unit (LOCEU) will render a decision on categorical relationship to the disabled using the same definition used by Social Security Administration. A follow-up is required with the Social Security Administration to be sure their disability decision agrees with the decision of LOCEU.

(2) Community agencies complete the UCAT, Part I and forward the form to the OHCA. If the UCAT, Part I indicates that the applicant does not qualify for SoonerCare long-term care services, the applicant is referred to appropriate community resources.

(3) The member and family are informed of agencies certified to deliver Medically Fragile Waiver case management and in-home care services in the local area to obtain the member's primary and secondary informed choices.

(A) If the member and/or family declines to make a provider choice, that decision is documented on the member choice form.

(B) A rotating system is used to select an agency for the member from a list of all local certified case management and in-home care agencies.

(4) The names of the chosen agencies and the agreement (by dated signature) of the member to receive services provided by the agencies are documented.

(5) If the needs of the member require an immediate interdisciplinary team (IDT) meeting with home health agency nurse participation to develop a care plan and service plan, the need is documented.

(6) If, based upon the information obtained during the assessment, the nurse determines that the member may be at risk for health and safety, ~~OKDHS~~DHS Adult Protective Services (APS) staff are notified immediately and the referral is documented on the UCAT.

(7) Within ten working days of receipt of a complete Medically Fragile Waiver application, medical eligibility is determined using level of care criteria and service eligibility criteria.

(8) Once eligibility has been established, notification is given to the member and the case management provider so that care plan and service plan development may begin. The member's case management provider is notified of the member's name, address, case number and social security number, the units of case management and, if applicable, the number of units of home health agency nurse evaluation authorized for care plan and service plan development, whether the needs of the member require an immediate IDT meeting with home health agency nurse

participation and the effective date for member entry into the Medically Fragile Waiver Program.

(9) ~~If the services must be in place to ensure the health and safety of the member upon discharge to the home from the NF, the member will be provided administrative case management to develop and implement the care plan and service plan. The provider of administrative case management follows Medically Fragile Waiver case management procedures for care plan and service plan development and implementation. Once the member returns home, case management is transitioned to the Medically Fragile Waiver case management provider chosen by the member.~~If the member has a current certification and requests a change to Medically Fragile Waiver services, a new UCAT is required. The UCAT is updated when a member requests a change from Medically Fragile Waiver services to Personal Care services. If a member is receiving Medically Fragile Waiver services and requests to go to a nursing facility, a new medical level of care decision is not needed.

(10) ~~If the member has a current certification and requests a change to Medically Fragile Waiver services, a new UCAT is required. The UCAT is updated when a member requests a change from Medically Fragile Waiver services to Personal Care services, or when a member requests a change from the nursing facility to Medically Fragile Waiver services. If a member is receiving Medically Fragile Waiver services and requests to go to a nursing facility, a new medical level of care decision is not needed.~~When a UCAT assessment has been completed more than 90 days prior to submission for determination of a medical decision, a new assessment is required.

~~(11) When a UCAT assessment has been completed more than 90 days prior to submission for determination of a medical decision, a new assessment is required.~~

317:50-1-10. Medically Fragile Waiver services during hospitalization or NF placement

If a member requires hospital or nursing facility services, the case manager assists the member in accessing institutional care, periodically monitors the member's progress during the institutional stay and, as appropriate, updates the service plan and prepares services to start on the date the member is discharged from the institution and returns home.

(1) **Hospital discharge.** When the member returns home from a hospital or when notified of the member's anticipated discharge date, the case manager notifies relevant providers and coordinates the resumption of services.

(2) **NF placement of less than 30 days.** When the member returns home from a NF stay of 30 days or less or when notified of the member's anticipated discharge date the case manager notifies relevant providers and coordinates the resumption of Medically Fragile Waiver services in the home.

(3) **NF placement greater than 30 days.** When the member is scheduled to be discharged and return home from a ~~SNF~~NF stay that is greater than 30 days, the member's case manager expedites the restart of Medically Fragile Waiver services for the member.

317:50-1-13. Coverage

Individuals receiving Waiver services must have been determined to be eligible for the program and must have an approved ~~plan of care.~~service plan. Any Medically Fragile Program service provided must be listed on the approved ~~plan of care~~service plan and must be necessary to prevent institutionalization of the member. Waiver services which are expansions of Oklahoma Medicaid State Plan services may only be provided after the member has exhausted these services available under the State Plan.

~~(1) To allow for development of administrative structures and provider capacity to adequately deliver Self-Directed services and Supports, availability of Self-Direction is limited to Medically Fragile Program members that reside in counties that have sufficient provider capacity to offer the Self-Directed Service option as determined by OHCA.~~

~~(2)~~(1) Case Managers within the Self-Directed Services approved area will provide information and materials that explain the service option to the members. The OHCA provides information and material on Self-Direction to Case Managers for distribution to members.

~~(3)~~(2) The member may request to Self-Direct their services from their Case Manager or call the Medically Fragile Program toll-free number to request the Self-Directed Services option.

317:50-1-14. Description of services

Services included in the Medically Fragile Waiver Program are as follows:

(1) **Case Management.**

(A) Case Management services are services that assist a member in gaining access to medical, social, educational or other services, regardless of payment source of services, that may benefit the member in maintaining health and safety. Case managers initiate and oversee necessary assessments and reassessments to establish or reestablish Waiver program eligibility. Case managers develop the member's comprehensive ~~plan of care,~~service plan, listing only services which are necessary to prevent institutionalization of the member, as determined through assessments. Case managers initiate the addition of necessary services or deletion of unnecessary services, as dictated by the member's condition and available support. Case managers monitor the member's condition to ensure delivery and appropriateness of services and initiate ~~plan of care~~service plan reviews. If a member requires hospital or skilled nursing facility

services, the case manager assists the member in accessing institutional care and, as appropriate, periodically monitors the member's progress during the institutional stay and helps the member transition from institution to home by updating the service plan and preparing services to start on the date the member is discharged from the institution. Case Managers must meet Medically Fragile Waiver Program minimum requirements for qualification and training prior to providing services to members. Prior to providing services to members choosing to Self-Direct their services, Case Managers are required to receive training and demonstrate knowledge regarding the Self-Directed Service delivery model.

(B) Providers may only claim time for billable Case Management activities described as follows:

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

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

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

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

(ii) Very Rural/Difficult Service Area Rate: Case Management services are billed using a Very Rural/Difficult Service Area rate for billable service activities provided to a member who resides in a county with population density equal to or less than 25 persons per square mile. An exception would be services to members that reside in OHCA identified zip codes in Osage County adjacent to metropolitan areas of Tulsa and Washington Counties. Services to these members are prior authorized and billed using the Standard rate.

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

resides in a county with a population density greater than 25 persons per square mile.

(D) ~~Providers of Home and Community Based Services (HCBS) for the member, or those who have an interest in or are employed by a provider of HCBS for the member, must not provide case management or develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS.~~Case Managers providing Case Management services to Medically Fragile waiver members must submit monthly monitoring case notes on a monthly basis to the OHCA Medically Fragile Waiver Staff.

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

(2) **~~Institutional Transition Services.~~Institutional Transition Case Management.**

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

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

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

(3) **Respite.**

(A) Respite services are provided to members who are unable to care for themselves. They are provided on a short-term basis because of the absence or need for relief of the primary caregiver. Payment for respite care does not include room and board costs unless more than seven hours are provided in a nursing facility. Respite care will only be utilized when other sources of care and support have been

exhausted. Respite care will only be listed on the ~~plan of care~~service plan when it is necessary to prevent institutionalization of the member. Units of services are limited to the number of units approved on the ~~plan of care.~~service plan.

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

(C) Facility-Based Extended Respite is filed for a per diem rate, if provided in Nursing Facility. Extended Respite must be at least eight hours in duration.

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

(4) **Environmental Modifications.**

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

(B) All services require prior authorization.

(5) **Specialized Medical Equipment and Supplies.**

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

(B) Specialized Medical Equipment and Supplies are billed using the appropriate HCPC procedure code. Reoccurring supplies which are shipped to the member are compensable only when the member remains eligible for Waiver services, continues to reside in the home and is not institutionalized in a hospital, skilled nursing facility or nursing home. It is the provider's responsibility to verify the member's status prior to shipping these items. Payment for medical supplies is limited to the Medicare rate, or the SoonerCare rate, or is determined through manual pricing. If manual pricing is used, the provider is reimbursed at the provider's documented Manufacturer's Suggested Retail Price (MSRP) minus 30% or invoice cost plus 30%, whichever is the lesser of the

two. OHCA may establish a fair market price through claims review and analysis.

(6) **Advanced Supportive/Restorative Assistance.**

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

(B) Advanced Supportive/Restorative Assistance service is billed per 15-minute unit of service. The number of units of this service a member may receive is limited to the number of units approved on the ~~plan of care.~~service plan.

(7) **Nursing.**

(A) Nursing services are services listed in the ~~plan of care~~service plan which are within the scope of the Oklahoma Nursing Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State. Nursing services includes skilled nursing and/or private duty nursing. Skilled nursing is provided on an intermittent or part-time basis. Private duty nursing is individual and continuous care provided to a participant at home by licensed nurses. The provision of the nursing service will work to prevent or postpone the institutionalization of the member.

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

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

assessment/evaluation of:

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

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

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

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

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

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

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

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

(C) Nursing service can be billed for service plan development and/or assessment/evaluation services or, for other services within the scope of the Oklahoma Nursing Practice Act including private duty nursing. Nursing services are billed per 15-minute unit of service. A specific procedure code is used to bill for assessment/evaluation/service plan development skilled nursing services and other procedure codes are used to bill for all other authorized nursing services. A maximum of eight units per day of skilled nursing for assessment/evaluation and/or service plan development are allowed. An agreement by a provider to perform a nurse

evaluation is also an agreement, to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted. Reimbursement for a nurse evaluation is denied if the provider that produced the nurse evaluation fails to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted.

(8) **Home Delivered Meals.**

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

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

(9) **Occupational Therapy services.**

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

based on the member's condition and ongoing rehabilitation potential.

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

(10) **Physical Therapy services.**

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

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

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

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

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

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

(12) **Respiratory Therapy Services.**

(A) Respiratory therapy services are provided for a member who, but for the availability of in-home respiratory services, would require respiratory care as an inpatient in a hospital or nursing facility. Services are provided in the member's home under the care of a physician who is familiar with the technical and medical components of home ventilator support and the physician must determine medically that in-home respiratory care is safe and feasible for the member. Treatment involves use of therapeutic means such as: evaluation, respiratory treatments, chest physiotherapy, and/or development and oversight of a therapeutic maintenance program. Under a physician's order, a registered respiratory therapist evaluates the member and develops an appropriate, written therapeutic regimen. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

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

(13) **Hospice Services**.

(A) Hospice is palliative and/or comfort care provided to the member and his/her family when a physician certifies that the member has a terminal illness and has six months or less to live and orders hospice Care. Medically Fragile Waiver Hospice Care is authorized for a six month period and requires a physician certification of a terminal illness and orders of hospice care. If the member requires more than six months of hospice care, a physician or nurse practitioner must have a face-to-face visit with the member thirty days prior to the initial hospice authorization end date and re-certify that the member has a terminal illness and has six months or less to live and orders additional hospice care. After the initial authorization period, additional periods of hospice may be authorized for a maximum of 60 day increments with physician certification that the member has a terminal illness and has six months or less to live. A member's service plan that includes hospice care must comply with

waiver requirements to be within total service plan cost limits.

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

(C) Hospice services are billed per diem of service for days covered by a Hospice plan of care and during which the hospice provider is responsible for providing hospice services as needed by the member or member's family.

(14) **Medically Fragile Waiver Personal Care.**

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

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

plan.

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

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

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

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

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

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

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

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

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

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

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

(17) **Self-Direction**.

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

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

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

(i) residence in the Self-Directed services approved area;

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

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

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

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

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

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

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

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

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

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

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

(vi) the member, even with Case Manager and Financial Management Services assistance, is unable to operate successfully within their Individual Budget Allocation; or

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

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

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

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

(F) Self-Directed Services are delivered as authorized on the service plan and are limited to Personal Care, Respite and Advanced Supportive/Restorative Care. The member employs the Respite or ~~Personal Services Assistant (PSA) and/or the Advanced Personal Services Assistant (APSA)~~PCA and/or the ASR provider and is responsible, with assistance from the Administrative Financial Management Services (FMS), for ensuring that the employment complies with State and Federal

Labor Law requirements. The member:

(i) recruits, hires and, as necessary, discharges the ~~PSA~~PCA and ~~APSA;~~ASR

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

(iii) determines where and how the ~~PSA~~PCA or ~~APSA~~ASR works, hours of work, what is to be accomplished and, within Individual Budget Allocation limits, wages to be paid for the work;

(iv) supervises and documents employee work time; and,

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

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

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

(ii) other employer related payment disbursements as agreed to with the member and in accordance with the member's Individual Budget Allocation;

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

(iv) providing to the member, as needed, assistance with employer related cognitive tasks, decision-making and specialized skills that may include assistance with Individual Budget Allocation planning and support for making decisions including training and providing reference material and consultation regarding employee management tasks such as recruiting, hiring, training and supervising the member's Respite or ~~Personal Services Assistant or Advanced Personal Services Assistant; and~~PCA or ASR provider; and

(H) The service of Respite or ~~Personal Services Assistance~~PCA is billed per 15-minute unit of service. The number of units of ~~PSA~~PCA a member may receive is limited to the number of

units approved on the Service Plan.

(I) ~~The service of Advanced Personal Services Assistance is billed per 15-minute unit of service.~~ASR services are billed per 15-minute unit of service. The number of units of ~~APSA~~ASR a member may receive is limited to the number of units approved on the Service Plan.

(J) Self-Directed Services rates are determined using the Individual Budget Allocation (IBA) Expenditure Accounts Determination process for each member. The IBA Expenditure Accounts Determination process includes consideration and decisions about the following:

(i) The Individual Budget Allocation (IBA) Expenditure Accounts Determination constrains total SoonerCare reimbursement for Self-Directed services to be less than expenditures for equivalent services using agency providers.

(ii) The ~~PSA~~PCA and ~~APSA~~ASR service unit rates are calculated by the OHCA during the Self-Directed service eligibility determination process. ~~The OHCA sets the PSA and APSA unit rates at a level that is not less than 80 percent and not more than 95 percent of the comparable Agency Personal Care (for PSA) or Advanced Supportive/Restorative (for APSA) service rate.~~ The allocation of portions of the ~~PSA~~PCA and/or ~~APSA~~ASR rate to cover salary, mandatory taxes, and optional benefits (including Worker's Compensation insurance, if available) is determined individually for each member using the Self-Directed Services Individualized Budget Allocation Expenditure Accounts Determination Process.

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

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

(A) Self-Directed Goods and Services (SD-GS) are incidental, non-routine goods and services that promote the member's self-care, daily living, adaptive functioning, general household activity, meal preparation and leisure skills

needed to reside successfully in the community and do not duplicate other services authorized in the member's ~~plan of care~~service plan.

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

(19) **Transitional Case Management Services.**

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

(B) Transitional Case Management Services must be reasonable and necessary as determined through the transition plan development process and must be clearly identified in the plan.

(C) Transitional Case Management Services assist members that are eligible to receive waiver services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational, and other services to assist the transition, regardless of the funding source for the services which access is gained.

Transitional Case Management Services may be authorized for assisting the member transition to the Medically Fragile Waiver by updating the service plan, including preparing for necessary services and supports to be in place or to start on the date the member is effective with the waiver.

317:50-1-16. Billing procedures for Medically Fragile Waiver services

(a) Billing procedures for long-term care medical services are contained in the OKMMIS Billing and Procedure Manual. Questions regarding billing procedures which cannot be resolved through a study of the manual should be referred to the OHCA.

(b) The approved Medically Fragile Waiver service plan is the basis for the MMIS service prior authorization, specifying:

(1) service;
(2) service provider;
(3) units authorized; and
(4) begin and end dates of service authorization.

(c) As part of Medically Fragile Waiver quality assurance, provider audits are used to evaluate whether paid claims are consistent with service plan authorizations and documentation of service provision. Evidence of paid claims that are not supported by service plan authorization and/or documentation of service provision will be turned over to the OHCA Provider Audit Unit for follow-up investigation.

~~(d) Service time of Personal Care, Case Management, Nursing, Advanced Supportive/ Restorative Assistance, In-Home Respite and Self Direction may be documented through the Interactive Voice Response Authentication (IVRA) system when provided in the home.~~

~~Providers are required to use the IVRA system after access to the system is made available by OKDHS. The IVRA system provides alternate backup solutions should the automated system be unavailable. In the event of IVRA backup system failure, the provider will document time in accordance with their agency backup plan. The agency=s backup procedures are only permitted when the IVRA system is unavailable.~~

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: February 16, 2016

The proposed policy is a Permanent Rule. This proposal is scheduled to be presented to the Medical Advisory Committee (MAC) on March 10, 2016 and the (OHCA) Board of Directors on March 24, 2016.
Reference: APA WF 15-58

SUMMARY:
DSM reference cleanup and Ad Hoc Reviews – Proposed policy revisions remove outdated references to Axis I and II diagnosis language. Additional revisions clarify assessment and evaluation criterion and include cleanup to outdated language. Rules are also revised to remove outdated references to provider manual to reflect current medical necessity manual. In addition policy is revised to include Service Quality Review requirements for Ad Hoc reviews.

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:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

TO: Tywanda Cox
Health Policy

FROM: Tatiana Reed
Health Policy

SUBJECT: Rule Impact Statement
APA WF # 15-58

A. Brief description of the purpose of the rule:

Proposed policy revisions remove outdated references to Axis I and II diagnosis language to align with changes to the Diagnostic and Statistical Manual of Mental Disorders (DSM). Additional revisions clarify assessment and evaluation criterion and include cleanup to outdated language. Rules are also revised to remove outdated references to provider manual to reflect current medical necessity manual regarding the outline for procedures for out-of-state reviews. In addition policy is revised to include Service Quality Review requirements for Ad Hoc reviews.

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:

Inpatient psychiatric facility providers who do not currently utilize start and stop times and exceed 10 days between therapy sessions will be affected by this rule change.

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

SoonerCare members who receive services in the inpatient psychiatric setting may benefit from this rule change as their individual/family therapy sessions will not exceed 10 days in between sessions. This will reflect best practices and improve quality 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:

The proposed rule could cause an economic impact if the hospital has to hire an additional Licensed Behavioral Health Professional in order to not exceed 10 days between individual/ family therapy sessions.

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. The cleanup to update the references to the Axis I and II in the Diagnostic Statistical Manual (DSM) are required to reflect changes in the new DSM edition.
Due to audit findings it was suggested that start and stop times be identified to assure that active treatment requirements are met.

Behavioral health practitioners suggested that 10 days between individual and family therapy. This change would reflect best practices and improve quality of care.

In addition policy is revised to include Quality Review requirements for Ad Hoc reviews to ensure quality of care for Soonercare members.

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. The proposed rule may have a positive impact on public health, safety and environment as rules reflect best practices and improve quality of care for soonercare members.

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, 2015.
The rule impact statement was modified January 22, 2016

TEXT

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 6. INPATIENT PSYCHIATRIC HOSPITALS

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

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

(1) ~~An Axis I~~A primary diagnosis from the most recent edition of "The Diagnostic and Statistical Manual of Mental Disorders" (DSM) with the exception of V-codes, adjustment disorders, and substance related disorders, accompanied by a detailed description of the symptoms supporting the diagnosis. In lieu of a qualifying ~~Axis I~~ diagnosis, children 18-21 years of age may have ~~an Axis II~~ a diagnosis of any personality disorder.

(2) Conditions are directly attributable to a psychiatric disorder as the primary need for professional attention (this does not include placement issues, criminal behavior, status offenses). Adjustment or substance related disorder may be a secondary ~~Axis I~~ diagnosis.
(3) It has been determined by the OHCA designated agent that the current disabling symptoms could not have been managed or have not been manageable in a lesser intensive treatment program.
(4) Child must be medically stable.
(5) Within the past 48 hours, the behaviors present an imminent life threatening emergency such as evidenced by:
(A) Specifically described suicide attempts, suicide intent, or serious threat by the patient.
(B) Specifically described patterns of escalating incidents of self-mutilating behaviors.
(C) Specifically described episodes of unprovoked significant physical aggression and patterns of escalating physical aggression in intensity and duration.
(D) Specifically described episodes of incapacitating depression or psychosis that result in an inability to function or care for basic needs.
(6) Requires secure 24-hour nursing/medical supervision as evidenced by:
(A) Stabilization of acute psychiatric symptoms.
(B) Needs extensive treatment under physician direction.
(C) Physiological evidence or expectation of withdrawal symptoms which require 24-hour medical supervision.

317:30-5-95.26. Medical necessity criteria for continued stay - acute psychiatric admission for children

For continued stay acute psychiatric admissions for children must meet all of the conditions set forth in (1) to (4) of this subsection.
(1) ~~An Axis I~~A primary diagnosis from the most recent edition of "The Diagnostic and Statistical Manual of Mental Disorders" (DSM) with the exception of V-Codes, adjustment disorders, and substance abuse related disorders, accompanied by a detailed description of the symptoms supporting the diagnosis. In lieu of a qualifying ~~Axis I~~ diagnosis, children 18-20 years of age may have ~~an Axis II~~ a diagnosis of any personality disorder. Adjustment or substance related disorders may be a secondary ~~Axis I~~ diagnosis.
(2) Patient continues to manifest a severity of illness that requires an acute level of care as defined in the admission

criteria and which could not be provided in a less restrictive setting.

(A) Documentation of regression is measured in behavioral terms.

(B) If condition is unchanged, evidence of re-evaluation of treatment objectives and therapeutic interventions.

(3) Conditions are directly attributable to a mental disorder as the primary need for professional attention (this does not include placement issues, criminal behavior, status offenses).

(4) Documented efforts of working with the child's family, legal guardians and/or custodians and other human service agencies toward a tentative discharge date.

317:30-5-95.33. Individual plan of care for children

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

(1) **"Licensed Behavioral Health Professional (LBHP)"** means licensed psychologists, licensed clinical social workers (LCSW), licensed marital and family therapists (LMFT), licensed professional counselors (LPC), licensed behavioral practitioners (LBP), licensed alcohol and drug counselors (LADC), and advanced practice nurses (APN).

(2) **"Licensure Candidate"** means practitioners actively and regularly receiving board approved supervision, and extended supervision by a fully licensed clinician if board's supervision requirement is met but the individual is not yet licensed, to become licensed by one of the following licensing boards:

(A) Psychology,

(B) Social Work (clinical specialty only),

(C) Professional Counselor,

(D) Marriage and Family Therapist,

(E) Behavioral Practitioner, or

(F) Alcohol and Drug Counselor.

(3) **"Individual plan of Care (IPC)"** means a written plan developed for each member within four calendar days of any admission to an acute psychiatric facility or a PRTF and is the document that directs the care and treatment of that member. In Community Based Transitional RTC, the IPC must be completed within 7 days. The individual plan of care must be recovery focused, trauma informed, and specific to culture, age and gender and includes:

(A) A primary diagnosis from the most recent edition of "The Diagnostic and Statistical Manual of Mental

Disorders" (DSM) with the exception of V-Codes, adjustment disorders, and substance abuse related disorders, accompanied by a detailed description of the symptoms supporting the diagnosis. Children 18-20 years of age may have a diagnosis of any personality disorder. Adjustment or substance related disorders may be a secondary diagnosis.

(B) the current functional level of the individual;

(C) treatment goals and measurable time limited objectives;

(D) any orders for psychotropic medications, treatments, restorative and rehabilitative services, activities, therapies, social services, diet and special procedures recommended for the health and safety of the member;

(E) plans for continuing care, including review and modification to the plan of care; and

(F) plan for discharge, all of which is developed to improve the child's condition to the extent that the inpatient care is no longer necessary.

(b) The individual plan of care:

(1) must be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the individual member and reflects the need for inpatient psychiatric care;

(2) must be developed by a team of professionals as specified in OAC 317:30-5-95.35 in collaboration with the member, and his/her parents for members under the age of 18, legal guardians, or others in whose care he/she will be released after discharge;

(3) must establish treatment goals that are general outcome statements and reflective of informed choices of the member served. Additionally, the treatment goal must be appropriate to the member's age, culture, strengths, needs, abilities, preferences and limitations;

(4) must establish measurable and time limited treatment objectives that reflect the expectations of the member served and parent/legal guardian (when applicable) as well as being age, developmentally and culturally appropriate. When modifications are being made to accommodate age, developmental level or a cultural issue, the documentation must be reflected on the individual plan of care. The treatment objectives must be achievable and understandable to the member and the parent/guardian (when applicable). The treatment objectives also must be appropriate to the treatment setting and list the frequency of the service;

(5) must prescribe an integrated program of therapies, activities and experiences designed to meet the objectives;
(6) must include specific discharge and after care plans that are appropriate to the member's needs and effective on the day of discharge. At the time of discharge, after care plans will include referral to medication management, out-patient behavioral health counseling and case management to include the specific appointment date(s), names and addresses of service provider(s) and related community services to ensure continuity of care and reintegration for the member into their family, school, and community;
(7) must be reviewed every five to nine calendar days when in acute care and a regular PRTF, every 11 to 16 calendar days in the OHCA approved longer term treatment programs or specialty PRTF and every 30 days in Community Based Transitional treatment programs by the team specified to determine that services are being appropriately provided and to recommend changes in the individual plan of care as indicated by the member's overall adjustment, progress, symptoms, behavior, and response to treatment;
(8) development and review must satisfy the utilization control requirements for physician re-certification and establishment of periodic reviews of the individual plan of care; and,
(9) each individual plan of care and plan of care review must be clearly identified as such and be signed and dated individually by the physician, LBHP or licensure candidate, member, parent/guardian (for members under the age of 18), registered nurse, and other required team members. All plans of care and plan of care reviews must be signed by the member upon completion, except when a member is too physically ill or ~~their~~ the member's acuity level precludes ~~them~~ him/her from signing. If the member ~~was~~ is too physically ill or ~~their~~ the member's acuity level ~~precluded them~~ precludes him/her from signing the plan of care and/or the plan of care review at the time of completion, the member must sign the plan when ~~their~~ his/her condition improves but before discharge. The documentation should indicate the reason the member was unable to sign and when the next review will occur to obtain the signature. Individual plans of care and individual plan of care reviews are not valid until completed and appropriately signed and dated. All requirements for the individual plan of care or individual plan of care reviews must be met or a partial per diem recoupment will be merited. If the member's parent/guardian is unable to sign the IPC or IPC review on the date it is completed, then within 72 hours

the ~~Provider~~provider must in good faith and with due diligence attempt to telephonically notify the parent/guardian of the document's completion and review it with them. Documentation of reasonable efforts to make contact with the member's parent/guardian must be included in the clinical file. In those instances where it is necessary to mail or fax an ~~Individual Plan of Care or Individual Plan of Care~~IPC or IPC review to a parent or OKDHS/OJA worker for review, the parent and/or OKDHS/OJA worker may fax back their signature. The ~~Provider~~provider must obtain the original signature for the clinical file within 30 days. Stamped or photocopied signatures are not allowed for any parent or member of the treatment team.

317:30-5-95.34. Active treatment for children

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

(1) **"Discharge/Transition Planning"** means a patient-centered, interdisciplinary process that begins with an initial assessment of the patient's potential needs at the time of admission and continues throughout the patient's stay. Active collaboration with the patient, family and all involved outpatient practitioners and agencies should be ongoing throughout treatment so that effective connections remain intact. Needed services may consist of the ~~Wraparound~~wraparound process through Systems of Care, counseling, case management and other supports in their community. The linkages with these supports should be made prior to discharge to allow for a smooth transition.

(2) **"Expressive group therapy"** means art, music, dance, movement, poetry, drama, psychodrama, structured therapeutic physical activities, experiential (ROPES), recreational, or occupational therapies that encourage the member to express themselves emotionally and psychologically.

(3) **"Family therapy"** means interaction between an LBHP or licensure candidate, member and family member(s) to facilitate emotional, psychological or behavioral changes and promote successful communication and understanding.

(4) **"Group rehabilitative treatment"** means behavioral health remedial services, as specified in the individual care plan which are necessary for the treatment of the existing primary behavioral health disorders and/or any secondary alcohol and other drug (AOD) disorders in order to increase the skills necessary to perform activities of daily living.

(5) **"Individual rehabilitative treatment"** means a face to face, one on one interaction which is performed to assist members who are experiencing significant functional impairment due to the existing primary behavioral health disorder and/or any secondary AOD disorder in order to increase the skills necessary to perform activities of daily living.

(6) **"Individual therapy"** means a method of treating existing primary behavioral health disorders and/or any secondary AOD disorders using face to face, one on one interaction between an LBHP or ~~Licensure Candidate~~licensure candidate and a member to promote emotional or psychological change to alleviate disorders.

(7) **"Process group therapy"** means a method of treating existing primary behavioral health disorders and/or secondary AOD disorders using the interaction between an LBHP or licensure candidate as defined in OAC 317:30-5-240.3, and two or more members to promote positive emotional and/or behavioral change.

(b) Inpatient psychiatric programs must provide "Active Treatment". Active Treatment involves the member and their family or guardian from the time of an admission throughout the treatment and discharge process. Families and/or guardians must be notified of the dates and times of treatment team meetings and be welcomed to attend. Family members must attend family therapy weekly for continued SoonerCare reimbursement. Reasons for exceptions to this requirement must be well documented in the member's treatment plan. For individuals in the age range of 18 up to 21, it is understood that family members and guardians will not always be involved in the member's treatment. Active Treatment also includes an ongoing program of assessment, diagnosis, intervention, evaluation of care and treatment, and planning for discharge and aftercare under the direction of a physician. Evidence based practices such as trauma informed methodology should be utilized to minimize the use of seclusion and restraint.

(c) For individuals age 18 up to 21, the Active Treatment program must be appropriate to the needs of the member and be directed toward restoring and maintaining optimal levels of physical and psychiatric-social functioning. The services and individual plan of care must be recovery focused, trauma informed, specific to culture, age and gender, and provided face-to-face. Services, including type and frequency, will be specified in the Individual Plan of Care.

(d) For individuals under age 18, the components of Active Treatment consist of face-to-face integrated therapies that are

provided on a regular basis and will remain consistent with the member's ongoing need for care. The services and individual plan of care must be recovery focused, trauma informed, and specific to culture, age, and gender. Individuals in acute care must receive seventeen (17) hours of documented active treatment services each week, with seven (7) of those hours being dedicated to core services as described in (1) below. Individuals in PRTFs must receive fourteen (14) hours of documented active treatment services each week, with four and a half (4.5) of those hours being dedicated to core services as described in (1) below. Individuals in Community Based Transitional (CBT) must receive ten (10) hours of documented active treatment services each week, with 4 of those hours being dedicated to core services as described in (1) below. The remainder of the active treatment services may include any or all of the elective services listed in (2) below or additional hours of any of the core services. Sixty minutes is the expectation to equal one hour of treatment. When appropriate to meet the needs of the child, the 60 minute timeframe may be split into sessions of no less than 15 minutes each on the condition that the Active Treatment requirements are fully met by the end of the treatment week. The following components meet the minimum standards required for Active Treatment, although an individual child's needs for treatment may exceed this minimum standard:

(1) **Core Services.**

(A) **Individual treatment provided by the physician.** Individual treatment provided by the physician is required three times per week for acute care and one time a week in Residential Treatment Facilities. Individual treatment provided by the physician will never exceed ten calendar days between sessions in PRTFs, never exceed seven calendar days in a specialty PRTF and never exceed 30 calendar days in CBTs. Individual treatment provided by the physician may consist of therapy or medication management intervention for acute and residential programs.

(B) **Individual therapy.** LBHPs or licensure candidates performing this service must use and document an approach to treatment such as cognitive behavioral treatment, narrative therapy, solution focused brief therapy or another widely accepted theoretical framework for treatment. Ongoing assessment of the member's status and response to treatment as well as psycho-educational intervention are appropriate components of individual therapy. Individual therapy must be provided in a

confidential setting. The therapy must be goal directed utilizing techniques appropriate to the individual member's plan of care and the member's developmental and cognitive abilities. Individual therapy must be provided two hours per week in acute care and one hour per week in residential treatment by an LBHP or licensure candidate as described in OAC 317:30-5-240.3. One hour of family therapy may be substituted for one hour of individual therapy at the treatment team's discretion.

(C) **Family therapy.** The focus of family therapy must be directly related to the goals and objectives on the individual member's plan of care. Family therapy must be provided one hour per week for acute care and residential. One hour of individual therapy addressing relevant family issues may be substituted for a family session in an instance in which the family is unable to attend a scheduled session by an LBHP or licensure candidate as described in OAC 317:30-5-240.3.

(D) **Process group therapy.** The focus of process group therapy must be directly related to goals and objectives on the individual member's plan of care. The individual member's behavior and the focus of the group must be included in each member's medical record. This service does not include social skills development or daily living skills activities and must take place in an appropriate confidential setting, limited to the therapist, appropriate hospital staff, and group members. Group therapy must be provided three hours per week in acute care and two hours per week in residential treatment by an LBHP or licensure candidate as defined in OAC 317:30-5-240.3. In lieu of one hour of process group therapy, one hour of expressive group therapy provided by an LBHP, licensure candidate, or Licensed Therapeutic Recreation Specialist may be substituted.

(E) **Transition/Discharge Planning.** Transition/discharge planning must be provided one hour per week in acute care and thirty minutes per week in residential and CBT. Transition/Discharge planning can be provided by any level of inpatient staff.

(2) **Elective services.**

(A) **Expressive group therapy.** Through active expression, inner-strengths are discovered that can help the member deal with past experiences and cope with present life situations in more beneficial ways. The focus of the group must be directly related to goals and objectives on the individual member's plan of care. Documentation must

include how the member is processing emotions/feelings. Expressive therapy must be a planned therapeutic activity, facilitated by staff with a relevant Bachelor's degree and/or staff with relevant training, experience, or certification to facilitate the therapy.

(B) **Group rehabilitative treatment.** Examples of educational and supportive services, which may be covered under the definition of group rehabilitative treatment services, are basic living skills, social skills (re)development, interdependent living, self-care, lifestyle changes and recovery principles. Each service provided under group rehabilitative treatment services must have goals and objectives, directly related to the individual plan of care.

(C) **Individual rehabilitative treatment.** Services will be for the reduction of psychiatric and behavioral impairment and the restoration of functioning consistent with the requirements of independent living and enhanced self-sufficiency. This service includes educational and supportive services regarding independent living, self-care, social skills (re)development, lifestyle changes and recovery principles and practices. Each individual rehabilitative treatment service provided must have goals and objectives directly related to the individualized plan of care and the member's diagnosis.

(D) **Recreation therapy.** Services will be provided to reduce psychiatric and behavioral impairment as well as to restore, remediate and rehabilitate an individual's level of functioning and independence in life activities. Services will also be provided in such a way as to promote health and wellness as well as reduce or eliminate the activity limitations and restrictions to participation in life situations caused by an illness or disabling condition. Recreational therapy can be provided in an individual or group setting. If the only activities prescribed for the individual are primarily diversional in nature, (i.e. to provide some social or recreational outlet for the individual), it will not be regarded as active treatment. If provided, recreational therapy must be a planned therapeutic activity, facilitated by a Licensed Therapeutic Recreation Specialist.

(E) **Occupational therapy.** Services will be provided to address developmental and/or functional needs related to the performance of self-help skills, adaptive behavioral, and/or sensory, motor and postural development. Services include therapeutic goal-directing activities and/or

exercises used to improve mobility and activities of daily living (ADL) functions when such functions have been impaired due to illness or injury. Services must be provided by an occupational therapist appropriately licensed in the state in which they practice.

(F) **Wellness resource skills development.** Services include providing direction and coordinating support activities that promote good physical health. The focus of these activities should include areas such as nutrition, exercise, support with averting or managing physical health concerns like heart disease, diabetes, and cholesterol, and support regarding the effects of medications have on physical health. Services can include support groups, exercise groups, and individual physical wellness plan development, implementation assistance and support.

(3) **Modifications to active treatment.** When a member is too physically ill or their acuity level precludes them from active behavioral health treatment, documentation must demonstrate that alternative clinically appropriate services were provided.

(e) The expectation is that active treatment will occur regularly throughout the treatment week. A treatment week in Acute is based on the number of days of acute service, beginning the day of admission (day 1). Required active treatment components will be based upon the length of stay as described below. A treatment week in RTC, PRTF and CBT is considered to be a calendar week (i.e. Sunday through Saturday). When a child is admitted to RTC, PRTF or CBT level of care on a day other than Sunday, or discharges on a day other than Saturday, the week will be considered a partial week and services will be required as described below. Active treatment components ~~do not~~ may include assessments/evaluations to serve as the initial individual or family session if completed by an LBHP or licensure candidate. Start and stop time must be documented. Active treatment begins the day of admission. Days noted are calendar days.

(1) **Individual treatment provided by the physician.**

(A) In acute, by day two, 1 visit is required. By day 4, 2 visits are required. By day 7, 3 visits are required.

(B) In RTC, PRTF or CBT, one visit during admission week is required. In RTCs, 1 visit during the admission week is required, then once a week thereafter. In PRTFs, one visit during the admission week is required, then once a week thereafter. In CBT, 1 visit is required within 7 days of admission. Individual treatment provided by the physician

will never exceed 10 days between sessions in PRTFs, never exceed 7 days in a specialty PRTF and never exceed 30 days in CBTs. The completion of a psychiatric evaluation or a combined psychiatric evaluation and a History and Physical (H&P) evaluation may count as the first visit by the physician if the evaluation was personally rendered by the psychiatrist. If the member is admitted on the last day of the admission week, then the member must be seen by a physician within 24 hours of admission time.

(2) **Individual therapy.**

(A) In acute, by day 3, 30 minutes of treatment are required. By day 5, 1 hour of treatment is required. Beginning on day 7, 2 hours of treatment are required each week. This does not include admission assessments/evaluations or Psychosocial Evaluations unless personally (face to face) rendered by the LBHP or licensure candidate.

(B) In residential treatment (including PRTF and CBT), by day 6, 30 minutes of treatment must be documented. Beginning on day 7, 1 hour of treatment is required each week. The treatment week is defined as Sunday through Saturday. Individual therapy may not exceed a total of 10 days between sessions. This does not include admission assessment/ evaluation or Psychosocial Evaluations unless personally (face to face) rendered by the LBHP or licensure candidate.

(3) **Family therapy.**

(A) In acute, by day 6, 30 minutes of treatment must be documented. Beginning on day 7, 1 hour of treatment is required each week. This does not include admission assessments/evaluation or Psychosocial Evaluations unless personally (face to face) rendered by the LBHP or licensure candidate and the assessments/evaluation or Psychosocial Evaluation has not been used to substitute the initial individual therapy requirement.

(B) In residential treatment (including PRTF and CBT), by day 6, 30 minutes of treatment must be documented. Beginning on day 7, 1 hour of treatment is required each week. This does not include admissions assessment/evaluation or Psychosocial Evaluations unless personally (face to face) rendered by the LBHP or licensure candidate and the assessment/evaluation or Psychosocial Evaluation has not been used to substitute the initial individual therapy requirement. Family therapy provided by the LBHP or licensure candidate should not exceed 10 days in between sessions.

(f) When an individual is determined to be too ill to participate in treatment, as determined by medical/nursing staff (RN/LPN), documentation must be in the record clearly indicating the reason, limitations, and timeframe for those services to be excused without penalty.

317:30-5-95.41. Documentation of records for children's inpatient services

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

(1) date;
(2) start and stop time for each session;
(3) dated signature of the therapist and/or staff that provided the service;
(4) credentials of the therapist;
(5) specific problem(s) addressed (problems must be identified on the plan of care);
(6) method(s) used to address problems;
(7) progress made towards goals;
(8) member's response to the session or intervention; and
(9) any new problem(s) identified during the session.

(b) Signatures of the member, parent/guardian for members under the age of 18, doctor, Licensed Behavioral Health Professional (LBHP), and RN are required on the individual plan of care and all plan of care reviews. The individual plan of care and plan of care review are not valid until signed and separately dated by the member, parent/legal guardian for members under the age of 18, doctor, RN, LBHP, and all other requirements are met. All treatment team staff providing individual therapy, family therapy and process group therapy must sign the individual plan of care and all plan of care reviews. All plans of care and plan of care reviews must be signed by the member upon completion, except when a member is too physically ill, or the member's acuity level precludes him/her from signing. If the member is too physically ill or the member's acuity level precludes him/her from signing the plan of care and/or the plan of care review at the time of completion, the member must sign the plan when his/her condition improves but before discharge. Documentation should indicate the reason the member was unable to sign and when the next review will occur to obtain the signature.

317:30-5-95.42. Service quality review of psychiatric facilities providing services to children

(a) The Service Quality Review conducted by OHCA or its designated agent meets the utilization control requirements as set forth in 42 CFR 456.

(b) There will be an on-site Service Quality Review (SQR) of each in-state psychiatric facility that provides care to SoonerCare eligible children which will be performed by the OHCA or its designated agent. Out-of-state psychiatric facilities that provide care to SoonerCare eligible children will be reviewed according to the procedures outlined in the ~~provider manual. The Oklahoma Health Care Authority will designate the members of the Service Quality Review team.~~ Medical Necessity Manual. OHCA or its designated agent may conduct ad hoc reviews. Ad hoc reviews may be conducted at the discretion of the agency.

(c) The Oklahoma Health Care Authority will designate the members of the Service Quality Review team. The SQR team will consist of one to three team members and will be comprised of Licensed Behavioral Health Professionals (LBHP) or Registered Nurses.

(d) The review will include observation and contact with members. The Service Quality Review will consist of members present or listed as facility residents at the beginning of the Service Quality Review visit as well as members on which claims have been filed with OHCA for acute or PRTF levels of care. The review includes validation of certain factors, all of which must be met for the services to be compensable.

(e) Following the on-site inspection, the SQR Team will report its findings to the facility. The facility will be provided with written notification if the findings of the review have resulted in any deficiencies. A copy of the final report will be sent to the facility's accrediting agency.

(f) Deficiencies found during the SQR may result in a partial per-diem recoupment or a full per-diem recoupment of the compensation received. The following documents are considered to be critical to the integrity of care and treatment, must be completed within the time lines designated in OAC 317:30-5-95.37, and cannot be substituted with any other evaluation/assessments not specifically mentioned:

(1) History and physical evaluation;
(2) Psychiatric evaluation;
(3) Psychosocial evaluation; and
(4) Individual Plan of Care.

(g) For each day that the History and Physical evaluation, Psychiatric evaluation, Psychosocial evaluation and/or

Individual Plan of Care are not contained within the member's records, those days will warrant a partial per-diem recoupment.
(h) If the review findings have resulted in a partial per-diem recoupment of $50.00 per event, the days of service involved will be reported in the notification. If the review findings have resulted in full per-diem recoupment status, the non-compensable days of service will be reported in the notification. In the case of non-compensable days full per diem or partial per diem, the facility will be required to refund the amount.
(i) In the event that CMS recoups from OHCA an amount that exceeds the provider's liability for findings described in this Section, the provider will not be held harmless and will be required to reimburse OHCA the total federal amount identified by CMS and/or its designated audit contractor.~~(j)Penalties of non-compensable days which are the result of the facility's failure to appropriately provide and document the services described herein, or adhere to applicable accreditation, certification, and/or state licensing standards, are not compensable or billable to the member or the member's family.~~
(j)Penalties of non-compensable days which are the result of the facility's failure to appropriately provide and document the services described herein, or adhere to applicable accreditation, certification, and/or state licensing standards, are not compensable or billable to the member or the member's family.

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: February 16, 2016

The proposed policy is a Permanent Rule. This proposal is scheduled to be presented to the Medical Advisory Committee (MAC) on March 10, 2016 and the (OHCA) Board of Directors on March 24, 2016.

Reference: APA WF 15-61

SUMMARY:
Appeal process for contract terminations- Proposed Grievance Procedures and Process policy is amended to add language about the panel composition and to better clarify the appeal 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 42 CFR 455.23.

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

TO: Tywanda Cox
Federal and State Policy

From: Likita Gunn

SUBJECT: Rule Impact Statement
APA WF # 15-61

A. Brief description of the purpose of the rule:

The proposed Grievance Procedures and Process policy amends language to clarify the appeals process for a 30 day for cause and immediate contract termination and removes references to suspended contracts. Proposed changes also add language to rules addressing 60 day without cause termination. The amendments makes clear that pursuant to contract terms, either party may terminate the contract with

a 30 day written notice when it is a for cause termination, or with a 60 day notice if the termination is without cause. Additionally, changes detail the post-termination panel committee composition and its function and add language that specifies the timeframe for which a provider must submit a written response to OHCA requesting reconsideration.

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:

All SoonerCare contracted providers will be affected by the proposed change as the appeal process for contract terminations will change.

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

The OHCA will benefit from the proposed rule as the change will allow for a more streamlined and efficient appeals process and alleviate administrative burden on agency staff. The proposed change will also improve quality 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:

A provider whose contract is terminated through grievance procedures and process could face an economic impact to their business.

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:

Agency staff has determined that the proposed rule 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 adverse economic impact on small businesses as a result of this 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 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. Opportunities for public input are provided throughout the rulemaking process, in addition to formal public comment periods and tribal consultations.

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

The proposed change creates a more streamlined and efficient process to the appeals process. Therefore, 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 11, 2015. This rule impact statement was modified on January 22, 2016.

RULE TEXT

TITLE 317: OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 2. GRIEVANCE PROCEDURES AND PROCESS

317:2-1-12. ~~For Cause provider contract suspension/termination appeals process~~For Cause and Immediate provider contract termination appeals process

This ~~Section~~section explains the appeals process for providers whose SoonerCare contracts have been ~~suspended/~~terminated by the OHCA for cause. ~~Those providers whose contracts have been affected by other OHCA actions cannot request an appeal of those measures. Contracts terminated or suspended for cause are either timed terminations (30, 60, or 90 day) or immediate terminations/suspensions. Paragraphs (1) and (2) apply to timed terminations/suspensions and paragraph (3) applies to immediate terminations.~~

(1) **~~Procedure for suspending/terminating provider's contract.~~30 day for cause termination.** Pursuant to the terms of all provider contracts with the OHCA, either party may terminate the contract for cause with a 30 day written notice to the other party.

(A) **Notice of proposed ~~suspension or~~ termination.** The OHCA will provide notice to the ~~medical services~~ provider of the proposed ~~suspension or~~ termination of ~~provider~~the provider's contract. The written notice of ~~suspension/~~termination will state:

(i) the reasons for the proposed ~~suspension/~~termination;

(ii) the date upon which the ~~suspension/~~termination will be effective; and

(iii) a statement that the ~~medical services~~ provider has a right to OHCA review prior to the ~~suspension/~~termination of the provider's contract (~~refer to subparagraph (B) of this paragraph~~).

(B) **Right to OHCA review prior to ~~suspension/~~termination of provider contract.** Before the ~~medical services~~ provider's contract is ~~suspended or~~ terminated, the OHCA will give the ~~medical services~~ provider the opportunity to submit documents and written arguments against the ~~suspension/~~termination of the provider's contract. The provider's written response requesting a review must be submitted within 20 days from the date of the notice. If a written response is not received within 20 days, the notice of termination will become final and there will be no further right to review or appeal post-termination.

(C) **Notice of ~~suspension or~~ termination.**

(i) ~~After the review of the medical services provider's written response, the OHCA will make a final~~

~~administrative decision subject to a post-suspension or termination hearing.~~After the OHCA review of the provider's written response, the OHCA will make a final administrative decision regarding the contract termination.

(ii) ~~After the review of the medical services provider's written response, the OHCA will make a final administrative decision subject to a post-sanction hearing.~~ Should the OHCA decide ~~not to suspend or terminate~~that the provider's contract should not be terminated, the ~~medical services~~ provider will be notified in writing of the reasons for the OHCA's decision.

(iii) Should the OHCA make a decision to ~~suspend or~~ terminate the ~~medical services~~ provider's contract, the OHCA will send a subsequent notice stating:

(I) the reasons for the decision;

(II) the effective date of the ~~suspension or~~ termination of the contract; and

~~(III) the medical services provider's right to request a post-suspension or termination hearing; and~~

(III) the provider's right to request a post termination panel committee desk review within 20 days of the date of the termination letter.

~~(IV) the requirements and procedures for reinstatement.~~

~~(2) **Post-suspension/termination hearing.** After the effective date of the suspension or termination of the provider's contract, the medical services provider is entitled to receive a post-suspension or termination hearing. The hearing committee for the OHCA will be comprised of three members of the OHCA and two other members as appointed. The representative who investigated the case will not be a representative if an investigation was initiated or completed.~~

~~(A) After the provider's request for the post-suspension/termination hearing is made, a hearing date will be established. A certified letter will be sent to the provider giving notification of the hearing date and naming the contact person. The contact person will answer procedural questions about the hearing.~~

~~(B) Ten days prior to the hearing, the medical services provider will submit a brief written statement detailing the evidence which will be presented by the provider at the hearing. Such statement must detail the facts which will be refuted by the provider. The purpose of the hearing will be limited to issues raised in the letter of~~

~~suspension or termination as the cause of suspending or terminating the provider contract.~~

~~(C) The provider may be represented by an authorized representative, with documentation to that effect, at the informal hearing and/or the provider may present testimony himself or herself and have witnesses present.~~

~~(D) At the conclusion of the hearing, a decision will be made by the Hearing Committee. The provider will be notified in writing of the decision within 20 days of the final day of the hearing. The decision letter will constitute the agency's final decision regarding the matter.~~

~~(3) **Notice of immediate suspension or termination.** The process below will be followed in the event of an immediate suspension or termination:~~

~~(A) A notice described in paragraph (1)(A) will be sent to the provider, except there is no right to review prior to an immediate termination or suspension.~~

~~(B) A post suspension termination review will be conducted in accordance with paragraph (2) above.~~

(2) **Immediate termination.** The OHCA will provide notice to the provider of the termination of the provider's contract. The written notice of termination will state:

(A) the reasons for the proposed termination;

(B) the date upon which the termination will be effective; and

(C) a statement that the provider has a right to appeal the termination of the provider's contract in a post-termination panel committee desk review within 20 days of the date of the termination letter.

(3) **Post-termination panel committee desk review**. After the effective date of the termination of the provider's contract, the provider is entitled to receive a post-termination panel committee desk review. The panel review committee for the OHCA will be comprised of three (3) employees of the OHCA as designated by the Chief Executive Officer or his/her designee. Any OHCA employee who was involved with the underlying investigation of the provider's case for purpose of the termination will not be a panel review committee member. The purpose and scope of the panel committee desk review will be limited to issues raised in the OHCA's letter of termination as the basis of terminating the provider's contract. The panel committee does not have jurisdiction to hear issues not addressed in the termination notice.

(A) The provider must request a panel committee desk review within 20 days of the date of the termination letter. The provider must submit a brief written statement

detailing the facts which are refuted by the provider. Any documentation the provider requests consideration of by the panel review committee must also be submitted with the written statement.

(B) The OHCA may submit any additional documents to the panel committee for the desk review that may contradict the documents submitted by the provider for the purposes of the desk review. Any additional information that OHCA submits to the panel review committee will also be provided to the provider.

(C) The panel review committee will issue a written decision regarding the provider's contract termination approximately 60 days from receipt of the provider's written statement and documentation.

(4) 60 day without cause termination. Pursuant to the terms of all provider contracts with the OHCA, either party may terminate the contract without cause with a 60 day written notice to the other party. As such, there is no right to appeal or review of a 60 day contract termination.

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: February 16, 2016

The proposed policy is a Permanent Rule. This proposal is scheduled to be presented to the Medical Advisory Committee (MAC) on March 10, 2016 and the (OHCA) Board of Directors on March 24, 2016.
Reference: APA WF 15-62

SUMMARY:
Proposed policy revisions clarify nurse staffing ratio, 24 hour nursing care requirements and outline supervisions requirements for psychiatric facilities. In addition, revisions clarify that any unit that does not allow clear line of site due to presence of walls or doors is a separate unit. Additionally, revisions include adding a requirement that admission assessments for inpatient psychiatric care both acute and residential levels must be completed by a Licensed Behavioral Health Professionals (LBHP) or candidate for licensure.

LEGAL AUTHORITY
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; Title 43A Mental Health Law; Behavioral Practitioner Act, Section 1930 of Title 59 of Oklahoma Statutes; 42 CFR 412.27;

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

TO: Tywanda Cox
Health Policy

FROM: Tatiana Reed
Health Policy

SUBJECT: Rule Impact Statement
APA WF #15-62

A. Brief description of the purpose of the rule:

Proposed policy revisions clarify nurse staffing ratio, 24 hour nursing care requirements and outline supervisions requirements for psychiatric facilities. In addition, revisions clarify that any unit that does not allow clear line of site due to presence of walls or doors is a separate unit. Additionally, revisions include adding a requirement that admission assessments for inpatient psychiatric care both acute and residential levels must be completed by a Licensed Behavioral Health Professionals (LBHP) or candidate for licensure.

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:

Inpatient psychiatric facility providers rendering services may be impacted by this rule change.

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

SoonerCare members may benefit from this rule change as it ensures patient safety and improves quality 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 could be an economic impact for inpatient providers who do not have enough staff for their units if there is not clear line of sight or if they do not have the appropriate level staff (LBHP) to do the admission assessments.

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 Agency has determined that there are no probable net costs to OHCA or other agencies expected as a result of the proposed rules nor is there an anticipated effect on State revenues.

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:

The Agency has determined that there is no potential adverse effect on small business as a result of the proposed rule change.

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. As a result to audit findings, it was discovered in some facilities admission assessments were performed by a non-certified/licensed professional. In order to ensure quality of care for SoonerCare members, the Service Quality Review Team expressed that an LBHP or candidate for licensure should perform these assessments. Per the Licensed Behavioral Practitioner Act, LBHP or candidate for licensure are able to provide admission assessment services.

The addition for RN staffing requirements allows staff to meet SoonerCare program needs. This policy change will maintain consistency with OSDH hospital standards for staffing as well as the federal requirements for Conditions of Participation and Special staff requirements for psychiatric hospitals.

The Current rule states that a unit is determined by separate and distinct sleeping, living, and treatment areas often separated by walls and/or doors. Per BH Staff, they received a lot of questions of uncertainty from the provider community about if their particular unit was considered a unit in accordance to OHCA policy. The request to add clarification that any unit that does not allow clear line of site due to the presence of walls or doors is a separate unit will hold the providers responsible for what their unit should look like in order to adequately assure patient safety for SoonerCare members.

In accordance to 42 CFR 412.27 psychiatric units must ensure the availability of a registered nurse 24 hours each day. There must be adequate numbers of registered nurses, licensed practical nurses, and mental health workers to provide the nursing care necessary under each inpatient's active treatment program.

Also, research and findings illustrate that Florida policy 65E-9.007 states the nursing staff to child ratio shall be no less than 1:30, and during normal sleeping hours, the nursing staff to child ratio shall be no less than 1:40. OHCA policy reference staffing ratio but not nurse to staffing ratio. This policy change will ensure patient safety and quality of care for SoonerCare members.

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. The proposed rule may have a positive impact on public health, safety and environment for soonercare members in terms of quality of care with staffing of units.

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

The Agency has determined that the proposed rules will have no detrimental effect on the public health, safety and environment if they are not implemented. However, if not

implemented the potential detrimental effect to soonercare members if not assessed by LBHP is perhaps not being admitted appropriately.

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

The rule impact statement was prepared December 18, 2015.
The rule impact statement was modified January 22, 2016.

TEXT

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

Part 6. INPATIENT PSYCHIATRIC HOSPITALS

317:30-5-95.24. Prior Authorization of inpatient psychiatric services for children

(a) All inpatient psychiatric services for members under 21 years of age must be prior authorized by the OHCA or its designated agent. All inpatient acute and residential psychiatric services will be prior authorized for an approved length of stay. Admission assessments for both acute and residential settings must be completed by an LBHP or candidate for licensure. Additional information will be required for a SoonerCare compensable approval on enhanced treatment units or in special population programs.

(b) Staffing ratios shall always be present for each individual unit not by facility or program. Patients shall be grouped for accommodation by gender, age, and treatment needs. At a minimum, children, adolescent, and adult treatment programs shall be separate with distinct units for each population. A unit is determined by separate and distinct sleeping, living, and treatment areas often separated by walls and/or doors. A unit that does not allow clear line of site due to the presence of walls or doors is considered a separate unit. Each individual unit shall have assigned staff to allow for appropriate and safe monitoring of patients and to provide active treatment.

(c) In an acute care setting, at least one Registered Nurse (RN) must be on duty per unit at all times, with additional RNs to meet program needs. RNs must adhere to Oklahoma Department of Health policy at OAC 310:667-15-3 and OAC 310:667-33-2(a)(3).

~~(c)~~(d) Regular residential treatment programs require a staffing ratio of 1:6 during routine waking hours and 1:8 during time

residents are asleep with 24 hour nursing care supervised by an RN for management of behaviors and medical complications. At a minimum, the supervising RN must be available by phone and on-site within one hour. Minimum requirements for 24 hour nursing care include on-site coverage by Licensed Practical Nurses (LPN) with a ratio of 1:30 during routine waking hours and 1:40 during time residents are asleep.

~~(d)~~(e) Specialty residential treatment at this level is a longer term treatment that requires a higher staff to member ratio because of the need for constant, intense, and immediate reinforcement of new behaviors to develop an understanding of the behaviors. The environment of specialized residential treatment centers requires special structure and configuration (e.g., sensory centers for autistic members) and specialized training for the staff in the area of the identified specialty. The physician will see the child at least one time a week.

~~(e)~~(f) A PRTF will not be considered a specialty treatment program for SoonerCare without prior approval of the OHCA behavioral health unit.

~~(f)~~(g) A treatment program that has been approved as a specialized treatment program must maintain medical records that document the degree and intensity of the psychiatric care delivered to the children.

~~(g)~~(h) Criteria for classification as a specialized PRTF will require a staffing ratio of 1:3 at a minimum during routine waking hours and 1:6 during time residents are asleep with 24 hour nursing care supervised by a RN for management of behaviors and medical complications. The PRTF will be a secure unit, due to the complexity of needs and safety considerations. Admissions will be restricted to children that meet the medical necessity criteria for RTC and also meet at least two or more of the following:

(1) Have failed at other levels of care or have not been accepted at other levels of care;

(2) Behavioral, emotional, and cognitive problems requiring secure residential treatment that includes 1:1, 1:2, or 1:3 staffing due to the member being a danger to themselves and others, for impairments in socialization problems, communication problems, and restricted, repetitive and stereotyped behaviors. These symptoms are severe and intrusive enough that management and treatment in a less restrictive environment places the child and others in danger but, do not meet acute medical necessity criteria. These symptoms which are exhibited across multiple environments must include at least two or more of the following:

(A) Marked impairments in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body

postures, and gestures to regulate social interaction;
(B) Inability to regulate impulse control with frequent displays of aggression or other dangerous behavior toward self and/or others regularly;
(C) Failure to develop peer relationships appropriate to developmental level;
(D) Lack of spontaneously seeking to share enjoyment, interests, or achievements with other people;
(E) Lack of social or emotional reciprocity;
(F) Lack of attachment to caretakers;
(G) Require a higher level of assistance with activities of daily living requiring multiple verbal cues 50 percent of the time to complete tasks;
(H) Delay, or total lack of, the development of spoken language which is not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime;
(I) Marked impairment in individuals with adequate speech in the ability to initiate or sustain a conversation with others;
(J) Stereotyped and repetitive use of language or idiosyncratic language;
(K) Lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level;
(L) Encompassing preoccupation with one or more stereotyped and restricted pattern and interest that is abnormal in intensity of focus;
(M) Inflexible adherence to specific, nonfunctional routines or rituals;
(N) Stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting or complex whole body movements);
(O) Persistent occupation with parts of objects;

(3) Member is medically stable, but has co-morbid medical conditions which require specialized medical care during treatment;

(4) Full scale IQ below 40 (profound mental retardation intellectual disability).

(h) Non-authorized inpatient psychiatric services will not be SoonerCare compensable.

(i) The designated agent will prior authorize all services for an approved length of stay based on the medical necessity criteria described in OAC 317:30-5-95.25 through 317:30-5-95.31.

(j) Out of state placements must be approved by the agent designated by the OHCA and subsequently approved by the OHCA, Medical Services Behavioral Health Division. Requests for admission to Psychiatric Residential Treatment Facilities or

acute care units will be reviewed for consideration of level of care, availability, suitability, and proximity of suitable services. A prime consideration for placements will be proximity to the family or guardian in order to involve the family or guardian in Active Treatment, including discharge and reintegration planning. Out of state facilities are responsible for insuring appropriate medical care as needed under SoonerCare provisions as part of the per-diem rate.

(k) Inpatient psychiatric services in all acute hospitals and psychiatric residential treatment facilities are limited to the approved length of stay. OHCA, or its designated agent, will approve lengths of stay using the current OHCA Behavioral Health medical necessity criteria as described in OAC 317:30-5-95.25 through OAC 317:30-5-95.31. The approved length of stay applies to both hospital and physician services. The Child and Adolescent Level of Care Utilization System (CALOCUS®) is a level of care assessment that will be used as a tool to determine the most appropriate level of care treatment for a member by LBHPs in the community.

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: February 16, 2016

The proposed policy is a Permanent Rule. This proposal is scheduled to be presented to the Medical Advisory Committee (MAC) on March 10, 2016 and the (OHCA) Board of Directors on March 24, 2016.
Reference: APA WF 15-65

SUMMARY:
Behavioral Health Admission Assessment and Evaluations – Proposed policy revisions clarify that candidates for licensure can perform assessments and psychosocial evaluations when appropriate and medically necessary. In addition revisions clarify evaluation and re-evaluation criteria.

LEGAL AUTHORITY
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; Title 43A Mental Health Law; Behavioral Practitioner Act, Section 1930 of Title 59 of Oklahoma Statutes

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

TO: Tywanda Cox
Health Policy

FROM: Tatiana Reed
Health Policy

SUBJECT: Rule Impact Statement
APA WF # 15-65

A. Brief description of the purpose of the rule:

Proposed policy revisions to clarify that candidates for licensure can perform assessments and psychosocial

evaluations when appropriate and medically necessary. In addition, revisions clarify that for existing evaluations of 30 days or less used when a member changes provider or level of care, the evaluation(s) must be reviewed, updated as necessary and signed and dated by the appropriate level of professional.

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:

Inpatient psychiatric facility providers who render assessment and psychosocial evaluation services will be affected by this rule.

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

Candidates for licensure under the supervision of a Licensed Behavioral Health Professional (LBHP) may benefit from this rule change as they are able to render assessment and psychosocial evaluation 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 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 16, 2015.
The rule impact statement was modified January 21, 2016.

Text

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 6. INPATIENT PSYCHIATRIC HOSPITAL

317:30-5-95.35. Credentialing requirements for treatment team members for children

(a) The team developing the individual plan of care for the child must include, at a minimum, the following:

(1) Allopathic or Osteopathic Physician with a current license and a board certification/eligible in psychiatry, or a current resident in psychiatry practicing as described in OAC 317:30-5-2(a)(1)(U), and

(2) a behavioral health professional licensed to practice by one of the following boards: Psychology (health service specialty only); Social Work (clinical specialty only); Licensed Professional Counselor, Licensed Behavioral Practitioner; Licensed Alcohol and Drug Counselor (LADC), (or) Licensed Marital and Family Therapist or 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 the services are provided), and

(3) a registered nurse with a minimum of two years of experience in a mental health treatment setting.

(b) Candidates for licensure for Licensed Professional Counselor, Social Work (clinical specialty only), Licensed Marital and Family Therapist, Licensed Behavioral Practitioner, Licensed Alcohol and Drug Counselor and Psychology (health services specialty only) can provide assessments, psychosocial evaluations, individual therapy, family therapy and process group therapy as long as they are involved in the supervision that complies with their respective approved licensing regulations and the Department of Health and their work must be co-signed and dated by a licensed LBHP who is additionally a member on the treatment team. Individuals who have met their supervision requirements and are waiting to be licensed by one of the licensing boards in OAC 317:30-5-95.35(a)(1) must have their work co-signed by a licensed MHP who is additionally a member on the treatment team. All co-signatures by fully licensed LBHPs must be accompanied by the date that the co-

signature was made. Documentation of the service is not considered complete until it is signed and dated by a fully licensed LBHP.
(c) Services provided by treatment team members not meeting the above credentialing requirements are not SoonerCare compensable and can not be billed to the SoonerCare member.

317:30-5-95.37. Medical, psychiatric and social evaluations for inpatient services for children

The member's medical record must contain complete medical, psychiatric and social evaluations.

(1) These evaluations are considered critical documents to the integrity of care and treatment and must be completed as follows:

(A) History and physical evaluation must be completed within 24 hours of admission by a licensed independent practitioner (M.D., D.O., A.P.N., or P.A.) and within 7 days in a CBT.

(B) Psychiatric evaluation must be completed within 60 hours of admission by an allopathic or osteopathic physician with a current license and a board certification/eligible in psychiatry and within 7 calendar days in a CBT.

(C) Psychosocial evaluation must be completed within 72 hours of an acute admission, within seven calendar days of admission to a PRTF and within 7 calendar days in a CBT by a licensed independent practitioner (M.D., D.O., A.P.N., or P.A.), a licensed behavioral health professional (LBHP), or Licensure Candidate as defined in OAC 317:30-5-240.3.

(2) Each of the evaluations must be clearly identified as such and must be signed and dated by the evaluators.

(3) Each of the evaluations must be completed when the member changes levels of care if the existing evaluation is more than 30 calendar days from admission. For continued stays at the same level of care, evaluations remain current for 12 months from the date of admission and must be updated annually within seven calendar days of that anniversary date.

(4) Existing evaluations of 30 days or less may be used when a member changes provider or level of care. The evaluation(s) must be reviewed, updated as necessary and signed and dated by the appropriate level of professional as defined by the type of evaluation.

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: February 16, 2015

The proposed policy is a Permanent Rule. This proposal is scheduled to be presented to the Medical Advisory Committee (MAC) on March 10, 2016 and the (OHCA) Board of Directors on March 24, 2016.
Reference: APA WF 15-66

SUMMARY:
The proposed rule revisions will allow active military personnel who applied for Home and Community-Based Services (HCBS) in another state to have the application date honored in the state of Oklahoma.

LEGAL AUTHORITY
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; Senate Bill 293; Section 162 and 166.2 of Title 52 of the Oklahoma Statues

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

TO: Tywanda Cox
Health Policy

FROM: Ray Hester, Programs Manager II
Developmental Disabilities Services

SUBJECT: Rule Impact Statement
APA WF # 15-66

A. Brief description of the purpose of the rule:

To comply with Senate Bill 293 the proposed rule amendment will allow active military personnel who applied for Home and Community-Based Services (HCBS) in another state to have the application date honored in the state of Oklahoma. Proposed revisions include language clean up.

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 that will be affected by this rule are members whom receive Developmental Disabilities Services. There will be no cost impacts associated with the implementation of this rule change as the change only addresses the DHS application date process.

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

SoonerCare members who receive Developmental Disabilities Services will benefit from 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 will be no probable economic impact or any fee changes for members who receive Developmental Disabilities Services. This proposed rule addresses the Department of Human Services application date process only.

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:

There are no probable costs associated with the enforcement 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 does not have an economic impact on any political subdivision or require cooperation from anyone regarding implementation or enforcement of 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:

The Department of Human Services 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 proposed rule will not increase 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 will not have any effect on public health, safety and environment as it is only addresses the DHS application date process.

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

DHS does not believe there is a detrimental effect on the public health and safety if the rule is not passed. The passing of this rule will guarantee compliance with Senate Bill 293.

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

Prepared date: December 15, 2015
Modified date: January 29, 2016

RULE TEXT:

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 40. DEVELOPMENTAL DISABILITIES SERVICES

SUBCHAPTER 1. GENERAL PROVISIONS

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

(a) **Applicability.** The rules in this Section apply to services funded through Medicaid HCBS Waivers per Oklahoma Administrative

Code (OAC) 317:35-9-5 and per Section 1915(c) of the Social Security Act. The specific ~~waivers~~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 an HCBS Waiver and his or her family or guardian are responsible for:

(1) accessing, with the assistance of ~~OKDHS~~the Oklahoma Department of Human Services (DHS) 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;

(3) choosing between services provided through ~~a~~an HCBS Waiver and institutional care; and

(4) reporting to DHS within 30 calendar days of moving any changes in address or other contact information.

(c) **Waiver ~~Eligibility~~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 (1)(A),(B), or (C) of this Subsection.

(1) Services provided through an 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 (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 per Section 1-819 of Title 63 of the Oklahoma Statutes (63 O.S. § 1-819), or Intermediate Care facility for individuals with intellectual disabilities (ICF/IID). The individual may not be receiving Developmental Disabilities Services (DDS) state-funded services, such as the Family Support Assistance Payment, Respite Voucher Program, sheltered workshop services, community integrated employment services, or assisted living without ~~waiver~~Waiver supports per OAC 340:100-5-22.2. The individual must also meet other Waiver-specific eligibility criteria.

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

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

(ii) be determined to have a disability and a diagnosis of

intellectual disability by the Social Security Administration (SSA); or

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

(iv) be ~~three~~3 years of age or older;

(v) be determined by the OHCA/LOCEU to meet the ICF/IID 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) a DHS Child Welfare ~~Service~~Services (CWS) foster home or shelter; or

(IV) a CWS group home; and

(vii) have critical support needs that can be met through a combination of non-paid, non-Waiver, and SoonerCare resources available to the individual, and with HCBS Waiver resources 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 listed in (c) of this Section;

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

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

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

(v) be ~~three~~3 years of age or older; and

(vi) be determined by the OHCA/LOCEU, to meet the ICF/IID 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 DDS 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 listed in (c) of this Section; and
(iii) be determined to have a disability and a diagnosis of intellectual disability by SSA; or
(iv) have an intellectual disability as defined in the Diagnostic and Statistical Manual of Mental Disorders or a related condition per OAC 317:35-9-45 by DDS, and to be covered under the State's alternative disposition plan adopted under Section 1919(e)(7)(E) of the Social Security Act; or
(v) have a disability as defined in the Diagnostic and Statistical Manual of Mental Disorders by the OHCA/LOCEU; and
(vi) meet ICF/IID 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 (a) of this Section participates in diagnostic evaluations and provides information necessary to determine HCBS Waiver services eligibility, including:

(A) a psychological evaluation, by a licensed psychologist that includes:
(i) a ~~full scale~~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~~full-scale, intelligence quotient.
(I)Intelligence testing results obtained at 16 years of age or older are considered valid of the current status, provided they are compatible with current behavior. Intelligence testing results obtained between 7 to 16 years of age are considered current for four years when the full scale intelligence quotient is less than 40, and for two years when the intelligence quotient is 40 or above.
(II) DDS may require a current psychological evaluation when a significant change of condition, disability, or psychological status is noted;

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

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

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

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

(3) OHCA reviews the diagnostic reports listed in (2) of this

subsection and makes a determination of eligibility for DDS HCBS Waivers.

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

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

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

(1) The Request for Waiver Services List is maintained in chronological order, based on the date of receipt of a written request for services on Form 06MP001E, Request for Developmental Disabilities Services. The applicant must submit the required documentation per Form 06MP001E, Request for Developmental Disabilities Services for initial consideration of potential eligibility. Active United States Armed Forces personnel, who have a pending HCBS Waiver application in another state for an immediate family member, may be placed on the list in accordance with the date they applied in the other state. The person's name is added to the list when they provide proof of application date from the other state.

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

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

(A) is found to be ineligible for services;

(B) cannot be located by DHS;

(C) fails to respond or does not provide requested information to DHS;

(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.

(4) An individual removed from the Request for Waiver Services List due to the inability to locate the individual by DHS, may later submit the DDS a written request to be returned to the Request for Waiver Services List. The individual ~~will be~~is returned at the same chronological place on the Request for Waiver Services List that the individual had prior to removal, provided ~~that~~ the individual was on the list prior to January 1, 2015.

(e) **Applications.** When resources are sufficient for initiation of

HCBS Waiver services, DDS ensures action regarding a request for services occurs within ~~45 calendar~~45-calendar days. When action is not taken within the required ~~45 calendar~~45-calendar days, the applicant may seek resolution per OAC 340:2-5.

(1) Applicants are allowed ~~60 calendar~~60-calendar days to provide information requested by DDS to determine eligibility for services.

(2) When requested information is not provided within ~~60 calendar~~60-calendar days, the applicant is notified that the request was denied, and the individual is removed from the Request for Waiver Services List.

(f) **Admission protocol.** Initiation of services funded through an HCBS Waiver occurs in chronological order from the Request for Waiver Services List ~~in accordance with~~per (d) of this Section based on the date of DDS receipt of a completed request for services, as a result of the informed choice of the person requesting services or the individual acting on the member's behalf, and upon determination of eligibility, ~~in accordance with~~per (c) of this Section. Exceptions to the chronological requirement may be made when:

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

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

(i) the person's caretaker, ~~as defined in Section 10-103 of Title 43A of the Oklahoma Statutes:~~per 43A O.S. § 10-103:

(I) is hospitalized;

(II) 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) DHS finds 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 an HCBS Waiver;

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

(4) individuals subject to the provisions of Public Law 100-203 residing in nursing facilities for at least ~~30 continuous~~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~~per Title 42 Section 483.100 of the Federal Code of Regulations to have an intellectual disability or a related condition, who are covered under the State's alternative disposition plan adopted under Section 1919(e)(7)(E) of the Social Security Act, choose to receive services funded through the Community or Homeward Bound Waiver.

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

(1) When a member receiving services funded through the IHSW for children becomes 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 health and safety support needs that cannot be met by IHSW services, non-Waiver services, or other resources as determined by the DDS director or designee; and

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

(3) Change to services funded through the IHSW from services funded through the Community Waiver may only occur when a member's history of annual service utilization ~~has been~~was within the IHSW 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~~was 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 the level of care per OAC 317:30-5-122 and confirms a diagnosis of intellectual disability ~~as defined in~~per the Diagnostic and Statistical Manual of Mental Disorders. DDS may require a new psychological evaluation and re-determination of eligibility at any time when a significant change of condition, disability, or psychological status ~~has been~~is noted.

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

(1) a member or the individual action on the member's behalf chooses to no longer receive Waiver services;

(2) a member is incarcerated;

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

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

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

(6) a member moves out of state, or the custodial parent or guardian of a member who is a minor moves out of state;

(7) a member is admitted to a nursing facility, ICF/IID, residential care facility, hospital, rehabilitation facility, or mental health facility for more than 30 consecutive calendar days;

(8) the guardian of a member who is a minor or adjudicated adult fails to cooperate during the annual review process per OAC 340:100-5-50 through 340:100-5-58;

(9) the guardian of a member who is a minor or adjudicated adult fails to cooperate in the implementation of DHS 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~~were not ~~been~~ effective;

(10) the member is determined to no longer be SoonerCare eligible; ~~or~~

(11) there is sufficient evidence the member or the individual acting on the member's behalf ~~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) the member or the individual action on the member's behalf either cannot be located, ~~has~~did not ~~responded~~respond to, or ~~has~~did not ~~allowed~~allow case management to complete plan development or monitoring activities as required by policy and the member or the individual action on the member's behalf:

(A) does not respond to the notice of intent to terminate; or

(B) the response prohibits the case manager from being able to complete plan development or monitoring activities as required by policy;

(13) the member or the individual action on the member's behalf fails to cooperate with the case manager to implement a Fair Hearing decision;
(14) it is determined ~~that~~ services provided through an HCBS Waiver are no longer necessary to meet the member's needs and professional documentation provides assurance the member's health, safety, and welfare can be maintained without Waiver supports;
(15) the member or the individual acting on the member's behalf fails to cooperate with service delivery;
(16) a family member, the individual acting on the member's behalf, other individual in the member's household, or persons who routinely visit, pose a threat of harm or injury to provider staff or official DHS representatives; or
(17) a member no longer receives a minimum of one Waiver service per month and DDS 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 calendar~~90-calendar days or less;
(3) a member is admitted to a nursing facility, ICF/IID, residential care facility, hospital, rehabilitation facility, or mental health facility for ~~90 calendar~~ 90-calendar days or less; or
(4) a member's SoonerCare eligibility is re-established within ~~90 calendar~~90-calendar days of the ~~date of~~ SoonerCare ineligibility~~.~~date.