Oklahoma Health Care Authority
MEDICAL ADVISORY COMMITTEE

AGENDA

March 15th, 2018
1:00 PM – 3:30 PM

Charles Ed McFall Board Room

I. Welcome, Roll Call, and Public Comment Instructions: **Chairman, Steven Crawford, M.D.**

II. Action Item: Approval of Minutes of the January 18th, 2018: **Medical Advisory Committee Meeting**

III. Public Comments (2 minute limit)

IV. MAC Member Comments/Discussion

V. Financial Report: **Gloria Hudson, Director of General Accounting**

VI. SoonerCare Operations Update: **Kevin Rupe, Member Services Director**

A. Virtual Visit Presentation: **Brenda Teel, Executive Officer of Revenue with Chickasaw Nation Department of Health**

VII. Legislative Update: **Cate Jeffries, Legislative Liaison**

VIII. Proposed Rule Changes: Presentation, and Discussion: **Sandra Puebla**, **Director of Federal & State Authorities**

A. 17–05A Medical Identification Card Policy Revisions
B. 17–06 Pharmacy Revisions
C. 17–07 School-Based Services Policy Revisions
D. 17–09 Behavioral Health (BH) Assessment and Targeted Case Management Revisions
E. 17–10A Expedited Appeals
F. 17–14 Adult Dental Emergency Extractions
G. 17–16 Accreditation Commission for Health Care (ACHC) Accreditation Option for Outpatient Behavioral Health Agencies
H. 17–19 Inpatient Behavioral Health Revisions
I. 17–21 Income Rounding for Non-disabled Adults and Children Eligibility
J. 17–22A Prior Authorization Policy
K. 17–22B Prior Authorization Policy
L. 17–24A ADvantage Waiver Revisions
M. 17–24B ADvantage Waiver Revisions
N. 17–26 Insure Oklahoma Policy revisions
O. 17–27 Medically Fragile Waiver Revisions
P. 17–30 Focus on Excellence (FOE) Policy Revisions
Q. 17–32 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Periodicity Schedule Policy Revisions

IX. Action Item: Vote on Proposed Rule Changes: **Chairman, Steven Crawford, M.D.**

X. New Business: **Chairman, Steven Crawford, M.D.**

XI. Future Meeting:
May 17th, 2018
July 19th, 2018
September 20th, 2018
November 15th, 2018

XII. Adjourn

Oklahoma Health Care Authority
MEDICAL ADVISORY COMMITTEE
MINUTES of the January 18th, 2018 Meeting
4345 N. Lincoln Blvd., Oklahoma City, OK 73105

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

Chairman Steven Crawford called the meeting to order at 1:00 PM.

***Delegates present were*:** Ms. Renee Banks, Ms. Mary Brinkley, Mr. Victor Clay, Dr. Steve Crawford, Ms. Wanda Felty, Dr. Arlen Foulks, Ms. Terri Fritz, Mr. Steve Goforth, Mr. Mark Jones, Ms. Annette Mays, Dr. Ashley Orynich, Ms. Toni Pratt-Reid, Dr. Edd Rhoades, Dr. Jason Rhynes, Dr. Dwight Sublett, Mr. Rick Snyder, Mr. Jeff Tallent, and Dr. Paul Wright.

Alternates present were: Ms. Sarah Baker, and Ms. Tandie Hastings.

***Delegates absent without an alternate were*:** Dr. Kenneth Calabrese, Dr. Joe Catalano, Mr. Don Flinn, Dr. John Linck, Mr. James Patterson, Dr. J. Daniel Post, Ms. Carrie Slatton-Hodges and Dr. Raymond Smith.

II. Approval of the November 16th, 2017 Minutes

Medical Advisory Committee
The motion to approve the minutes was by Mr. Jeff Tallent and seconded by Dr. Arlen Foulks and passed unanimously.

III. SoonerCare Operations Update:

Melissa McCully, Director of Insure Oklahoma

Ms. McCully presented the SoonerCare Operations Update to the committee. She presented information based on data for November of 2017. Patient Centered Medical Home enrollment is at 538,365 which is 652 less than September. Sooner Care Traditional has a current enrollment of 237,120 which is 2,017 more than September. SoonerPlan is up by 178, giving a total of 32,325. Insure Oklahoma has a total enrollment of 19,587 of which 5,236 are in the Individual Plan and 14,351 are in the Employee Sponsored Plan. In total, SoonerCare enrollment is at 827,397 for November which is an increase of 1,759.

IV. Legislative Update:

Cate Jeffries, Interim Legislative Liaison

Ms. Jeffries provided an update on legislation. January 18th is the bill filing deadline for our next legislative session which will convene February 5th. 2,700 bills were requested and up toward 1,000 bills have already been filed. Currently about 30 of those bills will have a direct impact on OHCA, which will be closely monitored. Last session there was a bill, SB773 which required the Health Care Authority to issue a request for information for Care Coordination models for children in state

custody. We worked with the Department of Mental Health and Substance Abuse Services and also the Department of Human Services to issue that RFI (request for information). We had a total of 8 responses of how certain organizations would tackle that group and provide Care Coordination for them. The report has been submitted to legislators and the governor as required, and there is also a copy available on our website.
We did receive temporary funding for CHIP through a continuing resolution and another continuing resolution is up for a vote in the house today. It does include a six year extension for CHIP.

V. Financial Report:

Carrie Evans, Chief Financial Officer

Ms. Evans presented the financial report ending in November, 2017. OHCA was positive by 2.1 million state dollars. Medicaid program expenditures were over budget for the first time by 6 million, with our administration running under budget. We are worried about the flu as it will significantly impact our budget with incoming claims. We did not include the flu with our budget and in past years, when we had many cases, we did go about 30 million over budget in one month.
Our budget hearing was held on Tuesday, January 16, 2018. We presented to the house and senate for 2019. However, we have many uncertainties for 2018 as we are not fully funded due to the tobacco tax revenue, which puts us 9.5 million short. We are still waiting on funding for CHIP on top of being short the original 22 million in appropriations. We do have a balanced budget on file that accommodates those lost revenues by us postponing two and one half cycles from 2018 into 2019. Our 2019 request is well over One hundred million. If CHIP is reauthorized then our request will be reduced by 67 million. If we also receive the 9.5 million from the cigarette fee then our request will also come down from that.
On December 11, 2017, we received a 31.7 million dollar Federal deferral for the Supplemental Payment Program for medical schools. The feds have decided that they do not want to participate in that program going forward, as well as deferred all payments that were made in the quarter ending in September 30, 2017. They have reduced our grant award by that 31.7 million, which will cause us some cash flow issues. We have sixty days to respond to that deferral, we have contracted with a Washington law firm, Covington and Burling, who is helping us respond. We feel like we have justification for making those payments or we would not have made them. We will continue to approach that angle with the Feds and see if we can't get that deferral to be lifted. If we can't it will go into a disallowance, then we will have more time to continue to debate it and if necessary we will take it to the appeals board where they will make a final decision.
Based on our cash projection, we can operate through the end of February, possibly part of March if we can get an early allocation on our monthly GR.

VI. Proposed Rule Changes:

Tywanda Cox, Chief of Federal and State Policy

There was a mishap with the rules getting out, so in an effort to have ample time to review the proposed rule change, items 17-24A and 17-24B will be pulled, and will be brought back in March.

Face-to-face tribal consultations regarding the following proposed changes were held on Tuesday, September 5, 2017, Tuesday, November 3, 2017 and Tuesday, January 2, 2018 in the Board Room of the Oklahoma Health Care Authority (OHCA).

APA work folder 17-15 was posted on the OHCA public website for a comment period from December 18, 2017 through January 17, 2018. APA work folders 17-17, 17-19, 17-20, 17-23, 17-24 A&B, and 17-25 A&B, were posted on the OHCA public website for a comment period from December 15, 2017 through January 16, 2018. APA work folder 17-28 was posted on the OHCA public website for a comment period from December 12, 2017 through January 11, 2018. APA work folders 17-33 A&B will be posted on the OHCA public website for a comment period through January 25, 2018.

17–15 Student Earned Income Exclusion for Aged, Blind and Disabled (ABD) Applicants — The proposed ABD countable income policy revisions will remove specific amounts for the income disregard of a student's earned income and will refer to the Oklahoma Department of Human Services (OKDHS) Appendix C-1. These amounts are used by OKDHS when determining countable income and eligibility for the ABD category. The Social Security Administration revises the student earned income exclusion yearly. Additionally, the proposed revisions will clarify the definition of student status to ensure that an unintended barrier is not created for the access of SoonerCare services.

Budget Impact: Budget neutral

The rule change motion to approve was by Mr. Jeff Tallent and seconded by Ms. Toni Pratt-Reid and passed unanimously.

17–17 Indian Health Services, Tribal Program and Urban Indian Clinics (I/T/U) Current Procedural Terminology (CPT) Language Removal — The proposed I/T/U policy revisions will remove the restriction to billing with only a CPT procedure code for outpatient behavioral health encounters. Proposed revisions will clarify and allow more flexibility when billing for these types of encounters. Additionally, revisions require that services are billed on an appropriate claim form using the appropriate procedure code and guidelines.

Budget Impact: Services provided to the Native American population are 100% federally funded; therefore, no impact on state revenue is expected.

The rule change motion to approve was by Mr. Jeff Tallent and seconded by Ms. Toni Pratt-Reid and passed unanimously.

17–19 Inpatient Behavioral Health Revisions — The proposed inpatient behavioral health policy will revise definitions and align them with federal regulations. Definitions will be incorporated throughout policy in the Sections in which they are used. In addition, the term "American Osteopathic Accreditation" will be removed as an accrediting body for Psychiatric Residential Treatment Facilities (PRTFs), as it is no longer an accreditation option for this kind of facility. The term "Licensed independent practitioner" will be removed from the rules, and the rules will now specifically explain which types of practitioners can order restraint or seclusion, or perform face-to-face assessments of patients.

Additionally, revisions will align policy with federal regulations regarding the standards of restraint or seclusion for members under the age of 21 receiving inpatient psychiatric services. Rules are revised to assure all general and psychiatric hospitals and PRTFs comply with the condition of participation for restraint or seclusion, as is established in federal regulations.
Budget Impact: Budget neutral
The rule change motion to approve was by Mr. Jeff Tallent and seconded by Ms. Toni Pratt-Reid and passed unanimously.

17–20 Grandfathered Children's Health Insurance Program (CHIP) Children — The proposed revisions will amend the Qualifying Categorical Relationship policy by removing the subsection "Grandfathered CHIP children." The current rule identifies that this eligibility group terminated December 31, 2015 necessitating the removal of this subsection from policy to eliminate any confusion.
Budget Impact: Budget neutral
The rule change motion to approve was by Dr. Dwight Sublett and seconded by Dr. Arlen Foulks and passed unanimously.

17–23 Breast and Cervical Cancer (BCC) Benefit Update — The proposed BCC benefit revisions will comply with federal regulation, which addresses optional eligibility for individuals needing treatment for breast and cervical cancer. In order to align revisions with federal regulation requirements, the references to "women" will be replaced with the terms that are inclusive of both males and females for eligibility purposes. Revisions also include removal of old references to the Oklahoma Department of Human Services (OKDHS) and outdated language regarding creditable coverage in order to reflect current business practices. In addition, the proposed revisions replace the term "OKDHS worker" with the term "eligibility coordinator."
Budget Impact: Agency staff has determined that the impact to expand the scope of BCC benefits will result in an approximately 1.7 percent increase in enrollment equaling an estimated total 12 month cost of $205,898 total dollars, $85,304 state dollars using FFY 2018 FMAP.
The rule change motion to approve was by Dr. Paul Wright and seconded by Ms. Toni Pratt-Reid and passed unanimously.

17–25A Developmental Disabilities Services (DDS) Revisions — The proposed DDS revisions will remove treatment extensions for Habilitation Services authorized by DDS area managers. New qualifications for psychological technicians will be added, which allow for services to be provided under the supervision of a licensed psychologist. Additional revisions will require psychologists to implement the Protective Intervention Protocol (PIP) for the member's individual plan. New billing requirements will not allow psychologists to bill for more than 12 hours (48 units) for PIP preparation. The proposed revisions also request that the authorization period for psychological services be changed from 6 to 12 months. Lastly, revisions will provide a detailed description and new documentation requirements for prevocational services.
Budget Impact: Budget neutral
The rule change motion to approve was by Mr. Mark Jones and seconded by Mr. Jeff Tallent and passed unanimously.

17–25B Developmental Disabilities Services (DDS) Revisions — The proposed DDS revisions will affirm a member's rights to have visitors of his/her choosing and allow eligible members, 16 years of age or older, access to waiver employment services through the Home and Community-Based Services waiver. Finally, revisions add new language to clarify state-funded employment services are available to members of the Homeward Bound class who are not eligible for DDS waiver services.
Budget Impact: Budget neutral
The rule change motion to approve was by Mr. Jeff Tallent and seconded by Ms. Terrie Fritz and passed unanimously.

17–28 Federally Qualified Health Center Services (FQHC) Alternative Payment Methodology (APM) — The proposed policy revisions will introduce a new optional payment methodology for Federally Qualified Health Centers (FQHCs). FQHCs are currently reimbursed through a Prospective Payment System (PPS) methodology; the proposed revision will add the Alternative Payment Methodology (APM) as an optional reimbursement method for FQHCs. In order to align with the methodology change, the FQHC policy will also be updated to reflect the term and definition for APM.
Budget Impact: Budget neutral
The rule change motion to approve was by Dr. Paul Wright and seconded by Ms. Annette Mays and passed unanimously.
Rule change was opposed by Mr. Steve Goforth

17–33 A&B Nursing Home Supplemental Payment Program — The proposed revisions will update and revise the nursing home supplemental payment program for nursing facilities by changing the

methodology for computing the Upper Payment Limit (UPL). Additionally, the proposed revisions will update the care criteria section and eligibility requirements that a nursing facility will be required to meet to participate in the UPL program and receive the UPL payments. Finally, revisions will update some acronyms, definitions and references to other legal authorities.

Budget Impact: There is no cost to the OHCA as the state share will be financed by the NSGO and will be transferred to the state by way of an intergovernmental transfer for claiming of federal financial participation.

The rule change motion to approve was by Ms. Annette Mays and seconded by Mr. Jeff Tallent and passed unanimously.

Comments- Tandie Hastings with Oklahoma Association of Health Care Providers made a request that the calculation go back to quarterly.

Steve Goforth made a motion to have OHCA involve the FQHC stakeholders in 17-33A&B as it goes forward. Motion to approve was seconded by Mr. Jeff Tallent and passed unanimously.

VII. Discussion Item Only:

Tywanda Cox, Chief of Federal and State Policy

A. 1115(a) waiver amendment for supplemental payments for residency training programs and loan repayment

Ms. Cox provided an update that we have been working with our partners at OU, OSU and PMCT to develop a new proposal to submit under our waiver. We did receive an extension of our 1115 waiver from January 1, 2018 through December 31, 2018. The supplemental payments were not included in that approval. So we do not have authority right now under the current approved waiver. We have been working with our partners to develop a proposal to get it approved under this existing waiver. These are programs that reimburse a residency training program, as well as loan repayment. Once we have submitted the proposal CMS has 15 days to deem it as complete or incomplete. If it is complete, they will post it on their website for 30 days for public comment. Once they complete their 30 days comment period then there is a 15 day "cool period", which means they will wait the 15 days to see if there is any written comments. After the 15 days they will move forward with reviewing the waiver and giving us feedback. This part of the process will take about 60 days total.

VIII. New Business: Chairman, Steven Crawford, M.D.

A. Wanda Felty put in a request to receive an update on issues that are voted on by the MAC that don't play out as the agency anticipated.

IX. Future Meeting

March 15th, 2018

X. Adjournment

Dr. Crawford asked for a motion to adjourn. Motion was provided by Ms. Sarah Baker and seconded by Dr. Paul Wright. There was no dissent and the meeting was adjourned at 2:03p.m.

FINANCIAL REPORT

For the Six Months Ended December 31, 2017
Submitted to the CEO & Board

- Revenues for OHCA through December, accounting for receivables, were **$2,071,293,898** or **1.4% under** budget.

- Expenditures for OHCA, accounting for encumbrances, were **$2,042,784,431** or **.4% over** budget.

- The state dollar budget variance through December is a **negative ($22,634,750).** This includes the $31,770,310 Federal Deferral for Graduate Medical Education (GME) payments.

- The budget variance is primarily attributable to the following (in millions):

Expenditures:	
Medicaid Program Variance	2.1
Federal Deferral-GME	(31.8)
Administration	1.1
Revenues:	
Drug Rebate	2.6
Taxes and Fees	3.2
Overpayments/Settlements	.2
Total FY 18 Variance	**$ (22.6)**

ATTACHMENTS

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures: OHCA
SFY 2018, For the Six Month Period Ending December 31, 2017

REVENUES	FY18 Budget YTD	FY18 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 536,876,677	$ 536,876,677	$ -	0.0%
Federal Funds	1,148,166,211	1,107,596,425	(40,569,787)	(3.5)%
Tobacco Tax Collections	24,710,710	27,647,801	2,937,091	11.9%
Quality of Care Collections	39,162,301	39,438,512	276,211	0.7%
Prior Year Carryover	41,749,967	41,749,967	-	0.0%
Federal Deferral - Interest	132,055	132,055	-	0.0%
Drug Rebates	162,548,355	168,895,493	6,347,138	3.9%
Medical Refunds	16,286,366	16,874,639	588,273	3.6%
Supplemental Hospital Offset Payment Program	120,830,665	120,830,665	-	0.0%
Other Revenues	11,229,720	11,251,664	21,945	0.2%
TOTAL REVENUES	**$ 2,101,693,027**	**$ 2,071,293,898**	**$ (30,399,129)**	**(1.4)%**

EXPENDITURES	FY18 Budget YTD	FY18 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 27,946,694**	**$ 25,092,165**	**$ 2,854,529**	**10.2%**
ADMINISTRATION - CONTRACTS	**$ 52,172,758**	**$ 51,770,550**	**$ 402,208**	**0.8%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	22,855,433	21,696,776	1,158,657	5.1%
Acute Fee for Service Payments:				
Hospital Services	451,597,898	451,624,487	(26,589)	(0.0)%
Behavioral Health	10,320,075	10,227,108	92,967	0.9%
Physicians	197,902,372	193,856,728	4,045,644	2.0%
Dentists	63,344,036	63,615,787	(271,751)	(0.4)%
Other Practitioners	27,474,347	26,632,063	842,284	3.1%
Home Health Care	8,598,202	9,197,300	(599,098)	(7.0)%
Lab & Radiology	15,581,857	13,610,690	1,971,167	12.7%
Medical Supplies	24,829,729	24,947,825	(118,096)	(0.5)%
Ambulatory/Clinics	100,424,152	101,967,898	(1,543,746)	(1.5)%
Prescription Drugs	294,435,594	294,706,079	(270,485)	(0.1)%
OHCA Therapeutic Foster Care	6,000	751	5,249	0.0%
Other Payments:				
Nursing Facilities	274,252,665	273,798,146	454,519	0.2%
Intermediate Care Facilities for Individuals with Intellectual Disabilities Private	30,866,524	30,588,176	278,349	0.9%
Medicare Buy-In	86,613,399	87,021,071	(407,673)	(0.5)%
Transportation	32,546,263	32,402,336	143,928	0.4%
Money Follows the Person-OHCA	118,404	147,712	(29,308)	0.0%
Electonic Health Records-Incentive Payments	4,444,924	4,444,924	-	0.0%
Part D Phase-In Contribution	54,432,619	54,950,229	(517,610)	(1.0)%
Supplemental Hospital Offset Payment Program	264,405,703	264,405,703	-	0.0%
Telligen	5,289,780	6,079,928	(790,148)	(14.9)%
Total OHCA Medical Programs	**1,970,339,975**	**1,965,921,716**	**4,418,260**	**0.2%**
OHCA Non-Title XIX Medical Payments	89,382	-	89,382	0.0%
TOTAL OHCA	**$ 2,050,548,809**	**$ 2,042,784,431**	**$ 7,764,379**	**0.4%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ 51,144,217**	**$ 28,509,467**	**$ (22,634,750)**	

OKLAHOMA HEALTH CARE AUTHORITY
Total Medicaid Program Expenditures
by Source of State Funds
SFY 2018, For the Six Month Period Ending December 31, 2017

Category of Service	Total	Health Care Authority	Quality of Care Fund	HEEIA	SHOPP Fund	BCC Revolving Fund	Other State Agencies
SoonerCare Choice	$ 21,761,591	$ 21,690,526	$ -	$ 64,815	$ -	$ 6,250	$ -
Inpatient Acute Care	570,496,440	300,227,701	243,343	1,673,682	199,681,510	400,071	68,270,133
Outpatient Acute Care	204,527,249	149,147,663	20,802	2,194,025	51,579,852	1,584,906	-
Behavioral Health - Inpatient	24,765,152	6,344,513	-	171,517	12,480,047	-	5,769,074
Behavioral Health - Psychiatrist	4,546,889	3,882,595	-	-	664,294	-	-
Behavioral Health - Outpatient	7,558,434	-	-	-	-	-	7,558,434
Behaviorial Health-Health Home	25,531,530	-	-	-	-	-	25,531,530
Behavioral Health Facility- Rehab	118,829,105	-	-	-	-	38,140	118,829,105
Behavioral Health - Case Management	4,562,759	-	-	-	-	-	4,562,759
Behavioral Health - PRTF	27,454,611	-	-	-	-	-	27,454,611
Behavioral Health - CCBHC	25,455,243	-					25,455,243
Residential Behavioral Management	7,435,799	-	-	-	-	-	7,435,799
Targeted Case Management	33,413,341	-	-	-	-	-	33,413,341
Therapeutic Foster Care	751	751	-	-	-	-	-
Physicians	227,631,622	191,736,377	29,050	2,456,475	-	2,091,301	31,318,419
Dentists	63,634,565	63,610,518	-	18,778	-	5,268	-
Mid Level Practitioners	1,204,343	1,195,970	-	7,912	-	461	-
Other Practitioners	25,674,850	25,152,387	223,182	239,218	-	60,063	-
Home Health Care	9,199,922	9,194,377	-	2,622	-	2,923	-
Lab & Radiology	14,002,772	13,510,073	-	392,083	-	100,617	-
Medical Supplies	25,132,243	23,580,464	1,355,766	184,418	-	11,595	-
Clinic Services	103,426,721	98,431,738	-	658,852	-	93,808	4,242,323
Ambulatory Surgery Centers	3,525,746	3,438,580	-	83,394	-	3,773	
Personal Care Services	5,699,247	-	-	-	-	-	5,699,247
Nursing Facilities	273,798,146	166,236,809	107,553,721	-	-	7,616	-
Transportation	32,410,549	31,117,532	1,173,784	60,025	-	59,208	-
GME/IME/DME	93,679,196	-	-	-	-	-	93,679,196
ICF/IID Private	30,588,176	24,933,022	5,655,153	-	-	-	-
ICF/IID Public	7,995,735	-	-	-	-	-	7,995,735
CMS Payments	141,971,300	141,641,063	330,238	-	-	-	-
Prescription Drugs	300,721,176	293,412,089	-	6,015,097	-	1,293,990	-
Miscellaneous Medical Payments	51,811	49,862	-	-	-	1,950	-
Home and Community Based Waiver	98,781,400	-	-	-	-	-	98,781,400
Homeward Bound Waiver	38,339,746	-	-	-	-	-	38,339,746
Money Follows the Person	147,712	147,712	-	-	-	-	-
In-Home Support Waiver	12,223,365	-	-	-	-	-	12,223,365
ADvantage Waiver	84,163,380	-	-	-	-	-	84,163,380
Family Planning/Family Planning Waiver	2,321,153	-	-	-	-	-	2,321,153
Premium Assistance*	28,981,572	-	-	28,981,572	-	-	-
Telligen	6,079,928	6,079,928	-	-	-	-	-
Electronic Health Records Incentive Payments	4,444,924	4,444,924	-	-	-	-	-
Total Medicaid Expenditures	**$ 2,712,170,191**	**$ 1,579,207,171**	**$ 116,585,041**	**$ 43,204,484**	**$ 264,405,703**	**$ 5,761,941**	**$ 703,043,992**

* Includes $28,784,737.79 paid out of Fund 245

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures:
Other State Agencies
SFY 2018, For the Six Month Period Ending December 31, 2017

		FY18 Actual YTD
REVENUE		
Revenues from Other State Agencies	$	313,376,881
Federal Funds		429,779,450
TOTAL REVENUES	**$**	**743,156,331**
EXPENDITURES		**Actual YTD**
Department of Human Services		
Home and Community Based Waiver	$	98,781,400
Money Follows the Person		-
Homeward Bound Waiver		38,339,746
In-Home Support Waivers		12,223,365
ADvantage Waiver		84,163,380
Intermediate Care Facilities for Individuals with Intellectual Disabilities Public		7,995,735
Personal Care		5,699,247
Residential Behavioral Management		4,337,629
Targeted Case Management		29,166,108
Total Department of Human Services		**280,706,609**
State Employees Physician Payment		
Physician Payments		31,318,419
Total State Employees Physician Payment		**31,318,419**
Education Payments		
Graduate Medical Education		50,325,348
Graduate Medical Education - Physicians Manpower Training Commission		4,665,226
Indirect Medical Education		34,013,202
Direct Medical Education		4,675,420
Total Education Payments		**93,679,196**
Office of Juvenile Affairs		
Targeted Case Management		1,139,968
Residential Behavioral Management		3,098,170
Total Office of Juvenile Affairs		**4,238,138**
Department of Mental Health		
Case Management		4,562,759
Inpatient Psychiatric Free-standing		5,769,074
Outpatient		7,558,434
Health Homes		25,531,530
Psychiatric Residential Treatment Facility		27,454,611
Certified Community Behavioral Health Clinics		25,455,243
Rehabilitation Centers		118,829,105
Total Department of Mental Health		**215,160,756**
State Department of Health		
Children's First		575,265
Sooner Start		2,001,836
Early Intervention		2,464,664
Early and Periodic Screening, Diagnosis, and Treatment Clinic		648,623
Family Planning		110,972
Family Planning Waiver		2,192,870
Maternity Clinic		2,226
Total Department of Health		**7,996,456**
County Health Departments		
EPSDT Clinic		364,728
Family Planning Waiver		17,312
Total County Health Departments		**382,040**
State Department of Education		**28**
Public Schools		**67,307**
Medicare DRG Limit		**65,000,000**
Native American Tribal Agreements		**1,224,909**
Department of Corrections		**707,943**
JD McCarty		**2,562,190**
Total OSA Medicaid Programs	**$**	**703,043,992**
OSA Non-Medicaid Programs	**$**	**43,254,875**
Accounts Receivable from OSA	**$**	**3,142,536**

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 205: Supplemental Hospital Offset Payment Program Fund
SFY 2018, For the Six Month Period Ending December 31, 2017

REVENUES		FY 18 Revenue
SHOPP Assessment Fee	$	120,717,805
Federal Draws		156,675,087
Interest		77,092
Penalties		35,768
State Appropriations		(15,100,000)
TOTAL REVENUES	$	262,405,752

EXPENDITURES	Quarter	Quarter		FY 18 Expenditures
Program Costs:	7/1/17 - 9/30/17	10/1/17 - 12/31/17		
Hospital - Inpatient Care	98,870,820	100,810,689	$	199,681,510
Hospital -Outpatient Care	25,537,046	26,042,806		51,579,852
Psychiatric Facilities-Inpatient	7,574,695	4,905,352		12,480,047
Rehabilitation Facilities-Inpatient	328,886	335,409		664,294
Total OHCA Program Costs	132,311,447	132,094,256	$	264,405,703
Total Expenditures			$	264,405,703

CASH BALANCE		(1,999,951)

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 230: Nursing Facility Quality of Care Fund
SFY 2018, For the Six Month Period Ending December 31, 2017

REVENUES	Total Revenue	State Share
Quality of Care Assessment	**$ 39,419,955**	**$ 39,419,955**
Interest Earned	**18,557**	**18,557**
TOTAL REVENUES	**$ 39,438,512**	**$ 39,438,512**

EXPENDITURES	FY 18 Total $ YTD	FY 18 State $ YTD	Total State $ Cost
Program Costs			
Nursing Facility Rate Adjustment	$ 105,706,789	$ 43,075,516	
Eyeglasses and Dentures	135,232	55,107	
Personal Allowance Increase	1,711,700	697,518	
Coverage for Durable Medical Equipment and Supplies	1,355,766	552,475	
Coverage of Qualified Medicare Beneficiary	516,378	210,424	
Part D Phase-In	330,238	134,572	
ICF/IID Rate Adjustment	2,663,229	1,085,266	
Acute Services ICF/IID	2,991,924	1,219,209	
Non-emergency Transportation - Soonerride	1,173,784	478,317	
Total Program Costs	**$ 116,585,041**	**$ 47,508,404**	**$ 47,508,404**
Administration			
OHCA Administration Costs	$ 267,926	$ 133,963	
DHS-Ombudsmen	76,585	76,585	
OSDH-Nursing Facility Inspectors	211,508	211,508	
Mike Fine, CPA	-	-	
Total Administration Costs	**$ 556,019**	**$ 422,056**	**$ 422,056**
Total Quality of Care Fee Costs	**$ 117,141,060**	**$ 47,930,460**	
TOTAL STATE SHARE OF COSTS			**$ 47,930,460**

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

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

Fund 245: Health Employee and Economy Improvement Act Revolving Fund

SFY 2018, For the Six Month Period Ending December 31, 2017

REVENUES	FY 17 Carryover	FY 18 Revenue	Total Revenue
Prior Year Balance	$ 7,673,082	$ -	$ 4,811,312
State Appropriations	(3,000,000)	-	-
Tobacco Tax Collections	-	22,739,665	22,739,665
Interest Income	-	82,990	82,990
Federal Draws	307,956	17,807,052	17,807,052
TOTAL REVENUES	**$ 4,981,038**	**$ 40,629,707**	**$ 45,441,019**

EXPENDITURES		FY 17 Expenditures	FY 18 Expenditures	Total $ YTD
Program Costs:				
	Employer Sponsored Insurance		$ 28,784,738	$ 28,784,738
	College Students/ESI Dental		196,834	80,210
Individual Plan				
	SoonerCare Choice		$ 62,649	$ 25,529
	Inpatient Hospital		1,645,195	670,417
	Outpatient Hospital		2,163,599	881,666
	BH - Inpatient Services-DRG		168,226	68,552
	BH -Psychiatrist		-	-
	Physicians		2,443,477	995,717
	Dentists		17,643	7,190
	Mid Level Practitioner		7,743	3,155
	Other Practitioners		236,012	96,175
	Home Health		2,622	1,069
	Lab and Radiology		384,345	156,621
	Medical Supplies		181,341	73,897
	Clinic Services		645,225	262,929
	Ambulatory Surgery Center		83,394	33,983
	Prescription Drugs		5,922,446	2,413,397
	Transportation		59,289	24,160
	Premiums Collected		-	(305,842)
Total Individual Plan			**$ 14,023,207**	**$ 5,408,614**
	College Students-Service Costs		**$ 199,705**	**$ 81,380**
Total OHCA Program Costs			**$ 43,204,484**	**$ 34,354,942**
Administrative Costs				
	Salaries	$ 40,359	$ 1,087,906	$ 1,128,265
	Operating Costs	25,578	92,202	117,780
	Health Dept-Postponing	-	-	-
	Contract - HP	103,788	407,626	511,414
Total Administrative Costs		**$ 169,725**	**$ 1,587,734**	**$ 1,757,459**
Total Expenditures				**$ 36,112,401**
NET CASH BALANCE		**$ 4,811,312**		**$ 9,328,618**

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

Fund 250: Belle Maxine Hilliard Breast and Cervical Cancer Treatment Revolving Fund

SFY 2018, For the Six Month Period Ending December 31, 2017

REVENUES	FY 18 Revenue	State Share
Tobacco Tax Collections	$ 453,775	$ 453,775
TOTAL REVENUES	**$ 453,775**	**$ 453,775**

EXPENDITURES	FY 18 Total $ YTD	FY 18 State $ YTD	Total State $ Cost
Program Costs			
SoonerCare Choice	$ 6,250	$ 1,783	
Inpatient Hospital	400,071	114,100	
Outpatient Hospital	1,584,906	452,015	
Inpatient Services-DRG	-	-	
Psychiatrist	-	-	
TFC-OHCA	-	-	
Nursing Facility	7,616	2,172	
Physicians	2,091,301	596,439	
Dentists	5,268	1,503	
Mid-level Practitioner	461	131	
Other Practitioners	60,063	17,130	
Home Health	2,923	834	
Lab & Radiology	100,617	28,696	
Medical Supplies	11,595	3,307	
Clinic Services	93,808	26,754	
Ambulatory Surgery Center	3,773	1,076	
Prescription Drugs	1,293,990	369,046	
Transportation	59,208	16,886	
Miscellaneous Medical	1,950	556	
Total OHCA Program Costs	**$ 5,723,800**	**$ 1,632,428**	
OSA DMHSAS Rehab	$ 38,140	$ 10,878	
Total Medicaid Program Costs	**$ 5,761,941**	**$ 1,643,306**	
TOTAL STATE SHARE OF COSTS			**$ 1,643,306**

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

MAC Meeting
March 15, 2018
(December 2017 Data)

SOONERCARE ENROLLMENT/EXPENDITURES

Delivery System			Enrollment December 2017	Children December 2017	Adults December 2017	Enrollment Change	Total Expenditures December	PMPM December 2017	December 2017 Trend PMPM
SoonerCare Choice Patient-Centered Medical Home			**528,165**	**435,424**	**92,741**	**-10,200**	**$143,762,098**		
	Lower Cost	*(Children/Parents; Other)*	483,501	421,170	62,331	-10,348	$102,773,105	$213	$239
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC)*	44,664	14,254	30,410	148	$40,988,993	$918	$1,067
SoonerCare Traditional			**238,754**	**91,241**	**147,513**	**1,634**	**$160,749,755**		
	Lower Cost	*(Children/Parents; Other; Q1; SLMB)*	123,230	86,302	36,928	1,708	$33,910,430	$275	$387
	Higher Cost	*(Aged, Blind or Disabled; LTC; TEFRA; BCC & HCBS Waiver)*	115,524	4,939	110,585	-74	$126,839,325	$1,098	$1,211
SoonerPlan			**30,840**	**2,557**	**28,283**	**-1,485**	**$244,651**	$8	$9
Insure Oklahoma			**19,474**	**490**	**18,984**	**-113**	**$7,159,964**		
	Employer-Sponsored Insurance		14,282	301	13,981	-69	$5,007,012	$351	$352
	Individual Plan		5,192	189	5,003	-44	$2,152,952	$415	$470
TOTAL			**817,233**	**529,712**	**287,521**	**-10,164**	**$311,916,469**		

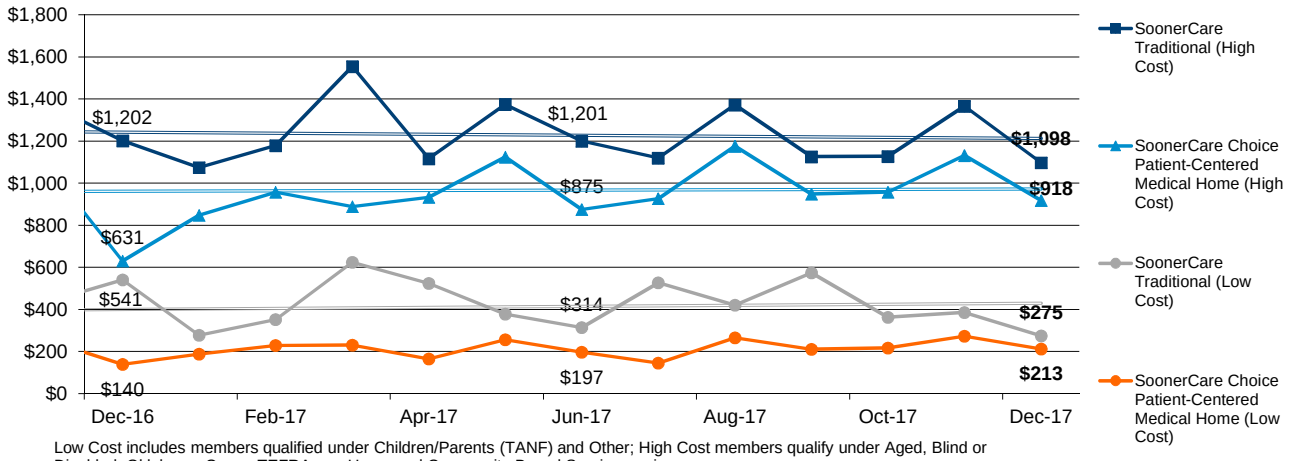
Enrollment totals include all members enrolled during the report month. Members may not have expenditure data. Children are members aged 0 - 20 or for Insure Oklahoma enrolled as Students or Dependents.
Dual Eligibles (Medicare & Medicaid) are in the Traditional delivery system in both the Low Cost (Q1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

Total In-State Providers: 31,399 (-863) **(In-State Providers counted multiple times due to multiple locations, programs, types, and specialties)**

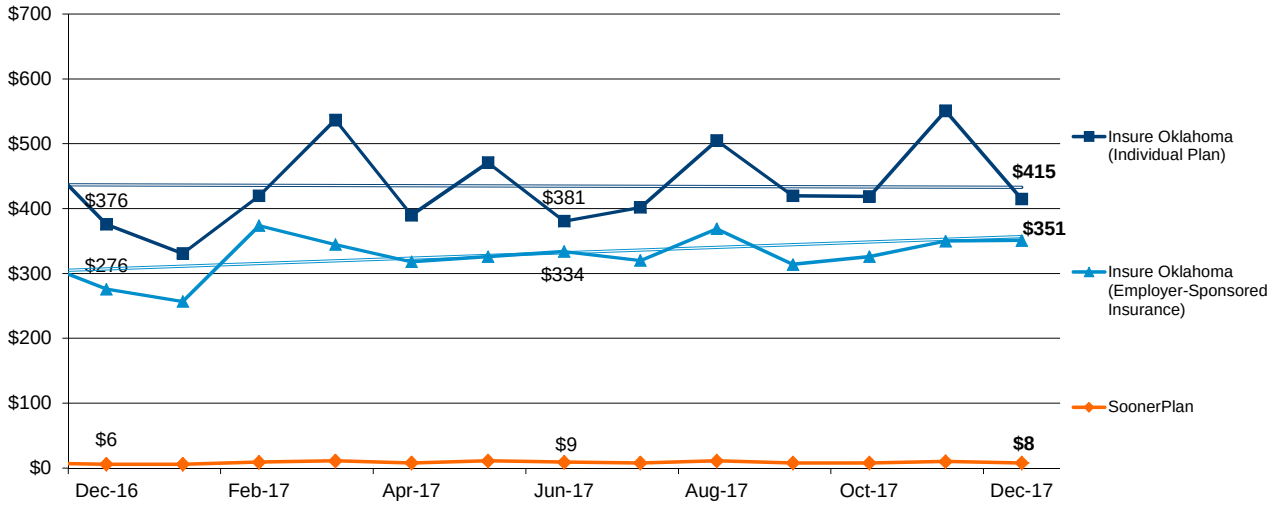
Physician	Pharmacy	Dentist	Hospital	Mental Health	Optometrist	Extended Care	Total PCPs*	PCMH
9,159	982	966	160	3,833	606	391	6,349	2,210

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

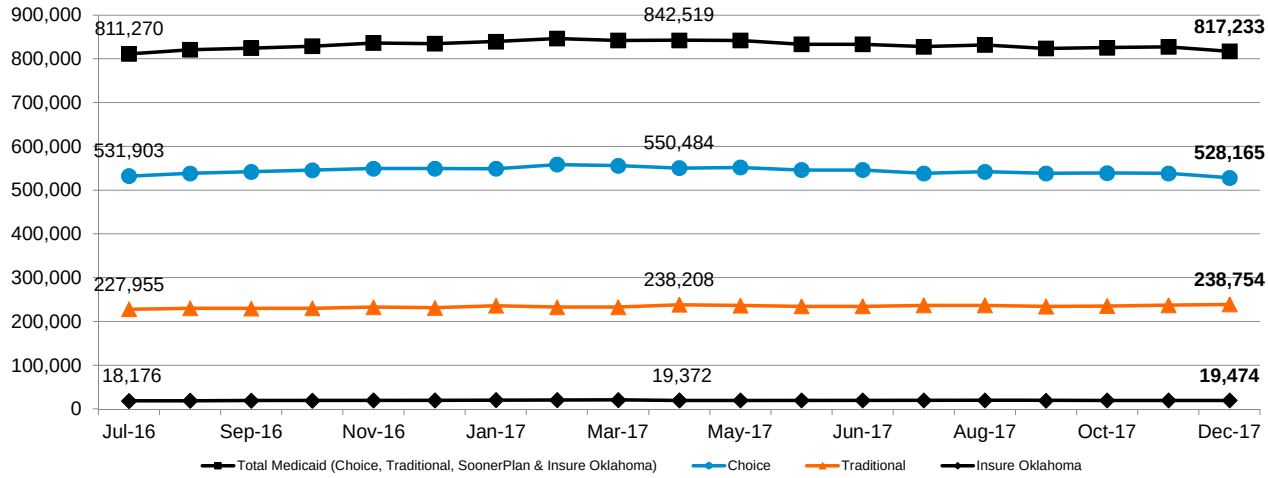
PER MEMBER PER MONTH COST BY GROUP



Low Cost includes members qualified under Children/Parents (TANF) and Other; High Cost members qualify under Aged, Blind or Disabled, Oklahoma Cares, TEFRA or a Home and Community-Based Services waiver.



ENROLLMENT BY MONTH



March MAC
Proposed Rule Amendment Summaries

Face-to-face tribal consultations regarding the following proposed changes were held on Tuesday, November 7, 2017 and Tuesday, January 2, 2018 in the Board Room of the Oklahoma Health Care Authority (OHCA).

APA work folders 17-24 A&B were posted on the OHCA public website for a comment period from December 15, 2017 through January 16, 2018. APA work folders 17-05A, 17-06, 17-07, 17-09, 17-10A, 17-14, 17-16, 17-19, 17-21, 17-22 A&B, 17-26, 17-27, 17-30, and 17-32 were posted on the OHCA public website for a comment period from January 17, 2018 through February 16, 2018.

17–05A Medical Identification Card Policy Revisions — The proposed medical identification card revisions will amend a sentence pertaining to SoonerCare insurance verification by a provider.
Budget Impact: Budget neutral

17–06 Pharmacy Revisions — The proposed pharmacy revisions will clarify eligible provider qualifications for pharmacies. Revisions will outline that pharmacies may be selected for audits; therefore, pharmacy records must be available for seven years. Language regarding Phenylketonuria (PKU) formula and amino acid bars will be stricken as coverage criteria is outlined in another section of policy. Additionally, naloxone for use in opioid overdose will be exempted from the prescription limit. Revisions will also remove coverage for over the counter cough and cold medicine. New rules will require providers to substitute generic medications for brand name medication when the net cost of the brand name is lower than the net cost of the generic medication. Furthermore, language will clarify and outline claim submission and reversals when not picked up by the member within 15 days of the date of service. Finally, revisions will update policy terminology to align with current practice.
Budget Impact: Revisions requiring pharmacy providers to reverse claim submissions after a certain timeframe will result in savings; however until changes are implemented, the agency is unable to project the savings amount. Additional rule changes will not result in a significant budget impact, if any.

17–07 School-Based Services Policy Revisions — The proposed school-based revisions will remove unintended barriers for medical services rendered in the school setting pursuant to an Individual Education Plan (IEP). The proposed revisions will allow an IEP and all relevant supporting documentation (hereinafter, “plan of care”) that meet certain requirements to serve as the prior medical authorization for most medically necessary services that can be provided in a school setting with the exception of personal care services. Personal care services must still receive prior authorization in accordance with the Oklahoma Health Care Authority's (OHCA) federally-approved Medicaid state plan.

Per 42 C.F.R. § 440.110, to obtain federal Medicaid reimbursement, physical therapy, occupational therapy, and services for members with speech, hearing, and language disorders, must be prescribed or referred by a physician or a practitioner of the healing arts. The proposed change will allow a valid plan of care to serve as a prescription or referral for the initial evaluation and any subsequent services for occupational therapy services and services for members with speech, hearing, and language disorders. A valid plan of care will not serve as a prescription or referral for physical therapy services because physical therapists are not considered a practitioner of the healing arts, per state law; a prescription from a physician shall

be required for physical therapy prior to the student's initial evaluation. The OHCA has submitted a request to Attorney General Mike Hunter on this particular state law issue.

Additionally, the revisions update the requirements needed in an IEP and plan of care. The proposed revisions also eliminate the reference to Early and Periodic Screening, Diagnostic and Treatment (EPSDT) where the term is no longer valid. All claims related to school-based services that are submitted to the OHCA for reimbursement must include any numeric identifier obtained from the Oklahoma State Department of Education. The proposed revisions also update eligibility requirements for practitioners who provide services in school-based settings. Finally, the revisions will remove specific references that are no longer applicable, update acronyms and references to other legal authorities, and cleanup some grammatical errors.
Budget Impact: It is estimated that the change will result in a positive impact to the Oklahoma school districts of about $6.5 million, as a result of federal matching funds.

17–09 Behavioral Health (BH) Assessment and Targeted Case Management Revisions — The proposed policy revisions will change requirements for behavioral health assessments by allowing for diagnostic impressions on the assessment, while still requiring a diagnosis on the service plan. Additionally, proposed rules will allow for one client signature that will apply to both the assessment and treatment plan as well as allow a temporary change of service provider to be documented in a progress note for the service provided. These changes will allow for more flexibility in performing an assessment and developing a treatment plan. Other revisions to the behavioral health assessment and treatment plan requirements and targeted case management rules will include minor updates of terminology to keep language consistent throughout OHCA policy.
Budget Impact: Budget neutral

17–10A Expedited Appeals — The proposed revisions will clarify timelines for appeal decisions and add a new section outlining expedited appeals which are required by new regulations in cases when an appellant's life or health could be in jeopardy. The timelines and process for expedited appeals will be outlined in the new section of policy. In addition, language referring to nursing home wage enhancement will be deleted due to changes in state statute that resulted in the policy being obsolete. Finally, revisions will clarify the purpose and other details of the appeal process, as well as, other general language cleanup.
Budget Impact: Budget neutral

17–14 Adult Dental Emergency Extractions — The proposed revisions will add new definitions for emergency extractions, as well as, for images that can accompany an emergency extraction. Additional revisions will update acronyms and correct grammatical and formatting errors.
Budget Impact: Budget neutral

17–16 Accreditation Commission for Health Care (ACHC) Accreditation Option for Outpatient Behavioral Health Agencies — The proposed behavioral health revisions will add the Accreditation Commission for Health Care (ACHC) as an additional accreditation option for outpatient behavioral health agencies. Additionally, proposed revisions will update policy terminology in order to align with current practice.
Budget Impact: Budget neutral

17–19 Inpatient Behavioral Health Revisions — The proposed inpatient behavioral health revisions will require general hospitals and psychiatric hospitals to maintain medical records and other documentation to demonstrate they comply with certification of need for care, plan of care,

and utilization review plans requirements. Psychiatric hospitals will also need to maintain these records to demonstrate they comply with medical evaluation and admission review requirements. Rule revisions will add medical necessity criteria for admission in cases of psychiatric disorders and chemical dependency detoxification for adults. Additionally, rule revisions will specify that the individual plan of care (IPC) must be developed in consultation with the member or others who will care for the member upon discharge. Revisions also describe the team of professionals and credentials required in the IPC development and review. Moreover, revisions will expand certificate of need requirements for PRTFs to mirror federal regulation. Other revisions will include replacing incorrect terminology used to refer to PRTFs and other settings.
Budget Impact: The agency anticipates that the proposed changes that clarify medical necessity criteria for adults from an acute psychiatric admission, will potentially result in approximately $890,000 total; $368,727 state share savings for SFY2018.

17–21 Income Rounding for Non-disabled Adults and Children Eligibility — The proposed policy changes will revise the income policy for how income is computed for non-disabled adults and children to mirror current system computations for income. The online eligibility system rounds cents down to the nearest dollar in its calculations therefore policy will be revised to match. Additionally, revisions will revise multiple sections of policy that paired "Prior to October 1, 2013" policy with "Effective October 1, 2013" policy. The pre-MAGI policy will be removed as it is no longer applicable.
Budget Impact: Budget neutral

17–22A Prior Authorization Policy — The proposed policy changes will revise prior authorization (PA) policy by adding language that clarifies the scope of a section as encompassing all PAs. Proposed revisions will add language about how a provider can obtain information on how and/or where to submit PA requests. Additionally, revisions will update a list of services requiring a PA, but will clarify that the list is not exhaustive and will explain other qualifying factors. Further revisions will add a new section that clarifies that what was previously called preauthorization of emergency medical services for certain aliens is actually retrospective review for payment for emergency medical services to certain aliens. Finally, the last remaining sections in Part 5 of Chapter 30 will be revoked as these sections are covered in other parts of policy.
Budget Impact: Budget neutral

17–22B Prior Authorization Policy — The proposed revisions will remove a section of policy in Chapter 35 because it is more appropriately covered in Chapter 30. Additional revisions will remove language regarding preauthorization of emergency medical services for certain aliens because it will be covered in a new section of policy in Chapter 30.
Budget Impact: Budget neutral

17–24A ADvantage Waiver Revisions — The proposed ADvantage Waiver policy revisions will replace references to the Interactive Voice Response Authentication system with references to the Electronic Visit Verification (EVV) system. The EVV system is the current industry standard for electronic billing and verification software systems. Proposed revisions will provide clarification of the EVV system billing process, which is currently in place for billing of personal care and nursing services in both the ADvantage and State Plan personal care programs. Finally, revisions will ensure that the technological terms used in this policy accurately reflect the advances in electronic billing and verification software systems.
Budget Impact: Budget neutral

17–24B ADvantage Waiver Revisions — The proposed ADvantage Waiver policy revisions will provide information regarding the certification and recertification periods of medical eligibility determination and systems that are used by the nurses in communicating with the Department of Human Services (DHS) county offices. In addition, proposed revisions will add new language outlining the rules and processes for the Ethics of Care Committee for the ADvantage and State Plan personal care programs. Finally, proposed revisions will update obsolete acronyms that are used in existing policy.
Budget Impact: Budget neutral

17–26 Insure Oklahoma Policy Revisions — The proposed Insure Oklahoma policy revisions will remove the definition/term "self-funded" and the "premium payment" section in order to update policy and reflect current business practices. Further revisions will add additional clarification on who is able to determine whether a college student is dependent or independent. Additionally, proposed revisions will update acronyms and correct grammatical and formatting errors.
Budget Impact: Budget neutral

17–27 Medically Fragile Waiver Revisions — The proposed policy revisions will revise the Medically Fragile Waiver policy by providing updates to the overview, services and annual re-evaluation sections of existing policy for general clarification and alignment with the approved waiver; including updating some acronyms used in existing policy. In addition, new language will provide guidelines on when the Uniform Comprehensive Assessment Tool is required to be updated if submitted after 90 days. In order to align revisions with federal regulation requirements, new environmental modifications service guidelines will be added in addition to guidelines on how payments are to be submitted for this service. Further revisions will provide new criteria in determining a member's eligibility for self-directed services. Finally, proposed revisions will include the removal of outdated language relating to program medical eligibility and updating obsolete acronyms.
Budget Impact: Budget neutral

17–30 Focus on Excellence (FOE) Policy Revisions — The proposed revisions will define and describe the eligibility criteria for the Focus on Excellence (FOE) program in policy. Additionally, the proposed revisions will add new language on the quality measure care criteria that a nursing facility must meet to continue status in the FOE program. Finally, the proposed revisions will add new language on the FOE payment and appeals processes.
Budget Impact: Budget neutral

17–32 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Periodicity Schedule Policy Revisions — The proposed revisions will update the EPSDT periodicity schedule recommended for physicians and other practitioners who provide screening services to children. The periodicity schedule recommended will reflect the recommendations by the American Academy of Pediatrics (AAP) and the American Academy of Pediatric Dentistry (AAPD). Additionally, it amends other sections that refer to the old periodicity schedule recommendations and updates the hearing, vision and dental EPSDT sections to align with current industry standards. Finally, revisions will update acronyms and titles, and correct any grammatical mistakes for better flow and understanding.
Budget Impact: Budget neutral

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~~the Oklahoma Health Care Authority (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.

(1) If a member has 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. 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 or use a participating provider is not a sufficient reason for SoonerCare to make payment. If the provider is aware of private insurance or 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.

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 3. GENERAL MEDICAL PROGRAM INFORMATION

317:30-3-57. General SoonerCare coverage - categorically needy

The following are general SoonerCare coverage guidelines for the categorically needy:

(1) Inpatient hospital services other than those provided in an institution for mental diseases.

(A) Adult coverage for inpatient hospital stays as described at OAC 317:30-5-41.

(B) Coverage for members under twenty-one (21) years of age is not limited. All admissions must be medically necessary. All psychiatric admissions require prior authorization for an approved length of stay.

(2) Emergency department services.

(3) Dialysis in an outpatient hospital or free standing dialysis facility.

(4) Outpatient therapeutic radiology or chemotherapy for proven malignancies or opportunistic infections.

(5) Outpatient surgical services - facility payment for selected outpatient surgical procedures to hospitals which have a contract with ~~OHCA~~the Oklahoma Health Care Authority (OHCA).

(6) Outpatient mental health services for medical and remedial care including services provided on an outpatient basis by certified hospital based facilities that are also qualified mental health clinics.

(7) Rural health clinic services and other ambulatory services furnished by rural health clinic.

(8) Optometrists' services - only as listed in Subchapter 5, Part 45, Optometrist specific rules of this Chapter.

(9) Maternity clinic services.

(10) Outpatient diagnostic x-rays and lab services. Other outpatient services provided to adults, not specifically addressed, are covered only when prior authorized by the agency's Medical Authorization Unit.

(11) Medically necessary screening mammography. Additional follow-up mammograms are covered when medically necessary.

(12) Nursing facility services (other than services in an institution for tuberculosis or mental diseases).

(13) Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT) are available for members under twenty-one (21) years of age to provide access to regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of

infants, children, and youth. Federal regulations also require that diagnosis and treatment be provided for conditions identified during a screening whether or not they are covered under the State Plan, as long as federal funds are available for these services. These services must be necessary to ameliorate or correct defects and physical or mental illnesses or conditions and require prior authorization. EPSDT/OHCA Child Health services are outlined in OAC 317:30-3-65.2 through 317:30-3-65.4.

(A) Child health screening examinations for eligible children by a medical or osteopathic physician, physician assistant, or advanced practice nurse practitioner.

(B) Diagnostic x-rays, lab, and/or injections when prescribed by a provider.

(C) Immunizations.

(D) Outpatient care.

(E) Dental services as outlined in OAC 317:30-3-65.8.

(F) Optometrists' services. The EPSDT periodicity schedule provides for at least one (1) visual screening and glasses each twelve (12) months. In addition, payment is made for glasses for children with congenital aphakia or following cataract removal. Interperiodic screenings and glasses at intervals outside the periodicity schedule for optometrists are allowed when a visual condition is suspected. Payment is limited to two (2) glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.

(G) Hearing services as outlined in OAC 317:30-3-65.9.

(H) Prescribed drugs.

(I) Outpatient psychological services as outlined in OAC 317:30-5-275 through 317:30-5-278.

(J) Inpatient ~~Psychotherapy~~psychiatric services ~~and psychological testing~~ as outlined in OAC 317:30-5-95 through ~~OAC~~ 317:30-5-97.

(K) Transportation. Provided when necessary in connection with examination or treatment when not otherwise available.

(L) Inpatient hospital services.

(M) Medical supplies, equipment, appliances and prosthetic devices beyond the normal scope of SoonerCare.

(N) EPSDT services furnished in a qualified child health center.

(14) Family planning services and supplies for members of child-bearing age, including counseling, insertion of intrauterine device, implantation of subdermal contraceptive device, and sterilization for members twenty-one (21) years of age and older who are legally competent, not institutionalized and have signed the "Consent Form" at least thirty (30) days prior to procedure. Reversal of

sterilization procedures for the purposes of conception is not covered. Reversal of sterilization procedures are covered when medically indicated and substantiating documentation is attached to the claim.

(15) Physicians' services whether furnished in the office, the member's home, a hospital, a nursing facility, ~~ICF/IID~~ Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), or elsewhere. For adults, payment is made for compensable hospital days described at OAC 317:30-5-41. Office visits for adults are limited to four (4) per month except when in connection with conditions as specified in OAC 317:30-5-9(b).

(16) Medical care and any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law. See applicable provider section for limitations to covered services for:

(A) Podiatrists' services
(B) Optometrists' services
(C) Psychologists' services
(D) Certified Registered Nurse Anesthetists
(E) Certified Nurse Midwives
(F) Advanced Practice Nurses
(G) Anesthesiologist Assistants

(17) Free-standing ambulatory surgery centers.

(18) Prescribed drugs not to exceed a total of six (6) prescriptions with a limit of two (2) brand name prescriptions per month. Exceptions to the six (6) prescription limit are:

(A) unlimited medically necessary monthly prescriptions for:

(i) members under the age of twenty-one (21) years; and
(ii) residents of nursing facilities or ~~Intermediate Care Facilities for Individuals with Intellectual Disabilities~~ICF/IID.

(B) seven (7) medically necessary generic prescriptions per month in addition to the six (6) covered under the State Plan (including three (3) brand name prescriptions) are allowed for adults receiving services under the 1915(c) Home and Community Based Services Waivers (HCBS). These additional medically necessary prescriptions beyond the three (3) brand name or thirteen (13) total prescriptions are covered with prior authorization.

(19) Rental and/or purchase of durable medical equipment.

(20) Adaptive equipment, when prior authorized, for members residing in private ICF/IID's.

(21) Dental services for members residing in private ICF/IID's in accordance with the scope of dental services for members under age twenty-one (21).

(22) Prosthetic devices limited to catheters and catheter accessories, colostomy and urostomy bags and accessories, tracheostomy accessories, nerve stimulators, hyperalimentation and accessories, home dialysis equipment and supplies, external breast prostheses and support accessories, oxygen/oxygen concentrator equipment and supplies, respirator or ventilator equipment and supplies, and those devices inserted during the course of a surgical procedure.
(23) Standard medical supplies.
(24) Eyeglasses under EPSDT for members under age twenty-one (21). Payment is also made for glasses for children with congenital aphakia or following cataract removal. Payment is limited to two (2) glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.
(25) Blood and blood fractions for members when administered on an outpatient basis.
(26) Inpatient services for members age sixty-five (65) or older in institutions for mental diseases, limited to those members whose Medicare, Part A benefits are exhausted for this particular service and/or those members who are not eligible for Medicare services.
(27) Nursing facility services, limited to members preauthorized and approved by OHCA for such care.
(28) Inpatient psychiatric facility admissions for members under twenty-one (21) are limited to an approved length of stay effective July 1, 1992, with provision for requests for extensions.
(29) Transportation and subsistence (room and board) to and from providers of medical services to meet member's needs (ambulance or bus, etc.), to obtain medical treatment.
(30) Extended services for pregnant women including all pregnancy-related and postpartum services to continue to be provided, as though the women were pregnant, for sixty (60) days after the pregnancy ends, beginning on the last date of pregnancy.
(31) Nursing facility services for members under twenty-one (21) years of age.
(32) Personal care in a member's home, prescribed in accordance with a plan of treatment and rendered by a qualified person under supervision of a ~~R.N.~~Registered Nurse (RN).
(33) Part A deductible and Part B Medicare Coinsurance and/or deductible.
(34) ~~Home and Community Based Waiver Services~~HCBS for the intellectually disabled.
(35) Home health services limited to thirty-six (36) visits per year and standard supplies for one (1) month in a twelve

(12) month period. The visits are limited to any combination of ~~Registered Nurse~~RN and nurse aide visits, not to exceed thirty-six (36) per year.
(36) Medically necessary solid organ and bone marrow/stem cell transplantation services for children and adults are covered services based upon the conditions listed in (A)-(D) of this paragraph:
(A) Transplant procedures, except kidney and cornea, must be prior authorized to be compensable.
(B) To be prior authorized all procedures are reviewed based on appropriate medical criteria.
(C) To be compensable under the SoonerCare program, all transplants must be performed at a facility which meets the requirements contained in Section 1138 of the Social Security Act.
(D) Finally, procedures considered experimental or investigational are not covered.
(37) ~~Home and community-based waiver services~~HCBS for intellectually disabled members who were determined to be inappropriately placed in a nursing facility (Alternative Disposition Plan - ADP).
(38) Case ~~Management~~management services for the chronically and/or severely mentally ill.
(39) Emergency medical services including emergency labor and delivery for illegal or ineligible aliens.
(40) Services delivered in Federally Qualified Health Centers. Payment is made on an encounter basis.
(41) Early ~~Intervention~~intervention services for children ages zero (0) to three (3).
(42) Residential ~~Behavior Management~~behavior management in therapeutic foster care setting.
(43) Birthing center services.
(44) Case management services through the Oklahoma Department of Mental Health and Substance Abuse Services.
(45) ~~Home and Community-Based Waiver services~~HCBS for aged or physically disabled members.
(46) Outpatient ambulatory services for members infected with tuberculosis.
(47) Smoking and ~~Tobacco Use Cessation Counseling~~tobacco use cessation counseling for children and adults.
(48) Services delivered to American Indians/Alaskan Natives in I/T/Us. Payment is made on an encounter basis.
(49) OHCA contracts with designated agents to provide disease state management for individuals diagnosed with certain chronic conditions. Disease state management treatments are based on protocols developed using evidence-based guidelines.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 5. PHARMACIES

317:30-5-70. Eligible providers

~~Eligible providers are:~~

~~(1) entities licensed under Title 59 O.S. 353.9 as pharmacies, or~~

~~(2) entities licensed under another state's law as a pharmacy.~~

Eligible providers are entities licensed under applicable provisions of Oklahoma law as pharmacies, including non-resident pharmacies not located in Oklahoma that are transacting or doing business in Oklahoma by soliciting, receiving, dispensing, and/or delivering prescription medications and devices to Oklahoma residents.

317:30-5-70.1. Pharmacist responsibility

Eligible providers in the SoonerCare program are expected to act in accordance with the rules of professional conduct as promulgated by the Oklahoma Board of Pharmacy~~(or the state's rules of professional conduct where the pharmacy is licensed) under Title 59 O.S. 353.7(12).~~, 59 Oklahoma Statutes, Sec. 353.7(12). A pharmacist may refuse to dispense any prescription which appears to be improperly executed or which, in their professional judgment, is unsafe as presented.

317:30-5-70.2. Record retention/post payment review

Post-payment audits of the SoonerCare program are performed routinely by state and federal agencies. This Section applies to any post-payment audit regardless of the agency performing the audit. Pharmacies ~~are~~may be selected at random, as a result of a peer comparison, or data analysis for audits. The ~~Pharmacy~~pharmacy is required to provide original written prescriptions and signature logs as well as purchase invoices and other records necessary to document their compliance with program guidelines at the time of the audit. Written prescriptions must conform with the standards set forth in ~~42 USC 1396b(i)~~42 United States Code, Sec. 1396b(i) and related federal regulations requiring the use of a tamper-resistant prescription pad. These standards do not apply to prescriptions transmitted via telephone, facsimile or electronic prescription systems. Original written prescriptions are defined as any order for drug or medical supplies written or signed, or transmitted by word of mouth, telephone or other means of communication by a practitioner licensed by law to prescribe such drugs and medical supplies intended to be filled, compounded, or dispensed by a pharmacist. Signature logs are defined as any document which verifies that the prescription was delivered to the member or their representative. This may include electronic forms of tracking including but not limited to scanning a bar code of the

filled prescription. The electronic tracking system must be able to produce a copy of the scan for audit purposes. Records must be available for seven (7) years. Failure to provide the requested information to the Reviewer may result in a recommendation ranging from a potential recoupment of SoonerCare payments for the service to contract termination.

317:30-5-72. Categories of service eligibility

(a) **Coverage for adults.** Prescription drugs for categorically needy adults are covered as set forth in this subsection.

(1) With the exception of (2) and (3) of this subsection, categorically needy adults are eligible for a maximum of six (6) covered prescriptions per month with a limit of two (2) brand name prescriptions. A prior authorization may be granted for a third brand name if determined to be medically necessary by OHCA and if the member has not already utilized their six (6) covered prescriptions for the month.

(2) Subject to the limitations set forth in OAC 317:30-5-72.1, 317:30-5-77.2, and 317:30-5-77.3, exceptions to the six (6) medically necessary prescriptions per month limit are:

(A) unlimited monthly medically necessary prescriptions for categorically related individuals who are residents of nursing facilities or ~~Intermediate Care Facilities for the Mentally Retarded~~ICF/IID; and

(B) seven (7) additional medically necessary prescriptions which are generic products per month to the six (6) covered under the State Plan (including three (3) brand name prescriptions) are allowed for adults receiving services under the 1915(c) ~~Home and Community Based Services~~HCBS Waivers. Medically necessary prescriptions beyond the three (3) brand name or thirteen (13) total prescriptions will be covered with prior authorization.

(3) Drugs exempt from the prescription limit include: Antineoplastics, anti-retroviral agents for persons diagnosed with Acquired Immune Deficiency Syndrome (AIDS) or who have tested positive for the Human Immunodeficiency Virus (HIV), certain prescriptions that require frequent laboratory monitoring, birth control prescriptions, over the counter contraceptives, hemophilia drugs, compensable smoking cessation products, ~~low-phenylalanine formula and amino acid bars for persons with a diagnosis of PKU,~~naloxone for use in opioid overdose, certain carrier or diluent solutions used in compounds (i.e. sodium chloride, sterile water, etc.), and drugs used for the treatment of tuberculosis. For purposes of this Section, exclusion from the prescription limit means claims filed for any of these prescriptions will not count toward the prescriptions allowed per month.

(4) When a brand drug is preferred over its generic equivalent due to lower net cost, that drug shall not count

toward the brand limit; however, it will count toward the monthly prescription limit.

(b) **Coverage for children.** Prescription drugs for SoonerCare eligible individuals under twenty-one (21) years of age are not limited in number per month, but may be subject to prior authorization, quantity limits or other restrictions.

(c) **Individuals eligible for Part B of Medicare.** Individuals eligible for Part B of Medicare are also eligible for the Medicare Part D prescription drug benefit. Coordination of benefits between Medicare Part B and Medicare Part D is the responsibility of the pharmacy provider. The SoonerCare pharmacy benefit does not include any products which are available through either Part B or Part D of Medicare.

(d) **Individuals eligible for a prescription drug benefit through a Prescription Drug Plan (PDP) or Medicare Advantage - Prescription Drug (MA-PD) plan as described in the Medicare Modernization Act (MMA) of 2003.** Individuals who qualify for enrollment in a PDP or MA-PD are specifically excluded from coverage under the SoonerCare pharmacy benefit. This exclusion applies to these individuals in any situation which results in a loss of Federal Financial Participation for the SoonerCare program. This exclusion shall not apply to items covered at OAC 317:30-5-72.1(2) unless those items are required to be covered by the prescription drug provider in the MMA or subsequent federal action.

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~~42 U.S.C. § 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 investigational, experimental or whose side effects make usage controversial~~.~~ including agents that have been approved by the FDA but are being investigated for additional indications.

(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 FDA.

(H) Agents used for the symptomatic relief of cough and colds.

(2) The drug categories listed in (A) through (D) 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)~~ (A) 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 fifty (50)~~;

(ii) fluoride preparations are covered for persons under sixteen (16) years of age or pregnant;

(iii) vitamin D, metabolites, and analogs when used to treat chronic kidney disease or 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 twenty-one (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)~~ (B) Coverage of non-prescription or over the counter drugs is limited to:

(i) Insulin;

(ii) certain smoking cessation products;

(iii) family planning products;

(iv) OTC products may be covered for children 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.

~~(D)~~ (C) 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.

317:30-5-76. Generic drugs

All eligible providers are required to substitute generic medications for prescription name brand medications with the exception of prescriptions in which a brand necessary certification as provided in OAC 317:30-5-77 is made by a prescribing provider~~.~~ or when the agency has notified pharmacy providers that the net cost of the brand name medication is lower than the net cost of the generic medication.

317:30-5-77.2. Prior authorization

(a) **Definition.** The term prior authorization in pharmacy means an approval for payment by OHCA to the pharmacy before a prescription is dispensed by the pharmacy. An updated list of all products requiring prior authorization is available at the agency's website.

(b) **Process.** Because of the required interaction between a prescribing provider (such as a physician) and a pharmacist to receive a prior authorization, OHCA allows a pharmacist up to thirty (30) calendar days from the point of sale notification to provide the data necessary for OHCA to make a decision regarding prior authorization. Should a pharmacist fill a prescription prior to the actual authorization he/she takes a business risk that payment for filling the prescription will be denied. In the case that information regarding the prior authorization is not provided within the thirty (30) days, claims will be denied.

(c) **Documentation.** Prior ~~Authorization~~authorization petitions with clinical exceptions must be mailed or faxed to the Medication Authorization Unit of OHCA's contracted prior authorization processor. Other authorization petitions, claims processing questions and questions pertaining to DUR alerts must be addressed by contacting the ~~Pharmacy~~pharmacy help desk. Authorization petitions with complete information are reviewed and a response returned to the dispensing pharmacy within twenty-four (24) hours. Petitions and other claim forms are available on the OHCA public website.

(d) **Emergencies.** In an emergency situation the ~~Health Care Authority~~OHCA will authorize a seventy-two (72) hour supply of medications to a member. The authorization for a seventy-two (72) hour emergency supply of medications does not count against the SoonerCare limit described in OAC 317:30-5-72(a)(1).

(e) **Utilization and scope.** There are three (3) reasons for the use of prior authorization: utilization controls, scope controls and product based controls. Product based prior authorization is covered in OAC 317:30-5-77.3. The Drug Utilization Review Board recommends the approved clinical criteria and any restrictions or limitations.

(1) **Utilization controls.** Prior authorizations that fall under this category generally apply to the quantity of medication or duration of therapy approved.

(2) **Scope controls.** Scope controls are used to ensure a drug is used for an approved indication and is clinically appropriate, medically necessary and cost effective.

(A) Medications which have been approved by the FDA for multiple indications may be subject to a scope-based prior authorization when at least one of the approved indications places that drug into a therapeutic category or treatment class for which a prior authorization is required. Prior authorizations for these drugs may be structured as step therapy or a tiered approach as recommended by the Drug Utilization Review Board and approved by the OHCA Board of Directors.

(B) Prior authorization may be required to assure compliance with FDA approved and/or medically accepted indications, dosage, duration of therapy, quantity, or other appropriate use criteria including pharmacoeconomic consideration.

(C) Prior authorization may be required for certain non-standard dosage forms of medications when the drug is available in standard dosage forms.

(D) Prior authorization may be required for certain compounded prescriptions if the allowable cost exceeds a predetermined limit as published on the agency's website.

317:30-5-78.1. Special billing procedures

(a) **Antihemophiliac Factor (AHF) Products.** AHF products are sold by the amount of drug (International Units of AHF) in the container. For their products, regardless of the container size, the package size is always "1". Therefore, pricing assumes that the "package size" actually dispensed is the actual number of units dispensed. Examples: If 250 AHF units are dispensed and multiplied by a unit cost of $.25, the allowable cost would be $62.50. Metric Quantity is shown as 250; if 500 AHF units are dispensed and multiplied by a unit cost of $.25, the allowable would be $125.00. Metric Quantity is shown as 500.

(b) **Compound and intravenous drugs.** Prescriptions claims for compound and Intravenous (IV) drugs are billed and reimbursed using the NDC number and quantity for each compensable ingredient in the compound or IV, up to 25 ingredients. Ingredients without an NDC number are not compensable. A dispensing fee as described in OAC 317:30-5-78(c) is added to the total ingredient cost.

(c) ~~**Co-Payment**~~ **Coordination of benefits.** Pharmacies must pursue all third party resources before filing a claim with the OHCA as set out in ~~42 CFR 433.139~~State Fiscal Administration, 42 Code of Federal Regulation, Sec. 433.139.

(d) **Over-the-counter drugs.** Payment for covered over-the-counter medication is made according to the reimbursement methodology in OAC 317:30-5-78(d).

(e) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the SoonerCare allowable for comparable services. The appropriate Durable Medical Equipment Regional Carrier ~~(DMERC)~~must be billed prior to billing OHCA for all Medicare compensable drugs. Part B crossover claims cannot be submitted through the pharmacy point of sale system and must be submitted using the CMS 1500 form or electronic equivalent.

(f) **Claims for prescriptions which are not picked up.** A prescription for a member which has been submitted to and approved for payment by OHCA which has not been received by the member within ~~15~~fifteen (15) days of the date of service must be reversed no later than the 15th day after claim submission. An electronic reversal will cause a refund to be generated to the agency. Claims may also be reversed using a manual process if electronic reversal is not possible. For the purpose of this Section, the date of service means the date the prescription was filled.

~~(g) **Non-prescription products.** The coverage of non-prescription products that are determined to be medically necessary must be billed through the pharmacy point of sale system.~~

(g) **Partially-filled prescriptions.** If a member has not picked up the remainder of any partially-filled prescription within fifteen (15) days of the date of service, the claim must be reversed on the 15th day and a new claim submitted for the quantity actually dispensed.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 103. QUALIFIED SCHOOLS AS PROVIDERS OF ~~HEALTH RELATED~~HEALTH-RELATED SERVICES

317:30-5-1020. General provisions

~~(a) Payment is made to eligible qualified school providers for delivery of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services to eligible individuals under the age of 21. School-based services must be medically necessary and have supporting documentation to be considered for reimbursement. In addition, services provided in the school setting are only compensable when provided to eligible SoonerCare members pursuant to an Individual Education Plan (IEP).~~

~~(b) EPSDT services are comprehensive child-health services, designed to ensure the availability of, and access to, required health care resources and to help parents and guardians of SoonerCare eligible children use these resources. Effective EPSDT services assure that health problems are diagnosed and treated early before they become more complex and their treatment more costly. The Schools play a significant role in educating parents and guardians about all services available through the EPSDT program.~~

~~(c) The receipt of an identified EPSDT screening makes the SoonerCare child eligible for all necessary follow-up care that is within the scope of the SoonerCare Program. An Individualized Education Program (IEP) or Individual Family Services Plan (IFSP) entitles the SoonerCare eligible child to medically necessary and appropriate health related EPSDT treatment services. For reimbursement purposes, prior to rendering a medically related evaluation and/or service pursuant to an eligible SoonerCare child's IEP or IFSP, either through an IEP/IFSP addendum or a new IEP/IFSP, parental consent must be obtained. An IEP or IFSP serves as the plan of care for consideration of reimbursement for health related EPSDT treatment services. The IEP or IFSP may not serve as an evaluation. Services that require prior authorization will need to be authorized prior to the development of the IEP or IFSP. The IEP/IFSP must be completed and signed during the meeting by all required providers and individuals and must include the type, frequency, and duration of the service(s) provided, the signatures, including credentials, of the provider(s) and the~~

~~direct care staff delivering services under the supervision of the professional, and the specific place of services if other than the school (e.g., field trip, home). The IEP/IFSP must also contain measurable goals for each of the identified needs. Goals must be updated to reflect the current therapy, evaluation, or service that is being provided and billed to SoonerCare. In order to bill SoonerCare for services rendered in the school, including evaluations, these services must result in or be identified in the IEP. Federal regulations require that diagnosis and treatment be provided for conditions identified during a screening whether or not they are covered under the Authority's current program. Such services must be allowable under federal Medicaid regulations and must be necessary to ameliorate or correct defects of physical or mental illnesses/conditions.~~

~~(d) Federal regulations require that the State set standards and protocols for each component of EPSDT services. The standards must provide for services at intervals which meet reasonable standards of medical and dental practice. The standards must also provide for EPSDT services at other intervals as medically necessary to determine the existence of certain physical and mental illnesses or conditions. SoonerCare providers who offer EPSDT screenings must assure that the screenings they provide meet the minimum standards for those services in order to be reimbursed at the level established for EPSDT services.~~

~~(e) To assure full payment for the EPSDT screening, providers must perform and document all necessary components of the screening examination. Documentation of screening services performed must be retained for future review.~~

~~(f) Evaluations must be prior authorized when medically necessary and/or required and prescribed or referred by a treating physician or other practitioner of the healing arts with supporting medical documentation. Initial evaluations (e.g. initial physical therapy evaluation) that do not require a prior authorization and that are performed as part of the IEP development process are compensable when the appropriate documented referral and supporting medical documentation are in place. Evaluations completed for educational purposes only are not compensable. All evaluations must be medically necessary and support the services billed to SoonerCare. The evaluations must be included in the IEP for reimbursement consideration. A diagnosis alone is not sufficient documentation to support the medical necessity of services. The child's diagnosis must clearly establish and support that the prescribed therapy is medically necessary. Evaluations must be completed annually and updated to accurately reflect the participant's current status. Evaluations include but are not limited to hearing and speech~~

~~services, physical therapy, occupational therapy, and psychological evaluations and must include the following information:~~

~~(1) Medical documentation that supports why the member was referred for evaluation;~~

~~(2) Diagnosis;~~

~~(3) Member's strengths, needs, and interests;~~

~~(4) Recommended interventions for identified needs, including outcomes and goals;~~

~~(5) Recommended units and frequency of services; and~~

~~(6) Dated signature and credentials of professional completing the evaluation.~~

~~(g) Annual evaluations/re-evaluations are required prior to each annual IEP.~~

~~(h) No more than five SoonerCare members can be present during a group therapy session. A daily log/list must be maintained and must identify the participants for each group session.~~

(a) School-based services are medically necessary health-related and rehabilitative services that are provided by a qualified school provider to a student under the age of 21 pursuant to an Individualized Education Program (IEP), in accordance with the Individuals with Disabilities Education Act (IDEA). Payment is made to qualified school providers for delivery of school-based services, provided that such services are, among other things, medically necessary and sufficiently supported by medical records and/or other documentation, as explained below.

(b) An IEP and all relevant supporting documentation, including, but not limited to, the documentation required by OAC 317:30-5-1020(c), below, serves as the plan of care for consideration of reimbursement for school-based services. The plan of care must contain, among other things, the signatures, including credentials, of the provider(s) and the direct care staff delivering services under the supervision of the professional; as well as a complete, signed, and current IEP which clearly establishes the type, frequency, and duration of the service(s) to be provided, the specific place of services if other than the school (e.g., field trip, home), and measurable goals for each of the identified needs. Goals must be updated to reflect the current therapy, evaluation, or service that is being provided and billed to SoonerCare.

(1) Except for those services, referenced in Oklahoma Administrative Code (OAC) 317:30-5-1023(b)(4)(H), a plan of care that meets the requirements of OAC 317:30-5-1020(b), above, shall serve as a prior medical authorization for the purpose of providing medically necessary and appropriate school-based services to students.

(2) For the purposes of occupational therapy services, and services for members with speech, hearing, and language disorders, a plan of care that meets the requirements of OAC 317:30-5-1020(b), above, may also, in accordance with sections (§§) 725.2(H) and 888.4(C) of Title 59 of the Oklahoma Statutes (O.S.) serve as a valid prescription or referral for an initial evaluation and any subsequent services, as is required by Title 42 of Code of Federal Regulations (C.F.R.), § 440.110.

(3) Physical therapy services, by contrast, shall require a signed and dated prescription from the student's physician prior to that student's initial evaluation, in accordance with OAC 317:30-5-291(1). Prescriptions for school-based physical therapy must be reauthorized at least annually, and documented within Oklahoma State Department of Education's (OSDE) online IEP system, as set forth in subsection (c), below.

(c) Qualified school providers must ensure that adequate documentation is maintained within the OSDE online IEP system in order to substantiate that all school-based services billed to SoonerCare are medically necessary and comply with applicable state and federal Medicaid law. Such documentation shall include, among other things:

(1) Documentation establishing sufficient notification to a member's parents and receipt of adequate, written consent from them, prior to accessing a member's or parent's public benefits or insurance for the first time, and annually thereafter, in accordance with 34 C.F.R. § 300.154;

(2) Any referral or prescription that is required by state or federal law for the provision of school-based services, or for the payment thereof, in whole or in part, from public funds, including, but not limited to, 42 C.F.R. § 440.110. However, any prescription or referral ordered by a physician or other licensed practitioner of the healing arts who has, or whose immediate family member has, a financial interest in the delivery of the underlying service in violation of Section 1395nn, Title 42 of United States Code shall not be valid, and services provided thereto shall not be eligible for reimbursement by the Oklahoma Health Care Authority (OHCA);

(3) An annual evaluation located in or attached to the IEP that clearly demonstrates, by means of the member's diagnosis and any other relevant supporting information, that school-based services are medically necessary, in accordance with OAC 317:30-3-1(f). Evaluations completed solely for educational purposes are not compensable. Evaluations must be completed annually and updated to accurately reflect the student's current status. Any evaluation for medically

necessary school-based services, including but not limited to, hearing and speech services, physical therapy, occupational therapy, and psychological therapy, must include the following information:

(A) Documentation that supports why the member was referred for evaluation;

(B) A diagnosis that clearly establishes and supports the need for school-based services;

(C) A summary of the member's strengths, needs, and interests;

(D) The recommended interventions for identified needs, including outcomes and goals;

(E) The recommended units and frequency of services; and

(F) A dated signature and the credentials of the professional completing the evaluation; and

(4) Documentation that establishes the medical necessity of the school-based services being provided between annual evaluations, including, for example, professional notes or updates, reports, and/or assessments that are signed, dated, and credentialed by the rendering practitioner.

(d) All claims related to school-based services that are submitted to OHCA for reimbursement must include any numeric identifier obtained from OSDE.

317:30-5-1021. Eligible providers

(a) ~~Eligible providers are local, regional, and state educational services agencies as defined by State law and the Individuals with Disabilities Education Act (IDEA), as amended in 1997. A completed contract to provide EPSDT services through the schools must be submitted to the Oklahoma Health Care Authority (OHCA). The must approve the contract in order for eligible school providers to receive reimbursement.~~ Eligible providers are local, regional, and state educational services agencies as defined by state law and the Individuals with Disabilities Education Act (IDEA), as most recently amended (hereinafter, "school providers"). School providers must submit a completed contract to the Oklahoma Health Care Authority (OHCA), including a Special Provisions for Schools, and must receive approval thereof prior to receiving reimbursement for school-based services.

(b) Qualified ~~Schools~~school providers must notify OHCA of all subcontractors performing ~~IEP~~Individualized Education Program (IEP) related evaluations and services in the school setting prior to services being rendered. The notification must include a copy of the agreement between the school and subcontractor and must reflect the start and ending dates of the agreement for services. ~~OHCA may request that schools enroll with SoonerCare~~

~~all entities and individuals that provide SoonerCare services in the school setting and may require that the rendering provider be included on any claim for payment by the school.~~All subcontractors must be individually contracted with SoonerCare and, if rendering services, must be identified on any claim for payment as the rendering provider.

317:30-5-1023. Coverage by category

(a) **Adults.** There is no coverage for services rendered to adults.

(b) **Children.** ~~Payment is made for compensable services rendered by local, regional, and state educational services agencies as defined by IDEA:~~Payment is made for the following compensable services rendered by qualified school providers:

(1) **~~Child health~~Child-health screening.** An initial screening may be requested by an eligible ~~individual~~member at any time and must be provided without regard to whether the ~~individual's~~member's age coincides with the established periodicity schedule. Coordination referral is made to the SoonerCare provider to assure at a minimum, that periodic screens are scheduled and provided in accordance with the periodicity schedule following the initial screening. ~~Child Health~~Child-health screening must adhere to the following requirements:

(A) Children and adolescents enrolled in SoonerCare must be referred to their SoonerCare provider for ~~child health~~child-health screenings. In cases where the SoonerCare provider authorizes the school to perform this screen or fails to schedule an appointment within three (3) weeks and a request has been made and documented by the school, the school may then furnish the ~~EPSDT child health~~ Early and Periodic Screening, Diagnosis and Treatment (EPSDT) child-health screening. Written notification must be mailed to the ~~Soonercare~~SoonerCare member's ~~PCP~~primary care provider (PCP) prior to the school's intent to furnish and bill for the screen. Results of this screening must be forwarded to the ~~child's~~member's SoonerCare provider.

(B) ~~Child health~~Child-health screenings must be provided by a ~~state licensed~~state-licensed physician (M.D. or D.O.), ~~state licensed~~state-licensed nurse practitioner with prescriptive authority, or ~~state licensed~~state-licensed physician assistant. Screening services must include the following:

(i) Comprehensive health and developmental history, including assessment of both physical and mental health development;

(ii) Comprehensive unclothed physical exam;

(iii) Appropriate immunizations according to the age and health history;

(iv) Laboratory test, including blood level assessment; and

(v) Health education, including anticipatory guidance.

(C) Mass screenings for any school-based service are not billable to SoonerCare, nor are screenings that are performed as a child or adolescent find activity pursuant to an ~~IDEA~~ Individuals with Disabilities Education Act (IDEA) requirement. There must be a documented referral in place that indicates the child or adolescent has an individualized need that warrants a screening to be performed.

(2) **~~Child health~~Child-health encounter.** The ~~child health~~child-health encounter may include a diagnosis and treatment encounter, a follow-up health encounter, or a home visit. A ~~Child Health Encounter~~child-health encounter may include any of the following services:

(A) vision;

(B) hearing;

(C) dental;

(D) a ~~child~~ health history;

(E) physical examination;

(F) developmental assessment;

(G) nutrition assessment and counseling;

(H) social assessment and counseling;

(I) genetic evaluation and counseling;

(J) indicated laboratory and screening tests;

(K) screening for appropriate immunizations; or

(L) health counseling and treatment of childhood illness and conditions.

(3) **Diagnostic encounters.** Diagnostic encounters are defined as those services necessary to fully evaluate defects, physical or behavioral health illnesses or conditions discovered by the screening. Approved diagnostic encounters may include the following:

(A) **Hearing and ~~Hearing Aid~~hearing aid evaluation.** Hearing evaluation includes pure tone air, bone and speech audiometry. Hearing evaluations ~~must adhere to guidelines found at OAC 317:30-5-676 and~~ must be provided by a state-licensed audiologist who:

(i) holds a ~~certificate of clinical competence~~Certificate of Clinical Competence from the American Speech ~~and~~-Language-Hearing Association (ASHA); or

(ii) has completed the equivalent educational requirements and work experience necessary for the certificate; or

(iii) has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

(B) **Audiometry test.** Audiometric test (Immittance [Impedance] audiometry or tympanometry) includes bilateral assessment of middle ear status and reflex studies (when appropriate) provided by a state-licensed audiologist who:

(i) holds a ~~certificate of clinical competence~~Certificate of Clinical Competence from the ~~American Speech and Hearing Association~~ASHA; or

(ii) has completed the equivalent educational requirements and work experience necessary for the certificate; or

(iii) has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

(C) **Ear impression (for earmold).** Ear impression (for earmold) includes taking impression of a member's ear and providing a finished earmold which is used with the member's hearing aid provided by a ~~state licensed~~state-licensed audiologist who:

(i) holds a ~~certificate of clinical competence~~Certificate of Clinical Competence from the ~~American Speech and Hearing Association~~ASHA; or

(ii) has completed the equivalent educational requirements and work experience necessary for the certificate; or

(iii) has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

(D) **Vision ~~Screening~~screening.** Vision screening in schools includes application of tests and examinations to identify visual defects or vision disorders. The vision screening may be performed by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) under the supervision of an RN, or ~~State Certified Vision Impairment Teacher~~state-certified vision impairment teacher. The service can be billed when a SoonerCare member has an individualized documented concern that warrants a screening. A vision examination must be provided by a ~~state licensed~~state-licensed Doctor of Optometry (O.D.) or licensed physician specializing in ophthalmology (M.D. or D.O.). This vision examination, at a minimum, includes diagnosis and treatment for defects in vision.

(E) **~~Speech Language~~Speech-language evaluation.** ~~Speech Language~~Speech-language evaluation is for the purpose of identification of children or adolescents with speech or language disorders and the diagnosis and appraisal of specific speech and language services. ~~Speech Language~~Speech-language evaluations ~~must adhere to guidelines found at OAC 317:30-5-676 and~~ must be provided by state-licensed speech-language pathologist who:

(i) holds a ~~certificate of clinical competence~~Certificate of Clinical Competence from the ~~American Speech and Hearing Association~~ASHA; or

(ii) has completed the equivalent educational requirements and work experience necessary for the certificate; or

(iii) has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

(F) **Physical ~~Therapy~~therapy evaluation.** Physical ~~Therapy~~therapy evaluation includes evaluating the student's ability to move throughout the school and to participate in classroom activities and the identification of movement dysfunction and related functional problems and must be provided by a state-licensed physical therapist. Physical ~~Therapy~~therapy evaluations must adhere to guidelines found at OAC 317:30-5-291.

(G) **Occupational ~~Therapy~~therapy evaluation.** Occupational ~~Therapy~~therapy evaluation services include determining what therapeutic services, assistive technology, and environmental modifications a student requires for participation in the special education program and must be provided by a state-licensed occupational therapist. ~~Occupational Therapy evaluations must adhere to guidelines found at OAC 317:30-5-296.~~

(H) **Psychological ~~Evaluation and Testing~~evaluation and testing.** Psychological ~~Evaluation and Testing~~evaluation and testing are for the purpose of diagnosing and determining if emotional, behavioral, neurological, or developmental issues are affecting academic performance and for determining recommended treatment protocol. Evaluation/testing for the sole purpose of academic placement (e.g. diagnosis of learning disorders) is not a compensable service. Psychological ~~Evaluation and Testing~~evaluation and testing must be provided by state-licensed, ~~Board Certified, Psychologist or School Psychologist~~board-certified psychologist or school psychologist certified by Oklahoma State Department of Education ~~(SDE)~~(OSDE). ~~Psychological evaluations and~~

~~testing services must adhere to guidelines found at OAC 317:30-5-241.1 and 317:30-5-241.2.~~

(4) **~~Child guidance~~Child-guidance treatment encounter.** A ~~child guidance~~child-guidance treatment encounter may occur through the provision of individual, family, or group treatment services to children and adolescents who are identified as having specific disorders or delays in development, emotional, or behavioral problems, or disorders of speech, language or hearing. These types of encounters are initiated following the completion of a diagnostic encounter and subsequent development of a treatment plan, or as a result of an ~~IEP or IFSP~~Individualized Education Program (IEP) and may include the following:

(A) **Hearing and ~~Vision Services~~vision services.** Hearing and vision services ~~must adhere to guidelines found at OAC 317:30-5-676 and~~ may include provision of habilitation activities, such as auditory training, aural and visual habilitation training, including Braille, and communication management, orientation and mobility, counseling for vision and hearing losses and disorders. Services must be provided by or under the direct guidance of one of the following individuals practicing within the scope of his or her practice under ~~State~~state law:

(i) state-licensed, Master's Degree Audiologist who:

(I) holds a ~~certificate of clinical competence~~Certificate of Clinical Competence from the ~~American Speech and Hearing Association~~ASHA; or

(II) has completed the equivalent educational requirements and work experience necessary for the certificate; or

(III) has completed the academic program and is acquiring supervised work experience to qualify for the certificate;

(ii) state-licensed, Master's Degree Speech-Language Pathologist who:

(I) holds a ~~certificate of clinical competence~~Certificate of Clinical Competence from the ~~American Speech and Hearing Association~~ASHA; or

(II) has completed the equivalent educational requirements and work experience necessary for the certificate; or

(III) has completed the academic program and is acquiring supervised work experience to qualify for the certificate;

(iii) ~~state certified~~state-certified deaf education teacher;

(iv) certified orientation and mobility specialists;

and

(v) ~~state certified~~state-certified vision impairment teachers.

(B) **~~Speech Language Therapy Services~~Speech-language therapy services**. ~~Speech Language Therapy Services~~Speech-language therapy services include provisions of speech and language services for the habilitation or prevention of communicative disorders. ~~Speech Language Therapy~~Speech-language therapy services ~~must adhere to guidelines found at OAC 317:30-5-676 and~~ must be provided by or under the direct guidance and supervision of a state-licensed Speech-Language Pathologist within the scope of his or her practice under ~~State~~state law who:

(i) holds a ~~certificate of clinical competence~~Certificate of Clinical Competence from the ~~American Speech and Hearing Association~~ASHA; or

(ii) has completed the equivalent educational requirements and work experience necessary for the certificate; or

(iii) has completed the academic program and is acquiring supervised work experience to qualify for the certificate; or

(C) **Physical ~~Therapy Services~~therapy services**. Physical ~~Therapy Services~~therapy services are provided for the purpose of preventing or alleviating movement dysfunction and related functional problems that adversely affects the ~~child's~~member's education. Physical ~~Therapy~~therapy services must adhere to guidelines found at OAC 317:30-5-291 and must be provided by or under the direct guidance and supervision of a ~~state licensed~~state-licensed physical therapist; services may also be provided by a Physical Therapy Assistant who has been authorized by the Board of Examiners working under the supervision of a licensed Physical Therapist. The licensed Physical Therapist may not supervise more than three Physical Therapy Assistants.

(D) **Occupational ~~Therapy Services~~therapy services**. Occupational therapy may include provision of services to improve, develop or restore impaired ability to function independently. Occupational ~~Therapy~~therapy services ~~must adhere to guidelines found at OAC 317:30-5-296 and~~ must be provided by or under the direct guidance and supervision of a ~~state licensed~~state-licensed Occupational Therapist; services may also be provided by an Occupational Therapy Assistant who has been authorized by the Board of Examiners, working under the supervision of a licensed Occupational Therapist.

(E) **Nursing ~~Services~~services**. Nursing ~~Services~~services

may include provision of services to protect the health status of children and adolescents, correct health problems and assist in removing or modifying health related barriers and must be provided by a ~~registered nurse~~RN or ~~licensed practical nurse~~LPN under supervision of a ~~registered nurse~~RN. Services include medically necessary procedures rendered at the school site, such as catheterization, suctioning, tube feeding, and administration and monitoring of medication.

(F) **Psychotherapy ~~Services~~services**. Psychotherapy services are the provision of counseling for children and parents. All services must be for the direct benefit of the ~~child~~member. Psychotherapy services must be provided by a ~~state licensed~~state-licensed Social Worker, a ~~state Licensed~~state-licensed Professional Counselor, a ~~State licensed~~state-licensed Psychologist or School Psychologist certified by the ~~SDE~~OSDE, a ~~State licensed~~state-licensed Marriage and Family Therapist or a ~~State licensed~~state-licensed Behavioral Practitioner, or under Board supervision to be licensed in one of the above stated areas. ~~Psychotherapy services must adhere to guidelines found at OAC 317:30-5-241.1 and 317:30-5-241.2.~~

(G) **Assistive ~~Technology~~technology**. Assistive technology are the provision of services that help to select a device and assist a student with disability(ies) to use an ~~Assistive~~assistive technology device including coordination with other therapies and training of ~~child~~member and caregiver. Services must be provided by a:

(i) ~~state licensed~~state-licensed, Speech-Language Pathologist who:

(I) holds a ~~certificate of clinical competence~~Certificate of Clinical Competence from the ~~American Speech and Hearing Association~~ASHA; or

(II) has completed the equivalent educational requirements and work experience necessary for the certificate; or

(III) has completed the academic program and is acquiring supervised work experience to qualify for the certificate;

(ii) ~~state licensed~~state-licensed Physical Therapist; or

(iii) ~~state licensed~~state-licensed Occupational Therapist.

(H) **Personal ~~Care~~care**. Provision of personal care services allow students with disabilities to safely attend school; includes, but is not limited to assistance with

toileting, oral feeding, positioning, hygiene, and riding school bus to handle medical or physical emergencies. Services must be provided by registered paraprofessionals/assistants that have completed training approved or provided by ~~SDE~~OSDE, or Personal Care Assistants, including ~~Licensed Practical Nurses~~LPNs, who have completed on-the-job training specific to their duties. Personal Care services do not include behavioral monitoring. Paraprofessionals are not allowed to administer medication, nor are they allowed to assist with or provide therapy services to SoonerCare members. Tube feeding of any type may only be reimbursed if provided by a ~~registered nurse or licensed practical nurse~~RN or LPN. Catheter insertion and Catheter/Ostomy care may only be reimbursed when done by a ~~registered nurse~~RN or ~~licensed practical nurse~~LPN.

(I) **Therapeutic ~~Behavioral Services~~behavioral services.** Therapeutic behavioral services are interventions to modify the non-adaptive behavior necessary to improve the student's ability to function in the community as identified on the plan of care. Medical necessity must be identified and documented through assessment and annual evaluations/re-evaluations. Services encompass behavioral management, redirection, and assistance in acquiring, retaining, improving, and generalizing socialization, communication and adaptive skills. This service must be provided by a Behavioral Health School Aide (BHSA) who has a high school diploma or equivalent and has successfully completed the paraprofessional training approved by the ~~State Department of Education~~OSDE and a training curriculum in behavioral interventions for ~~Pervasive Developmental Disorders~~pervasive developmental disorders as recognized by OHCA. BHSA must be supervised by a ~~bachelors~~bachelor's level individual with a special education certification. BHSA must have CPR and First Aid certification. Six (6) additional hours of related continuing education are required per year.

(J) **Immunization.** Immunizations must be coordinated with the ~~Primary Care Physician~~PCP for children and adolescents enrolled in SoonerCare. An administration fee, only, can be paid for immunizations provided by the schools.

(c) **~~Individuals~~Members eligible for Part B of Medicare.** EPSDT school ~~health related~~health-related services provided to Medicare eligible members are billed directly to the fiscal agent.

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~~behavioral health (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 (6) months. To qualify for reimbursement, the screening tools used must be evidence-based or otherwise approved by ~~OHCA and ODMHSAS~~Oklahoma Health Care Authority (OHCA) and Oklahoma Department of Mental Health and Substance Abuse Services (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 person(s) 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~~a licensed behavioral health professional (LBHP) or licensure candidate.

(C) **Target population and limitations.** The ~~Behavioral Health Assessment~~BH assessment 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 (6) months and it has been more than one (1) year since the previous assessment.

(D) **Documentation requirements.** The assessment must include all elements and tools required by the OHCA. In the case of children under the age of eighteen (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 or diagnostic impression. The information in the assessment must contain but is not limited to the following:

(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; and

(vii) Signature of parent or guardian participating in face-to-face assessment. Signatures are required for members over the age of fourteen (14)~~; and~~. Signature and credentials of the practitioner who performed the face-to-face behavioral assessment. The signatures may be included in a signature page applicable to both the assessment and treatment plan if the signature page clearly indicates that the signatories consent and approve of both.

~~(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, including 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 eighteen (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 six (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~~licensure candidate.

(C) **Time requirements.** Service Plan updates must be conducted face-to-face and are required every six (6) months during active treatment. However, updates can be conducted whenever it is clinically needed as determined by the qualified practitioner and member, but are only compensable twice in one (1) year.

(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)~~[signatures are required from the member, if fourteen (14) or over], the parent/guardian ~~(if younger than 18 or otherwise applicable)~~[if younger than eighteen (18) or otherwise applicable], and the primary LBHP or ~~Licensure Candidate~~licensure candidate.

The signatures may be included in a signature page applicable to both the assessment and treatment plan if the signature page clearly indicates that the signatories consent and approve of both; and

(xi) all changes in a service plan must be documented in either a scheduled six (6) month service plan update (low complexity) or within the existing service plan through an amendment until time for the update (low complexity). Any changes to the existing service plan must, prior to implementation, be signed and dated by the member ~~(if 14 or over)~~[if fourteen (14) or over], the parent/guardian ~~(if younger than 18 or otherwise applicable)~~[if younger than eighteen (18) or otherwise applicable], and the lead LBHP or ~~Licensure Candidate~~licensure candidate.

(xii) Amendment of an existing service plan to revise or add goals, objectives, service provider, service type, and service frequency, may be completed prior to the scheduled six (6) month review/update. A plan amendment must be documented through an addendum to the service plan, dated and signed prior to the implementation, by the member ~~(if 14 or over)~~[if fourteen (14) or over], the parent/guardian ~~(if younger than 18 or otherwise applicable)~~[if younger than eighteen (18) or otherwise applicable], and the lead LBHP or ~~Licensure Candidate~~licensure candidate. A temporary change of service provider may be documented in the progress note for the service provided, rather than an amendment.

(xiii) Behavioral health service plan development, low complexity, 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 plan updates (low complexity) are not valid until all signatures are present. The required signatures are: from the member ~~(if 14 or over)~~[if fourteen (14) or over], the parent/guardian ~~(if younger than 18 or otherwise applicable)~~[if younger than eighteen (18) or otherwise applicable], and the primary LBHP or ~~Licensure Candidate~~licensure candidate.

(E) **Service limitations:**

(i) Behavioral Health Service Plan Development, Moderate Complexity (i.e., pre-admission procedure code group) is limited to one (1) per member, per provider, unless more than one (1) year has passed between services, in which case, one can be requested and performed, if authorized by OHCA or its designated agent.

(ii) Behavioral Health Service Plan Development, Low Complexity: Service Plan updates are required every six (6) months during active treatment. Updates, however, can be conducted whenever clinically needed as determined by the provider and member, but are only reimbursable twice in one (1) year. 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~~licensure candidate. For assessments conducted in a school setting, the Oklahoma State Department of Education (OSDE) requires that a licensed supervisor sign the assessment. Each qualified professional must have a current contract with the OHCA.

(C) **Documentation requirements.** All psychological services must be documented 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 (3) must be medically necessary and meet established ~~Child (0-36 months of age)~~child [zero (0) to thirty-six (36) months of age] criteria as set forth in the Prior Authorization Manual. Evaluation and testing is clinically appropriate and allowable when an accurate diagnosis and determination of treatment needs is needed. Eight (8) hours/units of testing per patient over the age of three (3), per provider is allowed every twelve (12) months. There may be instances when further testing is appropriate based on established medical necessity criteria found in the Prior Authorization Manual. Justification for additional testing beyond allowed amount as specified in this ~~section~~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 twelve (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~~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

OSDE requires that a licensed supervisor sign the assessment. For 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.

317:30-5-241.6. Behavioral Health Case Management

Payment is made for behavioral health case management services as set forth in this Section. The limitations set forth in this Section do not apply to case management provided in programs and service delivery models which are not reimbursed for case management on a fee-for-service basis.

(1) **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 twenty-one (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 authorized for the target group based on established medical necessity criteria.

(A) 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~~ Oklahoma Department of Mental Health and Substance Abuse Services (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 seventy-two (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 seventy-two (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 (2) 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.

(B) 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.

(C) 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.

(D) 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~~licensed behavioral health professional (LBHP) or licensure candidate as defined in OAC 317:30-5-240.3(a) and (b).

(E) 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) 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 thirty (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.

(2) **Levels of Case Management.**

(A) 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 sixteen (16) units per member per year. Additional units may be authorized up to 25 units per member per month if medical necessity criteria are met.

(B) Intensive Case Management (ICM) is targeted to adults with serious and persistent mental illness ~~(including members in PACT programs)~~in PACT programs and Wraparound Facilitation Case Management (WFCM) is targeted to children with serious mental illness and emotional disorders ~~(including members in a System of Care Network)~~ being treated 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 eight (8) and ten (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 two (2) years Behavioral

Health Case Management experience, crisis diversion experience, must have attended the ODMHSAS six (6) hours ICM training, and twenty-four (24) hour availability is required. ICM/WFCM is limited to fifty-four (54) units per member per month.

(3) **Excluded Services.** SoonerCare reimbursable behavioral health case management does not include the following activities:

(A) physically escorting or transporting a member or family to scheduled appointments or staying with the member during an appointment;

(B) managing finances;

(C) providing specific services such as shopping or paying bills;

(D) delivering bus tickets, food stamps, money, etc.;

(E) counseling, rehabilitative services, psychiatric assessment, or discharge planning;

(F) filling out forms, applications, etc., on behalf of the member when the member is not present;

(G) filling out SoonerCare forms, applications, etc.;

(H) mentoring or tutoring;

(I) provision of behavioral health case management services to the same family by two separate behavioral health case management agencies;

(J) non-face-to-face time spent preparing the assessment document and the service plan paperwork;

(K) monitoring financial goals;

(L) services to nursing home residents;

(M) psychotherapeutic or rehabilitative services, psychiatric assessment, or discharge; or

(N) services to members residing in ICF/IID facilities.

(O) leaving voice or text messages for clients and other failed communication attempts.

(4) **Excluded Individuals.** The following SoonerCare members are not eligible for behavioral health case management services:

(A) children/families for whom behavioral health case management services are available through ~~OKDHS/OJA~~Oklahoma Department of Human Services (OKDHS) and Oklahoma Office of Juvenile Affairs (OJA) staff without special arrangements with OKDHS, OJA, and ~~OHCA~~the Oklahoma Health Care Authority (OHCA); (B) members receiving Residential Behavior Management Services (RBMS) in a foster care or group home setting unless transitioning into the community;

(C) residents of ICF/IID and nursing facilities unless transitioning into the community;

(D) members receiving services under a Home and Community Based services (HCBS) waiver program; or

(E) members receiving services in the Health Home program.

(5) **Filing Requirements.** Case management services provided to Medicare eligible members should be filed directly with the fiscal agent.

(6) **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:

(A) date;

(B) person(s) to whom services are rendered;

(C) start and stop times for each service;

(D) original signature or the service provider (original signatures for faxed items must be added to the clinical file within 30 days);

(E) credentials of the service provider;

(F) specific service plan needs, goals and/or objectives addressed;

(G) 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;

(H) progress and barriers made towards goals, and/or objectives;

(I) member (family when applicable) response to the service;

(J) any new service plan needs, goals, and/or objectives identified during the service; and

(K) member satisfaction with staff intervention.

(7) **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.

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~~relating to program benefits. 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~~(Member Complaint/Grievance Form) within ~~20~~twenty (20) days of the triggering event. The triggering event occurs at the time when the ~~Appellant (Appellant is the person who files a grievance)~~member (the "Appellant") knew or should have known ~~of such condition or circumstance for appeal~~the facts or circumstances serving as the basis for an appeal.

(3) If the LD-1 form is not received within ~~20~~twenty (20) days of the triggering event, OHCA ~~sends the Appellant a letter~~will cause to be issued 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 the timeframe pursuant to Title 68 ~~O.S. S~~Oklahoma Statutes, Sec. 205.2, OHCA ~~sends the Appellant a letter~~similarly will cause to be issued a letter stating the appeal will not be heard because it is untimely.

(4) If the LD-1 form is not completely filled out or if necessary documentation is not included, then the appeal will not be heard.

(5) ~~The staff advises the Appellant~~OHCA will advise members that if ~~there is a need for~~ assistance is needed in reading or completing the grievance form ~~that~~, arrangements will be made to provide such assistance.

(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~~of the hearing. ~~The member must appear at this hearing and it is conducted according to OAC 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 (OAC 317:2-1-13).~~ The member must appear at the hearing, either in person or telephonically. Requests for a telephone hearing must be received in writing on OHCA's LD-4(Request for Telephonic Hearing) form no later than ten (10) calendar days prior to the scheduled hearing date. Telephonic hearing requests will only be granted by the OHCA's Chief Executive Officer (CEO) or his/her designee,

at his/her sole discretion, for good cause shown, including, for example, the member's physical condition, travel distances, or other limitations that either preclude an in-person appearance or would impose a substantial hardship on the member.

(7) The hearing shall be conducted according to OAC 317:2-1-5. The ALJ's decision may be appealed to the CEO of the OHCA, which is a record review at which the parties do not appear (OAC 317:2-1-13).

~~(7)~~ (8) Member appeals are ordinarily decided within ~~90~~ninety (90) days from the date ~~OHCA receives~~on which the member's timely request for a fair hearing is received, unless~~the member waives this requirement. [Title 42 CFR 431.244(f)]~~, in accordance with 42 Code of Federal Regulations, Sec. 431.244(f):

(A) The Appellant was granted an expedited appeal pursuant to OAC 317:2-1-2.4;

(B) OHCA cannot reach a decision because the Appellant requests a delay or fails to take a required action, as reflected in the record; or

(C) There is an administrative or other emergency beyond OHCA's control, as reflected in the record.

~~(8)~~ (9) Tax warrant intercept appeals will be heard directly by the ALJ. A decision is normally rendered by the ALJ within ~~20~~twenty (20) days of the hearing before the ALJ.

(b) **Provider Process Overview.**

(1) The proceedings as described in this subsection contain the hearing process for those appeals filed by providers. These appeals encompass all subject matter cases contained in OAC 317:2-1-2(c)(2).

(2) All provider appeals are initially heard by the OHCA ~~Administrative Law Judge~~ALJ under OAC 317:2-1-2(c)(2).

(A) ~~The Appellant(Appellant is the provider who files an appeal) files an~~A provider who wants to contest an adverse OHCA determination (the "Appellant") must initiate an appeal by filing with OHCA the proper LD form ~~requesting an appeal hearing~~ within ~~20~~twenty (20) days of the ~~triggering event~~date of notice of an adverse determination or other action taken by OHCA. ~~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 appeals and LD-3 forms are for nursing home wage enhancement grievances.)~~LD-2 forms should be used for Program Integrity audit appeals; LD-3 forms are to be used for all other provider appeals.

(B) If the appropriate LD form is not received within ~~20~~twenty (20) days of the ~~triggering event~~date of notice,

OHCA ~~sends the Appellant~~will cause a letter to be issued stating that the appeal will not be heard because it is untimely.

(C) A decision ordinarily will be ~~rendered~~issued by the ALJ ~~ordinarily~~ within ~~45~~forty-five (45) days of the close of all evidence in the ~~case~~appeal.

(D) Unless ~~an exception is provided in~~otherwise limited by OAC 317:2-1-7 or 317:2-1-13, the ~~Administrative Law Judge's~~ALJ's decision is appealable to OHCA's CEO ~~under 317:2-1-13~~.

(c) **ALJ jurisdiction.** The ~~Administrative Law Judge~~ALJ has jurisdiction of the following matters:

(1) ~~Member Appeals:~~**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~~OHCA. Tax warrant intercept appeals will be heard directly by the ALJ. A decision will be rendered by the ~~Administrative Law Judge~~ALJ within ~~20~~twenty (20) days of the hearing ~~before the ALJ~~;

(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~~twenty (20) days of the hearing before the ALJ. This is the final and only appeals process for proposed administrative sanctions;

(F) Appeals which relate to eligibility determinations made by OHCA;

(G) Appeals of insureds participating in Insure Oklahoma which are authorized by OAC 317:45-9-8(a); and

(2) ~~Provider Appeals:~~**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

~~OAC 317:30-5-131.2(b)(5), (e)(8), and (e)(12)~~OAC 317:30-5-131.2(b)(5)(B) and (d)(8);

(D) Appeals of Professional Service Contract awards and other matters related to the Central Purchasing Act pursuant to Title 74 O. S. § 85.1;

(E) Drug rebate appeals;

(F) Provider appeals of OHCA Program Integrity audit findings pursuant to OAC 317:2-1-7. This is the final and only appeals process for appeals of OHCA ~~audits~~Program Integrity audit findings; ~~and~~

(G) 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~~.~~;

(H) Supplemental Hospital Offset Payment Program (SHOPP) annual assessment, Supplemental Payment, fees or penalties as specifically provided in OAC 317:2-1-15~~.~~; and

(I) ~~Nursing Facility Supplemental Payment Program (NFSPP) eligibility determinations, the assessed amount for each component of the Intergovernmental transfer, Upper Payment Limit payments, the Upper Payment Limit Gap, and penalties specifically provided in OAC 317:30-5-136.~~The Nursing Facility Supplemental Payment Program (NFSPP) and its issues consisting of the amount of each component of the Intergovernmental transfer, the Upper Payment Limit payment, the Upper Payment Limit gap, and the penalties specifically provided in OAC 317:30-5-136. This is the final and only process for appeals regarding NFSPP.

317:2-1-2.5 Expedited appeals

(a) An expedited hearing request may be granted within three (3) working days of the request for hearing, if the time otherwise permitted for a hearing as described in OAC 317:2-1-2(a)(8) could jeopardize the Appellant's life or health or ability to attain, maintain, or regain maximum function.

(b) If OHCA determines that the request meets the criteria for an expedited hearing, it shall:

(1) Initiate the hearing process as described in OAC 317:2-1-5; and

(2) All matters relating to the hearing must be heard and disposed of as expeditiously as possible, but no later than three (3) working days after OHCA has received the request for an expedited hearing.

(c) If OHCA determines that the request does not meet the criteria for an expedited hearing, it shall:

(1) Initiate the ordinary hearing process timeframe, in

accordance with OAC 317:2-1-2(a)(8); and
(2) Notify the Appellant of the denial orally or through an electronic notice as described in OAC 317:35-5-66. If oral notification is provided, OHCA will follow up with a written notice within three (3) calendar days of the denial.

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 §§~~Title 59 of Oklahoma Statutes (O.S.), Sections (§§) 328.21, 328.22, and 328.23 (licensed dentists, specialty dentists and out of state dentists);

(2) individuals issued permits as dental interns under 59 ~~Oklahoma Statute~~O.S. § 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~~Oklahoma Administrative Code (OAC) 317:30-3-15.

(d) The American Dental Association's version of Code on Dental Procedures and Nomenclature (CDT) is used by the ~~OHCA~~Oklahoma Health Care Authority (OHCA) to communicate information related to codes, and procedures for administration. Definitions, nomenclature, and descriptors as listed in the CDT will apply, with the exception of more specific definitions or limitations set forth.

(1) ~~"Decay"~~**"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~~**"Emergency Dental Care"** means, but is not limited to, the immediate service that must be provided to relieve the member from pain due to an acute infection, swelling, trismus or trauma.

(3) **"Emergency Extraction"** means, but is not limited to, an extraction of a tooth due to presence of pathology, trauma, severe periodontal involvement, significant caries or to relieve pain or infection.

(4) **"Images"** means radiographs and diagnostic imaging that are part of the clinical record. Images should only be taken for clinical reasons as determined by the dentist and must be of diagnostic quality, properly identified, and dated.

~~(3) "Palliative Treatment"~~(5) **"Palliative Treatment"** means action that relieves pain but is not curative. Palliative Treatment is an all-inclusive service. No other codes are reimbursable on the same date of service.

~~(4) "Radiographic Caries"~~(6) **"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.~~

(7) **"Unbundling"** means billing separately for several individual procedures that are included within one CDT or Current Procedural Terminology (CPT) code.

(8) **"Upcoding"** means reporting a more complex and/or higher cost procedure than actually performed.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 21. OUTPATIENT BEHAVIORAL HEALTH AGENCY SERVICES

317:30-5-240.1. Definitions

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

"Accrediting body" means one (1) of the following:

(A) Accreditation Association for Ambulatory Health Care (AAAHC);

(B) American Osteopathic Association (AOA);

(C) Commission on Accreditation of Rehabilitation Facilities (CARF);

(D) Council on Accreditation of Services for Families and Children, Inc. (COA);

(E) The Joint Commission (TJC) formerly known as Joint Commission on Accreditation of Healthcare Organizations; ~~or~~

~~(F) other OHCA approved accreditation.~~

(F) Accreditation Commission for Health Care (ACHC); or

(G) other OHCA approved accreditation.

"Adult" means an individual ~~21~~twenty-one (21) and over, unless otherwise specified.

"AOD" means Alcohol and Other Drug.

"AODTP" means Alcohol and Other Drug Treatment Professional.

"ASAM" means the American Society of Addiction Medicine.

"ASAM Patient Placement Criteria (ASAM PPC)" means the most current edition of the American Society of Addiction Medicine's published criteria for admission to treatment, continued services, and discharge.

"Behavioral Health (BH) Services" means a wide range of diagnostic, therapeutic, and rehabilitative services used in the treatment of mental illness, substance abuse, and co-occurring disorders.

"BHAs" means Behavioral Health Aides.

"Certifying Agency" means the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS).

"C.F.R." means Code of Federal Regulations.

"Child" means an individual younger than ~~21~~twenty-one (21), unless otherwise specified.

"Client Assessment Record (CAR)" means the standardized tool recognized by OHCA and ODMHSAS to evaluate the functioning of the member.

"CM" means case management.

~~**"CMHCs"** means Community Mental Health Centers who are state-operated or privately contracted providers of behavioral health services for adults with serious mental illnesses, and youth with serious emotional disturbances.~~

"Cultural competency" means the ability to recognize, respect, and address the unique needs, worth, thoughts, communications, actions, customs, beliefs and values that reflect an individual's racial, ethnic, age group, religious, sexual orientation, and/or social group.

"DSM" means the most current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

"EBP" means an Evidence Based Practice per the Substance Abuse & Mental Health Services Administration (SAMHSA).

"EPSDT" means the Medicaid Early and Periodic Screening, Diagnostic and Treatment benefit for children. In addition to screening services, EPSDT also covers the diagnostic and treatment services necessary to ameliorate acute and chronic physical and mental health conditions.

"FBCS" means Facility Based Crisis Stabilization.

"FSPs" means Family Support Providers.

"ICF/IID" means Intermediate Care Facility for Individuals with Intellectual Disabilities.

"Institution" means an inpatient hospital facility or Institution for Mental Disease (IMD).

"IMD" means Institution for Mental Disease as per 42 ~~C.F.R~~C.F.R. § 435.1009 as a hospital, nursing facility, or other institution of more than ~~16~~sixteen (16) beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care and related services. The regulations indicate that an institution is an IMD if its overall character is that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases. Title XIX of the Social Security Act provides that, except for individuals under age ~~21~~twenty-one (21) receiving inpatient psychiatric care, Medicaid (Title XIX) does not cover services to IMD patients under ~~65~~sixty-five (65) years of age [~~section~~Section 1905(a)(24)(B)of the Social Security Act].

"Level of Functioning Rating" means a standardized mechanism to determine the intensity or level of services needed based upon the severity of the member's condition. The CAR level of function rating scale is the tool that links the clinical assessment to the appropriate level of Mental Health treatment. Either the Addiction Severity Index (ASI) or the Teen Addiction Severity Index (TASI), based on age, is the tool that links the clinical assessment to the appropriate level of Substance Abuse (SA) treatment.

"LBHP" means a ~~Licensed Behavioral Health Professional~~licensed behavioral health professional.

"MST" means the EBP Multi-Systemic Therapy.

"OAC" means Oklahoma Administrative Code, the publication authorized by ~~75 O.S. 256~~75 Oklahoma Statutes, Sec. 256 known as The Oklahoma Administrative Code, or, prior to its publication, the compilation of codified rules authorized by 75 O.S. § 256(A)(1)(a) and maintained in the Office of Administrative Rules.

"Objectives" means a specific statement of planned accomplishments or results that are specific, measurable, attainable, realistic, and time-limited.

"ODMHSAS" means the Oklahoma Department of Mental Health and Substance Abuse Services.

"ODMHSAS contracted facilities" means those providers that have a contract with the ODMHSAS to provide mental health or substance use disorder treatment services, and also contract directly with the Oklahoma Health Care Authority to provide Outpatient Behavioral Health Services.

"OHCA" means the Oklahoma Health Care Authority.

"OJA" means the Office of Juvenile Affairs.

"O.S." means Oklahoma Statutes.

~~**"Provider Manual"** means the OHCA BH Provider Billing Manual.~~

"RBMS" means Residential Behavioral Management Services within a group home or therapeutic foster home.

"Recovery" means an ongoing process of discovery and/or rediscovery that must be self defined, individualized and may contain some, if not all, of the ten fundamental components of recovery as outlined by SAMHSA.

"PRSS" means Peer Recovery Support Specialist.

"SAMHSA" means the Substance Abuse and Mental Health Services Administration.

"Serious Emotional Disturbance (SED)" means a condition experienced by persons from birth to ~~18~~eighteen (18) that show evidence of points of (A), (B) and (C) below:

(A) The disability must have persisted for six (6) months and be expected to persist for a year or longer.

(B) A condition or serious emotional disturbance as defined by the most recently published version of the DSM or the International Classification of Disease (ICD) equivalent with the exception of DSM "V" codes, substance abuse, and developmental disorders which are excluded, unless they co-occur with another diagnosable serious emotional disturbance.

(C) The child must exhibit either ~~i or ii~~(i) or (ii) below:

(i) Psychotic symptoms of a serious mental illness (e.g. Schizophrenia characterized by defective or lost contact with reality, often hallucinations or delusions); or

(ii) Experience difficulties that substantially interfere

with or limit a child or adolescent from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills. There is functional impairment in at least two (2) of the following capacities (compared with expected developmental level):

(I) Impairment in self-care manifested by a person's consistent inability to take care of personal grooming, hygiene, clothes and meeting of nutritional needs.

(II) Impairment in community function manifested by a consistent lack of age appropriate behavioral controls, decision-making, judgment and value systems which result in potential involvement or involvement with the juvenile justice system.

(III) Impairment of social relationships manifested by the consistent inability to develop and maintain satisfactory relationships with peers and adults.

(IV) Impairment in family function manifested by a pattern of disruptive behavior exemplified by repeated and/or unprovoked violence to siblings and/or parents, disregard for safety and welfare or self or others (e.g., fire setting, serious and chronic destructiveness, inability to conform to reasonable limitations and expectations which may result in removal from the family or its equivalent).

(V) Impairment in functioning at school manifested by the inability to pursue educational goals in a normal time frame (e.g., consistently failing grades, repeated truancy, expulsion, property damage or violence toward others).

"Serious Mental Illness (SMI)" means a condition experienced by persons age ~~18~~eighteen (18) and over that show evidence of points of (A), (B) and (C) below:

(A) The disability must have persisted for six (6) months and be expected to persist for a year or longer.

(B) A condition or serious mental illness as defined by the most recently published version of the DSM or the International Classification of Disease (ICD) equivalent with the exception of DSM "V" codes, substance abuse, and developmental disorders which are excluded, unless they co-occur with another diagnosable serious mental illness.

(C) The adult must exhibit either (i) or (ii) below:

(i) Psychotic symptoms of a serious mental illness (e.g. Schizophrenia characterized by defective or lost contact with reality, often hallucinations or delusions); or

(ii) Experience difficulties that substantially interfere with or limit an adult from achieving or maintaining one or more developmentally appropriate social, behavioral,

cognitive, communicative, or adaptive skills. There is functional impairment in at least two (2) of the following capacities (compared with expected developmental level):

(I) Impairment in self-care manifested by a person's consistent inability to take care of personal grooming, hygiene, clothes and meeting of nutritional needs.

(II) Impairment in community function manifested by a consistent lack of appropriate behavioral controls, decision-making, judgment and value systems which result in potential involvement or involvement with the criminal justice system.

(III) Impairment of social relationships manifested by the consistent inability to develop and maintain satisfactory relationships with peers.

(IV) Impairment in family function manifested by a pattern of disruptive behavior exemplified by repeated and/or unprovoked violence, disregard for safety and welfare of self or others (e.g., fire setting, serious and chronic destructiveness, inability to conform to reasonable limitations and expectations).

(V) Impairment in functioning at school or work manifested by the inability to pursue educational or career goals.

"Trauma informed" means the recognition and responsiveness to the presence of the effects of past and current traumatic experiences in the lives of members.

317:30-5-240.2. Provider participation standards

(a) **Accreditation and certification status.** Any agency may participate as an ~~OPBH~~Outpatient Behavioral Health (OPBH) provider if the agency is qualified to render a covered service and meets the OHCA requirements for provider participation.

(1) Private, Community-based Organizations must be accredited as a provider of outpatient behavioral health services from one of the accrediting bodies listed in (c)(1) below and be an incorporated organization governed by a board of directors or be certified by the certifying agency in accordance with ~~Section(s) 3-317, 3-323A, 3-306.1, or 3-415 of Title 43A of the Oklahoma Statutes~~43A O.S. §§ 3-317, 3-323A, 3-306.1, or 3-415;

(2) State-operated programs under the direction of ODMHSAS must be accredited by one of the accrediting bodies or be certified by the certifying agency in accordance with ~~Section(s) 3-317, 3-323A, 3-306.1 or 3-415 of Title 43A of the Oklahoma Statues~~43A O.S. §§ 3-317, 3-323A, 3-306.1 or 3-415;

(3) Freestanding Psychiatric Hospitals must be licensed and certified by the State Survey Agency as meeting Medicare psychiatric hospital standards and JCAHO accreditation;

(4) General Medical Surgical Hospitals must be appropriately licensed and certified by the State Survey Agency as meeting Medicare standards, including a JCAHO or AOA accreditation;
(5) Federally Qualified Health Centers/Community Health Centers facilities that qualify under OAC 317:30-5-660;
(6) Indian Health Services/Tribal Clinics/Urban Tribal Clinics facilities that qualify under ~~Federal~~federal regulation;
(7) Rural Health Clinics facilities that qualify under OAC 317:30-5-355;
(8) Public Health Clinics and County Health Departments;
(9) Public School Systems.

(b) **Certifications.** In addition to the accreditation in paragraph (a) above or ODMHSAS certification in accordance with ~~Section(s) 3-317, 3-323A, 3-306.1 or 3-415 of Title 43A of the Oklahoma Statutes~~43A O.S. §§ 3-317, 3-323A, 3-306.1 or 3-415, provider specific credentials are required for the following:
(1) Substance Abuse agencies (OAC 450:18-1-1);
(2) Evidence Based Best Practices but not limited to:
(A) Assertive Community Treatment (OAC 450:55-1-1);
(B) Multi-Systemic Therapy (Office of Juvenile Affairs); and
(C) Peer Support/Community Recovery Support;
(3) Systems of Care (OAC 340:75-16-46);
(4) Mobile and Facility-based Crisis Intervention (OAC 450:23-1-1);
(5) Case Management (OAC 450:50-1-1);
(6) RBMS in group homes (OAC 377:10-7) or therapeutic foster care settings (OAC 340:75-8-4);
(7) Day Treatment - CARF, JCAHO, ACHC or COA for Day Treatment Services; and
(8) Partial Hospitalization/Intensive Outpatient CARF, JCAHO, ACHC or COA for Partial Hospitalization services.

(c) **Provider enrollment and contracting.**
(1) Organizations who have JCAHO, CARF, COA, ACHC or AOA accreditation or ODMHSAS certification in accordance with ~~Section(s) 3-317, 3-323A, 3-306.1 or 3-415 or Title 43A of the Oklahoma Statutes~~43A O.S. §§ 3-317, 3-323A, 3-306.1 or 3-415 will supply the documentation from the accrediting body or certifying agency, along with other information as required for contracting purposes to the OHCA. The contract must include copies of all required state licenses, accreditation and certifications.
(2) If the contract is approved, a separate provider identification number for each outpatient behavioral health service site will be assigned. Each site operated by an outpatient behavioral health facility must have a separate provider contract and site-specific accreditation and/or certification as applicable. A site is defined as an office,

clinic, or other business setting where outpatient behavioral health services are routinely performed. When services are rendered at the member's residence, a school, or when provided occasionally at an appropriate community based setting, a site is determined according to where the professional staff perform administrative duties and where the member's chart and other records are kept. Failure to obtain and utilize site specific provider numbers will result in disallowance of services.

(3) All behavioral health providers are required to have an individual contract with OHCA in order to receive SoonerCare reimbursement. This requirement includes outpatient behavioral health agencies and all individual rendering providers who work within an agency setting. Individual contracting rendering provider qualification requirements are set forth in OAC 317:30-3-2 and 317:30-5-240.3.

(d) **Standards and criteria.** Eligible organizations must meet each of the following:

(1) Have a well-developed plan for rehabilitation services designed to meet the recovery needs of the individuals served.

(2) Have a multi-disciplinary, professional team. This team must include all of the following:

(A) One of the LBHPs;

(B) A Certified Behavioral Health Case Manager II (CM II) or CADC, if individual or group rehabilitative services for behavioral health disorders are provided, and the designated LBHP(s) or ~~Licensure~~licensure candidate(s) on the team will not be providing rehabilitative services;

(C) An AODTP, if treatment of substance use disorders is provided;

(D) A registered nurse, advanced practice nurse, or physician assistant, with a current license to practice in the state in which the services are delivered if Medication Training and Support Service is provided;

(E) The member for whom the services will be provided, and parent/guardian for those under ~~18~~eighteen (18) years of age.

(F) A member treatment advocate if desired and signed off on by the member.

(3) Demonstrate the ability to provide each of the following outpatient behavioral health treatment services as described in OAC 317:30-5-241 et seq., as applicable to their program. Providers must provide proper referral and linkage to providers of needed services if their agency does not have appropriate services.

(A) Assessments and Service Plans;

(B) Psychotherapies;

(C) Behavioral Health Rehabilitation services;

(D) Crisis Intervention services;

(E) Support Services; and
(F) Day Treatment/Intensive Outpatient.

(4) Be available ~~24~~twenty-four (24) hours a day, seven (7) days a week, for Crisis Intervention services.

(5) Provide or have a plan for referral to physician and other behavioral health services necessary for the treatment of the behavioral disorders of the population served.

(6) Comply with all applicable ~~Federal and State Regulations~~ federal and state regulations.

(7) Have appropriate written policy and procedures regarding confidentiality and protection of information and records, member grievances, member rights and responsibilities, and admission and discharge criteria, which shall be posted publicly and conspicuously.

(8) Demonstrate the ability to keep appropriate records and documentation of services performed.

(9) Maintain and furnish, upon request, a current report of fire and safety inspections of facilities clear of any deficiencies.

(10) Maintain and furnish, upon request, all required staff credentials including certified transcripts documenting required degrees.

317:30-5-241.2. Psychotherapy

(a) **Psychotherapy.**

(1) **Definition.** Psychotherapy is a face-to-face treatment for mental illnesses and behavioral disturbances, in which the clinician, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior and encourage growth and development. Insight oriented, behavior modifying and/or supportive psychotherapy refers to the development of insight of affective understanding, the use of behavior modification techniques, the use of supportive interactions, the use of cognitive discussion of reality, or any combination of these items to provide therapeutic change. Ongoing assessment of the member's status and response to treatment as well as psycho-educational intervention are appropriate components of individual therapy. The therapy must be goal directed, utilizing techniques appropriate to the service plan and the member's developmental and cognitive abilities.

(2) **Interactive Complexity.** Psychotherapy is considered to involve "interactive complexity" when there are communication factors during a visit that complicate delivery of the psychotherapy by the qualified practitioner. Sessions typically involve members who have other individuals legally responsible for their care (i.e. minors or adults with guardians); members who request others to be involved in their care during the

session (i.e. adults accompanied by one or more participating family members or interpreter or language translator); or members that require involvement of other third parties (i.e. child welfare, juvenile justice, parole/probation officers, schools, etc.). Psychotherapy should only be reported as involving interactive complexity when at least one (1) of the following communication factors is present:

(A) The need to manage maladaptive communication (i.e. related to high anxiety, high reactivity, repeated questions, or disagreement) among participants that complicate delivery of care.

(B) Caregiver emotions/behavior that interfere with implementation of the service plan.

(C) Evidence/disclosure of a sentinel event and mandated report to a third party (i.e. abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with patient and other visit participants.

(D) Use of play equipment, physical devices, interpreter or translator to overcome barriers to therapeutic interaction with a patient who is not fluent in the same language or who has not developed or lost expressive or receptive language skills to use or understand typical language.

(3) **Qualified practitioners.** Psychotherapy must be provided by a ~~Licensed Behavioral Health Professional~~licensed behavioral health professional (LBHP) or ~~Licensure Candidate~~licensure candidate in a setting that protects and assures confidentiality.

(4) **Limitations.** A maximum of four (4) units per day per member is compensable. A cumulative maximum of eight (8) units of individual psychotherapy and family psychotherapy per week per member is compensable. Except for psychotherapy involving interactive complexity as described in this Section, only the member and the qualified practitioner should be present during the session. Psychotherapy 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 Prior Authorization Manual. Limitations exclude outpatient behavioral health services provided in a foster care setting.

(b) **Group Psychotherapy.**

(1) **Definition.** Group psychotherapy is a method of treating behavioral disorders using the interaction between the qualified practitioner and two or more individuals to promote positive emotional or behavioral change. The focus of the group must be directly related to the goals and objectives in the individual member's current service plan. This service does not include social or daily living skills development as described under Behavioral Health Rehabilitation Services.

(2) **Group sizes.** Group Psychotherapy is limited to a total of eight (8) adult ~~(18 and over)~~[eighteen (18) and over]

individuals except when the individuals are residents of an ICF/IID where the maximum group size is six (6). For all children under the age of eighteen (18), the total group size is limited to six (6).

(3) **Multi-family and conjoint family therapy.** Sessions are limited to a maximum of eight (8) families/units. Billing is allowed once per family unit, though units may be divided amongst family members.

(4) **Qualified practitioners.** Group psychotherapy will be provided by an LBHP or ~~Licensure Candidate~~licensure candidate. Group Psychotherapy must take place in a confidential setting limited to the qualified practitioner, an assistant or co-therapist, if desired, and the group psychotherapy participants.

(5) **Limitations.** A maximum of six (6) units per day per member is compensable, not to exceed twelve (12) units per week. Group Psychotherapy is not reimbursable for a child younger than the age of three (3). Limitations exclude outpatient behavioral health services provided in a foster care setting.

(c) **Family Psychotherapy.**

(1) **Definition.** Family Psychotherapy is a face-to-face psychotherapeutic interaction between a qualified practitioner and the member's family, guardian, and/or support system. It is typically inclusive of the identified member, but may be performed if indicated without the member's presence. When the member is an adult, his/her permission must be obtained in writing. Family psychotherapy must be provided for the direct benefit of the SoonerCare member to assist him/her in achieving his/her established treatment goals and objectives and it must take place in a confidential setting. This service may include the Evidence Based Practice titled Family Psychoeducation.

(2) **Qualified practitioners.** Family Psychotherapy must be provided by an LBHP or ~~Licensure Candidate~~licensure candidate.

(3) **Limitations.** A maximum of four (4) units per day per member/family unit is compensable. A cumulative maximum of eight (8) units of individual psychotherapy and family psychotherapy per week per member is compensable. The practitioner may not bill any time associated with note taking and/or medical record upkeep. The practitioner may only bill the time spent in direct face-to-face contact. Practitioner must comply with documentation requirements listed in OAC 317:30-5-248. Limitations exclude outpatient behavioral health services provided in a foster care setting.

(d) **Multi-Systemic Therapy (MST).**

(1) **Definition.** MST intensive outpatient program services are limited to children within an Office of Juvenile Affairs (OJA) MST treatment program which provides an intensive, family and community-based treatment targeting specific BH disorders in children with SED who exhibit chronic, aggressive, antisocial, and/or substance abusing behaviors, and are at risk for out of

home placement. Case loads are kept low due to the intensity of the services provided.

(2) **Qualified professionals.** Masters level professionals who work with a team that may include bachelor level staff.

(3) **Documentation requirements.** Providers must comply with documentation requirements in OAC 317:30-5-248.

(4) **Service limitations.** Partial billing is not allowed, when only one service is provided in a day, providers should not bill for services performed for less than eight (8) minutes.

(e) **Children/Adolescent Partial Hospitalization Program (PHP).**

(1) **Definition.** Partial hospitalization services are services that (1) Are reasonable and necessary for the diagnosis or active treatment of the member's condition; (2) Are reasonably expected to improve the member's condition and functional level and to prevent relapse or hospitalization and (3) Include the following:

(A) Assessment, diagnostic and service plan services for mental illness and/or substance use disorders provided by LBHPs or ~~Licensure Candidates~~licensure candidates.

(B) Individual/Group/Family (primary purpose is treatment of the member's condition) psychotherapies provided by LBHPs or ~~Licensure Candidates~~licensure candidates.

(C) Substance use disorder specific services are provided by LBHPs or ~~Licensure Candidates~~licensure candidates qualified to provide these services.

(D) Drugs and biologicals furnished for therapeutic purposes.

(E) Family counseling, the primary purpose of which is treatment of the member's condition.

(F) Behavioral health rehabilitation services to the extent the activities are closely and clearly related to the member's care and treatment, provided by a Certified Behavioral Health Case Manager II, Certified Alcohol and Drug Counselor (CADC), LBHP, or ~~Licensure Candidate~~licensure candidate who meets the professional requirements listed in OAC 317:30-5-240.3.

(G) Care Coordination of behavioral health services provided by certified behavioral health case managers.

(2) **Qualified practitioners.**

(A) All services in the PHP are provided by a clinical team, consisting of the following required professionals:

(i) A licensed physician;

(ii) Registered nurse; and

(iii) One or more of the licensed behavioral health professionals (LBHP) or ~~Licensure Candidates~~licensure candidates listed in OAC 317: 30-5-240.3(a) and (b).

(B) The clinical team may also include a Certified Behavioral Health Case Manager.

(C) The service plan is directed under the supervision of a physician and the number of professionals and paraprofessionals required on the clinical team is dependent

on the size of the program.

(3) **Qualified providers.** Provider agencies for PHP must be accredited by one of the national accrediting bodies; The Joint Commission (TJC), Commission on Accreditation of Rehabilitation Facilities (CARF), Accreditation Commission for Health Care (ACHC) or The Council on Accreditation (COA) for partial hospitalization and enrolled in SoonerCare. Staff providing these services are employees or contractors of the enrolled agency.

(4) **Limitations.** Services are limited to children 0-20 only. Children under age six (6) are not eligible for behavioral health rehabilitation services, unless a prior authorization for children ages four (4) and five (5) has been granted by OHCA or its designated agent based on a finding of medical necessity. Services must be offered at a minimum of three (3) hours per day, five (5) days per week. Therapeutic services are limited to four (4) billable hours per day. PHP services are all inclusive with the exception of physician services and drugs that cannot be self-administered, those services are separately billable. Group size is limited to a maximum of eight (8) individuals as clinically appropriate given diagnostic and developmental functioning. Occupational, Physical and Speech therapy will be provided by the Independent School District (ISD). Academic instruction, meals, and transportation are not covered.

(5) **Service requirements.**

(A) Therapeutic Services are to include the following:

(i) Psychiatrist/physician face-to-face visit two (2) times per month;

(ii) Crisis management services available ~~24~~twenty-four (24) hours a day, seven (7) days a week;

(B) Psychotherapies to be provided a minimum of four (4) hours per week and include the following:

(i) Individual therapy - a minimum of one (1) session per week;

(ii) Family therapy - a minimum of one (1) session per week; and

(iii) Group therapy - a minimum of two (2) sessions per week;

(C) Interchangeable services which include the following:

(i) Behavioral Health Case Management (face-to-face);

(ii) Behavioral health rehabilitation services/alcohol and other drug abuse education except for children under age six (6), unless a prior authorization has been granted for children ages four (4) and five (5);

(iii) Medication Training and Support; and

(iv) Expressive therapy.

(6) **Documentation requirements.** Documentation needs to specify active involvement of the member's family, caretakers, or significant others involved in the individual's treatment. A nursing health assessment must be completed within ~~24~~twenty-four

(24) hours of admission. A physical examination and medical history must be coordinated with the Primary Care Physician. Service plan updates are required every three (3) months or more frequently based on clinical need. Records must be documented according to ~~Section~~ OAC 317:30-5-248.

(7) **Staffing requirements.** Staffing requirements must consist of the following:

(A) RN trained and competent in the delivery of behavioral health services as evidenced by education and/or experience that is available onsite during program hours to provide necessary nursing care and/or psychiatric nursing care ~~(one (1) RN at a minimum can be backed up by an LPN but an RN must always be onsite)~~[one (1) RN at a minimum can be backed up by an LPN but an RN must always be onsite]. Nursing staff administers medications, follows up with families on medication compliance, and restraint assessments.

(B) Medical director must be a licensed psychiatrist.

(C) A psychiatrist/physician must be available ~~24~~twenty-four (24) hours a day, seven (7) days a week.

(f) **Children/Adolescent Day Treatment Program.**

(1) **Definition.** Day Treatment Programs are for the stabilization of children and adolescents with severe emotional and/or behavioral disturbances. Treatment is designed for children who have difficulty functioning in mainstream community settings such as classrooms, and who need a higher intensity of services than outpatient counseling provides. Treatment is time limited and includes therapeutically intensive clinical services geared towards reintegration to the home, school, and community.

(2) **Qualified practitioners.** All services in Day Treatment are provided by a team, which must be composed of one (1) or more of the following participants: physician, registered nurse, licensed behavioral health professional (LBHP) or ~~Licensure Candidate~~licensure candidate, a case manager, or other certified Behavioral Health/Substance Abuse paraprofessional staff. Services are directed by an LBHP or ~~Licensure Candidate~~licensure candidate.

(3) **Qualified providers.** Provider agencies for Day Treatment must be accredited to provide Day Treatment services by one of the national accrediting bodies; The Joint Commission (TJC), Commission on Accreditation of Rehabilitation Facilities (CARF), Accreditation Commission for Health Care (ACHC) or The Council on Accreditation (COA).

(4) **Limitations.** Services must be offered at a minimum of four (4) days per week at least three (3) hours per day. Behavioral Health Rehabilitation Group size is limited to a maximum of eight (8) individuals as clinically appropriate given diagnostic and developmental functioning. Children under age six (6) are not eligible for behavioral health rehabilitation services, unless a prior authorization for children ages four (4) and five

(5) has been granted by OHCA or its designated agent based on a finding of medical necessity.

(5) **Service requirements.** On-call crisis intervention services must be available ~~24~~twenty-four (24) hours a day, seven (7) days a week (When members served have psychiatric needs, psychiatric services are available which include the availability of a psychiatrist ~~24~~twenty-four (24) hours a day, seven (7) days a week. A psychiatrist can be available either on site or on call but must be available at all times). Day treatment program will provide assessment and diagnostic services and/or medication monitoring, when necessary.

(A) Treatment activities are to include the following every week:

(i) Family therapy at least one (1) hour per week (additional hours of FT may be substituted for other day treatment services);

(ii) Group therapy at least two (2) hours per week; and

(iii) Individual therapy at least one (1) hour per week.

(B) Additional services are to include at least one (1) of the following services per day:

(i) Medication training and support (nursing) once monthly if on medications;

(ii) Behavioral health rehabilitation services to include alcohol and other drug education if the child meets the criteria established in OAC 317:30-5-241.3 and is clinically necessary and appropriate except for children under age six (6), unless a prior authorization has been granted for children ages four (4) and five (5);

(iii) Behavioral health case management as needed and part of weekly hours for member;

(iv) Occupational therapy as needed and part of weekly hours for member; and

(v) Expressive therapy as needed and part of weekly hours for the member.

(6) **Documentation requirements.** Service plans are required every three (3) months.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 6. INPATIENT PSYCHIATRIC SERVICES

317:30-5-95.1. ~~Coverage for adults ages 21 to 64~~Medical necessity criteria and coverage for adults aged twenty-one (21) to sixty-four (64)

~~Coverage for adults age 21 to 64 is limited to services in acute inpatient hospital settings (see OAC 317:30-5-95). OHCA rules that apply to inpatient psychiatric coverage for adults ages 21 to 64 are found in Sections OAC 317:30-5-95.2 through 317:30-5-95.10.~~

(a) **Coverage for adults.** Coverage for adults aged twenty-one (21) to sixty-four (64) is limited to services in a psychiatric unit of a general hospital (see OAC 317:30-5-95). OHCA rules that apply to inpatient psychiatric coverage for adults aged twenty-one (21) to sixty-four (64) are found in Sections OAC 317:30-5-95.1 through 317:30-5-95.10.

(b) **Medical necessity criteria for admission of adults aged twenty-one (21) to sixty-four (64) for psychiatric disorders.** An inpatient admission of an adult aged twenty-one (21) to sixty-four (64) that is attributable to a psychiatric disorder must meet the terms or conditions contained in (1), (2), (3), (4), one of (5)(A) to (5)(D), and one of (6)(A) to (6)(C) of this subsection.

(1) A primary diagnosis from the most recent edition of "The Diagnostic and Statistical Manual of Mental Disorders" (DSM) with the exception of V-codes, adjustment disorders, and substance related disorders, accompanied by a detailed description of the symptoms supporting the diagnosis.

(2) Conditions are directly attributable to a psychiatric disorder as the primary need for professional attention (this does not include placement issues, criminal behavior, or status offenses). Adjustment or substance related disorder may be a secondary 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 less intensive treatment program.

(4) Adult must be medically stable.

(5) Within the past forty-eight (48) hours, the behaviors present an imminent life-threatening emergency such as evidenced by:

(A) Specifically described suicide attempts, suicidal 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 twenty-four (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 twenty-four (24) hour medical supervision.

(c) **Medical necessity criteria for admission of adults aged twenty-one (21) to sixty-four (64) for inpatient chemical dependency detoxification.** An inpatient admission of an adult aged twenty-one (21) to sixty-four (64) for chemical dependency/ substance use/ detoxification must meet the terms and conditions contained in (1), (2), (3), and one of (4)(A) through (D) of this subsection.
(1) Any psychoactive substance dependency disorder described in the most recent edition of "The Diagnostic and Statistical Manual of Mental Disorders" (DSM) with detailed symptoms supporting the diagnosis and need for medical detoxification, except for cannabis, nicotine, or caffeine dependencies.
(2) Conditions are directly attributable to a substance dependency disorder as the primary need for professional attention (this does not include placement issues, criminal behavior, or status offenses).
(3) It has been determined by the OHCA designated agent that the current disabling symptoms could not be managed or have not been manageable in a less intensive treatment program.
(4) Requires secure twenty-four (24) hour nursing/medical supervision as evidenced by:
(A) Need for active and aggressive pharmacological interventions.
(B) Need for stabilization of acute psychiatric symptoms.
(C) Need extensive treatment under physician direction.
(D) Physiological evidence or expectation of withdrawal symptoms which require twenty-four (24) hour medical supervision.

317:30-5-95.4. Individual plan of care for adults ~~ages 21 to 64~~aged twenty-one (21) to sixty-four (64)

(a) Before admission to a psychiatric unit of a general hospital or immediately after admission, the attending physician or staff physician must establish a written plan of care for each member ~~age 21 to 64~~aged twenty-one (21) to sixty-four (64). The plan of care must include:

(1) Diagnoses, symptoms, complaints, and complications indicating the need for admission;

(2) A description of the functional level of the individual;

(3) Objectives;

(4) Any order for medication, treatments, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures recommended for the health and safety of the member;

(5) Plans for continuing care, including review and modification to the plan of care; and

(6) Plans for discharge.

(b) The attending or staff physician and other treatment team personnel involved in the member's care must review each plan of care at least every seven (7) days.

(c) All plans of care and plan of care reviews must be clearly identified as such in the member's medical records. All must be signed and dated by the physician, RN, LBHP or licensure candidate, member, and other treatment team members that provide individual, family, and group therapy in the required review interval. 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~~his or her acuity level precludes ~~them~~him or her from signing. If the member has designated an advocate, the advocate's signature is also required on all plans of care and plan of care reviews. If the member was too physically ill or ~~their~~his or her acuity level precluded ~~them~~him or her from signing the plan of care and/or the plan of care review at the time of completion, the member must sign the plan when ~~their~~his or her condition improves, but before discharge.

(d) The plan of care must document appropriate member participation in the development and implementation of the treatment plan.

317:30-5-95.6. Medical, psychiatric, and social evaluations for adults ~~age 21 to 64~~aged twenty-one (21) to sixty-four (64)

The record for an adult member ~~age 21 to 64~~aged twenty-one (21) to sixty-four (64) must contain complete medical, psychiatric, and social evaluations.

(1) The evaluations must be completed as follows:

(A) History and Physical must be completed within ~~24~~ twenty-four (24) hours of admission by a licensed independent practitioner ~~(M.D., D.O., Advanced Practice Nurse (A.P.N.),~~

~~or Physician Assistant (P.A.)].~~[MD, DO, Advanced Practice Register Nurse (APRN), or Physician Assistant (PA)].

(B) Psychiatric Evaluation must be completed within ~~60~~sixty (60) hours of admission by an ~~allopathic or osteopathic physician~~Allopathic Or Osteopathic Physician with a current license and a board certification/eligible in psychiatry.

(C) Psychosocial Evaluation must be completed within ~~72~~ seventy-two (72) hours of admission by a licensed independent practitioner (~~M.D., D.O., A.P.N.~~MD, DO, APRN, or PA), a ~~Licensed Behavioral Health Professional~~licensed behavioral health professional, or a ~~Licensure Candidate~~licensure candidate as defined in OAC 317:30-5-240.3.

(2) The evaluations must be clearly identified as such and must be signed and dated by the evaluator.

317:30-5-95.9. Therapeutic services for adults ~~age~~aged 21 to 64

An interdisciplinary team of a physician, licensed behavioral health professional(s) (LBHP), ~~registered nurse~~Registered Nurse, and other staff who provide services to adult members ~~age 21 to 64~~aged twenty-one (21) to sixty-four (64) in the facility oversee all components of the active treatment and provide services appropriate to ~~their~~each team member's respective discipline. The team developing the individual plan of care 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) An LBHP licensed to practice by one of the boards in (A) through (F):

(A) Psychology (health service specialty only);

(B) Social Work (clinical specialty only);

(C) Licensed Professional Counselor;

(D) Licensed Behavioral Practitioner;

(E) Licensed Marital and Family Therapist;

(F) Licensed Alcohol and Drug Counselor; or

(G) ~~Advanced Practice Nurse~~Advanced Practice Registered Nurse (APRN) (certified in a psychiatric mental health specialty, licensed as a ~~registered nurse~~Registered Nurse with a current certification of recognition from the Board of Nursing in the state in which the services are provided);

(3) Under the supervision of an LBHP, a licensure candidate actively and regularly receiving board approved supervision to become licensed by one of the boards in A through F above, and extended supervision if the board's supervision requirement is met but the individual is not yet licensed, may be a part of the team; and

(4) ~~a registered nurse~~A Registered Nurse with a minimum of two (2) years of experience in a mental health treatment setting.

317:30-5-95.10. Discharge plan for adults ~~age 21 to 64~~aged twenty-one (21) to sixty-four (64)

Each adult member ~~age 21 to 64~~aged twenty-one (21) to sixty-four (64) must have a discharge plan that includes a recapitulation of the member's hospitalization~~,~~; recommendations for follow-up and aftercare, to include referral to medication management, ~~out-patient~~outpatient behavioral health counseling, and/or case management, to include the specific appointment information (time, date, and name, address, and telephone number of provider and related community services)~~,~~; and a summary of the member's condition at discharge. All discharge and aftercare plans must be documented in the member's medical records.

317:30-5-95.11. Inpatient acute psychiatric services for persons ~~over 65~~sixty-five (65) years of age or older

Payment is made for medically necessary inpatient acute psychiatric services~~, including free-standing psychiatric facilities,~~ for persons ~~over 65~~sixty-five (65) years of age or older. OHCA rules that apply to inpatient acute psychiatric coverage for persons ~~over 65~~sixty-five (65) years of age or older are found in Sections OAC 317:30-5-95.12 through 317:30-5-95.21.

317:30-5-95.12. Utilization control requirements for inpatient acute psychiatric services for persons ~~over 65~~sixty-five (65) years of age or older

~~Federal regulations require that medical records include the factors which must be met for the Medicaid services to be compensable (Reference 42 CFR 456.150).~~

As set forth in 42 C.F.R. §§ 456.50 and 456.150, general hospitals and psychiatric hospitals must maintain medical records and other documentation sufficient to show that all requirements concerning certification of need for care, plan of care, and utilization review plans have been met. Psychiatric hospitals must also maintain medical records and other documentation sufficient to show that all requirements concerning medical evaluation and admission review have been met, in accordance with 42 C.F.R. § 456.150.

317:30-5-95.13. Certification and recertification of need for inpatient care for inpatient acute psychiatric services for persons ~~over 65~~sixty-five (65) years of age or older

The certification and recertification of need for inpatient care for persons ~~over 65~~sixty-five (65) years of age or older must be in

writing and must be signed and dated by the physician who has knowledge of the case and the need for continued inpatient psychiatric care. The certification and recertification documents for all SoonerCare members must be maintained in the member's medical records or in a central file at the facility where the member is or was a resident.

(1) **Certification.** A physician must certify for each applicant or member that inpatient services in ~~a psychiatric hospital~~an acute care setting are or were needed. The certification must be made at the time of admission or, if an individual applies for assistance while ~~in a psychiatric hospital~~hospitalized, before OHCA, or its designated agent, authorizes payment.

(2) **Recertification.** A physician must recertify for each applicant or member that inpatient services in the ~~psychiatric hospital~~acute care setting are needed. Recertification must be made at least every ~~60~~sixty (60) days after certification.

317:30-5-95.14. Individual plan of care for persons ~~over 65~~sixty-five (65) years of age or older receiving inpatient acute psychiatric services

(a) Before admission to a psychiatric hospital or psychiatric unit of a general hospital or immediately after admission, the attending physician or staff physician must establish a written plan of care for each applicant or member. The plan of care must include:

(1) Diagnoses, symptoms, complaints, and complications indicating the need for admission;

(2) A description of the functional level of the individual;

(3) Objectives;

(4) Any order for medication, treatments, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures recommended for the health and safety of the member;

(5) Plans for continuing care, including review and modification to the plan of care; and

(6) Plans for discharge.

(b) The attending or staff physician and other treatment team personnel involved in the member's care must review each plan of care at least every seven (7) days.

(c) All plans of care and plan of care reviews must be clearly identified as such in the member's medical records. All must be signed and dated by the physician, RN, LBHP or licensure candidate, member, and other treatment team members that provide individual, family, and group therapy in the required review interval. 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~~his or her acuity level precludes ~~them~~him or her from signing. If the member has designated an advocate, the advocate's signature

is also required on all plans of care and plan of care reviews. If the member was too physically ill or ~~their~~his or her acuity level precluded ~~them~~him or her from signing the plan of care and/or the plan of care review at the time of completion, the member must sign the plan when ~~their~~his or her condition improves, but before discharge.
(d) The plan of care must document appropriate member participation in the development and implementation of the treatment plan.

317:30-5-95.16. Medical psychiatric and social evaluations for persons ~~over 65~~sixty-five (65) years of age or older receiving inpatient acute psychiatric services

The record of a member ~~over 65~~sixty-five (65) years of age or older receiving inpatient acute psychiatric services must contain complete medical, psychiatric, and social evaluations.

(1) The evaluations must be completed as follows:

(A) History and Physical must be completed within ~~24~~ twenty-four (24) hours of admission by a licensed independent practitioner ~~[M.D., D.O., Advanced Practice Nurse (A.P.N.), or Physician Assistant (P.A.)].~~[MD, DO, Advanced Practice Register Nurse (APRN), or Physician Assistant (PA)].

(B) Psychiatric Evaluation must be completed within ~~60~~sixty (60) hours of admission by an allopathic or osteopathic physician with a current license and a board certification/eligible in psychiatry.

(C) Psychosocial Evaluation must be completed within ~~72~~seventy-two (72) hours of admission by a licensed independent practitioner, a licensed behavioral health professional (LBHP), or ~~Licensure Candidate~~licensure candidate as defined in OAC~~:~~ 317:30-5-240.3.

(2) The evaluations must be clearly identified as such and must be signed and dated by the evaluator.

317:30-5-95.19. Therapeutic services for persons ~~over 65~~sixty-five (65) years of age or older receiving inpatient acute psychiatric services

An interdisciplinary team of a physician, licensed behavioral health professional(s) (LBHP), ~~registered nurse~~Registered Nurse, and other staff who provide services to members ~~over 65~~sixty-five (65) years of age or older who are receiving inpatient acute psychiatric services in the facility oversee all components of the active treatment and provide services appropriate to ~~their~~each team member's respective discipline. The team developing the individual plan of care 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) ~~an~~An LBHP licensed to practice by one of the boards in (A) through (F):

(A) Psychology (health service specialty only);

(B) Social Work (clinical specialty only);

(C) Licensed Professional Counselor;

(D) Licensed Behavioral Practitioner;

(E) Licensed Marital and Family Therapist;

(F) Licensed Alcohol and Drug Counselor; or

(G) ~~Advanced Practice Nurse~~Advanced Practice Registered Nurse (APRN) (certified in a psychiatric mental health specialty, licensed as a ~~registered nurse~~Registered Nurse with a current certification of recognition from the Board of Nursing in the state in which the services are provided);

(3) Under the supervision of an LBHP, a licensure candidate actively and regularly receiving board approved supervision to become licensed by one of the boards in A through F above, and extended supervision if the board's supervision requirement is met but the individual is not yet licensed, may be a part of the team; and

(4) ~~a registered nurse~~A Registered Nurse with a minimum of two (2) years of experience in a mental health treatment setting.

317:30-5-95.20. Discharge plan for persons ~~over 65~~sixty-five (65) years of age or older receiving inpatient acute psychiatric services

Each member ~~over 65~~sixty-five (65) years of age or older receiving inpatient acute psychiatric services must have a discharge plan that includes a recapitulation of the member's hospitalization~~,~~; recommendations for follow-up and aftercare, to include referral to medication management, ~~out-patient~~outpatient behavioral health counseling, and/or case management, to include the specific appointment information (time, date, and name, address, and telephone number of provider and related community services)~~,~~; and a summary of the member's condition at discharge. All discharge and aftercare plans must be documented in the member's medical records.

317:30-5-95.21. Continued stay review for persons ~~over 65~~sixty-five (65) years of age or older receiving inpatient acute psychiatric services

The facility must complete a continued stay review at least every ~~90~~ninety (90) days each time the facility utilization review committee determines that the continued inpatient psychiatric hospital stay is required for persons ~~over 65~~sixty-five (65) years of age or older.

(1) The methods and criteria for continued stay review must be contained in the facility utilization review plan.
(2) Documentation of the continued stay review must be clearly identified as such, signed, and dated by the committee chairperson, and must clearly state the continued stay dates and time period approved.

317:30-5-95.33. Individual plan of care for ~~children~~members under the age of twenty-one (21)

(a) The following words and terms, when used in this ~~section~~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)~~Advanced Practice Registered Nurses (APRN).

(2) **"Licensure Candidate"** means practitioners actively and regularly receiving board approved supervision, and extended supervision by a fully licensed clinician if board's supervision requirement is met but the individual is not yet licensed, to become licensed by one of the following licensing boards:

(A) Psychology,
(B) Social Work (clinical specialty only),
(C) Professional Counselor,
(D) Marriage and Family Therapist,
(E) Behavioral Practitioner, or
(F) Alcohol and Drug Counselor.

(3) **"Individual ~~plan~~Plan of Care (IPC)"** means a written plan developed for each member within four (4) 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~~IPC must be recovery focused, trauma informed, and specific to culture, age, and gender and ~~includes~~include:

(A) A primary diagnosis from the most recent edition of "The Diagnostic and Statistical Manual of Mental Disorders" (DSM) with the exception of V-Codes, adjustment disorders, and substance abuse related disorders, accompanied by a detailed description of the symptoms supporting the diagnosis. ~~Children 18-20~~Members eighteen (18) to twenty (20) years of age may have a diagnosis of any personality disorder. Adjustment or substance related disorders may be a secondary diagnosis~~.~~;

(B) the current functional level of the individual;

(C) treatment goals and measurable, ~~time limited~~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~~IPC; and

(F) plan for discharge, all of which is developed to improve the ~~child's~~member's condition to the extent that the inpatient care is no longer necessary.

(b) The ~~individual plan of care~~IPC:

(1) must be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the individual member and reflects the need for inpatient psychiatric care;

(2) must be developed by a team of professionals ~~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;~~in consultation with the member, his or her parents or legal guardians [for members under the age of eighteen (18)], or others in whose care he or she will be released after discharge. This team must consist of professionals as specified below:

(A) for a member admitted to a psychiatric hospital or PRTF, by the "interdisciplinary team" as defined by OAC 317:30-5-95.35(b)(2), per 42 C.F.R. §§ 441.155 and 483.354; or

(B) for a member admitted to a psychiatric unit of a general hospital, by a team comprised of at least:

(i) an Allopathic or Osteopathic Physician with a current license and a board certification/eligible in psychiatry, or a current resident in psychiatry practicing as described in OAC 317:30-5-2(a)(1)(U); and

(ii) a Registered Nurse (RN) with a minimum of two (2) years of experience in a mental health treatment setting; and

(iii) an LBHP.

(3) must establish treatment goals that are general outcome statements and reflective of informed choices of the member served. Additionally, the treatment ~~goal~~goals must be appropriate to the member's age, culture, strengths, needs, abilities, preferences, and limitations;

(4) must establish measurable and ~~time limited~~time-limited treatment objectives that reflect the expectations of the member served and ~~parent/legal guardian~~parents/legal guardians (when applicable), as well as being age, developmentally, and culturally appropriate. When modifications are being made to

accommodate age, developmental level, or a cultural issue, the documentation must be reflected on the ~~individual plan of care~~IPC. The treatment objectives must be achievable and understandable to the member and the ~~parent/guardian~~parents/legal guardians (when applicable). The treatment objectives also must be appropriate to the treatment setting and list the frequency of the service;
(5) must prescribe an integrated program of therapies, activities, and experiences designed to meet the objectives;
(6) must include specific discharge and after care plans that are appropriate to the member's needs and effective on the day of discharge. At the time of discharge, after care plans will include referral to medication management, ~~out-patient~~outpatient behavioral health counseling, and case management, to include the specific appointment date(s), names, and addresses of service provider(s) and related community services to ensure continuity of care and reintegration for the member into ~~their~~his or her family, school, and community;
~~(7) must be reviewed at a minimum every five (5) to nine (9) calendar days when in acute care, every fourteen (14) calendar days when in a regular PRTF, every twenty-one (21) calendar days when in an OHCA approved longer term treatment program or specialty PRTFs, and every thirty (30) calendar 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 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. 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 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 IPC or IPC review to a parent or Oklahoma Department of Human Services/Office of Juvenile Affairs (OKDHS/OJA) worker for review, the parent and/or OKDHS/OJA worker may fax back their signature. The 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.~~

(7) must be reviewed, at a minimum, every five (5) to nine (9) calendar days for members admitted to an acute care setting; every fourteen (14) calendar days for members admitted to a regular PRTF; every twenty-one (21) calendar days for members admitted to an OHCA-approved longer-term treatment program or specialty PRTF; and every thirty (30) calendar days for members admitted to a Community Based Transitional PRTF. Review must be undertaken by the appropriate team specified in OAC 317:30-5-95.33(b)(2), above, to determine that services being provided are or were required on an inpatient basis, and to recommend changes in the IPC as indicated by the member's overall adjustment, progress, symptoms, behavior, and response to treatment;

(8) development and review must satisfy the utilization control requirements for recertification [42 C.F.R. §§ 456.60(b), 456.160(b), and 456.360(b)], and establishment and periodic review of the IPC (42 C.F.R. §§ 456.80, 456.180, and 456.380); and,

(9) each IPC and IPC review must be clearly identified as such and be signed and dated individually by the member, parents/legal guardians [for members under the age of eighteen (18)], and required team members. All IPCs and IPC reviews must be signed by the member upon completion, except when a member is too physically ill or the member's acuity level precludes him or her from signing. If the member is too physically ill or the member's acuity level precludes him or her from signing the IPC and/or the IPC review at the time of completion, the member must sign the plan when his or her condition improves, but before discharge. The documentation should indicate the reason the member was unable to sign and when the next review will occur to

obtain the signature. IPCs and IPC reviews are not valid until completed and appropriately signed and dated. All requirements for the IPCs and IPC reviews must be met; otherwise, a partial per diem recoupment will be merited. If the member's parent/legal guardian is unable to sign the IPC or IPC review on the date it is completed, then within seventy-two (72) hours the provider must in good faith and with due diligence attempt to telephonically notify the parent/legal guardian of the document's completion and review it with them. Documentation of reasonable efforts to make contact with the member's parent/legal guardian must be included in the clinical file. In those instances where it is necessary to mail or fax an IPC or IPC review to a parent/legal guardian or Oklahoma Department of Human Services/Office of Juvenile Affairs (DHS/OJA) worker for review, the parent/legal guardian and/or DHS/OJA worker may fax back his or her signature. The provider must obtain the original signature for the clinical file within thirty (30) days. Stamped or photocopied signatures are not allowed for any parent/legal guardian or member of the treatment team.

317:30-5-95.35. ~~Credentialing requirements for treatment team members for children~~Certificate of need requirements for members under the age of twenty-one (21) in PRTFs

~~(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.~~

(a) This Section establishes the requirements for certification of the need for inpatient psychiatric services provided to members under twenty-one (21) years of age in psychiatric hospitals, in accordance with Section 1905(a) 16 and (h) of the Social Security Act, and in PRTFs, in accordance with 42 C.F.R. § 483.354. Pursuant to this federal law, a team, consisting of physicians and other qualified personnel, shall determine that inpatient services are necessary and can reasonably be expected to improve the member's condition. These requirements do not apply to an admission to a psychiatric unit of a general hospital.

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

(1) **"Independent team"** means a team that is not associated with the facility, such that no team member has an employment or consultant relationship with the admitting facility. The independent team shall include a licensed physician who has competence in diagnosis and treatment of mental illness, preferably child psychiatry, and who has knowledge of the member's clinical condition and situation. The independent team shall also include at least one other licensed behavioral health professional, as defined by OAC 317:30-5-240.3.

(2) **"Interdisciplinary team"** as defined by 42 C.F.R. § 441.156, means a team of physicians and other personnel who are employed by, or who provide services to, SoonerCare members in the facility or program. The interdisciplinary team must include, at a minimum, either a board-eligible or board-certified psychiatrist; or, a licensed physician and a psychologist licensed by the Oklahoma State Board of Examiners of Psychologists (OSBED) who has a doctoral degree in clinical psychology; or, a licensed physician with specialized training and experience in the diagnosis and treatment of mental diseases, and a psychologist licensed by the OSBED. The

interdisciplinary team must also include one of the following:

(A) a licensed clinical social worker;

(B) a Registered Nurse with specialized training or one (1) year of experience in treating mentally ill individuals;

(C) and a psychologist licensed by the OSBED who has a doctoral degree in clinical psychology; or,

(D) an occupational therapist who is licensed by the state in which the individual is practicing, if applicable, and who has specialized training or one (1) year of experience in treating mentally ill individuals.

(c) **Certification of the need for services.** As described in 42 C.F.R. § 441.152, the certification shall be made by a team, either independent or interdisciplinary, as specified in (d), below, and shall certify that:

(1) Ambulatory care resources available in the community do not meet the treatment needs of the member;

(2) Proper treatment of the member's psychiatric condition requires services on an inpatient basis under the direction of a physician; and

(3) Services can reasonably be expected to improve the member's condition or prevent further regression so that inpatient services would no longer be needed.

(d) **Certification for admission.** The certification of the need for services, as stated in (c), above, shall be made by the appropriate team, in accordance with 42 C.F.R. § 441.153 and as specified as follows:

(1) Certification for the admission of an individual who is a member when admitted to a facility or program shall be made by an independent team, as described in (b)(1), above.

(2) Certification for an inpatient applying for SoonerCare while in the facility or program shall be made by an interdisciplinary team responsible for the plan of care and as described in (b)(2), above.

(3) Certification of an emergency admission of a member shall be made by the interdisciplinary team responsible for the plan of care within fourteen (14) days after admission, in accordance with 42 C.F.R. § 441.156.

317:30-5-97. ~~Child abuse~~Reporting abuse and/or neglect

~~(a) Instances of child abuse and/or neglect 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.~~

~~(b) Each hospital must designate a person, or persons, within the facility who is responsible for reporting suspected instances of~~

~~medical neglect, including instances of withholding of medically indicated treatment (including appropriate nutrition, hydration and medication) from disabled infants with life-threatening conditions. The hospital must report the name of the individual so designated to this agency, which is responsible for administering this provision within the State of Oklahoma. The hospital administrator is assumed to be the contact person unless someone else is specifically designated.~~

~~(c) The Child Abuse Unit of the Oklahoma Child Welfare Unit is responsible for coordination and consultation with the individual designated. In turn, the hospital is responsible for prompt notification to the Child Abuse Unit of any case of suspected medical neglect or withholding of medically-indicated treatment.~~

Instances of abuse and/or neglect are to be reported in accordance with state law, including, but not limited to, 10A O.S. § 1-2-101 and 43A O.S. § 10-104. Any person suspecting child abuse or neglect shall immediately report it to the Oklahoma Department of Human Services (DHS) hotline, at 1-800-522-3511; any person suspecting abuse, neglect, or exploitation of a vulnerable adult shall immediately report it to the local DHS County Office, municipal or county law enforcement authorities, or, if the report occurs after normal business hours, the DHS hotline. Health care professionals who are requested to report incidents of domestic abuse by adult victims with legal capacity shall promptly make a report to the nearest law enforcement agency, per 22 O.S. § 58.

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

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 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 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.

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

PART 7. DETERMINATION OF FINANCIAL ELIGIBILITY

317:35-9-67. Determining financial eligibility of categorically needy individuals

Financial eligibility for ICF/MR, HCBW/MR, and individuals age 65 or older in mental health hospitals medical care for categorically needy individuals is determined as follows:

~~(1) **Prior to October 1, 2013, financial eligibility/categorically related to AFDC.** In determining income for the individual related to AFDC, all family income is considered. The "family", for purposes of determining need, includes the following persons if living together (or if living apart but there has been no break in the family relationship):~~

~~(A) spouse; and~~

~~(B) parent(s) and minor children of their own. Individuals related to AFDC but not receiving a money payment are not entitled to one-half income disregard following the earned income deduction.~~

~~(i) For adults, to be categorically needy, the net income must be less than the categorically needy standard as shown on the OKDHS Appendix C-1, Schedule X.~~

~~(ii) For individuals under 19, to be categorically needy, the net income must be equal to or less than the categorically needy standard as shown on the OKDHS Appendix C-1, Schedule I. A.~~

~~(2)~~(1) ~~**Effective October 1, 2013, financial**~~**Financial eligibility in a Modified Adjusted Gross Income (MAGI) eligibility group.** In determining financial eligibility for an individual related to a group for whom the MAGI

methodology is used, rules in Subchapter 6 of this Chapter are followed.

(3) **Financial eligibility/categorically related to ABD.** In determining income and resources for the individual related to ABD, the "family" includes the individual and spouse, if any. To be categorically needy, the individual's countable income must be less than the categorically needy standard as shown on the OKDHS Appendix C-1, Schedule VI. If an individual and spouse cease to live together for reasons other than institutionalization, income and resources are considered available to each other through the month in which they are separated. Mutual consideration ceases with the month after the month in which the separation occurs. Any amounts which are actually contributed to the spouse after the mutual consideration has ended are considered. If the individual and spouse cease to live together because of the individual entering an ICF/MR, see OAC 317:35-9-68 (a)(3) to determine financial eligibility.

(A) The categorically needy standard on OKDHS Appendix C-1, Schedule VI, is applicable for individuals related to ABD. If the individual is in an ICF/MR and has received services for 30 days or longer, the categorically needy standard in OKDHS Appendix C-1, Schedule VIII. B., is used. If the individual leaves the facility prior to the 30 days, or does not require services past the 30 days, the categorically needy standard on OKDHS Appendix C-1, Schedule VI, is used. The rules on determination of income and resources are applicable only when an individual has entered an ICF/MR and is likely to remain under care for 30 consecutive days. The 30-day requirement is considered to have been met even if it is interrupted by a hospital stay or the individual is deceased before the 30-day period ends [Refer to OAC 317:35-9-68 (a)(3)(B)(x)]. An individual who is a patient in an extended care facility may have SSI continued for a three month period if he/she meets conditions described in Subchapter 5 of this Chapter. The continuation of the payments is intended for use of the member and does not affect the vendor payment. If the institutional stay exceeds the three month period, SSI will make the appropriate change.

(B) In determining eligibility for HCBW/MR services, refer to OAC 317:35-9-68(b).

(C) In determining eligibility for individuals age 65 or older in mental health hospitals, refer to OAC 317:35-9-68(c).

(4) **Transfer of capital resources on or before August 10, 1993.** Individuals who have transferred capital resources on or before August 10, 1993 and are applying for or receiving NF, ICF/MR or HCBW/MR services are subject to penalty if the individual, the individual's spouse, the guardian, or legal representative of the individual or individual's spouse, disposes of resources for less than fair market value during the 30 months immediately prior to eligibility for SoonerCare if the individual is eligible at institutionalization. If the individual is not eligible for SoonerCare at institutionalization, the individual is subject to penalty if a resource was transferred during the 30 months immediately prior to the date of application for SoonerCare. Any subsequent transfer is also subject to this rule. When there have been multiple transfers of resources without commensurate return, all transferred resources are added together to determine the penalty period. The penalty consists of a period of ineligibility (whole number of months) determined by dividing the total uncompensated value of the resource by the average monthly cost to a private patient in a nursing facility in Oklahoma. The penalty period begins with the month the resource or resources were first transferred and cannot exceed 30 months. Uncompensated value is defined as the difference between the equity value and the amount received for the resource.

(A) However, the penalty would not apply if:

(i) The transfer was prior to July 1, 1988.

(ii) The title to the individual's home was transferred to:

(I) the spouse;

(II) the individual's child under age 21 or who is blind or totally disabled;

(III) a sibling who has equity interest in the home and resided in the home for at least one year prior to the individual's admission to the nursing facility; or

(IV) the individual's son or daughter who resided in the home and provided care for at least two years prior to the individual's admission to the nursing facility.

(iii) The individual can show satisfactorily that the intent was to dispose of resources at fair market value or that the transfer was for a purpose other than eligibility.

(iv) The transfer was to the community spouse or to another person for the sole benefit of the community

spouse in an amount equal to the community spouse's resource allowance.

(v) The resource was transferred to the individual's child who is under 21 or who is blind or totally disabled.

(vi) The resource was transferred to the spouse (either community or institutionalized) or to another person for the sole benefit of the spouse if the resources are not subsequently transferred to still another person for less than fair market value.

(vii) The denial would result in undue hardship. Such determination should be referred to OKDHS State Office, FSSD, Health Related and Medical Services, for a decision.

(B) The individual is advised by a written notice of a period of ineligibility due to transfer of assets. The notice explains the period of ineligibility for payment of NF services and the continuance of eligibility for other SoonerCare services.

(C) The penalty period can be ended by either the resource being restored or commensurate return being made to the individual. The cost of care during the penalty period cannot be used to shorten or end the penalty period.

(D) Once the restoration or commensurate return is made, eligibility is redetermined considering the value of the restored resource or the amount of commensurate return.

(E) The restoration or commensurate return will not entitle the member to benefits for the period of time that the resource remained transferred. An applicant cannot be certified for NF, HCBW/MR, or ADvantage waiver services for a period of resource ineligibility.

(5) **Transfer of assets on or after August 11, 1993 but before February 8, 2006.** An institutionalized individual, an institutionalized individual's spouse, the guardian or legal representative of the individual or individual's spouse who disposes of assets on or after August 11, 1993 but before February 8, 2006 for less than fair market value on or after the look-back date specified in (A) of this paragraph subjects the individual to a penalty period for the disposal of such assets.

(A) For an institutionalized individual, the look-back date is 36 months before the first day the individual is both institutionalized and has applied for medical assistance. However, in the case of payments from a trust or portions of a trust that are treated as transfers of assets, the look-back date is 60 months.

(B) For purposes of this paragraph, an "institutionalized" individual is one who is residing in an ICF/MR or receiving HCBW/MR services.
(C) The penalty period begins the first day of the first month during which assets have been transferred and which does not occur in any other period of ineligibility due to an asset transfer. When there have been multiple transfers, all transferred assets are added together to determine the penalty.
(D) The penalty period consists of a period of ineligibility (whole number of months dropping any leftover portion) determined by dividing the total uncompensated value of the asset by the average monthly cost to a private patient in a nursing facility in Oklahoma. There is no limit to the length of the penalty period for these transfers. Uncompensated value is defined as the difference between the fair market value at the time of transfer less encumbrances and the amount received for the resource.
(E) Assets are defined as all income and resources of the individual and the individual's spouse, including any income or resources which the individual or such individual's spouse is entitled to but does not receive because of action:

(i) by the individual or such individual's spouse;
(ii) by a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or such individual's spouse; or
(iii) by any person, including any court or administrative body acting at the direction or upon the request of the individual or such individual's spouse.

(F) A penalty would not apply if:

(i) the title to the individual's home was transferred to:

(I) the spouse;
(II) the individual's child under age 21 or who is blind or totally disabled as determined by Social Security;
(III) a sibling who has equity interest in the home and resided in the home for at least one year prior to the institutionalization of the individual; or
(IV) the individual's son or daughter who resided in the home and provided care for at least two years immediately prior to the individual's institutionalization;

(ii) the individual can show satisfactorily that the intent was to dispose of assets at fair market value or that the transfer was exclusively for a purpose other than eligibility. It is presumed that any transfer of assets made for less than fair market value was made in order to qualify the individual for SoonerCare. In order to rebut this presumption, the individual must present compelling evidence that a transfer was made for reasons other than to qualify for SoonerCare. It is not sufficient for an individual to claim that assets were transferred solely for the purposes of allowing another to have them with ostensibly no thought of SoonerCare if the individual qualifies for SoonerCare as a result of the transfer;

(iii) the transfer was to the community spouse or to another person for the sole benefit of the community spouse in an amount equal to the community spouse's asset allowance;

(iv) the asset was transferred to the individual's child who is blind or totally disabled as determined by Social Security. The transfer may be to a trust established for the benefit of the individual's child;

(v) the asset was transferred to or from the spouse (either community or institutionalized) or to another person for the sole benefit of the spouse if the assets are not subsequently transferred to still another person for less than fair market value;

(vi) the asset is transferred to a trust established solely for the benefit of a disabled individual under the age of 65; or

(vii) the denial would result in undue hardship. Such determination should be referred to OKDHS State Office for a decision.

(G) The individual is advised by a written notice of a period of ineligibility due to transfer of assets. The notice explains the period of ineligibility for payment of ICF/MR or HCBW/MR services and the continuance of eligibility for other SoonerCare services.

(H) The penalty period can be ended by either all assets being restored or commensurate return being made to the individual.

(I) Once the restoration or commensurate return is made, eligibility is redetermined considering the value of the restored asset or the amount of commensurate return.

(J) The restoration or commensurate return will not entitle the member to benefits for the period of time that

the asset remained transferred. An applicant cannot be certified for NF, ICF/MR, HCBW/MR, or ADvantage waiver services for a period of asset ineligibility.

(K) Assets which are held by an individual with another person or persons, whether held in joint tenancy or tenancy in common or similar arrangement, and the individual's ownership or control of the asset is reduced or eliminated is considered a transfer.

(L) When a transfer of assets by the spouse of an individual results in a period of ineligibility and the spouse who made such transfer subsequently becomes institutionalized, the period of ineligibility will be apportioned between the two institutionalized spouses.

(6) **Transfer of assets on or after February 8, 2006.** An institutionalized individual, an institutionalized individual's spouse, the guardian or legal representative of the individual or individual's spouse who disposes of assets on or after February 8, 2006 for less than fair market value on or after the look-back date specified in (A) of this paragraph subjects the individual to a penalty period for the disposal of such assets.

(A) For an institutionalized individual, the look-back date is 60 months before the first day the individual is both institutionalized and has applied for medical assistance. However, individuals that have purchased an Oklahoma Long-Term Care Partnership Program approved policy may be completely or partially exempted from this Section depending on the monetary extent of the insurance benefits paid.

(B) For purposes of this paragraph, an "institutionalized" individual is one who is residing in an ICF/MR or receiving HCBW/MR services.

(C) The penalty period will begin with the later of:

(i) the first day of a month during which assets have been transferred for less than fair market value; or

(ii) the date on which the individual is:

(I) eligible for medical assistance; and

(II) receiving institutional level of care services that, were it not for the imposition of the penalty period, would be covered by SoonerCare.

(D) The penalty period:

(i) cannot begin until the expiration of any existing period of ineligibility;

(ii) will not be interrupted or temporarily suspended once it is imposed;

(iii) when there have been multiple transfers, all

transferred assets are added together to determine the penalty.

(E) The penalty period consists of a period of ineligibility determined by dividing the total uncompensated value of the asset by the average monthly cost to a private patient in a nursing facility in Oklahoma shown on OKDHS Appendix C-1. In this calculation, the penalty must include a partial month disqualification based upon the relationship between that fractional amount and the average monthly cost to a private patient in a nursing facility in Oklahoma. There is no limit to the length of the penalty period for these transfers. Uncompensated value is defined as the difference between the fair market value at the time of transfer less encumbrances and the amount received for the resource.

(F) Assets are defined as all income and resources of the individual and the individual's spouse, including any income or resources which the individual or such individual's spouse is entitled to but does not receive because of action:

(i) by the individual or such individual's spouse;

(ii) by a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or such individual's spouse; or

(iii) by any person, including any court or administrative body acting at the direction or upon the request of the individual or such individual's spouse.

(G) Special Situations.

(i) Separate Maintenance or Divorce.

(I) There shall be presumed to be a transfer of assets if an applicant or member receives less than half of the couple's resources pursuant to a Decree of Separate Maintenance or a Decree of Divorce.

(II) There shall be presumed to be a transfer of assets if the income is reduced to an amount lower than the individual's own income plus half of the joint income. The transfer penalty shall be calculated monthly.

(III) Assets which were exempt lose the exempt character when not retained by the applicant or member in the divorce or separate maintenance. These assets, if received by the other spouse, are counted when determining the penalty.

(IV) The applicant or member may rebut the

presumption of transfer by showing compelling evidence that the uneven division of income or resources was the result of factors unrelated to SoonerCare eligibility.

(ii) Inheritance from a spouse.

(I) Oklahoma law provides that a surviving spouse is entitled to a minimum portion of a deceased spouse's probate estate. The amount depends on several factors.

(II) It is considered a transfer if the deceased spouse's will places all, or some, of the statutory share the applicant or member is entitled to receive in a trust which the applicant or member does not have unfettered access to or leaves less than the statutory amount to the applicant or member, who does not then elect to receive the statutory share in probate proceedings.

(H) A penalty would not apply if:

(i) the title to the individual's home was transferred to:

(I) the spouse; or

(II) the individual's child under age 21 or who is blind or totally disabled as determined by Social Security; or

(III) a sibling who has equity interest in the home and resided in the home for at least one year immediately prior to the institutionalization of the individual; or

(IV) the individual's son or daughter who resided in the home and provided care for at least two years immediately prior to the individual's institutionalization.

(ii) the individual can show satisfactorily that the intent was to dispose of assets at fair market value or that the transfer was exclusively for a purpose other than eligibility. It is presumed that any transfer of assets made for less than fair market value was made in order to qualify the individual for SoonerCare. In order to rebut this presumption, the individual must present compelling evidence that a transfer was made for reasons other than to qualify for SoonerCare. It is not sufficient for an individual to claim that assets were transferred solely for the purpose of allowing another to have them with ostensibly no thought of SoonerCare if the individual qualifies for SoonerCare as a result of the transfer.

(iii) the transfer was to the community spouse or to another person for the sole benefit of the community spouse in an amount equal to the community spouse's asset allowance. "Sole benefit" means that the amount transferred will be used for the benefit of the community spouse during his or her expected life.

(iv) the asset was transferred to the individual's child who is blind or totally disabled as determined by Social Security. The transfer may be to a trust established for the benefit of the individual's child.

(v) the asset was transferred to or from the spouse (either community or institutionalized) or to another person for the sole benefit of the spouse if the assets are not subsequently transferred to still another person for less than fair market value. "Sole benefit" means that the amount transferred will be used for the benefit of the spouse (either community or institutionalized) during his or her expected life.

(vi) the asset is transferred to a trust established solely for the benefit of a disabled individual under the age of 65.

(vii) the denial would result in undue hardship. Undue hardship exists when application of a transfer of assets penalty would deprive the individual of medical care such that the individual's health or life would be endangered; or of food, clothing, shelter, or other necessities of life.

(I) An undue hardship does not exist if the individual willingly transferred assets for the purpose of qualifying for SoonerCare services through the use of the undue hardship exemption.

(II) Such determination should be referred to OKDHS State Office for a decision.

(III) If the undue hardship exists because the applicant was exploited, legal action must be pursued to return the transferred assets to the applicant before a hardship waiver will be granted. Pursuing legal action means an APS referral has been made to the district attorney's office or a lawsuit has been filed and is being pursued against the perpetrator.

(I) The individual is advised by a written notice of a period of ineligibility due to transfer of assets, a timely process for determining whether an undue hardship waiver will be granted and a process for an adverse determination appeal. The notice explains the period of

ineligibility for payment of ICF/MR or HCBW/MR services and the continuance of eligibility for other SoonerCare services.

(J) The penalty period can be ended by either all assets being restored or commensurate return being made to the individual.

(K) Once the restoration or commensurate return is made, eligibility is redetermined considering the value of the restored asset or the amount of commensurate return.

(L) The restoration or commensurate return will not entitle the member to benefits for the period of time that the asset remained transferred. An applicant cannot be certified for nursing care services or HCBW for a period of asset ineligibility.

(M) Assets which are held by an individual with another person or persons, whether held in joint tenancy or tenancy in common or similar arrangement, and the individual's ownership or control of the asset is reduced or eliminated is considered a transfer. The exception to this rule is if ownership of a joint account is divided according to the amount contributed by each owner.

(i) Documentation must be provided to show each co-owner's contribution;

(ii) The funds contributed by the applicant or SoonerCare member end up in an account owned solely by the applicant or member.

(N) When a transfer of assets by the spouse of an individual results in a period of ineligibility and the spouse who made such transfer subsequently becomes institutionalized, the period of ineligibility will be apportioned between the two institutionalized spouses.

(7) **Commensurate return.** Commensurate return for purposes of this Section is defined as actual money payment or documentation of money spent on the member's behalf; i.e., property taxes, medical debts, nursing care expenses, etc., corresponding to the market value of the transferred property. The definition does not include personal services, labor or provision of rent-free shelter. It also does not include a monetary value assigned and projected for future payment either by cash or provision of services. Any transfer of property within the five years prior to application or during receipt of assistance must be analyzed in regard to commensurate return as well as determination of intent.

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

PART 3. RESOURCES

317:35-10-10. Capital resources

Capital resources are disregarded for individuals related to the children, parent and caretaker relative, former foster care children, SoonerPlan, or pregnancy eligibility groups, including pregnancies covered under Title XXI. ~~Prior to October 1, 2013, the countable income generated from any resource is considered in accordance with Part 5 of this Subchapter. Effective October 1, 2013, countable~~Countable income generated from any resource is considered in accordance with Part 6 of Subchapter 6 of this Chapter.

PART 5. INCOME

317:35-10-26. Income

(a) **General provisions regarding income.**

(1) The income of categorically needy individuals who are related to the children, parent or caretaker relative, SoonerPlan, or Title XIX and XXI pregnancy eligibility groups does not require verification, unless questionable. If the income information is questionable, it must be verified. If there appears to be a conflict in the information provided, the worker must investigate the situation to determine if income verification is necessary.

(2) All available income, except that required to be disregarded by law or OHCA's policy, is taken into consideration in determining need. Income is considered available both when actually available and when the applicant or member has a legal interest in a liquidated sum and has the legal ability to make such sum available for support and maintenance. When an individual's income is reduced due to recoupment of an overpayment or garnishment, the gross amount before the recoupment or garnishment is counted as income. The member is responsible for reporting all income, the source, amount and how often received.

(A) Income received on behalf of a member of the benefit group by another individual such as, but not limited to, a guardian or conservator, is considered available to the benefit group.

(B) Money received and used for the care and maintenance of a third party who is not included in the benefit group is not counted as income if it can be identified and verified as intended for third party use.

(C) If it appears any member of the benefit group or an

individual whose income is considered when determining eligibility is eligible for any type of income or benefits, the benefit group must be notified in writing by the Oklahoma Health Care Authority (OHCA). The notice must contain the information that failure to apply for and take all appropriate steps to obtain such benefits within ~~10~~ten (10) days from the date of the notice will result in a determination of ineligibility. An application for Supplemental Security Income (SSI) is not required.

(D) If the member and spouse are living together or they are living apart but there has not been a clear break in the family relationship, income received by either spouse and income received jointly is considered as family income. Income cannot be diverted to a household member who is not included in the household size for health benefits. Consideration is not given to a SSI recipient's income in computing eligibility for the AFDC or Pregnancy related unit. ~~Effective October 1, 2013, the~~The MAGI methodology rules determine whose income is considered in a particular household for MAGI eligibility groups as defined in OAC 317:35-6-1.

(E) Income which can reasonably be anticipated to be received is considered to be available for the month its receipt is anticipated.

(F) Income produced from resources must be considered as unearned income.

(3) Income that must be verified is verified by the best available information such as pay stubs presented by the member or an interview with the employer. If OHCA is unable to verify income through the Employment Securities Commission, then pay stubs may only be used for verification if they have the member's name and/or social security number indicating that the pay stubs are in fact the member's wages. The stubs should also include the date(s) of the pay period and the amount of income before deductions. If this information is not included, employer verification is required. The worker verifies medical insurance which may be available at the same time that income is verified. When a member of the benefit group accepts employment and has not received any wages, verification (if necessary) of the amount of income to be considered and the anticipated date of receipt must be obtained from the employer and provided to OHCA within ~~10~~ten (10) days. Income which is expected to be received during a month is considered available to the benefit group and is counted in determining eligibility for the month of receipt.

(4) Monies received in a lump sum from any source are considered income in the month received. Changing a resource from one form to another, such as converting personal property to cash, is not considered a lump sum payment. Exception: lump sum payments used to establish dedicated bank accounts by representative payees in order to receive and maintain retroactive SSI benefits for disabled/blind children under age ~~18~~eighteen (18) are excluded as income. The interest income generated from dedicated bank accounts is also excluded.

(A) ~~Prior to October 1, 2013, a nonrecurring lump sum payment considered as income includes payments based on accumulation of income and payments which may be considered windfall in nature and may include but are not limited to TANF grant diversion, VA or Social Security lump sum payments, inheritance, gifts, worker's compensation payments, cash winnings, personal injury awards, etc. Retirement benefits received in a lump-sum are considered as unearned income. A non-recurring lump sum SSI retroactive payment, made to a member of the children, parent or caretaker relative, or pregnancy groups who is not currently eligible for SSI, is not counted as income. Effective October 1, 2013, whether~~Whether a source of income is countable for MAGI eligibility groups is determined in accordance with Part 6 of Subchapter 6 of this Chapter.

(B) ~~Prior to October 1, 2013, lump sum payments (minus allowable deductions related to establishing the lump sum payment) which are received by AFDC/Pregnancy related individuals or applicants are considered as income. Allowable deductions are expenses earmarked in the settlement or award to be used for a specific purpose which may include, but are not limited to, attorney's fees and court costs that are identified in the lump sum settlement, medical or funeral expenses for the immediate family, etc. "Earmarked" means that such expense is specifically set forth in the settlement or award. Effective October 1, 2013, whether~~Whether a source of income is countable is determined in accordance with Part 6 of Subchapter 6 of this Chapter.

(C) When a lump sum is received by a stepparent not included in the household size, only the stepparent's contribution is considered in accordance with the stepparent's liability policy. ~~Effective October 1, 2013, income~~Income received by a stepparent is considered in accordance with MAGI household and income counting rules.

(D) When a third party reveals that a lump sum payment has been received or is expected to be received by the applicant or member, adverse action notification is given or mailed to the applicant/member and appropriate action taken.

(E) Recurring lump sum income received from any source for a period covering more than one (1) month, that is received in a lump sum recurrently (such as annual rentals from surface or minerals, Windfall Profits tax refund, etc.) is prorated over a period of time it is intended to cover, beginning with the month of receipt of a lump sum payment.

(F) Net income from oil and gas production (gross minus production taxes withheld), received in varying amounts on a regular or irregular basis for the past six (6) months, will be averaged and considered as income for the next six (6) months. In instances where an applicant or a member receives new income from oil and gas production and verification for the past six (6) months is not available, the worker accepts the available verification and averages over the period of time intended to cover. Net income may be verified by seeing the individual's production check stub, or by contacting the oil and gas company. ~~Effective October 1, 2013, whether~~Whether a source of income is countable is determined in accordance with Part 6 of Subchapter 6 of this Chapter.

(5) Income that is based on the number of hours worked, as opposed to income based on regular monthly wages, must be computed as irregular income. The income received irregularly or in varying amounts will be averaged using the past two (2) months to establish the amount to be anticipated and considered for prospective budgeting.

(6) ~~Prior to October 1, 2013, a caretaker relative can only be included in the benefit group when the biological or adoptive parent is not in the home. A stepparent can be included when the biological or adoptive parent is either incapacitated or not in the home. Effective October 1, 2013,~~ MAGI household rules are used to determine whether a caretaker relative or stepparent is included in a household.

(A) ~~Prior to October 1, 2013, consideration is not given to the income of the caretaker relative or the income of his or her spouse in determining the eligibility of the children. However, if that person is the stepparent, the policy on stepparent liability is applicable. Effective October 1, 2013,~~ MAGI household and income counting rules are used to determine whether a caretaker relative and

his/her spouse or a stepparent are included in the household and whether their income is considered for the children.

(B) ~~Prior to October 1, 2013, if a caretaker relative is married and living with the spouse who is an SSI or SSP recipient, the spouse or spouse's income is not considered in determining the eligibility of the caretaker relative. The income of the caretaker relative and the spouse who is not an SSI or SSP recipient must be considered. Only one caretaker relative is eligible to be included in any one month. Effective October 1, 2013,~~ MAGI household and income counting rules are used to determine whose income is considered and whether that income is counted. If an individual is eligible in the parent or caretaker relative group, his/her spouse, if living with him/her, is also related to the parent or caretaker relative group.

(7) ~~Prior to October 1, 2013, a stepparent can be included when the biological or adoptive parent is either incapacitated or not in the home. The income of the stepparent is counted if the stepparent's needs are being included. Effective October 1, 2013, a~~A stepparent, if living with the parent or caretaker relative, can also be related to the parent or caretaker relative group, regardless of whether the parent is incapacitated or not in the home.

(8) ~~Prior to October 1, 2013, when there is a stepparent or person living in the home with the biological or adoptive parent who is not a spouse by legal marriage to or common-law relationship with the own parent, the worker determines the amount of income that will be made available to meet the needs of the child(ren) and the parent. Only contributions made in cash directly to the benefit group can be counted as income. In-kind contributions are disregarded as income. When the individual and the member state the individual does not make a cash contribution, further exploration is necessary. This statement can only be accepted after clarifying that the individual's contributions are only in-kind. Effective October 1, 2013,~~ MAGI household and income counting rules are used to determine whose income is considered and whether that income is counted.

(b) **Earned income.** The term "earned income" refers to monies earned by an individual through the receipt of wages, salary, commission or profit from activities in which the individual is engaged as self-employed or as an employee. ~~Prior to October 1, 2013, payments made for accumulated annual leave/vacation leave, sick leave or as severance pay are considered as earned income whether paid during employment or at termination of employment.~~

~~Temporary disability insurance payment(s) and temporary worker's compensation payments are considered as earned income if payments are employer funded and the individual remains employed. Income received as a one-time nonrecurring payment is considered as a lump sum payment. Earned income includes in-kind benefits received by an employee from an employer in lieu of wages or in conjunction with wages. An exchange of labor or services, e.g., barter, is considered as an in-kind benefit. Such benefits received in-kind are considered as earned income only when the employee/employer relationship has been established. Income from self-employment also includes in-kind benefits for a work activity or service for which the self-employed person ordinarily receives payment in the business enterprise. Medical insurance secured through the employer, whether purchased or as a benefit, is not considered in-kind income. Gross earned income is used to determine eligibility. Gross earned income is defined as the wage prior to payroll deductions and/or withholdings. Effective October 1, 2013, whether~~Whether income is countable for MAGI eligibility groups is determined using MAGI income counting rules in Part 6 of Subchapter 6 of this Chapter.

~~(1) **Earned income from self-employment prior to October 1, 2013.** If the income results from the individual's activities primarily as a result of the individual's own labor from the operation of a business enterprise, the "earned income" is the total profit after deducting the business expenses (cost of the production). Money from the sale of whole blood or blood plasma is also considered as self-employment income subject to necessary business expense and appropriate earned income exemptions.~~

~~(A) Allowable costs of producing self-employment income include, but are not limited to, the identifiable cost of labor, stock, raw material, seed and fertilizer, interest payments to purchase income-producing property, insurance premiums, and taxes paid on income-producing property.~~

~~(i) The federal or state income tax form for the most recent year is used for calculating the income only if it is representative of the individual's current situation. The individual's business records beginning the month income became representative of the individual's current situation is used if the income tax information does not represent the individual's current situation.~~

~~(ii) If the self-employment enterprise has been in existence for less than a year, the income is averaged over the period of time the business has been in~~

~~operation to establish the monthly income amount.~~

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

~~(B) **Items not considered.** The following items are not considered as a cost of producing self-employed income:~~

~~(i) The purchase price and/or payments on the principal of loans for capital assets, equipment, machinery, and other durable goods;~~

~~(ii) Net losses from previous periods;~~

~~(iii) Depreciation of capital assets, equipment, machinery, and other durable goods; and~~

~~(iv) Federal, state and local income taxes, FICA, money set aside for retirement purposes, and other work related personal expenses, such as meals and necessary transportation. These expenses are accounted for by the work related expense deduction.~~

~~(C) **Room and/or board.** Earned income from a room rented in the home is determined by considering 25% of the gross amount received as a business expense. If the earned income includes payment for room and board, 50% of the gross amount received is considered as a business expense.~~

~~(D) **Rental property.** Income from rental property is to be considered income from self employment if none of the activities associated with renting the property is conducted by an outside person or agency.~~

~~(2)~~(1) **Earned income from self-employment ~~effective October 1, 2013~~.** For MAGI eligibility groups, the calculation of countable self-employment income is determined in accordance with MAGI income counting rules in Part 6 of Subchapter 6 of this Chapter.

~~(3)~~(2) **Earned income from wages, salary or commission.** ~~Prior to October 1, 2013, if the income is from wages, salary or commission, the "earned income" is the gross income prior to payroll deductions and/or withholdings. Income from the Older American Community Service Employment Act (Title V), including AARP and Green Thumb organizations as well as employment positions allocated at the discretion of the Governor of Oklahoma, is counted as any other earned income. Effective October 1, 2013, countable~~Countable income for MAGI eligibility groups is determined in accordance with MAGI income counting rules in Part 6 of Subchapter 6 of this Chapter.

~~(4)~~(3) **Earned income from work and training programs.** ~~Prior to October 1, 2013,earned income from work and training programs such as the Job Training Partnership Act (JTPA) received by an adult as wages is considered as any other earned income. Also, JTPA earned income of a dependent child is considered when received in excess of six months in any calendar year. Effective October 1, 2013, countable~~Countable income for MAGI eligibility groups is determined in accordance with MAGI income counting rules in Part 6 of Subchapter 6 of this Chapter.

~~(5) **Individual earned income exemptions prior to October 1, 2013.** Exemptions from each individual's earned income include a monthly standard work related expense and child care expenses the individual is responsible for paying. Expenses cannot be exempt if paid through state or federal funds or the care is not in a licensed facility or home. Exempt income is that income which by law may not be considered in determining need.~~

~~(A) **Work related expenses.** 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.~~

~~(B) **Child care expenses.** Disregard of child care expense is applied after all other income disregards.~~

~~(i) Child care expense may be deducted when:~~

~~(I) suitable care for a child included in the benefit group is not available from responsible persons living in the home or through other alternate sources; and~~

~~(II) the employed member whose income is considered must purchase care.~~

~~(ii) The actual amount paid for child care per month, up to a maximum of $200 for a child under the age of two or $175 for a child age two or older may be deducted.~~

~~(iii) Oklahoma law requires all child care centers and homes be properly approved or licensed; therefore, child care expenses can only be deducted if the child is in a properly licensed facility or receiving care from an approved in-home provider.~~

~~(iv) Child care provided by another person in the household who is not a member of the benefit group may be considered as child care expenses as long as the home meets applicable standards of State, local or Tribal law.~~

~~(v) Documentation is made of the child care arrangement indicating the name of the child care facility or the name of the in-home provider, and the documentation used to verify the actual payment of child care per month.~~

~~(6)~~(4) **No individual earned income exemptions ~~effective October 1, 2013~~.** No earned income exemptions are subtracted to determine countable income for MAGI eligibility groups. The only deduction applied to determine net countable income under the MAGI methodology is the deduction of ~~5%~~five percent (5%) of the FPL for the individual's household size as defined in OAC 317:35-6-39.

~~(7) **Formula for determining the individual's net earned income prior to October 1, 2013.** Formulas used to determine net earned income to be considered are:~~

~~(A) **Net earned income from employment other than self-employment.** Gross Income minus work related expense minus child care expense equals net income.~~

~~(B) **Net earned income from self-employment.** Gross income minus allowable business expenses minus work related expense and child care expense equals net income.~~

~~(8)~~(5) **Formula for determining the individual's net earned income ~~effective October 1, 2013~~ for MAGI eligibility groups.** To determine net income, see MAGI rules in OAC 317:35-6-39.

~~(c) **Unearned income prior to October 1, 2013.**~~

~~(1) **Capital investments.** Proceeds, i.e., interest or dividends from capital investments, such as savings accounts, bonds (other than U.S. Savings Bonds, Series A through EE), notes, mortgages, etc., received constitute income.~~

~~(2) **Life estate and homestead rights.** Income from life estate or homestead rights, constitute income after deducting actual business expenses.~~

~~(3) **Minerals.** If the member owns mineral rights, only actual income from minerals, delayed rentals, or production is considered. Evidence is obtained from documents which the member has in hand. When the member has no documentary evidence of the amount of income, the evidence, if necessary, is secured from the firm or person who is making the payment.~~

~~(4) **Contributions.** Monetary contributions are considered as income except in instances where the contribution is not made directly to the member.~~

~~(5) **Retirement and disability benefits.** Income received monthly from retirement and disability benefits are considered as unearned income. Information as to receipt and amount of OASDI benefits is obtained, if necessary, from BENDEX, the member's award letter, or verification from SSA.~~

~~Retirement benefits received as a lump sum payment at termination of employment are considered as income. Supplemental Security Income (SSI) does not fall under these types of benefits.~~

~~(6) **Unemployment benefits.** Unemployment benefits are considered as unearned income.~~

~~(7) **Military benefits.** Life insurance, pensions, compensation, servicemen dependents' allowances and the like, are all sources of income which the member and/or dependents may be eligible to receive. In each case under consideration, information is obtained as to whether the member's son, daughter, husband or parent, has been in any military service. Clearance is made with the proper veterans' agency, both state and federal, to determine whether the benefits are available.~~

~~(8) **Casual and inconsequential gifts.** Monetary gifts which do not realistically represent income to meet living expenses, e.g., Christmas, graduation and birthday gifts, not to exceed $30 per calendar quarter for each individual, are disregarded as income. The amount of the gifts are disregarded as received during the quarter until the aggregate amount has reached $30. At that time the portion exceeding $30 is counted as lump sum income. If the amount of a single gift exceeds $30, it is not inconsequential and the total amount is therefore counted. If the member claims that the gift is intended for more than one person in the family unit, it is allowed to be divided. Gifts between members of the family unit are not counted.~~

~~(9) **Grants.** Grants which are not based on financial need are considered income.~~

~~(d)~~(c) **Unearned income ~~effective October 1, 2013~~.** Countable earned and unearned income for MAGI eligibility groups is determined in accordance with MAGI income counting rules in Part 6 of Subchapter 6 of this Chapter.

~~(c) **Income disregards prior to October 1, 2013.** Income that is disregarded in determining eligibility includes:~~

~~(1) Food Stamp benefits;~~

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

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

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

~~a loan as bona fide includes an acknowledgment of obligation to repay or evidence that the loan was from an individual or financial institution in the loan business. If the loan was from a person(s) not in the loan business, the borrower's acknowledgment of obligation to repay (with or without interest) is required to indicate that the loan is bona fide. If the loan agreement is not written, OKDHS Form 08AD103E, Loan Verification, should be completed by the borrower attesting that the loan is bona fide and signed by the lender verifying the date and amount of the loan. When copies of written agreements or OKDHS Form 08AD103E are not available, detailed case documentation must include information that the loan is bona fide and how the debt amount and date of receipt was verified;~~

~~(5) Indian payments (including judgment funds or funds held in trust) which are distributed by the Secretary of the Interior (BIA) or distributed by the tribe subject to approval by the Secretary of the Interior. Also, any interest or investment income accrued on such funds while held in trust or any purchases made with judgment funds, trust funds, interest or investment income accrued on such funds. Any income from mineral leases, from tribal business investments, etc. However, any interest or income derived from the principal or produced by purchases made with the funds after distribution is considered as any other income;~~

~~(6) Special allowance for school expenses made available upon petition in writing from trust funds of the student;~~

~~(7) Benefits from State and Community Programs on Aging under Title III of the Older Americans Act of 1965 amended by PL 100-175 to become the Older Americans Act amendments of 1987;~~

~~(8) Unearned income received by a child, such as a needs based payment, cash assistance, compensation in lieu of wages, allowance, etc., from a program funded by the Job Training and Partnership Act (JTPA) including Job Corps income. Also, JTPA earned income received as wages, not to exceed six~~ (6) ~~months in any calendar year;~~

~~(9) Payments for supportive services or reimbursement for out-of-pocket expenses made to individual volunteers serving as foster grandparents, senior health aids, or senior companions, and to persons serving in the Service Corps of Retired Executives (SCORE) and Active Corps of Executives (ACE);~~

~~(10) Payments to volunteers under the Domestic Volunteer Service Act of 1973 (VISTA), unless the gross amount of VISTA payments equals or exceeds the state or federal minimum wage, whichever is greater;~~

~~(11) The value of supplemental food assistance received under the Child Nutrition Act or the special food service program for children under the National School Lunch Act;~~
~~(12) Any portion of payments, made under the Alaska Native Claims Settlement Act to an Alaska Native, which are exempt from taxation under the Settlement Act;~~
~~(13) If an adult or child from the family group is living in the home and is receiving SSI, his/her individual income is considered by the Social Security Administration in determining eligibility for SSI. Therefore, that income cannot be considered as available to the benefit group;~~
~~(14) Experimental Housing Allowance Program (EHAP) payments made under Annual Contributions Contracts entered into prior to January 1, 1975, under Section 23 of the U.S. Housing Act of 1937, as amended;~~
~~(15) Earnings of a child who is a full-time student are disregarded;~~
~~(16) The first $50 of the current monthly child support paid by an absent parent. Only one disregard is allowed regardless of the number of parents paying or amounts paid. An additional disregard is allowed if payments for previous months were paid when due but not received until the current month;~~
~~(17) Government rental or housing subsidies by governmental agencies, e.g., HUD (received in-kind or in cash) for rent, mortgage payments or utilities;~~
~~(18) Reimbursements from an employer for out-of-pocket expenditures and allowances for travel or training to the extent the funds are used for expenses directly related to such travel or training, and uniform allowances if the uniform is uniquely identified with company name or logo;~~
~~(19) Low Income Home and Energy Assistance Program (LIHEAP) and Energy Crisis Assistance Program (ECAP) payments;~~
~~(20) Advance payments of Earned Income Tax Credit (EITC) or refunds of EITC as a result of filing a federal income tax return;~~
~~(21) Payments made from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In Re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.);~~
~~(22) Payments made from the Radiation Exposure Compensation Trust Fund as compensation for injuries or deaths resulting from the exposure to radiation from nuclear testing and uranium mining;~~
~~(23) Federal major disaster and emergency assistance provided under the Disaster Relief Act of 1974, and comparable~~

~~disaster assistance provided by states, local governments and disaster assistance organizations;~~

~~(24) Interests of individual Indians in trust or restricted lands;~~

~~(25) Any home produce from garden, livestock and poultry utilized by the member and his/her household for their consumption (as distinguished from such produce sold or exchanged);~~

~~(26) Any payments made directly to a third party for the benefit of a member of the benefit group;~~

~~(27) Financial aid provided to individuals by agencies or organizations which base their payment on financial need;~~

~~(28) Assistance or services received from the Vocational Rehabilitation Program, such as transportation expenses to a rehabilitation center, extra clothing, lunches, grooming needed for a training program and any other such complimentary payments;~~

~~(29) Payments made by a public or private non-profit child care agency for a child placed in foster care or subsidized adoption;~~

~~(30) Payments made to certain Vietnam veterans' children with spina bifida (PL 104-214);~~

~~(31) Payments made to certain Korea service veterans' children with spina bifida (PL 108-183);~~

~~(32) Payments made to the children of women Vietnam veterans who suffer from certain birth defects (PL 106-419);~~

~~(33) Additional payments of regular unemployment compensation in the amount of $25 per week ending June 30, 2010, and any amount of emergency unemployment compensation paid through May 31, 2010, as authorized under the American Recovery and Reinvestment Tax Act of 2009; and~~

~~(34) Wages paid by the Census Bureau for temporary employment related to Census activities.~~

~~(f)~~(d) **Income disregards ~~effective October 1, 2013~~.** For MAGI eligibility groups, whether a source of income is disregarded is determined in accordance with MAGI income counting rules in Part 6 of Subchapter 6 of this Chapter.

(g) In computing monthly income, ~~cents will be carried at all steps until the monthly amount is determined and then will be rounded to the nearest dollar. These rounding procedures apply to each individual and each type of income.~~cents will be rounded down at each step. Income which is received monthly but in irregular amounts is averaged using two month's income, if possible, to determine income eligibility. Less than two month's income may be used when circumstances (e.g., new employment, unpaid sick leave, etc.) would indicate that

previous income amounts would not be appropriate to use in determining future income amounts. Income received more often than monthly is converted to monthly amounts as follows:

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

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

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

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

SUBCHAPTER 15. PERSONAL CARE SERVICES

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

Financial eligibility for Personal Care for categorically needy individuals is determined as follows:

~~(1) **Financial eligibility/categorically related to AFDC prior to October 1, 2013.** In determining income for the individual related to AFDC, all family income is considered. (See OAC 317:35-5-45 for Exceptions to AFDC rules.) The "family", for purposes of determining need, includes the following persons if living together (or if living apart but there has been no break in the family relationship):~~

~~(A) spouse; and~~

~~(B) parent(s) and minor children of their own.~~

~~(i) For adults, to be categorically needy, the net income must be less than the categorically needy standard as shown on the OKDHS form 08AX001E (Appendix C-1), Schedule X.~~

~~(ii) For individuals under 19, to be categorically needy, the net income must be equal to or less than the categorically needy standard as shown on the OKDHS form 08AX001E (Appendix C-1), Schedule I. A.~~

~~(2)~~(1) **Financial eligibility for MAGI eligibility groups ~~effective October 1, 2013~~.** See MAGI eligibility rules in Subchapter 6 of this Chapter to determine financial eligibility for MAGI eligibility groups.

~~(3)~~(2) **Financial eligibility/categorically related to ABD.** In determining income and resources for the individual related to ABD, the "family" includes the individual and spouse, if any. To be categorically needy, the countable income must be less than the categorically needy standard as shown on the OKDHS form 08AX001E (Appendix C-1), Schedule VI (QMBP standard). If an individual and spouse cease to live together for reasons other than institutionalization or receipt of the

ADvantage waiver or HCBW/MR services, income and resources are considered available to each other through the month in which they are separated. Mutual consideration ceases with the month after the month in which the separation occurs. Any amounts which are actually contributed to the spouse after the mutual consideration has ended are considered.

~~(4)~~(3) **Determining financial eligibility for Personal Care.** For individuals determined categorically needy for Personal Care, the member will not pay a vendor payment for Personal Care services.

SUBCHAPTER 19. NURSING FACILITY SERVICES

317:35-19-20. Determining financial eligibility of categorically needy individuals

Financial eligibility for NF medical care is determined as follows:

~~(1) **Financial eligibility/categorically related to AFDC prior to October 1, 2013.**~~

~~(A) In determining income for the individual related to AFDC, all family income is considered. The "family", for purposes of determining need, includes the following persons if living together (or if living apart but there has been no break in the family relationship):~~

~~(i) spouse; and~~

~~(ii) parent(s) and minor children of their own.~~

~~(I) For adults, to be categorically needy, the net income must be less than the categorically needy standard as shown on the OKDHS Appendix C-1, Schedule X.~~

~~(II) For individuals under 19, to be categorically needy, the net income must be equal to or less than the categorically needy standard as shown on the OKDHS Appendix C-1, Schedule I. A.~~

~~(B) Individuals related to AFDC but not receiving a money payment are not entitled to one-half income disregard following the earned income deduction.~~

~~(2)~~(1) **Financial eligibility for MAGI eligibility groups ~~effective October 1, 2013~~.** See MAGI eligibility rules in Subchapter 6 of this Chapter to determine financial eligibility for MAGI eligibility groups.

~~(3)~~(2) **Financial eligibility/categorically related to ABD.** In determining income and resources for the individual related to ABD, the "family" includes the individual and spouse, if any. If an individual and spouse cease to live together for reasons other than institutionalization, income

and resources are considered available to each other through the month in which they are separated. Mutual consideration ceases with the month after the month in which the separation occurs. Any amounts which are actually contributed to the spouse after the mutual consideration has ended are considered. If the individual and spouse cease to live together because of the individual entering a nursing facility, see paragraph (3) of OAC 317:35-19-21 to determine financial eligibility.

(A) The categorically needy standard on OKDHS Appendix C-1, Schedule VI., is applicable for individuals related to ABD. If the individual is in an NF and has received services for 30 days or longer, the categorically needy standard in OKDHS Appendix C-1, Schedule VIII. B.1., is used. If the individual leaves the facility prior to the 30 days, or does not require services past the 30 days, the categorically needy standard in OKDHS Appendix C-1, Schedule VI., is used. The rules on determination of income and resources are applicable only when an individual has entered a NF and is likely to remain under care for 30 consecutive days. The 30-day requirement is considered to have been met even if it is interrupted by a hospital stay or the individual is deceased before the 30-day period ends.

(B) An individual who is a patient in an extended care facility may have SSI continued for a three month period if he/she meets conditions described in Subchapter 5 of this Chapter. The continuation of the payments is intended for use of the member and does not affect the vendor payment. If the institutional stay exceeds the three month period, SSI will make the appropriate change.

~~(4)~~(3) **Transfer of capital resources on or before August 10, 1993.** Individuals who have transferred capital resources on or before August 10, 1993 and applying for or receiving NF, ICF/MR, or receiving HCBW/MR services are subject to penalty if the individual, the individual's spouse, the guardian, or legal representative of the individual or individual's spouse, disposes of resources for less than fair market value during the 30 months immediately prior to eligibility for SoonerCare if the individual is eligible at institutionalization. If the individual is not eligible for SoonerCare at institutionalization, the individual is subject to penalty if a resource was transferred during the 30 months immediately prior to the date of application for SoonerCare. Any subsequent transfer is also subject to this policy. When there have been multiple transfers of resources without

commensurate return, all transferred resources are added together to determine the penalty period. The penalty consists of a period of ineligibility (whole number of months) determined by dividing the total uncompensated value of the resource by the average monthly cost to a private patient in a nursing facility in Oklahoma. The penalty period begins with the month the resource or resources were first transferred and cannot exceed 30 months. Uncompensated value is defined as the difference between the equity value and the amount received for the resource.

(A) However, the penalty would not apply if:

(i) The transfer was prior to July 1, 1988.

(ii) The title to the individual's home was transferred to:

(I) the spouse;

(II) the individual's child under age 21 or who is blind or totally disabled;

(III) a sibling who has equity interest in the home and resided in the home for at least one year prior to the individual's admission to the nursing facility; or

(IV) the individual's son or daughter who resided in the home and provided care for at least two years prior to the individual's admission to the nursing facility.

(iii) The individual can show satisfactorily that the intent was to dispose of resources at fair market value or that the transfer was for a purpose other than eligibility.

(iv) The transfer was to the community spouse or to another person for the sole benefit of the community spouse in an amount equal to the community spouse's resource allowance.

(v) The resource was transferred to the individual's minor child who is blind or totally disabled.

(vi) The resource was transferred to the spouse (either community or institutionalized) or to another person for the sole benefit of the spouse if the resources are not subsequently transferred to still another person for less than fair market value.

(vii) The denial would result in undue hardship. Such determination should be referred to OKDHS State Office for a decision.

(B) The individual is advised by a written notice of a period of ineligibility due to transfer of assets. The notice explains the period of ineligibility for payment of

NF and the continuance of eligibility for other SoonerCare services.

(C) The penalty period can be ended by either the resource being restored or commensurate return being made to the individual.

(D) Once the restoration or commensurate return is made, eligibility is redetermined considering the value of the restored resource or the amount of commensurate return.

(E) The restoration or commensurate return will not entitle the member to benefits for the period of time that the resource remained transferred. An applicant cannot be certified for NF, ICF/MR, HCBW/MR, or ADvantage waiver services for a period of resource ineligibility.

~~(5)~~(4) **Transfer of assets on or after August 11, 1993 but before February 8, 2006.** An institutionalized individual, an institutionalized individual's spouse, the guardian or legal representative of the individual or individual's spouse who disposes of assets on or after August 11, 1993 but before February 8, 2006 for less than fair market value on or after the look-back date specified in (A) of this paragraph subjects the individual to a penalty period for the disposal of such assets.

(A) For an institutionalized individual, the look-back date is 36 months before the first day the individual is both institutionalized and has applied for medical assistance. However, in the case of payments from a trust or portions of a trust that are treated as transfers of assets, the look back date is 60 months.

(B) For purposes of this paragraph, an "institutionalized" individual is one who is residing in an NF.

(C) The penalty period begins the first day of the first month during which assets have been transferred and which does not occur in any other period of ineligibility due to an asset transfer. When there have been multiple transfers, all transferred assets are added together to determine the penalty.

(D) The penalty period consists of a period of ineligibility (whole number of months) determined by dividing the total uncompensated value of the asset by the average monthly cost to a private patient in a nursing facility in Oklahoma. In this calculation, any partial month is dropped. There is no limit to the length of the penalty period for these transfers. Uncompensated value is defined as the difference between the fair market value at the time of transfer less encumbrances and the amount received for the resource.

(E) Assets are defined as all income and resources of the individual and the individual's spouse, including any income or resources which the individual or such individual's spouse is entitled to but does not receive because of action:

(i) by the individual or such individual's spouse;

(ii) by a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or such individual's spouse; or

(iii) by any person, including any court or administrative body acting at the direction or upon the request of the individual or such individual's spouse.

(F) A penalty would not apply if:

(i) the title to the individual's home was transferred to:

(I) the spouse;

(II) the individual's child under age 21 or who is blind or totally disabled as determined by Social Security;

(III) a sibling who has equity interest in the home and resided in the home for at least one year immediately prior to the institutionalization of the individual; or

(IV) the individual's son or daughter who resided in the home and provided care for at least two years immediately prior to the individual's institutionalization.

(ii) the individual can show satisfactorily that the intent was to dispose of assets at fair market value or that the transfer was exclusively for a purpose other than eligibility. It is presumed that any transfer of assets made for less than fair market value was made in order to qualify the individual for SoonerCare. In order to rebut this presumption, the individual must present compelling evidence that a transfer was made for reasons other than to qualify for SoonerCare. It is not sufficient for an individual to claim that assets were transferred solely for the purposes of allowing another to have them with ostensibly no thought of SoonerCare if the individual qualifies for SoonerCare as a result of the transfer.

(iii) the transfer was to the community spouse or to another person for the sole benefit of the community spouse in an amount equal to the community spouse's asset allowance.

(iv) the asset was transferred to the individual's child who is blind or totally disabled as determined by Social Security. The transfer may be to a trust established for the benefit of the individual's child.

(v) the asset was transferred to or from the spouse (either community or institutionalized) or to another person for the sole benefit of the spouse if the assets are not subsequently transferred to still another person for less than fair market value.

(vi) the asset is transferred to a trust established solely for the benefit of a disabled individual under the age of 65.

(vii) the denial would result in undue hardship. Such determination should be referred to OKDHS State Office for a decision.

(G) The individual is advised by a written notice of a period of ineligibility due to transfer of assets. The notice explains the period of ineligibility for payment of NF and the continuance of eligibility for other SoonerCare services.

(H) The penalty period can be ended by either all assets being restored or commensurate return being made to the individual.

(I) Once the restoration or commensurate return is made, eligibility is redetermined considering the value of the restored asset or the amount of commensurate return.

(J) The restoration or commensurate return will not entitle the member to benefits for the period of time that the asset remained transferred. An applicant cannot be certified for nursing care services for a period of asset ineligibility.

(K) Assets which are held by an individual with another person or persons, whether held in joint tenancy or tenancy in common or similar arrangement, and the individual's ownership or control of the asset is reduced or eliminated is considered a transfer.

(L) When a transfer of assets by the spouse of an individual results in a period of ineligibility and the spouse who made such transfer subsequently becomes institutionalized, the period of ineligibility will be apportioned between the two institutionalized spouses.

~~(6)~~(5) **Transfer of assets on or after February 8, 2006.** An institutionalized individual, an institutionalized individual's spouse, the guardian or legal representative of the individual or individual's spouse who disposes of assets on or after February 8, 2006 for less than fair market value

on or after the look-back date specified in (A) of this paragraph subjects the individual to a penalty period for the disposal of such assets.

(A) For an institutionalized individual, the look-back date is 60 months before the first day the individual is both institutionalized and has applied for medical assistance. However, individuals that have purchased an Oklahoma Long-Term Care Partnership Program approved policy may be completely or partially exempted from this Section depending on the monetary extent of the insurance benefits paid.

(B) For purposes of this paragraph, an "institutionalized" individual is one who is residing in an NF.

(C) The penalty period will begin with the later of:

(i) the first day of a month during which assets have been transferred for less than fair market value; or

(ii) the date on which the individual is:

(I) eligible for medical assistance; and

(II) receiving institutional level of care services that, were it not for the imposition of the penalty period, would be covered by SoonerCare.

(D) The penalty period:

(i) cannot begin until the expiration of any existing period of ineligibility;

(ii) will not be interrupted or temporarily suspended once it is imposed;

(iii) When there have been multiple transfers, all transferred assets are added together to determine the penalty.

(E) The penalty period consists of a period of ineligibility determined by dividing the total uncompensated value of the asset by the average cost to a private patient in a nursing facility in Oklahoma shown on OKDHS Appendix C-1. In this calculation, the penalty must include a partial month disqualification based upon the relationship between that fractional amount and the average cost to a private patient in a nursing facility in Oklahoma. There is no limit to the length of the penalty period for these transfers. Uncompensated value is defined as the difference between the fair market value at the time of transfer less encumbrances and the amount received for the resource.

(F) Assets are defined as all income and resources of the individual and the individual's spouse, including any income or resources which the individual or such individual's spouse is entitled to but does not receive

because of action:

(i) by the individual or such individual's spouse;

(ii) by a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or such individual's spouse; or

(iii) by any person, including any court or administrative body acting at the direction or upon the request of the individual or such individual's spouse.

(G) Special Situations.

(i) Separate Maintenance or Divorce.

(I) There shall be presumed to be a transfer of assets if an applicant or member receives less than half of the couple's resources pursuant to a Decree of Separate Maintenance or a Decree of Divorce.

(II) There shall be presumed to be a transfer of assets if the income is reduced to an amount lower than the individual's own income plus half of the joint income. The transfer penalty shall be calculated monthly.

(III) Assets which were exempt lose the exempt character when not retained by the applicant or member in the divorce or separate maintenance. These assets, if received by the other spouse, are counted when determining the penalty.

(IV) The applicant or member may rebut the presumption of transfer by showing compelling evidence that the uneven division of income or resources was the result of factors unrelated to SoonerCare eligibility.

(ii) Inheritance from a spouse.

(I) Oklahoma law provides that a surviving spouse is entitled to a minimum portion of a deceased spouse's probate estate. The amount depends on several factors.

(II) It is considered a transfer if the deceased spouse's will places all, or some, of the statutory share the applicant or member is entitled to receive in a trust which the applicant or member does not have unfettered access to or leaves less than the statutory amount to the applicant or member, who does not then elect to receive the statutory share in probate proceedings.

(H) A penalty would not apply if:

(i) the title to the individual's home was transferred to:

(I) the spouse;
(II) the individual's child under age 21 or who is blind or totally disabled as determined by Social Security;
(III) a sibling who has equity interest in the home and resided in the home for at least one year immediately prior to the institutionalization of the individual; or
(IV) the individual's son or daughter who resided in the home and provided care for at least two years immediately prior to the individual's institutionalization.

(ii) the individual can show satisfactorily that the intent was to dispose of assets at fair market value or that the transfer was exclusively for a purpose other than eligibility. It is presumed that any transfer of assets made for less than fair market value was made in order to qualify the individual for SoonerCare. In order to rebut this presumption, the individual must present compelling evidence that a transfer was made for reasons other than to qualify for SoonerCare. It is not sufficient for an individual to claim that assets were transferred solely for the purposes of allowing another to have them with ostensibly no thought of SoonerCare if the individual qualifies for SoonerCare as a result of the transfer.

(iii) the transfer was to the community spouse or to another person for the sole benefit of the community spouse in an amount equal to the community spouse's asset allowance. "Sole benefit" means that the amount transferred will be used for the benefit of the community spouse during his or her expected life.

(iv) the asset was transferred to the individual's child who is blind or totally disabled as determined by Social Security. The transfer may be to a trust established for the benefit of the individual's child.

(v) the asset was transferred to or from the spouse (either community or institutionalized) or to another person for the sole benefit of the spouse if the assets are not subsequently transferred to still another person for less than fair market value. "Sole benefit" means that the amount transferred will be used for the benefit of the spouse (either community or institutionalized) during his or her expected life.

(vi) the asset is transferred to a trust established solely for the benefit of a disabled individual under

the age of 65.

(vii) the denial would result in undue hardship. Undue hardship exists when application of a transfer of assets penalty would deprive the individual of medical care such that the individual's health or life would be endangered; or of food, clothing, shelter, or other necessities of life.

(I) An undue hardship does not exist if the individual willingly transferred assets for the purpose of qualifying for SoonerCare services through the use of the undue hardship exemption.

(II) Such determination should be referred to OKDHS State Office for a decision.

(III) If the undue hardship exists because the applicant was exploited, legal action must be pursued to return the transferred assets to the applicant before a hardship waiver will be granted. Pursuing legal action means an APS referral has been made to the district attorney's office or a lawsuit has been filed and is being pursued against the perpetrator.

(I) The individual is advised by a written notice of a period of ineligibility due to transfer of assets, a timely process for determining whether an undue hardship waiver will be granted and a process for an adverse determination appeal. The notice explains the period of ineligibility for payment of NF and the continuance of eligibility for other SoonerCare services.

(J) The penalty period can be ended by either all assets being restored or commensurate return being made to the individual.

(K) Once the restoration or commensurate return is made, eligibility is redetermined considering the value of the restored asset or the amount of commensurate return.

(L) The restoration or commensurate return will not entitle the member to benefits for the period of time that the asset remained transferred. An applicant cannot be certified for nursing care services for a period of asset ineligibility.

(M) Assets which are held by an individual with another person or persons, whether held in joint tenancy or tenancy in common or similar arrangement, and the individual's ownership or control of the asset is reduced or eliminated is considered a transfer. The exception to this rule is if ownership of a joint account is divided according to the amount contributed by each owner.

(i) Documentation must be provided to show each co-owner's contribution;

(ii) The funds contributed by the applicant or SoonerCare member end up in an account owned solely by the applicant or member.

(N) When a transfer of assets by the spouse of an individual results in a period of ineligibility and the spouse who made such transfer subsequently becomes institutionalized, the period of ineligibility will be apportioned between the two institutionalized spouses.

~~(7)~~(6) **Commensurate return.** Commensurate return for purposes of this Section is defined as actual money payment or documentation of money spent on the member's behalf; i.e., property taxes, medical debts, nursing care expenses, etc., corresponding to the market value of the transferred property. The definition does not include personal services, labor or provision of rent-free shelter. It also does not include a monetary value assigned and projected for future payment either by cash or provision of services. Any transfer of property within the five years prior to application or during receipt of assistance must be analyzed in regard to commensurate return as well as determination of intent.

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-31. Prior authorization for health care-related goods and services

(a) Under the Oklahoma SoonerCare program, there are health care-related goods and services that require prior authorization (PA) by the Oklahoma Health Care Authority (OHCA). PA is a process to determine if a prescribed good or service is medically necessary; it is not, however, a guarantee of member eligibility or of SoonerCare payment. All goods or services requiring PA will be authorized on the basis of information submitted to OHCA, including:

(1) the relevant code, as is appropriate for the good or service requested (for example, Current Procedural Terminology (CPT) codes for services; Healthcare Common Procedure Coding System (HCPCS) codes, for durable medical equipment; or National Drug Codes (NDC), for drugs); and

(2) any other information required by OHCA, in the format as prescribed. The OHCA authorization file will reflect the codes that have been authorized.

(b) The OHCA staff will issue a determination for each requested good or service requiring a PA. The provider will be advised of that determination through the provider portal. The member will be advised by letter. Policy regarding member appeal of a denied PA is available at OAC 317:2-1-2.

(c) The following is an inexhaustive list of the goods and services that may require a PA, for at least some SoonerCare member populations, under some circumstances. This list is subject to change, with OHCA expressly reserving the right to add a PA requirement to a covered good or service or to remove a PA requirement from a covered good or service.

(1) Physical therapy for children
(2) Speech therapy for children
(3) Occupational therapy for children
(4) High Tech Imaging (for ex. CT, MRA, MRI, PET)
(5) Some dental procedures, including, but not limited to orthodontics (orthodontics are covered for children only)
(6) Inpatient psychiatric services
(7) Some prescription drugs and/or physician administered drugs
(8) Ventilators
(9) Hearing aids (covered for children only)

(10) Prosthetics
(11) High risk OB services
(12) Urine drug testing
(13) Enteral therapy (covered for children only)
(14) Hyperalimentation
(15) Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services, supplies, or equipment that are determined to be medically necessary for a child or adolescent, and which are included within the categories of mandatory and optional services in Section 1905(a) of Title XIX, regardless of whether such services, supplies, or equipment are listed as covered in Oklahoma's State Plan
(16) Adaptive equipment for persons residing in private Intermediate Care Facilities for Individuals with Intellectual Disabilities
(17) Some ancillary services provided in a long term care hospital or in a long term care facility
(18) Rental of hospital beds, support surfaces, oxygen and oxygen related products, continuous positive airway pressure devices (CPAP and BiPAP), pneumatic compression devices, and lifts
(19) Allergy testing and immunotherapy
(20) Bariatric surgery
(21) Genetic testing

(d) Providers should refer to the relevant Part of OAC 317:30-5 for additional, provider-specific guidance on PA requirements. Providers may also refer to the OHCA Provider Billing and Procedure Manual, available on OHCA's website, to see how and/or where to submit PA requests, as well as to find information about documentation.

317:30-3-32. Retrospective review for payment for services to certain aliens

Certain aliens are only eligible for emergency medical services (Refer to OAC 317:35-5-25). Requests for alien services should be submitted to the local county Oklahoma Department of Human Services (OKDHS) office on Form 08MA005E (MS-MA-5), Notification of Needed Medical Services. OKDHS forwards the appropriate paperwork to the Oklahoma Health Care Authority where the case undergoes retrospective review for payment by medical staff. Retrospective review is a process in which a claim and medical records are reviewed after care is provided to validate that the services provided meet the definition of emergency before payment is made. Once a decision to approve or deny the requested services is made then the county OKDHS office is notified and the county OKDHS office is responsible for notifying the applicant and the provider of the decision.

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 5. ELIGIBILITY [REVOKED]

317:30-3-78. Request for prior authorization for dental services [REVOKED]

~~The currently approved ADA form is used to request prior authorization for dental services that require a treatment plan or as indicated in Part 79 of Subchapter 5 of this Chapter.~~

317:30-3-79. Hearing appliance prescription and supplier request for prior authorization [REVOKED]

~~A state licensed audiologist who holds a certificate of clinical competence from the American Speech and Hearing Association, or has completed the equivalent educational requirements and work experience necessary for the certificate, or has completed the academic program and is acquiring supervised work experience to qualify for the certificate may request prior authorization for hearing appliances from the Oklahoma Health Care Authority, Medical Authorization Unit.~~

317:30-3-82. Prior authorization for services to individuals under 21 years of age [REVOKED]

~~Under the Medicaid Program, the following services require prior authorization by the OHCA for all recipients under 21 years of age:~~

~~(1) Orthotic procedures (HCPCS Codes L5000 to L9999)~~
~~(2) Appliances (orthopedic, hearing aids)~~
~~(3) Dental services requiring a treatment plan as indicated in Subchapter 5 (Part 79 of this Chapter)~~
~~(4) Food supplements~~
~~(5) Hyperalimentation~~
~~(6) Enteral therapy~~
~~(7) Emergency medical services for certain aliens.~~
~~(8) Adaptive Equipment for persons residing in private ICF/MR's.~~
~~(9) Outpatient psychotherapy by a psychologist for children under three.~~
~~(10) Psychological testing by a psychologist beyond four hours per recipient each 12 months.~~
~~(11) Diagnosis and treatment services not otherwise covered under the program when identified during an EPSDT screening examination.~~

317:30-3-83. Prior authorization for services to adults [REVOKED]

~~(a) Under the Medicaid Program, the following services require prior authorization:~~

~~(1) Respirators~~
~~(2) Ventilators~~
~~(3) Hyperalimentation~~
~~(4) Emergency medical services for certain aliens.~~
~~(5) Adaptive equipment for persons residing in private ICF/MR's.~~

~~(b) All services requiring Prior Authorization will be authorized on the basis of the procedures involved and the OHCA authorization file will reflect the procedure codes given prior authorization. A Prior Authorization Number will be assigned and a notice generated to the medical provider. The notice of authorization will contain the Prior Authorization (PA) Number which must be on the claim for the services.~~

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

SUBCHAPTER 3. COVERAGE AND EXCLUSIONS

317:35-3-3. Prior authorization requirements [REVOKED]

~~Requests for prior authorization of medical services should be submitted on Form MS-MA-5, Notification of Needed Medical Services, except for those specific forms indicated below. The MS-MA-5, the Prescription for Appliances, Prostheses and/or Medical Suppliers Request for Prior Authorization form, Hearing Appliance Prescription and Supplier Request for Prior Authorization form, and Request for Prior Authorization for Dental Services form, should be sent to OHCA, Medical Authorization Unit. The Medical authorization unit approves or disapproves each medical service. A computer generated prior Authorization Notice, Form MS-S-4, showing approval or denial of the service is mailed to the provider, client and county office. The MS-S-4, is not a notice of the individual's eligibility for Title XIX, and the approval may go beyond the period of eligibility.~~

~~(1) **Adults and children**. The following medical services require prior authorization by the OHCA, Special Health Care Needs, for all individuals:~~

~~(A) Purchase of oxygen systems, rental or purchase of ventilators, respirators, and hyperalimentation. Physician's Prescription for Appliances, Prostheses, and/or Medical Equipment and Medical Suppliers Request for Prior Authorization form must be completed by the physician and medical supplier.~~

~~(B) Dental services as indicated in the OHCA Medical Services Provider Manual. Services include limited oral surgery and treatment procedure and dental care for individuals receiving Intermediate Care Facility Services for the Mentally Retarded. Form MS-MA-5 and/or Request for Prior Authorization for Dental Services form must be completed by the dentist.~~

~~(C) Blood and blood fractions.~~

~~(D) Medical services rendered in behalf of Legalized, Illegal, and Ineligible Aliens. The provider must clearly indicate on the MS-MA-5 in Section III whether the service was rendered as an emergency.~~

~~(E) Adaptive equipment uniquely specialized for an individual's needs (equipment, appliances and prosthetic devices) beyond the scope of the Title XIX program for individuals in Intermediate Care Facilities for the~~

~~Mentally Retarded.~~

~~(2) **Children.** In addition to those services that are covered, when preauthorized, for all ages, the following medical services require prior authorization by the OHCA, Special Health Care Needs, for individuals under 21 years of age:~~

~~(A) Orthotic procedures listed by HCPC codes L5000 through L9999.~~

~~(B) Hearing aids. Form MS-MA-5 must be completed by the physician and the Hearing Appliance Prescription and Supplier Request for Prior Authorization form must be completed by the audiologist and supplier.~~

~~(C) Dental services requiring a treatment plan as indicated in OAC 317:30-5-695. Form MS-MA-5 and/or Request for Prior Authorization for Dental Services must be completed by the dentist.~~

~~(D) EPSDT services beyond the scope of Title XIX when identified by an EPSDT screening as necessary to correct or ameliorate defects and physical and mental illness and conditions.~~

SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME
PART 3. NON-MEDICAL ELIGIBILITY REQUIREMENTS

317:35-5-25. Citizenship/alien status and identity verification requirements

(a) **Citizenship/alien status and identity verification requirements.** Verification of citizenship/alien status and identity are required for all adults and children approved for SoonerCare. An exception is individuals who are initially eligible for SoonerCare as deemed newborns; according to Section 1903(x) of the Social Security Act, they will not be required to further document citizenship or identity at any subsequent SoonerCare eligibility redetermination. They are considered to have provided satisfactory documentation of citizenship and identity by virtue of being born in the United States.

(1) The types of acceptable evidence that verify identity and citizenship include:

(A) United States (U.S.) Passport;

(B) Certificate of Naturalization issued by U.S. Citizenship & Immigration Services (USCIS)(Form N-550 or N-570);

(C) Certificate of Citizenship issued by USCIS (Form N-560 or N-561);

(D) Copy of the Medicare card or printout of a BENDEX or SDX screen showing receipt of Medicare benefits, Supplemental Security Income or disability benefits from the Social Security Administration; or

(E) Tribal membership card or Certificate of Degree of Indian Blood (CDIB) card, with a photograph of the individual.

(2) The types of acceptable evidence that verify citizenship but require additional steps to obtain satisfactory evidence of identity are listed in subparagraphs (A) and (B). Subparagraph (A) lists the most reliable forms of verification and is to be used before using items listed in (B). Subparagraph (B) lists those verifications that are less reliable forms of verification and are used only when the items in (A) are not attainable.

(A) Most reliable forms of citizenship verification are:

(i) A U.S. public Birth Certificate showing birth in one of the 50 states, the District of Columbia, Puerto Rico (on or after 1/13/1941), Guam (on or after 4/10/1899), the U.S. Virgin Islands (on or after 1/17/1917), American Samoa, Swain's Island, or the Northern Mariana Islands after 11/4/1986. For Puerto Ricans whose eligibility is being determined for the first time on or after October 1, 2010 and using a birth certificate to verify citizenship, the birth certificate must be a certified birth certificate issued by Puerto Rico on or after July 1, 2010;

(ii) A Report of Birth Abroad of a U.S. citizen issued by the Department of Homeland Security or a Certification of birth issued by the State Department (Form FS-240, FS-545 or DS-1350);

(iii) A U.S. Citizen ID Card (Form I-179 or I-197);

(iv) A Northern Mariana Identification Card (Form I-873) (Issued by the INS to a collectively naturalized citizen of the U.S. who was born in the Northern Mariana Islands before 11/3/1986);

(v) An American Indian Card issued by the Department of Homeland Security with the classification code "KIC" (Form I-872);

(vi) A Final Adoption Decree showing the child's name and U. S. place of birth;

(vii) Evidence of U.S. Civil Service employment before 6/1/1976;

(viii) An Official U.S. Military Record of Service showing a U.S. place of birth (for example a DD-214);

(ix) Tribal membership card or Certificate of Degree of Indian Blood (CDIB) card, without a photograph of the individual, for Native Americans;

(x) Oklahoma Voter Registration Card; or

(xi) Other acceptable documentation as approved by OHCA.

(B) Other less reliable forms of citizenship verification are:

(i) An extract of a hospital record on hospital letterhead established at the time of the person's birth that was created five years before the initial application date and that indicates a U.S. place of birth. For children under 16 the evidence must have been created near the time of birth or five years before the date of application;

(ii) Life, health, or other insurance record showing a U.S. place of birth that was created at least five years before the initial application date and that indicates a U.S. place of birth;

(iii) Federal or State census record showing U.S. citizenship or a U.S. place of birth (generally for persons born 1900 through 1950). The census record must also show the applicant's/member's age; or

(iv) One of the following items that show a U.S. place of birth and was created at least five years before the application for SoonerCare. This evidence must be one of the following and show a U.S. place of birth:

(I) Seneca Indian tribal census record;

(II) Bureau of Indian Affairs tribal census records of the Navajo Indians;

(III) U.S. State Vital Statistics official notification of birth registration;

(IV) An amended U.S. public birth record that is amended more than five years after the person's birth; or

(V) Statement signed by the physician or midwife who was in attendance at the time of birth.

(3) Acceptable evidence of identity that must accompany citizenship evidence listed in (A) and (B) of paragraph (2) of this subsection includes:

(A) A driver's license issued by a U.S. state or territory with either a photograph of the individual or other identifying information such as name, age, sex, race, height, weight, or eye color;

(B) A school identification card with a photograph of the individual;

(C) An identification card issued by Federal, state, or local government with the same information included on driver's licenses;

(D) A U.S. military card or draft record;

(E) A U.S. military dependent's identification card;

(F) A Native American Tribal document including Certificate of Degree of Indian Blood, or other U.S.

American Indian/Alaska Native Tribal document with a photograph of the individual or other personal identifying information;

(G) A U.S. Coast Guard Merchant Mariner card;

(H) A state court order placing a child in custody as reported by the OKDHS;

(I) For children under 16, school records may include nursery or daycare records;

(J) If none of the verification items on the list are available, an affidavit may be used for children under 16. An affidavit is only acceptable if it is signed under penalty of perjury by a parent or guardian stating the date and place of the birth of the child and cannot be used if an affidavit for citizenship was provided.

(b) **Reasonable opportunity to obtain citizenship verification.**

(1) When the applicant/member is unable to obtain citizenship or alienage verification, a reasonable opportunity is afforded to the applicant/member to obtain the evidence as well as assistance in doing so. A reasonable opportunity is afforded to the applicant/member before taking action affecting the individual's eligibility for SoonerCare. The reasonable opportunity timeframe afforded to SoonerCare members is the same as authorized under Section 1902(ee) of the Social Security act and is stated on the documentation request the agency sends to the applicant/member.

(2) The following methods of verification are the least reliable forms of verification and should only be used as a last resort:

(A) Institutional admission papers from a nursing facility, skilled care facility or other institution. Admission papers generally show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth;

(B) Medical (clinic, doctor, or hospital) record created at least five (5) years before the initial application date that indicates a U.S. place of birth. For children under ~~16~~the age of sixteen (16), the document must have been created near the time of birth. Medical records generally show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth. An immunization record is not considered a medical record for purposes of establishing U.S. citizenship;

(C) Written affidavit. Affidavits are only used in rare circumstances. If the verification requirements need to be met through affidavits, the following rules apply:

(i) There must be at least two affidavits by two (2) individuals who have personal knowledge of the event(s) establishing the applicant's/member's claim of citizenship;
(ii) At least one (1) of the individuals making the affidavit cannot be related to the applicant/member;
(iii) In order for the affidavit to be acceptable, the persons making them must be able to provide proof of their own citizenship and identity;
(iv) If the individual(s) making the affidavit has information which explains why evidence establishing the applicant's/member's claim of citizenship does not exist or cannot be readily obtained, the affidavit must contain this information as well;
(v) The State must obtain a separate affidavit from the applicant/member or other knowledgeable individual (guardian or representative) explaining why the evidence does not exist or cannot be obtained; and
(vi) The affidavits must be signed under penalty of perjury.

(c) **Alienage verification requirements.** SoonerCare services are provided as listed to the defined groups as indicated in this subsection if they meet all other factors of eligibility. Persons determined as having lawful alien status must have the status verified through Systematic Alien Verification for Entitlement (SAVE).

(1) **Eligible aliens (qualified aliens).** The groups listed in the following subparagraphs are eligible for the full range of SoonerCare services. A qualified alien is:

(A) an alien who was admitted to the United States and has resided in the United States for a period greater than five (5) years from the date of entry and who was:

(i) lawfully admitted for permanent residence under the Immigration and Nationality Act;

(ii) paroled into the United States under Section 212(d)(5) of such Act for a period of at least one (1) year;

(iii) granted conditional entry pursuant to Section 203(a)(7) of such Act as in effect prior to April 1, 1980; or

(iv) a battered spouse, battered child, or parent or child of a battered person with a petition under 204(a)(1)(A) or (B) or 244(a)(3) of the Immigration and Naturalization Act.

(B) an alien who was admitted to the United States and who was:

(i) granted asylum under Section 208 of such Act regardless of the date asylum is granted;
(ii) a refugee admitted to the United States under Section 207 of such Act regardless of the date admitted;
(iii) an alien with deportation withheld under Section 243(h) of such Act regardless of the date deportation was withheld;
(iv) a Cuban or Haitian entrant as defined in Section 501(e) of the Refugee Education Assistance Act of 1980, regardless of the date of entry;
(v) an alien who is a veteran as defined in 38 U.S.C. § 101, with a discharge characterized as an honorable discharge and not on the grounds of alienage;
(vi) an alien who is on active duty, other than active duty for training, in the Armed Forces of the United States;
(vii) the spouse or unmarried dependent child of an individual described in (C) of this paragraph;
(viii) a victim of a severe form of trafficking pursuant to Section 107(b) of the Trafficking Victims Protection Act of 2000; or
(ix) admitted as an Amerasian immigrant.

(C) permanent residents who first entered the country under (B) of this paragraph and who later converted to lawful permanent residence status.

(2) **Other aliens lawfully admitted for permanent residence (non-qualified aliens).** Non-qualified aliens are those individuals who were admitted to the United States and who do not meet any of the definitions in paragraph (1) of this subsection. Non-qualified aliens are ineligible for SoonerCare for five (5) years from the date of entry except that non-qualified aliens are eligible for emergency services only when the individual has a medical condition (including emergency labor and delivery) with acute symptoms which may result in placing his/her health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of body organ or part without immediate medical attention, in accordance with 317:30-3-32. The only exception is when a pregnant woman qualifies under the pregnancy related benefits covered under the Title XXI program because the newborn child will meet the citizenship requirement at birth.

(3) **Afghan Special Immigrants.** Afghan special immigrants, as defined in Public Law 110-161, who have special immigration status after December 26, 2007, are exempt from the five (5) year period of ineligibility for SoonerCare services. All other eligibility requirements must be met to qualify for

SoonerCare services. If these individuals do not meet one of the categorical relationships, they may apply and be determined eligible for Refugee Medical Assistance. Afghan special immigrants are considered lawful permanent residents.

(4) **Iraqi Special Immigrants.** Iraqi special immigrants, as defined in Public Law 110-181, who have special immigration status after January 28, 2008, are exempt from the five (5) year period of ineligibility for SoonerCare services. All other eligibility requirements must be met to qualify for SoonerCare services. If these individuals do not meet one of the categorical relationships, they may apply and be determined eligible for Refugee Medical Assistance. Iraqi special immigrants are considered lawful permanent residents.

(5) **Undocumented aliens.** Undocumented aliens who do not meet any of the definitions in (1)-(2) of this subsection are eligible for emergency services only when the individual has a medical condition (including emergency labor and delivery) with acute symptoms which may result in placing his/her health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of body organ or part without immediate medical attention, in accordance with 30-3-32. The only exception is when a pregnant woman qualifies under the pregnancy related benefits covered under the Title XXI program because the newborn child will meet the citizenship requirement at birth.

(6) **Ineligible aliens.**

(A) Ineligible aliens who do not fall into the categories in (1) and (2) of this subsection, yet have been lawfully admitted for temporary or specified periods of time include, but are not limited to: foreign students, visitors, foreign government representatives, crewmen, members of foreign media and temporary workers including agricultural contract workers. This group is ineligible for SoonerCare, including emergency services, because of the temporary nature of their admission status. The only exception is when a pregnant woman qualifies under the pregnancy related benefits covered under the Title XXI program because the newborn child will meet the citizenship requirement at birth.

(B) These individuals are generally issued Form I-94, Arrival Departure Record, on which an expiration date is entered. This form is not the same Form I-94 that is issued to persons who have been paroled into the United States. Parolees carry a Form I-94 that is titled "Arrival-Departure Record B Parole Edition". Two other forms ~~thatdo~~that do not give the individual "Immigrant" status are Form ~~I-186,Nonresident~~I-186, Nonresident Alien

Mexican Border Crossing Card, and Form SW-434, Mexican Border Visitors Permit.

~~(7) **Preauthorization.** Preauthorization is required for payment of emergency medical services rendered to non-qualified and undocumented aliens. Persons determined as having lawful alien status must have the status verified through Systematic Alien Verification for Entitlements (SAVE).~~

(d) **Alienage.** A decision regarding eligibility cannot be made until the eligibility condition of citizenship and alienage is determined.

(1) **Immigrants.** Aliens lawfully admitted for permanent residence in the United States are classified as immigrants by the ~~BCIS~~USCIS. These are individuals who entered this country with the express intention of residing here permanently.

(2) **Parolees.** Under Section 212(d)(5) of the Immigration and Nationality Act, individuals can be paroled into the United States for an indefinite or temporary period at the discretion of the United States Attorney General. Individuals admitted as Parolees are considered to meet the "citizenship and alienage" requirement.

(3) **Refugees and Western Hemisphere aliens.** Under Section 203(a)(7) of the Immigration and Nationality Act, Refugees and Western Hemisphere aliens may be lawfully admitted to the United States if, because of persecution or fear of prosecution due to race, religion, or political opinion, they have fled from a Communist or Communist-dominated country or from the area of the Middle East; or if they are refugees from natural catastrophes. These entries meet the citizenship and alienage requirement. Western Hemisphere aliens will meet the citizenship requirement for SoonerCare if they can provide either of the documents in subparagraphs (A) and (B) of this paragraph as proof of their alien status.

(A) Form I-94 endorsed "Voluntary Departure Granted-Employment Authorized", or

(B) The following court-ordered notice sent by ~~BCIS~~USCIS to each of those individuals permitted to remain in the United States: "Due to a Court Order in Silva vs. Levi, 76 C4268 entered by District Judge John F. Grady in the District Court for the Northern District of Illinois, we are taking no action on your case. This means that you are permitted to remain in the United States without threat of deportation or expulsion until further notice. Your employment in the United States is authorized".

(4) **Special provisions relating to Kickapoo Indians.** Kickapoo Indians migrating between Mexico and the United States carry

Form I-94, Arrival-Departure Record (Parole Edition). If Form I-94 carries the statement that the Kickapoo is "paroled pursuant to Section 212(d)(5) of the Immigration and Nationality Act" or that the "Kickapoo status is pending clarification of status by Congress" regardless of whether such statements are preprinted or handwritten and regardless of a specific mention of the "treaty", they meet the "citizenship and alienage" requirement. All Kickapoo Indians paroled in the United States must renew their paroled status each year at any local Immigration Office. There are other Kickapoos who have entered the United States from Mexico who carry Form I-151 or Form I-551, Alien Registration Receipt Cards. These individuals have the same status as other individuals who have been issued Form I-151 or Form I-551 and, therefore, meet the citizenship and alienage requirements. Still other Kickapoos are classified as Mexican Nationals by the ~~BCIS~~USCIS. They carry Form I-94, Arrival-Departure Record, which has been issued as a visiting visa and does not make mention of the treaty. Such form does not meet the "citizenship and alienage" requirements but provides only the ineligible alien status described in (c)(4)(b) of this Section.

(5) **American Indians born in Canada.** An American Indian born in Canada, who has maintained residence in the United States since entry, is considered to be lawfully admitted for permanent residence if he/she is of at least one-half (1/2) American Indian blood. This does not include the non-citizen whose membership in an Indian tribe or family is created by adoption, unless such person is of at least ~~50~~fifty (50) percent or more Indian blood. The methods of documentation are birth or baptismal certificate issued on a reservation, tribal records, letter from the Canadian Department of Indian Affairs, or school records.

(6) **Permanent non-immigrants.** Marshall Islanders and individuals from the Republic of Palau and the Federated States of Micronesia are classified as permanent non-immigrants by ~~BCIS~~USCIS. They are eligible for emergency services only, in accordance with 30-3-32.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 95. AGENCY PERSONAL CARE SERVICES

317:30-5-950. Eligible providers

~~Payment~~Reimbursement for personal care is made only to agencies that ~~have been~~are certified as ~~personal care~~home care agency providers by the Oklahoma State Department of Health and are certified by the ADvantage Administration ~~AA~~(AA) as meeting applicable federal, state and local laws, rules and regulations. In order to be eligible for ~~payment,~~reimbursement, the ~~personal care~~home care agency must have an approved provider agreement on file with the ~~OHCA, in accordance with OAC 317:30-3-2.~~Oklahoma Health Care Authority (OHCA), per Oklahoma Administrative Code (OAC) 317:30-30-3-2. Service time of ~~Personal Care~~personal care is documented solely through the ~~Interactive Voice Response Authentication (IVRA)~~Electronic Visit Verification (EVV) system when services are provided in the member's home. ~~Providers are~~The home care agency is required to use the ~~IVRA~~EVV system ~~after access to the system is made available by OKDHS~~. The ~~IVRA~~EVV system provides alternate backup solutions ~~should~~when the automated system ~~be~~is unavailable. In the event of ~~IVRA~~EVV backup system failure, the provider ~~will document~~documents the time in accordance with their agency backup plan. The agency's backup procedures are only permitted when the ~~IVRA~~EVV system is unavailable. Refer to OAC 317:35-17-22 for additional instructions.

317:30-5-953. Billing

~~A billing unit of service for Personal Care skilled nursing service equals a visit.~~ A billing unit~~ of service~~ for ~~Personal Care~~personal care services provided by a ~~PC service~~home care agency is 15 minutes of ~~PC services delivery.~~service delivery and equals a visit. Billing procedures for ~~Personal Care~~personal care services are contained in the ~~OKMMIS~~Oklahoma Medicaid Management Information Systems (OKMMIS) Billing and Procedure Manual. Service time for ~~Personal Care~~personal care and ~~Nursing~~nursing is documented solely through the ~~Interactive Voice Response Authentication (IVRA)~~Electronic Visit Verification (EVV) system~~ after access to the system is made available by OKDHS~~. The ~~IVRA~~EVV system provides alternate backup solutions ~~should~~when the automated system ~~be~~is unavailable. In the event of ~~IVRA~~EVV backup system failure, the provider ~~will document~~documents time in accordance with their agency backup plan. The agency's backup procedures are ~~only~~ permitted only

when the ~~IVRA~~EVV system is unavailable.

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

SUBCHAPTER 17. ADVANTAGE WAIVER SERVICES

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

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

(b) ~~OKDHS~~The Oklahoma Department of Human Services (DHS) nurse reviews the~~ ADvantage case manager~~ UCAT Parts I and III submitted by the ADvantage case manager for a level of care redetermination. ~~If~~When policy defined criteria for ~~Nursing Facility~~nursing facility level of care cannot be determined or ~~cannot be~~ justified from available documentation~~ available~~ or ~~via~~through direct contact with the ADvantage case manager, ~~a~~ UCAT Parts I and III ~~is~~are completed in the member's home by the ~~local OKDHS~~DHS nurse. The ~~local OKDHS~~DHS nurse submits the UCAT evaluation to the area nurse~~,~~ or nurse designee, to make the medical eligibility level of care determination.

(c) ~~If~~When medical eligibility redetermination is not made prior to the current medical eligibility expiration, the existing medical eligibility certification is automatically extended ~~until level of care redetermination is established~~. ~~If the member no longer meets medical eligibility the area nurse, or nurse designee, updates the system's "medical eligibility end~~

~~date" and simultaneously notifies AA electronically.~~

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

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

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

(d) ~~If OKDHS determines a member no longer meets medical eligibility, the AA communicates to the member's case manager that the member has been determined to no longer meet medical eligibility for ADvantage as of the effective date of the eligibility determination. The case manager communicates with the member and if requested, assists the member to access other services.~~When DHS determines a member no longer meets medical eligibility, to receive waiver services, the:

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

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

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

317:35-17-19. Closure or termination of ADvantage services

(a) **Voluntary closure of ADvantage services.** ~~If~~When the member requests a lower level of care than ADvantage services, or ~~if the member~~ agrees that ADvantage services are no longer needed to meet ~~his/her~~his or her needs, a medical level of care decision by the area nurse~~,~~ or nurse designee, is not needed. The closure request is completed and signed by the member and the ADvantage case manager and sent to the ~~AA~~ADvantage Administration (AA) to be placed in the member's case record. The AA notifies the ~~OKDHS county office~~Oklahoma Department of Human Services (DHS) area nurse or area nurse designee of the voluntary closure and effective date of closure. ~~The~~When the member's written request for closure cannot be secured, the ADvantage case manager documents in the member's case record~~ all~~

~~circumstances involving~~ the reasons for the voluntary termination of services and alternatives for services~~ if written request for closure cannot be secured~~.

(b) **Closure due to financial or medical ineligibility.** The process for closure due to financial or medical ineligibility is described in this subsection.

(1) **Financial ineligibility.** ~~Anytime~~When the local ~~OKDHS~~DHS office determines a member does not meet~~ the~~ financial eligibility criteria, the ~~local OKDHS~~DHS office notifies the~~,~~ area nurse or area nurse designee who closes the member's authorization and notifies the member~~ provider,~~ and AA of financial ineligibility~~.~~ by system-generated mail. The AA notifies the member's providers of the decision. A medical eligibility redetermination is not required when a financial ineligibility period does not exceed the medical certification period.

(2) **Medical ineligibility.** ~~Any time~~When the ~~local OKDHS~~DHS office is notified ~~through MEDATS~~by the nurse or area nurse designee of a decision that the ~~individual~~member is no longer medically eligible for ADvantage services, the ~~local~~DHS office notifies the ~~individual,~~member and AA~~ and provider~~ of the decision. Refer to Oklahoma Administrative Code (OAC) 317:35-17-16 (d). The AA notifies the member's providers of the decision.

(c) **Closure due to other reasons.** Refer to OAC 317:35-17-3(e) - (h).

(d) **Resumption of ADvantage services.** ~~If~~When a member approved for ADvantage services ~~has been~~is without services for less than ~~90~~ninety (90) calendar days and has a current medical and financial eligibility determination, services may be resumed using the ~~previously approved~~previous authorized person-centered service plan. ~~If~~When a member ~~decides he/she desires~~requests to have ~~his/her~~his or her services restarted after ~~90~~ninety (90) calendar days, the member must request~~ the services as~~ a new referral for services through the DHS county office~~.~~ or AA. ~~If an individual~~When a member is determined~~ to be~~ eligible for ~~Advantage~~ADvantage services and ~~is transitioning~~transistions from a hospital or a nursing facility to a community setting, an ADvantage case manager may provide Institution Transition case ~~managemet~~management services to assist the ~~individual~~member to establish or re-establish him or herself safely in the home.

317:35-17-26. Ethics of Care Committee

The ADvantage Program Ethics of Care Committee (EOCC) reviews members cases when the ADvantage, State Plan Personal Care programs or a provider contracted to provide these services determines that a member's identified needs cannot be met through the provision of the ADvantage program or State Plan

Personal Care program and other formal or informal services are not in place or immediately available to meet the members health and safety needs. The EOCC is a core group of designated representatives from Oklahoma Department of Human Services (DHS) Aging Services and Oklahoma Health Care Authority staff and are experts in State Medicaid programs, specifically ADvantage waiver and State Plan Personal Care, and experienced in addressing member issues as it pertains to policy, program, and service delivery.

(a) EOCC decisions are predicated upon four (4) guiding principles.

(1) **Sustainability of member services.** The overarching concern of EOCC is to ensure that all efforts are made to sustain the member's services when possible. EOCC explores options and renders a decision that maintains member safety while averting the primary issue of concern before the EOCC. This is done while assuring member health and safety as outlined in Oklahoma Administrative Code (OAC) 317:35-17-3 (h) (1-7).

(2) **Cultural competence.** EOCC considers the contextual details of the situation to promote needs and interests of ADvantage members and emphasizes understanding of the members culture and relevant circumstances.

(3) **Balance and reciprocity.** This assures member health and safety is reliant upon the member's cooperation and that of the member's community network, or informal supports. EOCC evaluates the viability of the member's resources to sustain health and safety independent of medicaid paid supports when making decisions.

(4) **Education and mitigation.** EOCC uses decision-making processes for determining program appropriateness for cases that are problematic or controversial with respect to being able to meet member needs within program constraints. The decision-making process engages expertise from any area of program function relevant to the case in question when necessary. When the case submitted for review is deemed invalid or lacking sufficient merit for review, EOCC rescinds the review until the case meets the appropriate criteria for review.

(b) EOCC reviews ADvantage and State Plan Personal Care cases, including but not limited to, when:

(1) the member can no longer safely remain in the community;

(2) the member shows a consistent pattern of non-compliance and non-cooperativeness that prevents delivery of the authorized person-centered service plan or care plan;

(3) the provider's and/or DHS staff's safety cannot be assured due to the actions of the member, visit or another household member;

(4) the services required to meet member needs are beyond the scope of defined waiver or State Plan Personal Care services;
(5) the new ADvantage or State Plan Personal Care members meet financial and medical eligibility for the program, but require review for program appropriateness or community potential;
(6) the previous dis-enrolled ADvantage or State Plan Personal Care members that request re-enrollment into the ADvantage or State Plan Personal Care programs;
(7) the member scheduled for an administrative hearing in which the hearing officer requests EOCC review and input;
(8) members under investigation or review by a federal authority; or
(9) all cases in which administrative review and input are warranted.

(c) ADvantage Consumer Directed Personal Assistance Service and Supports (CD-PASS) service option cases are reviewed for the:
(1) circumstances under review are not addressed by CD-PASS requirements for member eligibility;
(2) a case scenario is not otherwise covered by an established process;
(3) established processes of the CD-PASS program do not allow for an adequate resolution to the issues; or
(4) CD-PASS eligibility impacts ADvantage eligibility, such as:
(A) eligibility is removed but that action may place the member at a greater risk; or
(B) a member and/or their legal agent are removed from CD-PASS services due to allegations of fraudulent or illegal actions that may result in the member's loss of ADvantage eligibility.

(d) EOCC review processes include:
(1) ADvantage Administration (AA) Program Assistant Administrator for Member/Provider Relations department chairs the EOCC. He or she is responsible to appoint qualified representatives to the EOCC committee;
(2) committee members, case representatives, or presenters are required to adhere to Health Insurance Portability and Accountability Act and DHS confidentiality standards and be discreet when reviewing and discussing cases under consideration of all records and information disclosed in carrying out the duties and activities of the committee;
(3) all cases that meet the defined criteria for EOCC review are submitted to AA Member/Provider Relations or Escalated Issues teams for processing and presentation;
(4) the Escalated Issues team formally requests a meeting for EOCC case review and develop a meeting agenda and provide EOCC members with relevant supporting documentation of EOCC review prior to the scheduled meeting;

(5) a quorum (half plus one committee member) is present to make a decision or recommendation on any case presented to the EOCC;
(6) designees are not substituted for EOCC members;
(7) the EOCC Chair is notified in advance when it becomes necessary for other parties to be invited due to their expertise on the subject matter;
(8) case presenters are dismissed after their presentations are complete and the EOCC proceeds to mitigate the case;
(9) upon completion of the committee discussion, the EOCC Chair calls for a vote. A majority vote carries the motion. When a tie ensues the Escalated Issues team Program Manager casts the deciding vote;
(10) a member determined by EOCC to be ineligible for ADvantage or Medicaid State Plan Personal Care program services is notified in writing by DHS of the determination and of his or her right to appeal the decision; and
(11) EOCC maintains all meeting minutes, decisions, court hearings, and files generated by our Escalated Issues department pertaining to the member indefinitely.

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.

"DHS" means the Oklahoma Department of Human Services.

"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.

"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 per Federal and State regulations.

"Full-time Employer" means the employer who employs an employee per Federal and State regulations, 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 benefit plan's network of providers with which it has negotiated a discount, and services provided by a physician or other health care provider with a contractual agreement with the insurance company paid at the highest benefit level.

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

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

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

"OESC" means the Oklahoma Employment Security Commission.

"OHCA" means the Oklahoma Health Care Authority.

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

"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~~OHCA to provide primary care services, including all medically necessary referrals.

"Premium" means a monthly payment to a carrier~~ or a self-funded plan~~ for benefit plan coverage.

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

~~**"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 expenses

(a) Out-of-pocket 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 expenses in excess of the 5 percent annual gross household income. ~~A~~An expense must be for an allowed and covered service by a qualified benefit plan(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 benefit plan's~~QBPs benefit summary and policies. For instance, if a 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 expenses as defined above in OAC ~~k~~317:45-1-4(a), the member must submit the OHCA required form and all OHCA required documentation to support that the member incurred and paid the out-of-pocket expense. The OHCA required documentation must substantiate that the member actually incurred and paid the eligible out-of-pocket expense. The OHCA may request additional documentation at any time to support a member's request for reimbursement of eligible out-of-pocket expenses.

SUBCHAPTER 5. INSURE OKLAHOMA QUALIFIED BENEFIT PLANS

317:45-5-1. Qualified Benefit Plan requirements

(a) Participating qualified 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 benefit plan, if required, must be approved by the Oklahoma Insurance Department for participation in the Oklahoma market ~~or a self-funded plan~~. All 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 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 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).

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 250 to 500 will be phased in over time as determined by the Oklahoma Health Care Authority~~.~~ (OHCA). 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~~Professional Employer Organization in accordance with OHCA rules, this determination is based on appropriate supporting documentation 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~~in the contracting stage to offer a qualified benefit plan~~. The qualified benefit plan coverage must begin on the first day of the month and continue through the last day of the month;~~ coverage to employees;
(4) ~~offer qualified benefit plan coverage to employees; and~~
~~(5)~~ contribute a minimum 25 percent of the eligible employee monthly benefit plan premium or an equivalent 40 percent of premiums for 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.

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 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 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 Benefits.
(2) be a US citizen or alien as described in OAC 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 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 benefit plan;
(9) not have full-time employment with any employer who does not meet the eligible employer guidelines listed in OAC 317:45-7-1(a)(1)-(2);
(10) select one of the qualified 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 dependents are eligible when:
(1) the employer's 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 OAC 317:45-7-1 (a) (1)-(2); and
(4) the dependents are enrolled in the same benefit plan as the employee.
(e) If an employee or their dependents are eligible for multiple qualified benefit plans, each may receive a subsidy under only

one benefit plan.
(f) College students may enroll in the Insure Oklahoma ESI program as dependents. Effective January 1, 2016, financial eligibility for Insure Oklahoma ESI benefits for college students is determined using the MAGI methodology. See OAC 317:35-6-39 through OAC 317:35-6-54 for the applicable MAGI rules for determining household composition and countable income. Dependent college students must enroll under their parents and all annual gross household income (including parent income) must be included in determining eligibility. Independent college students may apply on their own without parent income included in the household. College student status as dependent or independent is determined by the student's current Free Application for Federal Student Aid (FAFSA)~~.~~ or the university's financial aid office. College students must also provide a copy of their current student schedule to prove full-time student status.
(g) ~~Dependent~~Working dependent children must have countable income at the appropriate standard according to the family size on the Insure Oklahoma ESI Income Limits Guidelines form. Effective January 1, 2016, financial eligibility for Insure Oklahoma ESI 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. Children found to be eligible for SoonerCare may not receive coverage through Insure Oklahoma.
(h) ESI approved individuals must notify the OHCA of any changes, including household status and income, that might impact individual and/or dependent eligibility in the program within 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.

317:45-9-2. Employee eligibility period
(a) Employee eligibility is contingent upon the employer's program eligibility.
(b) The employee's eligibility is determined using the eligibility requirements listed in OAC 317:45-9-1.
(c) If the employee is determined eligible, he/she is approved for a period not greater than 12 months.
(d) The employee's eligibility period begins on the first day of the month following the date of approval.

SUBCHAPTER 11. INSURE OKLAHOMA IP

PART 3. INSURE OKLAHOMA IP MEMBER HEALTH CARE BENEFITS

317:45-11-10. Insure Oklahoma IP adult benefits

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

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

(1) behavioral health services;

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

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

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

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

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

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

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

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

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

(4) Diagnostic X-ray, including Ultrasound. Covered in accordance with OAC 317:30-5-22(b)(2). PCP referral is required. ~~(5) Emergency Room Treatment, services and supplies for treatment in an emergency. Contracted provider services are subject to a $30 co-pay per occurrence. The emergency room co-pay will be waived if the member is admitted to the hospital or death occurs before admission.~~

(5) Emergency Room Treatment, services and supplies for

treatment in an emergency. Contracted provider services are subject to a $30 co-pay per occurrence. The emergency room co-pay will be waived if the member is admitted to the hospital or death occurs before admission.

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

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

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

(9) Outpatient Hospital/Facility Services.

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

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

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

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

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

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

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

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

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

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

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

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

as medically necessary.

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

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

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

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

(I) Psychology,
(II) Social Work (clinical specialty only),
(III) Professional Counselor,
(IV) Marriage and Family Therapist,
(V) Behavioral Practitioner, or
(VI) Alcohol and Drug Counselor.

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

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

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

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

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

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

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

(22) Pharmacy. Covered in accordance with OAC 317:30-5-72.1 and OAC 317:30-5-72. Prenatal vitamins and smoking cessation products do not count against monthly prescription limits.

(23) Smoking Cessation Products. Products do not count

against monthly prescription limits. Covered in accordance with OAC 317:30-5-72.1.
(24) Nutrition Services. Covered in accordance with OAC 317:30-5-1076.
(25) External Breast Prosthesis, Bras and Prosthetic Garments. Covered in accordance with OAC 317:30-5-211.13.
(26) Surgery. Covered in accordance with OAC 317:30-5-8.
(27) Home Dialysis. Covered in accordance with OAC 317:30-5-211.13.
(28) Parenteral Therapy. Covered in accordance with OAC 317:30-5-211.14.
(29) Family Planning Services and Supplies, including Sterilizations. Covered in accordance with OAC 317:30-3-57.
(30) Home Health and Medications, Intravenous (IV) Therapy and Supplies. Covered in accordance with OAC 317:30-5-211.15 and OAC 317:30-5-42.16(b)(3).
(31) Fundus photography.
(32) Emergency ground ambulance transportation. Covered in accordance with OAC 317:30-5-336.

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

Certain health care services are not covered in the Insure Oklahoma IP adult benefit package listed in OAC 317:45-11-10. These services include, but are not limited to:
(1) services not considered medically necessary;
(2) any medical service when the member refuses to authorize release of information needed to make a medical decision;
(3) organ and tissue transplant services;
(4) weight loss intervention and treatment including, but not limited to, bariatric surgical procedures or any other weight loss surgery or procedure, drugs used primarily for the treatment of weight loss including appetite suppressants and supplements, and/or nutritional services prescribed only for the treatment of weight loss;
(5) procedures, services and supplies related to sex transformation;
(6) supportive devices for the feet (orthotics) except for the diagnosis of diabetes;
(7) cosmetic surgery, except as medically necessary and as covered in OAC 317:30-3-59(19);
(8) over-the-counter drugs, medicines and supplies except contraceptive devices and products, and diabetic supplies;
(9) experimental procedures, drugs or treatments;
(10) dental services (preventive, basic, major, orthodontia, extractions or services related to dental accident) as covered in OAC 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 transportation and emergency air transportation;
(15) allergy testing and treatment;
(16) hospice regardless of location;
(17) Temporomandibular Joint Dysfunction (TMD) (TMJ);
(18) genetic counseling;
(19) fertility evaluation/treatment/and services;
(20) sterilization reversal;
(21) Christian Science Nurse;
(22) Christian Science Practitioner;
(23) skilled nursing facility;
(24) long-term care;
(25) stand by services;
(26) thermograms;
(27) abortions (for exceptions, refer to OAC 317:30-5-6);
(28) services of a Lactation Consultant;
(29) services of a Maternal and Infant Health Licensed Clinical Social Worker;
(30) enhanced services for medically high risk pregnancies as found in OAC 317:30-5-22.1;
(31) ultraviolet treatment-actinotherapy;
(32) private duty nursing;
(33) payment for removal of benign skin lesions;
(34) sleep studies;
(35) prosthetic devices; and
(36) continuous positive airway pressure devices (CPAP).

PART 5. INSURE OKLAHOMA IP MEMBER ELIGIBILITY

317:45-11-23. Member eligibility period

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

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

(A) If the application is approved and the premium payment is ~~not~~ made by the last day of the same month, eligibility will begin the first day of the next month.

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

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

(2) Employee eligibility is contingent upon the employer

meeting the program guidelines.

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

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

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

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

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

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

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.~~

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

SUBCHAPTER 1. MEDICALLY FRAGILE WAIVER SERVICES

317:50-1-2. Definitions

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

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

(A) bathing,
(B) eating,
(C) dressing,
(D) grooming,
(E) transferring (includes getting in and out of a tub, bed to chair, etc.),
(F) mobility,
(G) toileting, and
(H) bowel/bladder control.

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

"Developmental Disability" means a severe, chronic disability of an individual that:

(A) is attributable to a mental or physical impairment or combination of mental and physical impairments;
(B) is manifested before the individual attains age 22;
(C) is likely to continue indefinitely;
(D) results in substantial functional limitations in three or more of the following areas of major life activity:
  (i) self-care;
  (ii) receptive and expressive language;
  (iii) learning;
  (iv) mobility;
  (v) self-direction;
  (vi) capacity for independent living; and
  (vii) economic self-sufficiency; and
(E) reflects the individual's need for a combination and

sequence of special, interdisciplinary, or generic services, supports, or other assistance that is of lifelong or extended duration and is individually planned and coordinated.

"IADL" means the instrumental activities of daily living.

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

(A) shopping,
(B) cooking,
(C) cleaning,
(D) managing money,
(E) using a telephone,
(F) doing laundry,
(G) taking medication, and
(H) accessing transportation.

"Intellectual Disability" means that the person has, as determined by a Preadmission Screening Resident Review level II evaluation, substantial limitations in functional ability due to significantly sub-average intellectual functioning related to an event occurring before the age of eighteen (18).

"Level of Care Services**"** To be eligible for level of care services, meeting the minimum ~~UCAT~~Uniform Comprehensive Assessment Test criteria established for ~~SNF~~skilled nursing facility or hospital level of care demonstrates the individual must:

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

~~**"Intellectual Disability"** means that the person has, as determined by a PASRR level II evaluation, substantial~~

~~limitations in functional ability due to significantly sub-average intellectual functioning related to an event occurring before the age of 18.~~

"MSQ" means the mental status questionnaire.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) case management;

(2) institutional transition ~~services;~~case management;

(3) respite;

(4) environmental modifications;

(5) specialized medical equipment and supplies;

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

(7) advanced supportive/restorative assistance;

(8) skilled nursing;

(9) home delivered meals;

(10) hospice care;

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

(12) ~~Medically Fragile Waiver~~ personal care;

(13) ~~Personal Emergency Response System~~personal emergency response system (PERS);

(14) ~~Self Directed~~self-directed personal care, respite and advanced supportive/restorative assistance;

(15) ~~Self Directed Goods and Services~~self-directed goods and services (SD-GS);

(16) ~~Transitional Case Management Services;~~transitional case management; and

(17) SoonerCare medical services within the scope of the ~~State Plan.~~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~~nineteen (19) or older with a physical disability and may ~~also have an intellectual disability or a cognitive impairment.~~be technology dependent.

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

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

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

(1) if the individual's needs as identified by ~~UCAT~~Uniform Comprehensive Assessment Test assessment and other professional assessments cannot be met through Medically Fragile Waiver program services, SoonerCare ~~State Plan~~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~~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~~provider for transitioning the member to other services.
(g) Redetermination of program eligibility can be requested for the following reasons:

(1) if the member fails to comply with the community service plan;

(2) if the member's health and safety cannot be ~~ensured;~~assured;

~~(3) if the member is unable or unwilling to accept the negotiated risk of living in the community; or~~

~~(4)~~ (3) as deemed necessary by waiver review staff or the member's case manager.

(h) Individuals determined ineligible for Medically Fragile Waiver program services are notified in writing of the determination and of ~~their~~his or her right to appeal the decision.

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~~skilled nursing facility (SNF) or hospital services to assure member health and safety. Medically Fragile Waiver services are initiated to support the informal care that is being provided in the member's home, or, that based on the UCAT, can be expected to be provided in the member's home upon discharge of the member from a SNF or hospital. These services are not intended to take the place of regular care provided by family members and/or by significant others. When there is an informal (not paid) system of care available in the home, Medically Fragile Waiver service provision will supplement the system within the limitations of Medically Fragile Waiver ~~Program~~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.~~Oklahoma Health Care Authority. 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~~member's health and safety may be at risk~~ for health and safety~~, ~~DHS~~Department of Human Services Adult Protective Services (APS) staff are notified immediately and the referral is documented on the UCAT.

(7) Within ten (10) working days of receipt of a complete ~~Medically Fragile Waiver application,~~UCAT, medical eligibility is determined using level of care criteria and service eligibility criteria.

(8) Once eligibility has been established, notification is given to the member and the case management provider so that care plan and service plan development may begin. The member's case management provider is notified of the member's name, address~~,~~ and case number~~ 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 member has a current certification and requests a change to Medically Fragile Waiver services, a new UCAT is required. The UCAT is updated when a member requests a change from Medically Fragile Waiver services to Personal Care services. If a member is receiving Medically Fragile Waiver services and requests to go to a nursing facility, a new medical level of care decision is not needed.

(10) When a UCAT assessment has been completed more than ~~90~~sixty (60) days prior to submission for determination of a medical decision, the UCAT must be updated to reflect changes

in the medical condition; if submitted after ninety (90) days, a new assessment is required.

317:50-1-6. Determining financial eligibility for the Medically Fragile Waiver program

Financial eligibility for Medically Fragile Waiver services is determined using the rules on income and resources according to the category to which the individual is related. Only individuals who are categorically related to ~~ABD~~Aged Blind and Disabled (ABD) may be served through the Medically Fragile Waiver. Income, resources and expenses are evaluated on a monthly basis for all individuals requesting payment for the Medically Fragile Waiver Program. In determining income and resources for the individual categorically related to ABD, the ~~"family"~~family includes the individual and spouse, if any. However, consideration is not given to the income and resources of a spouse included in a ~~TANF~~Temporary Assistance for Needy Families case. If an individual and spouse cease to live together for reasons other than institutionalization, income and resources are considered available to each other through the month in which they are separated. Mutual consideration ceases with the month after the month in which the separation occurs. Any amounts which are actually contributed to the spouse after the mutual consideration has ended are considered. Financial eligibility for individuals in Medically Fragile Waiver ~~Program~~program services is as follows:

(1) **Individual without a spouse**. For an individual without a spouse, the following rules are used to determine financial eligibility.

(A) **Income eligibility**. To determine the income of the individual, the rules in (i) through (iii) of this subparagraph apply.

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

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

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

(B) **Resource eligibility**. In order for an individual without a spouse to be eligible for Medically Fragile Waiver services, his/her countable resources cannot exceed

the maximum resource standard for an individual listed in ~~OKDHS~~DHS form 08AX001E, Schedule VIII. D.

(C) **Equity in capital resources.** If the equity in the individual's capital resources is in excess of the maximum resource standards, certification is delayed up to ~~30~~thirty (30) days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources cannot reasonably be expected to come within standards in one month, the application is denied.

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

(A) **Income eligibility.** Income is determined separately for an individual and his/her spouse if the spouse is in a ~~HCBW~~HCBS program, or is institutionalized in a NF or ~~ICF/MR,~~ICF/IID, or is ~~65~~sixty-five (65) or older and in a mental health hospital. The income of either spouse is not considered as available to the other during the receipt of Medically Fragile Waiver services. The rules in (i) - (v) of this subparagraph apply in this situation:

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

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

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

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

(v) After determination of income, the gross income of

the individual cannot exceed the categorically needy standard in ~~OKDHS~~DHS form 08AX001E, Schedule VIII. B. 1., to be eligible for Medically Fragile Waiver services. If the individual's gross income exceeds this standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust OAC 317:35-5-41.6(6)(B)].

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

(C) **Equity in capital resources.** If the equity in the individual's capital resources is in excess of the maximum resource standards, certification is delayed up to ~~30~~thirty (30) days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources cannot reasonably be expected to come within standards in one month, the application is denied.

(3) **Individual with a spouse in the home who is not in a Home and Community Based ~~Waiver Program.~~Services program.** When only one individual of a couple in their own home is in a ~~HCBW~~HCBS Program, income and resources are determined separately. However, the income and resources of the individual who is not in the ~~HCBW~~HCBS program (community spouse) must be included on the application form. At redetermination of eligibility, the community spouse's income must be included in the review process. During any month that the individual is receiving Medically Fragile Waiver program services, the income of the community spouse is not considered available to that individual. The following rules are used to determine the income and resources of each:

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

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

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

(iii) If payment of income is made to either one or both and another person(s), the income is considered in

proportion to either spouse's interest (if payment is to that spouse) or one-half of the joint interest if no interest is specified.

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

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

(B) **Resource eligibility**. To determine resource eligibility, it is necessary to determine the amount of resources for both spouses for the month of the individual's application for the Medically Fragile Waiver program. Of the resources available to the couple (both individual and joint ownership) an amount will be protected for the community spouse which will not be considered available to the spouse receiving Medically Fragile Waiver program services. The amount determined as the spousal share is used for all subsequent applications for SoonerCare, regardless of changes in the couple's resources. The protected spousal share cannot be changed for any reason. When application for SoonerCare is made at the same time the individual begins receiving Medically Fragile program services, ~~OKDHS~~DHS Form 08MA012E, Title XIX Worksheet, is used.

(i) The first step in the assessment process is to establish the total amount of resources for the couple during the month of application of the spouse into the Medically Fragile Waiver program (regardless of payment source).

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

(iii) The minimum resource standard for the community spouse, as established by the OHCA, is found on ~~OKDHS~~DHS form 08AX001E, Schedule XI. When the community spouse's share is less than the minimum standard, an amount may be deemed from the other spouse's share to ensure the minimum resource standard for the community spouse. If the community spouse's share equals or exceeds the minimum resource standard, deeming cannot be done.

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

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

(vi) When determining eligibility for SoonerCare, the community spouse's share of resources is protected and the remainder considered available to the spouse receiving Medically Fragile Waiver program services.

(vii) The resources determined in (i) - (vi) of this subparagraph for the individual receiving Medically Fragile Waiver program services cannot exceed the maximum resource standard for an individual as shown in ~~OKDHS~~DHS form 08AX001E, Schedule VIII. D.

(viii) Once the dollar value of the community spouse's share of resources is established for the month of the other spouse's entry into the Medically Fragile Waiver program, that amount is used when determining resource eligibility for a subsequent SoonerCare application for ~~Long-Term Care~~long-term care for either spouse.

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

(I) the community spouse's monthly income allowance;

(II) the amount of monthly income otherwise available to the community spouse;

(III) determination of the spousal share of resource;

(IV) the attribution of resources (amount deemed); or

(V) the determination of the community spouse's resource allowance.

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

(C) **Excess resources.** If the equity in the individual's capital resources is in excess of the maximum resource standards, certification is delayed up to ~~30~~thirty (30) days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources cannot reasonably be expected to come within standards in one month, the application is denied.

(4) **Transfer of assets on or after August 11, 1993 but before February 8, 2006.** An institutionalized individual, an institutionalized individual's spouse, the guardian or legal representative of the individual or individual's spouse who disposes of assets on or after August 11, 1993 but before February 8, 2006 for less than fair market value on or after the look-back date specified in (A) of this paragraph subjects the individual to a penalty period for the disposal of such assets.

(A) For an institutionalized individual, the look-back date is ~~36~~thirty-six (36) months before the first day the individual is both institutionalized and has applied for SoonerCare. However, in the case of payments from a trust or portions of a trust that are treated as transfers of assets, the look back date is ~~60~~sixty (60) months.

(B) For purposes of this paragraph, an ~~"institutionalized"~~institutionalized individual is one who is receiving ~~HCBW~~HCBS program services.

(C) The penalty period begins the first day of the first month during which assets have been transferred and which does not occur in any other period of ineligibility due to an asset transfer. When there have been multiple transfers, all transferred assets are added together to determine the penalty.

(D) The penalty period consists of a period of ineligibility (whole number of months) determined by

dividing the total uncompensated value of the asset by the average monthly cost ($2,000) to a private patient in an ~~SNF~~skilled nursing facility or ~~Hospital~~hospital level of care in Oklahoma. In this calculation, any partial month is dropped. There is no limit to the length of the penalty period for these transfers. Uncompensated value is defined as the difference between the fair market value at the time of transfer less encumbrances and the amount received for the resource.

(E) Assets are defined as all income and resources of the individual and the individual's spouse, including any income or resources which the individual or such individual's spouse is entitled to but does not receive because of action:

(i) by the individual or such individual's spouse;

(ii) by a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or such individual's spouse; or

(iii) by any person, including any court or administrative body acting at the direction or upon the request of the individual or such individual's spouse.

(F) A penalty would not apply if:

(i) the title to the individual's home was transferred to:

(I) the spouse;

(II) the individual's child who is under age ~~21~~twenty-one (21) or is blind or totally disabled as determined by ~~Social Security;~~the Social Security Administration;

(III) a sibling who has equity interest in the home and resided in the home for at least one (1) year immediately prior to the institutionalization of the individual; or

(IV) the individual's son or daughter who resided in the home and provided care for at least two (2) years immediately prior to the individual's institutionalization.

(ii) the individual can show satisfactorily that the intent was to dispose of assets at fair market value or that the transfer was exclusively for a purpose other than eligibility. It is presumed that any transfer of assets made for less than fair market value was made in order to qualify the individual for SoonerCare. In order to rebut this presumption, the individual must present compelling evidence that a transfer was made for reasons other than to qualify for SoonerCare. It is not sufficient for an individual to claim that assets were transferred solely for the purposes of

allowing another to have them with ostensibly no thought of SoonerCare if the individual qualifies for SoonerCare as a result of the transfer.

(iii) the transfer was to the community spouse or to another person for the sole benefit of the community spouse in an amount equal to the community spouse's asset allowance.

(iv) the asset was transferred to the individual's child who is blind or totally disabled as determined by the Social Security~~.~~ Administration. The transfer may be to a trust established for the benefit of the individual's child.

(v) the asset was transferred to or from the spouse (either community or institutionalized) or to another person for the sole benefit of the spouse if the assets are not subsequently transferred to still another person for less than fair market value.

(vi) the asset is transferred to a trust established solely for the benefit of a disabled individual under the age of ~~65.~~sixty-five (65).

(vii) the denial would result in undue hardship. Such determination should be referred to ~~OKDHS State Office~~DHS for a decision.

(G) The individual is advised by a written notice of a period of ineligibility due to transfer of assets. The notice explains the period of ineligibility for payment of Medically Fragile Waiver program services and the continuance of eligibility for other SoonerCare services.

(H) The penalty period can be ended by either all assets being restored or commensurate return being made to the individual.

(I) Once the restoration or commensurate return is made, eligibility is re-determined considering the value of the restored asset or the amount of commensurate return.

(J) The restoration or commensurate return will not entitle the member to benefits for the period of time that the asset remained transferred. An applicant cannot be certified for Medically Fragile Waiver program services for a period of asset ineligibility.

(K) When assets are held by an individual with another person or persons, whether held in joint tenancy or tenancy in common or similar arrangement, and the individual's ownership or control of the asset is reduced or eliminated is considered a transfer.

(L) When a transfer of assets by the spouse of an individual results in a period of ineligibility and the spouse who made such transfer subsequently becomes institutionalized, the period of ineligibility will be apportioned between the two institutionalized spouses.

(5) **Transfer of assets on or after February 8, 2006.** An institutionalized individual, an institutionalized individual's spouse, the guardian or legal representative of the individual or individual's spouse who disposes of assets on or after February 8, 2006 for less than fair market value on or after the look-back date specified in (A) of this paragraph subjects the individual to a penalty period for the disposal of such assets.

(A) For an institutionalized individual, the look-back date is ~~60~~sixty (60) months before the first day the individual is both institutionalized and has applied for SoonerCare. However, individuals that have purchased an Oklahoma Long-Term Care Partnership ~~Program~~program approved policy may be completely or partially exempted from this Section depending on the monetary extent of the insurance benefits paid.

(B) For purposes of this paragraph, an ~~"institutionalized"~~institutionalized individual is one who is receiving Medically Fragile program services.

(C) The penalty period will begin with the later of:

(i) the first day of a month during which assets have been transferred for less than fair market value; or

(ii) the date on which the individual is:

(I) eligible for medical assistance; and

(II) receiving institutional level of care services that, were it not for the imposition of the penalty period, would be covered by SoonerCare.

(D) The penalty period:

(i) cannot begin until the expiration of any existing period of ineligibility;

(ii) will not be interrupted or temporarily suspended once it is imposed;

(iii) when there have been multiple transfers, all transferred assets are added together to determine the penalty.

(E) The penalty period consists of a period of ineligibility determined by dividing the total uncompensated value of the asset by the average monthly cost to a private patient in a nursing facility in Oklahoma shown on ~~OKDHS~~DHS form 08AX001E. In this calculation, the penalty must include a partial month disqualification based upon the relationship between that fractional amount and the average monthly cost to a private patient in a nursing facility in Oklahoma. There is no limit to the length of the penalty period for these transfers. Uncompensated value is defined as the difference between the fair market value at the time of transfer less encumbrances and the amount received for the resource.

(F) Assets are defined as all income and resources of the individual and the individual's spouse, including any income or resources which the individual or such individual's spouse is entitled to but does not receive because of action:

(i) by the individual or such individual's spouse;

(ii) by a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or such individual's spouse; or

(iii) by any person, including any court or administrative body acting at the direction or upon the request of the individual or such individual's spouse.

(G) ~~Special Situations.~~Special situations that would apply:

(i) ~~Separate Maintenance or Divorce.~~**Separate Maintenance or Divorce.**

(I) There shall be presumed to be a transfer of assets if an applicant or member receives less than half of the couple's resources pursuant to a Decree of Separate Maintenance or a Decree of Divorce.

(II) There shall be presumed to be a transfer of assets if the income is reduced to an amount lower than the individual's own income plus half of the joint income. The transfer penalty shall be calculated monthly.

(III) Assets which were exempt lose the exempt character when not retained by the applicant or member in the divorce or separate maintenance. These assets, if received by the other spouse, are counted when determining the penalty.

(IV) The applicant or member may rebut the presumption of transfer by showing compelling evidence that the uneven division of income or resources was the result of factors unrelated to SoonerCare eligibility.

(ii) ~~Inheritance from a spouse.~~**Inheritance from a spouse.**

(I) Oklahoma law provides that a surviving spouse is entitled to a minimum portion of a deceased spouse's probate estate. The amount depends on several factors.

(II) It is considered a transfer if the deceased spouse's will places all, or some, of the statutory share the applicant or member is entitled to receive in a trust which the applicant or member does not have unfettered access to or leaves less than the statutory amount to the applicant or member, who does not then elect to receive the statutory share

in probate proceedings.

(H) A penalty would not apply if:

(i) the title to the individual's home was transferred to:

(I) the spouse; or

(II) the individual's child who is under age ~~21~~twenty-one (21) or is blind or totally disabled as determined by ~~Social Security; or~~the Social Security Administration; or

(III) a sibling who has equity interest in the home and resided in the home for at least one (1) year immediately prior to the institutionalization of the individual; or

(IV) the individual's son or daughter who resided in the home and provided care for at least two (2) years immediately prior to the individual's institutionalization.

(ii) the individual can show satisfactorily that the intent was to dispose of assets at fair market value or that the transfer was exclusively for a purpose other than eligibility. It is presumed that any transfer of assets made for less than fair market value was made in order to qualify the individual for SoonerCare. In order to rebut this presumption, the individual must present compelling evidence that a transfer was made for reasons other than to qualify for SoonerCare. It is not sufficient for an individual to claim that assets were transferred solely for the purposes of allowing another to have them with ostensibly no thought of SoonerCare if the individual qualifies for SoonerCare as a result of the transfer.

(iii) the transfer was to the community spouse or to another person for the sole benefit of the community spouse in an amount equal to the community spouse's asset allowance. ~~"Sole benefit"~~Sole benefit means that the amount transferred will be used for the benefit of the community spouse during his or her expected life.

(iv) the asset was transferred to the individual's child who is blind or totally disabled as determined by Social Security. The transfer may be to a trust established for the benefit of the individual's child.

(v) the asset was transferred to or from the spouse (either community or institutionalized) or to another person for the sole benefit of the spouse if the assets are not subsequently transferred to still another person for less than fair market value. ~~"Sole benefit"~~Sole benefit means that the amount transferred will be used for the benefit of the spouse (either community or institutionalized) during his or her

expected life.

(vi) the asset is transferred to a trust established solely for the benefit of a disabled individual under the age of ~~65.~~sixty-five (65).

(vii) the denial would result in undue hardship. Undue hardship exists when application of a transfer of assets penalty would deprive the individual of medical care such that the individual's health or life would be endangered; or of food, clothing, shelter, or other necessities of life.

(I) An undue hardship does not exist if the individual willingly transferred assets for the purpose of qualifying for SoonerCare services through the use of the undue hardship exemption.

(II) Such determination should be referred to ~~OKDHS~~DHS State Office for a decision.

(III) If the undue hardship exists because the applicant was exploited, legal action must be pursued to return the transferred assets to the applicant before a hardship waiver will be granted. Pursuing legal action means an ~~APS~~Adult Protective Services referral has been made to the district attorney's office or a lawsuit has been filed and is being pursued against the perpetrator.

(I) The individual is advised by a written notice of a period of ineligibility due to transfer of assets, a timely process for determining whether an undue hardship waiver will be granted and a process for an adverse determination appeal. The notice explains the period of ineligibility for payment of Medically Fragile Waiver program services and the continuance of eligibility for other SoonerCare services.

(J) The penalty period can be ended by either all assets being restored or commensurate return being made to the individual.

(K) Once the restoration or commensurate return is made, eligibility is re-determined considering the value of the restored asset or the amount of commensurate return.

(L) The restoration or commensurate return will not entitle the member to benefits for the period of time that the asset remained transferred. An applicant cannot be certified for Medically Fragile Waiver program services for a period of asset ineligibility.

(M) Assets which are held by an individual with another person or persons, whether held in joint tenancy or tenancy in common or similar arrangement, and the individual's ownership or control of the asset is reduced or eliminated is considered a transfer. The exception to this rule is if ownership of a joint account is divided

according to the amount contributed by each owner.

(i) Documentation must be provided to show each co-owner's contribution;

(ii) The funds contributed by the applicant or SoonerCare member end up in an account owned solely by the applicant or member.

(N) When a transfer of assets by the spouse of an individual results in a period of ineligibility and the spouse who made such transfer subsequently becomes institutionalized, the period of ineligibility will be apportioned between the two (2) institutionalized spouses.

(6) **Commensurate return.** Commensurate return for purposes of this Section is defined as actual money payment or documentation of money spent on the member's behalf; i.e., property taxes, medical debts, nursing care expenses, etc., corresponding to the market value of the transferred property. The definition does not include personal services, labor or provision of rent-free shelter. It also does not include a monetary value assigned and projected for future payment either by cash or provision of services. Any transfer of property within the five (5) years prior to application or during receipt of assistance must be analyzed in regard to commensurate return as well as determination of intent.

317:50-1-9. Member annual level of care re-evaluation and annual re-authorization of service plan

(a) Annually, the case manager reassesses the member's needs and the service plan, especially with respect to progress of the member toward service plan goals and objectives. Based on the reassessment, the case manager develops a new service plan with the member and service providers, as appropriate, and submits the new service plan for certification along with the supporting documentation and the assessment of the existing service plan. The case manager initiates the fourth quarter monitoring to allow sufficient time for certification of a new service plan prior to the expiration date on the existing service plan.

(b) At a maximum of every ~~11~~eleven (11) months, the case manager makes a home visit to evaluate the Medically Fragile Waiver member using the ~~UCAT,~~Uniform Comprehensive Assessment Tool (UCAT), Parts I and III and other information as necessary as part of the annual service plan development process.

(1) The case manager's assessment of a member done within a 60-day period prior to the existing service plan end date is the basis for medical eligibility redetermination.

(2) As part of the service plan recertification process, the member is evaluated for the continued need for ~~Skilled Nursing Facility~~skilled nursing facility or hospital level of care.

(3) Based on evaluation of the UCAT, a determination of continued medical eligibility is made and recertification of medical eligibility is done prior to the expiration date of current medical eligibility certification. If medical eligibility recertification is not made prior to current medical eligibility expiration, the existing medical eligibility certification is automatically extended until recertification is determined or for ~~60~~sixty (60) days, whichever is less. If the member no longer meets medical eligibility, upon making the level of care determination, the member's ~~"medical eligibility end date"~~medical eligibility end date is updated in the system. The member's case manager is notified that the member has been determined to no longer meet medical eligibility for Medically Fragile Waiver services as of the effective date of the eligibility determination. The member is notified and if the member requests, the case manager helps the member arrange alternate services in place of Medically Fragile Waiver services.

317:50-1-11. Closure or termination of Medically Fragile Waiver services

(a) **Voluntary closure of Medically Fragile Waiver services.** If the member requests a lower level of care than Medically Fragile Waiver services or if the member agrees that Medically Fragile Waiver services are no longer needed to meet his/her needs, a medical decision is not needed. The closure request is completed and signed by the member and the case manager and placed in the member's case record. Documentation is made of all circumstances involving the reasons for the voluntary termination of services and alternatives for services if written request for closure cannot be secured.

(b) **Closure due to financial or medical ineligibility.** The process for closure due to financial or medical ineligibility is described in this subsection.

(1) **Financial ineligibility.** Anytime it is determined that a member does not meet the financial eligibility criteria, the member and provider are notified of financial ineligibility. A medical eligibility redetermination is not required when a financial ineligibility period does not exceed the medical certification period.

(2) **Medical ineligibility.** When the member is found to no longer be medically eligible for Medically Fragile Waiver services, the individual and provider are notified of the decision.

(c) **Closure due to other reasons.** Refer to OAC 317:50-1-3(e) - (f).

(d) **Resumption of Medically Fragile Waiver services.** If a member approved for Medically Fragile Waiver services has been without services for less than ~~90~~ninety (90) days and has a

current medical and financial eligibility determination, services may be resumed using the previously approved service plan. If a member decides he/she desires to have his/her services restarted after ~~90~~ninety (90) days, the member must request the services.

317:50-1-12. Eligible providers

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

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

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

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

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

(5) Providers of ~~Medical Equipment and Supplies, Environmental Modifications, Personal Emergency Response Systems, Hospice, and SNF Respite~~medical equipment and supplies environmental modifications, personal emergency response systems, hospice, and skilled nursing facility respite services do not have a programmatic evaluation after the initial certification.

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

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

(i) either no other provider is available; or

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

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

(B) The service must:

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

(ii) be necessary to avoid institutionalization;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

317:50-1-14. Description of services

Services included in the Medically Fragile Waiver ~~Program~~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~~waiver program eligibility. Case managers develop the member's comprehensive service plan, listing only services which are necessary to prevent institutionalization of the member, as determined through assessments. Case managers initiate the addition of necessary services or deletion of unnecessary services, as dictated by the member's condition and available support. Case managers monitor the member's condition to ensure

delivery and appropriateness of services and initiate service plan reviews. If a member requires hospital or skilled nursing facility 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~~managers must meet Medically Fragile Waiver ~~Program~~program minimum requirements for qualification and training prior to providing services to members. Prior to providing services to members choosing to ~~Self-Direct~~self-direct their services, ~~Case Managers~~case managers are required to receive training and demonstrate knowledge regarding the ~~Self-Directed Service~~self-directed service delivery model.

(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 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~~fifteen-minute unit of service using the rate associated with the location of residence of the member served.

(i) Standard ~~Rate:~~rate: Case 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 population density greater than ~~25~~twenty-five (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 rate for billable service activities provided to a member who resides in a county with population density equal to or less than ~~25~~twenty-five (25)

persons per square mile. An exception would be services to members that reside in OHCA identified zip codes in Osage ~~County~~county adjacent to metropolitan areas of Tulsa and Washington ~~Counties.~~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~~twenty-five (25) persons per square mile, or resides in a county with a population density greater than ~~25~~twenty-five (25) persons per square mile.

(D) Case ~~Managers~~managers providing ~~Case Management~~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.~~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 Case Management.~~transitional case management.**

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

(B) Institutional ~~Transition Case Management~~transition case management services assist institutionalized members that are eligible to receive waiver services in gaining access to needed waiver and other ~~State~~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~~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~~member's transition from institution to home by updating the services plan, including preparing for necessary services and supports to be in place or to start on the date the

member is discharged from the institution.

(3) **Respite.**

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

(B) In-Home Respite services are billed per ~~15-minute~~fifteen (15) minute unit service. Within any one-day period, a minimum of eight (8) 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 (8) hours in duration.

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

(4) **Environmental Modifications.**

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

(B) All services require prior authorization.

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

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

(5) **Specialized Medical Equipment and Supplies.**

(A) Specialized ~~Medical Equipment and Supplies~~medical equipment and supplies are devices, controls, or appliances specified in the service plan, which enable members to increase their abilities to perform activities

of daily living, or to perceive, control, or communicate with the environment in which they live. Also included are items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment 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~~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%~~thirty (30) percent or invoice cost plus ~~30%,~~thirty (30) percent, 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~~fifteen (15) minute unit of service. The number of units of this service a member may receive is limited to the number of units approved on the service plan.

(7) **Nursing.**

(A) Nursing services are services listed in the service plan which are within the scope of the Oklahoma Nursing Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State. Nursing services includes skilled nursing and/or private duty nursing. Skilled nursing is provided on an intermittent or part-time basis. Private duty

nursing is individual and continuous care provided to a participant at home by licensed nurses. The provision of the nursing service will work to prevent or postpone the institutionalization of the member.

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

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

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

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

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

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

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

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

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

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

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

(8) **Home Delivered Meals.**

(A) Home Delivered Meals provide one (1) meal per day. A home delivered meal is a meal prepared in advance and brought to the member's home. Each meal must have a nutritional content equal to at least one third (1/3) of the ~~Recommended Daily Allowance~~recommended daily allowance as established by the Food and Nutrition Board of the National Academy of Sciences. Meals are only provided to

members who are unable to prepare meals and lack an informal provider to do meal preparation.

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

(9) **Occupational Therapy services.**

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

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

(10) **Physical Therapy services.**

(A) Physical Therapy services are those services that prevent physical disability through the evaluation and rehabilitation of members disabled by pain, disease or injury. Services are provided in the member's home and are intended to help the member achieve greater independence

to reside and participate in the community. Treatment involves use of physical therapeutic means such as massage, manipulation, therapeutic exercise, cold or heat therapy, hydrotherapy, electrical stimulation and light therapy. Under a physician's order, a licensed physical therapist evaluates the member's rehabilitation potential and develops an appropriate, written therapeutic regimen. The regimen utilizes paraprofessional physical therapy assistant services, within the limits of their practice, working under the supervision of the licensed physical therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

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

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

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

(B) Speech/Language Therapy services are billed per ~~15-minute~~fifteen (15) minute unit of service. Payment is not

allowed solely for written reports or record documentation.

(12) **Respiratory Therapy Services.**

(A) Respiratory therapy services are provided for a member who, but for the availability of in-home respiratory services, would require respiratory care as an inpatient in a hospital or nursing facility. Services are provided in the member's home under the care of a physician who is familiar with the technical and medical components of home ventilator support and the physician must determine medically that in-home respiratory care is safe and feasible for the member. Treatment involves use of therapeutic means such as: evaluation, respiratory treatments, chest physiotherapy, and/or development and oversight of a therapeutic maintenance program. Under a physician's order, a registered respiratory therapist evaluates the member and develops an appropriate, written therapeutic regimen. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

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

(13) **Hospice Services.**

(A) Hospice is palliative and/or comfort care provided to the member and his/her family when a physician certifies that the member has a terminal illness and has six (6) months or less to live and orders hospice ~~Care.~~care. Medically Fragile Waiver ~~Hospice Care~~hospice care is authorized for a ~~six month~~six (6) month period and requires a physician certification of a terminal illness and orders of hospice care. If the member requires more than six months of hospice care, a physician or nurse practitioner must have a face-to-face visit with the member thirty (30) days prior to the initial hospice authorization end date and re-certify that the member has a terminal illness and has six months or less to live and orders additional hospice care. After the initial authorization period, additional periods of hospice may be authorized for a maximum of ~~60 days~~sixty (60) days increments with physician certification that the member has a terminal illness and has six months or less to live. A member's service plan that includes hospice care must

comply with waiver requirements to be within total service plan cost limits.

(B) A hospice program offers palliative and supportive care to meet the special needs arising out of the physical, emotional and spiritual stresses which are experienced during the final stages of illness and during dying and bereavement. The member signs a statement choosing hospice care instead of routine medical care that has the objective to treat and cure the member's illness. Once the member has elected hospice care, the hospice medical team assumes responsibility for the member's medical care for the terminal illness in the home environment. Hospice care services include nursing care, physician services, medical equipment and supplies, drugs for symptom control and pain relief, home health aide and personal care services, physical, occupational and/or speech therapy, medical social services, dietary counseling and grief and bereavement counseling to the member and/or family. A ~~Hospice~~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~~thirty (30) day period. A member that is eligible for Medicare Hospice provided as a Medicare Part A benefit, is not eligible to receive Medically Fragile ~~Hospice~~hospice services.

(C) Hospice services are billed per diem of service for days covered by a ~~Hospice~~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~~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~~fifteen (15) minute unit of service with units of service limited to the number of units on the approved service plan.

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

(A) Personal Emergency Response System (PERS) is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable ~~"help"~~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"~~help button is activated. The response center is staffed by trained professionals. For an Medically Fragile ~~Program~~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~~health care procedure codes for installation, monthly service or purchase of PERS. All services are prior authorized in accordance with the Medically Fragile approved service plan.

(16) **Prescription drugs.** Members are eligible for a maximum of six (6) prescriptions per month with a limit of three (3) ~~brand name~~brand-name prescriptions. Seven additional generic prescriptions per month are allowed if medically necessary.

Medically necessary prescriptions beyond the three (3) ~~brand name~~brand-name or thirteen (13) 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 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:~~option:

(i) ~~residence in the Self-Directed services approved area;~~have an existing need for Self-Directed services to prevent institutionalization;

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

(I) the member does not have the ability to make decisions about his/her care or service planning and the member's ~~"authorized representative"~~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"~~authorized representative to assume responsibility, in one (1) or more areas of Self-Direction such as in service planning, or in assuming the role of employer of the Personal Care Assistant (PCA) or Advanced Supportive/Restorative (ASR) service provider, or in monitoring and managing health or in preparation for emergency backup, or

(III) the member has a recent history of self-neglect or self-abuse as evidenced by Adult Protective Services intervention within the past 12 months and does not have an ~~"authorized representative"~~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~~case manager provides consultation and assistance as the member completes a self-assessment of preparedness to assume the role of employer for their 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~~able to participate in the Self-Directed ~~Services~~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"~~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"~~authorized representative to assume responsibility, in one or more areas of Self-Direction such as in service planning, or in assuming the role of employer of the PCA or ASR service providers, or in monitoring and managing health or in preparation for emergency backup; or

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

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

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

(vi) the member, even with ~~Case Manager~~case manager and ~~Financial Management Services~~financial management services assistance, is unable to operate successfully within their Individual Budget Allocation~~;~~ (IBA); or

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

(E) The member may designate a family member or friend as an "authorized representative" to assist in the service planning process and in executing member employer responsibilities. If the member chooses to designate an

"authorized representative", the designation and agreement identifying the "willing adult" to assume this role and responsibility is documented with dated signatures of the member, the designee and the member's ~~Case Manager~~case manager or the OHCA staff.

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

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

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

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

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

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

(iv) supervises and documents employee work time; and,

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

(G) ~~Financial Management Services~~FMS are program administrative services provided to participating Self-Directed Service employer/members by agencies contracted with the OHCA. ~~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) employer payroll, at a minimum of semi monthly, and

associated withholding for taxes, or for other payroll withholdings performed on behalf of the member as employer of the PCA or ASR provider;

(ii) other employer related payment disbursements as agreed to with the member and in accordance with the member's ~~Individual Budget Allocation;~~IBA;

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

(iv) providing to the member, as needed, assistance with employer related cognitive tasks, decision-making and specialized skills that may include assistance with ~~Individual Budget Allocation~~IBA planning and support for making decisions including training and providing reference material and consultation regarding employee management tasks such as recruiting, hiring, training and supervising the member's ~~Respite~~respite or PCA or ASR provider; and

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

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

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

(i) The ~~Individual Budget Allocation (IBA) Expenditure Accounts Determination~~IBA expenditure accounts determination constrains total SoonerCare reimbursement for Self-Directed services to be less than expenditures for equivalent services using agency providers.

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

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

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

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

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

(19) **Transitional ~~Case Management Services.~~case management.**

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

(B) Transitional ~~Case Management Services~~case management must be reasonable and necessary as determined through the transition plan development process and must be clearly identified in the plan.

(C) Transitional ~~Case Management Services~~case management assist members that are eligible to receive waiver services in gaining access to needed waiver and other ~~State~~state plan services, as well as needed medical, social, educational, and other services to assist the transition, regardless of the funding source for the services which access is gained.

(D) Transitional ~~Case Management Services~~case management may be authorized for assisting the member transition to the Medically Fragile Waiver by updating the service plan, including preparing for necessary services and supports to

be in place or to start on the date the member is effective with the waiver.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 9. ~~LONG TERM~~LONG-TERM CARE FACILITIES

317:30-5-137 Focus on Excellence

(a) **Purpose.** The Focus on Excellence (FOE) program was established through Oklahoma State Statute, Title 56, Section 56-1011.5. FOE's mission is to enhance the quality of life for target citizens by delivering effective programs and facilitating partnerships with providers and the community they serve. The program has a full commitment to the very best in quality, service and value which will lead to measurably improved quality outcomes, healthier lifestyles; greater satisfaction and confidence for our members.

(b) **Eligible Providers.** Any Oklahoma long-term care nursing facilities that are licensed and certified by the Oklahoma State Department of Health and accommodate SoonerCare members at their facility as defined in Oklahoma Administrative Code (OAC) 317:30-5-120.

(c) **Quality measure care criteria.** To maintain status in the FOE program, each nursing facility must enter quality data either monthly, quarterly, annually for the following care criteria metrics. All metrics in detail can be found on the Oklahoma Health Care Authority's (OHCA) FOE website or on FOE/QOC (Quality of Care) Data Collection Portal.

(1) **Person-Centered Care.** Facility must meet six (6) out of ten (10) of the established measurement criteria for this metric to receive the points. This metric is measured quarterly and must be completed by the 15th of the month following the close of the quarter.

(2) **Direct-Care Staffing.** Facility must maintain a direct care staffing ratio of three and a half (3.5) hours per patient day to receive the points for this metric. This metric must be completed monthly by the 15th of each month.

(3) **Resident/Family Satisfaction.** Facility must maintain a score of 76 of a possible 100 points on overall satisfaction to receive the points for this metric. This metric is collected in a survey format and must be completed once a year in the fall. Surveys are to be completed by the resident, power of attorney and/or with staff assistance.

(4) **Employee Satisfaction.** Facility must maintain a score of 70 points or higher in order to receive the points for this metric. Surveys are completed by FOE facility employees and must be completed once a year in the fall.

(5) **Licensed-Nurse Retention.** Facility must maintain a one-year tenure rate of 60 percent (60%) or higher of its licensed nursing staff to receive the points for this metric. This metric must be completed monthly by the 15th of the month.

(6) **Certified Nurse Assistant (CNA) Retention.** Facility must maintain a one-year tenure rate of 50 percent (50%) or higher of its CNA staff to receive the points for this metric. This metric must be completed monthly by the 15th of the month.

(7) **Distance Learning Program Participation.** Facility must contract and use an approved distance learning vendor for its frontline staff in order to receive points for this metric. This metric is measured quarterly and must be completed by the 15th of the month following the close of the quarter.

(8) **Peer Mentoring.** Facility must establish a peer-mentoring program in accordance with OHCA guidelines. This metric is measured quarterly and must be completed by the 15th of the month following the close of the quarter.

(9) **Leadership Commitment.** Facility must meet six (6) out of ten (10) of the established measurement criteria for this metric to receive the points. This metric is measured annually and must be completed in the fall.

(c) **Payment.** The amount of eligible dollars is reimbursable based on the SoonerCare FOE nursing facility meeting the quality metric thresholds listed in (b). Facilities must meet a minimal of 100 points to even be eligible for reimbursement.

(1) **Distribution of Payment.** OHCA will notify the FOE facility of the quality reimbursement amount on a quarterly basis.

(2) **Penalties.** Facilities that do not submit on the appropriate due dates will not receive reimbursable dollars. Facilities that do not submit quality measures will not receive reimbursable dollars for those specific measures. Due dates can be found on the OHCA FOE webpage.

(d) **Appeals.** Facilities can file an appeal with the Quality Review Committee and in accordance, with the grievance procedures found at OAC 317:2-1-2(b) and 317:2-1-16.

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 4. EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) PROGRAM/~~CHILD HEALTH SERVICES~~CHILD-HEALTH SERVICES

317:30-3-65. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) ~~program/Child Health Services~~Program/Child-health Services

Payment is made to eligible providers for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services on behalf of eligible individuals under the age of 21.

(1) The EPSDT program is a comprehensive child-health program, designed to ensure the availability of, and access to, required health care resources and help parents and guardians of Medicaid-eligible children and adolescents use these resources. An effective EPSDT program assures that health problems are diagnosed and treated early before they become more complex and their treatment more costly. The physician plays a significant role in educating parents and guardians about all services available through the EPSDT program. The receipt of an identified EPSDT screening makes the ~~Medicaid child~~member eligible for all necessary follow-up care that is within the scope of the ~~Medicaid~~SoonerCare program. ~~Federal regulations require that diagnosis and treatment be provided for conditions identified during a screening whether or not they are covered under the Authority's current program. Such services must be allowable under federal regulations and must be necessary to ameliorate or correct defects and physical or behavioral health illnesses or conditions and will require prior authorization.~~ Early and Periodic Screening, Diagnosis and Treatment (EPSDT) covers services, supplies, or equipment that are determined to be medically necessary for a child or adolescent, and which are included within the categories of mandatory and optional services in Section 1905(a) of Title XIX, regardless of whether such services, supplies, or equipment are listed as covered in Oklahoma's State Plan.

(2) Federal regulations also require that the State set standards and protocols for each component of EPSDT services. The standards must provide for services at intervals which meet reasonable standards of medical and dental practice. The standards must also provide for EPSDT services at other intervals as medically necessary to determine the existence

of certain physical or behavioral health illnesses or conditions.

(3) ~~Medicaid~~SoonerCare providers who perform EPSDT screenings must assure that the screenings they provide meet the minimum standards established by the ~~OHCA and outlined at OAC 317:30-3-65.1~~Oklahoma Health Care Authority in order to be reimbursed at the level established for EPSDT services.

(4) An EPSDT screening is considered a comprehensive examination. A provider billing ~~the Medicaid program~~SoonerCare for an EPSDT screen may not bill any other Evaluation and Management Current Procedure Terminology (CPT) code for that patient on that same day. It is expected that the screening provider will perform necessary treatment as part of the screening charge. However, there may be other additional diagnostic procedures or treatments not normally considered part of a comprehensive examination, including diagnostic tests and administration of immunizations, required at the time of screening. Additional diagnostic procedures or treatments may be billed independently from the screening. Some services as set out in this section may require prior authorization.

(5) For an EPSDT screening to be considered a completed reimbursable service, providers must perform, and document, all required components of the screening examination. Documentation of screening services performed must be retained for future review.

(6) All comprehensive screenings provided to individuals under age 21 must be filed on HCFA-1500 using the appropriate preventive medicine procedure code or an appropriate Evaluation and Management code from the Current Procedural Terminology Manual (CPT) accompanied by the appropriate "V" diagnosis code.

317:30-3-65.1. Minimum required screenings [REVOKED]

~~(a) The Oklahoma EPSDT program has established and adopted a periodicity schedule based on recommendations from recognized medical and dental organizations and individuals involved in child health care in Oklahoma.~~

~~(b) A complete description of services to be provided at each screening interval is outlined in the Periodicity Schedule found at OAC 317:30-3-65.2.~~

317:30-3-65.2. Periodicity schedule

The ~~OHCA~~Oklahoma Health Care Authority (OHCA) requires that physicians providing reimbursable ~~EPSDT Screens~~Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screens adopt and utilize ~~the version of the Oklahoma Health Care Authority EPDST Periodicity schedule. Providers are allowed and~~

~~encouraged to provide optional screenings as indicated and/or as recommended in~~ the guidelines established by the ~~American Academy of Pediatrics~~American Academy of Pediatrics' Bright Futures' periodicity schedule. ~~Optional screenings may be completed at one week, fifteen months, and eleven, thirteen, fifteen, seventeen and nineteen years of age. At a minimum, practitioners are required to perform the OHCA recommended elements for each age related visit as follows:~~

~~(1) Each EPSDT visit whether optional or required will consist, at a minimum, of a history of occurrences since the last screening visit (Health History), measurements of height, weight and head circumference (as appropriate through age two), an age appropriate developmental and a behavioral screening as well as a complete unclothed physical exam. Immunizations are to be checked and provided as needed according to the Advisory Committee on Immunization Practices (ACIP) schedule and any appropriate laboratory testing should be performed. Additionally, age appropriate anticipatory guidance is also required to be given to parents in the areas of injury prevention, violence prevention, sleep positioning (through 6 months of age), and nutritional counseling. Beginning at age 4 and with each subsequent visit, a Body Mass Index (BMI) is to be calculated and charted. A tuberculin test is required to be given to any at risk child from the ages of 12 months to age 20 years and a cholesterol screening is required to be given to at risk children between the ages of 2 years and 20 years. Beginning at age 12, at risk female children should also be given a pelvic exam and all at risk children should be given STD screening. Dental screens begin at the first sign of tooth eruption by the primary care provider and with each subsequent visit to determine if the children needs a referral to a dental provider. In addition to the elements listed above, each compensable EPSDT visit also requires the following as designated by age:~~

~~(2) Newborn visit. The newborn visit occurs inpatient. The visit consists, at a minimum, of a prenatal history and physical examination of all body systems. The practitioner also conducts a screening of vision that consists of an assessment of the anatomy of the lids, alignment of the eyes and clarity of the ocular media with particular attention to documenting the presence of a normal red reflex. A newborn hearing screen is required. The Heb B Immunizations is required. A Hereditary/Metabolic Screening is required between birth and one month.~~

~~(3) One week visit. One week visit occurs approximately one week from the hospital discharge date. A hearing screen is required to be done if the child failed the newborn hearing~~

~~screen or if there are parental concerns or any other indicator of potential problems. A Hereditary/Metabolic Screening is required between birth and one month. This is an optional visit for infants who were discharged early or have other health concerns.~~

~~(4) By one month old visit. The practitioner conducts a screening of vision that consists of a Red reflex and external appearance exam. A hearing screen is required if there are parental concerns or any other indicator of potential problems. A Hereditary/Metabolic Screening is required between birth and one month.~~

~~(5) Two month old visit. The practitioner conducts a screening of vision that consists of a Red reflex and external appearance exam. A hearing screen is required if there are parental concerns or any other indicator of potential problems.~~

~~(6) Four month old visit. The practitioner conducts a screening of vision that consists of a Red reflex and external appearance exam. A hearing screen is required if there are parental concerns or any other indicator of potential problems.~~

~~(7) Six month old visit. The practitioner conducts a screening of vision that consists of a Red reflex and external appearance exam and evaluation of ocular alignment with a corneal light reflex test. A hearing screen is required to be done if there are parental concerns or any other indicator of potential problems.~~

~~(8) Nine month old visit. The practitioner conducts a screening of vision between the ages of nine and twelve months (if the vision screening is done at this visit, it need not be repeated at the twelve month visit) that consists of a Red reflex and external appearance exam and evaluation of ocular alignment with a corneal light reflex test. A hearing screen is required to be done if there are parental concerns or any other indicator of potential problems. A blood lead test may be provided as early as nine months but is required at 12 and 24 months. A hematocrit or hemoglobin test is required to be performed between the ages of nine months and three years.~~

~~(9) One year old visit. The practitioner conducts a screening of vision between the ages of nine and twelve months (if the vision screening was deferred at the nine month visit, it must be provided at the twelve month visit) that consists of a Red reflex and external appearance exam and evaluation of ocular alignment with a corneal light reflex test. A hearing screen is required to be done if there are parental concerns or any other indicator of potential problems. A blood lead test may be provided as early as nine months but is required~~

~~at 12 and 24 months. A hematocrit or hemoglobin test is required to be performed between the ages of nine months and three years and a tuberculin test is required to be given to any at risk child from the ages of 12 months to age 20 years.~~

~~(10) Fifteen month old visit. A hearing screen is required to be done if there are parental concerns or any other indicator of potential problems. A hematocrit or hemoglobin test is required to be performed between the ages of nine months and three years. A tuberculin test is required to be given to any at risk child from the ages of 12 months to age 20 years. This is an optional visit.~~

~~(11) Eighteen month old visit. A hearing screen is required to be done if there are parental concerns or any other indicator of potential problems. A hematocrit or hemoglobin test is required to be performed between the ages of nine months and three years. A tuberculin test is required to be given to any at risk child from the ages of 12 months to age 20 years.~~

~~(12) Two years old visit. A hearing screen should be done if there are parental concerns or any other indicator of potential problems. A blood lead test may be provided as early as nine months but is required at 12 and 24 months. A hematocrit or hemoglobin test is required to be performed between the ages of nine months and three years.~~

~~(13) Three years old visit. The practitioner conducts one vision screening between the ages three to five. The screening consists of an alignment and an acuity test e.g., Allen Cards, Snellen chart or HOTV Test in each eye. A hearing screen, subjective by history, is done if there are parental concerns or any other indicator of potential problems. A hematocrit or hemoglobin test is required to be performed between the ages of nine months and three years.~~

~~(14) Four years old visit. The practitioner conducts one vision screening between the ages three to five. The screening consists of an alignment and an acuity test e.g., Allen Cards, Snellen chart or HOTV Test in each eye. A hearing screen should be done.~~

~~(15) Five years old visit. The practitioner conducts one vision screening between the ages three to five. The screening consists of an alignment and an acuity test e.g., Allen Cards, Snellen chart or HOTV Test in each eye. A hearing screen is required to be done if the screening was not provided in the school.~~

~~(16) Six years old visit. The practitioner conducts a screening of vision that consists of visual acuity testing. An objective hearing screen is required if the screening was not provided in the school.~~

~~(17) Eight years old visit. The practitioner conducts a screening of vision that consists of visual acuity testing. An objective hearing screen is required if the screening was not provided in the school.~~

~~(18) Ten years old visit. The practitioner conducts a screening of vision that consists of visual acuity testing. An objective hearing screen should be done if the screening was not provided in the school.~~

~~(19) Eleven and thirteen years old visit. The practitioner conducts one screening of vision that consists of visual acuity testing between the ages of 11 through 18. Hearing screens are subjective by history. A hematocrit or hemoglobin test and a urinalysis test are required to be done once from ages 11 through age 20 on menstruating females. These visits are optional visits.~~

~~(20) Twelve years old visit. The practitioner conducts one screening of vision that consists of visual acuity testing between the ages of 11 through 18 (all other years are subjective by history). Hearing screens are subjective by history. A hematocrit or hemoglobin test and a urinalysis test are required to be done once from ages 11 through age 20 on menstruating females.~~

~~(21) Fourteen, sixteen, eighteen, and twenty years old visit. The practitioner conducts one screening of vision that consists of visual acuity testing between the ages of 11 through 18. Hearing screenings are subjective by history.~~

~~(22) Fifteen, seventeen and nineteen years old visit. The practitioner conducts one vision screening that consists of visual acuity testing between the ages of 11 through 18. Hearing screenings are subjective by history. These are all optional visits.~~

317:30-3-65.4. Screening components

Comprehensive ~~EPSDT~~Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screenings are performed by, or under the supervision of, a SoonerCare physician or other SoonerCare practitioner. SoonerCare physicians are defined as all licensed allopathic and osteopathic physicians in accordance with the rules and regulations covering ~~OHCA's~~the Oklahoma Health Care Authority's (OHCA) SoonerCare program. Other SoonerCare practitioners are defined as all contracted physician assistants and ~~advanced practice nurses~~advanced practice registered nurses in accordance with the rules and regulations covering the OHCA's SoonerCare program. At a minimum, screening examinations must include, but not be limited to, the following components:

(1) **Comprehensive health and developmental history.** Health and developmental history information may be obtained from the parent or other responsible adult who is familiar with

the ~~child's~~member's history and include an assessment of both physical and mental health development. Coupled with the physical examination, this includes:

(A) **Developmental assessment.** Developmental assessment includes a range of activities to determine whether an individual's developmental processes fall within a normal range of achievement according to age group and cultural background. Screening for development assessment is a part of every routine, initial and periodic screening examination. Acquire information on the ~~child's~~member's usual functioning as reported by the ~~child,~~member, teacher, health professional or other familiar person. Review developmental progress as a component of overall health and well-being given the ~~child's~~member's age and culture. As appropriate, assess the following elements:

(i) Gross and fine motor development;

(ii) Communication skills, language and speech development;

(iii) Self-help, self-care skills;

(iv) Social-emotional development;

(v) Cognitive skills;

(vi) Visual-motor skills;

(vii) Learning disabilities;

(viii) Psychological/psychiatric problems;

(ix) Peer relations; and

(x) Vocational skills.

(B) **Assessment of nutritional status.** Nutritional assessment may include preventive treatment and follow-up services including dietary counseling and nutrition education if appropriate. This is accomplished in the basic examination through:

(i) Questions about dietary practices;

(ii) Complete physical examination, including an oral dental examination;

(iii) Height and weight measurements;

(iv) Laboratory test for iron deficiency; and

(v) Serum cholesterol screening, if feasible and appropriate.

(2) **Comprehensive unclothed physical examination.** Comprehensive unclothed physical examination includes the following:

(A) **Physical growth.** Record and compare height and weight with those considered normal for that age. Record head circumference for children under one year of age. Report height and weight over time on a graphic recording sheet.

(B) **Unclothed physical inspection.** Check the general appearance of the ~~child~~member to determine overall health status and detect obvious physical defects. Physical

inspection includes an examination of all organ systems such as pulmonary, cardiac, and gastrointestinal.

(3) **Immunizations.** Legislation created the Vaccine for Children Program effective October 1, 1994. Vaccines are provided free of charge to all enrolled providers for SoonerCare eligible children and adolescents. Participating providers may bill for an administration fee set by the Centers for Medicare and Medicaid Services (CMS) on a regional basis. They may not refuse to immunize based on inability to pay the administration fee.

(4) **Appropriate laboratory tests.** A blood lead screening test (by either finger stick or venipuncture) must be performed between the ages of nine and 12 months and at 24 months. A blood lead test is required for any child up to age 72 months who had not been previously screened. A blood lead test equal to or greater than 10 micrograms per deciliter (ug/dL) obtained by capillary specimen (fingerstick) must be confirmed using a venous blood sample. If a child is found to have blood lead levels equal to or greater than 10 ug/dL, the Oklahoma Childhood Lead Poison Prevention Program (OCLPPP) must be notified according to rules set forth by the Oklahoma State Board of Health ~~(OAC 310:512-3-5)~~defined in Oklahoma Administrative Code (OAC) 310:512-3-5.

(A) The OCLPPP schedules an environmental inspection to identify the source of the lead for children who have a persistent blood lead level 15 ug/dL or greater. Environmental inspections are provided through the Oklahoma State Department of Health (OSDH) upon notification from laboratories or providers and reimbursed through the OSDH cost allocation plan approved by OHCA.

(B) Medical judgment is used in determining the applicability of all other laboratory tests or analyses to be performed unless otherwise indicated on the periodicity schedule. If any laboratory tests or analyses are medically contraindicated at the time of the screening, they are provided when no longer medically contraindicated. Laboratory tests should only be given when medical judgment determines they are appropriate. However, laboratory tests should not be routinely administered. ~~General procedures including immunizations and lab tests, such as blood lead, are outlined in the periodicity schedule found at OAC 317:30-3-65.2.~~

(5) **Health education.** Health education is a required component of screening services and includes anticipatory guidance. At the outset, the physical and dental assessment, or screening, gives the initial context for providing health education. Health education and counseling to parents, guardians or ~~children~~members is required. It is designed to

assist in understanding expectations of the ~~child's~~member's development and provide information about the benefits of healthy lifestyles and practices as well as accident and disease prevention.

(6) **Vision and hearing screens.** Vision and hearing services are subject to their own periodicity schedules. However, age-appropriate vision and hearing assessments may be performed as a part of the screening as outlined~~ in the periodicity schedule found~~ at OAC 317:30-3-65.7 and 317:30-3-65.9.

(7) **Dental screening services.** An oral ~~dental examination~~screening may be included in the EPSDT screening and as a part of the nutritional status assessment. Federal regulations require a direct dental referral for every ~~child~~member in accordance with the American Academy of Pediatric Dentistry periodicity schedule and at other intervals as medically necessary. Therefore, when an oral ~~examination~~screening is done at the time of the EPSDT screening, the ~~child~~member may be referred directly to a dentist for further screening and/or treatment. Specific dental services are outlined in OAC 317:30-3-65.8.

(8) **Child abuse.** ~~Instances of child abuse and/or neglect discovered through screenings and regular examinations are to be reported in accordance with State Law. Section 7103 of Title 10 of the Oklahoma Statutes mandates reporting suspected abuse or neglect to the Oklahoma Department of Human Services. Section 7104 of Title 10 of the Oklahoma Statutes further requires reporting of criminally injurious conduct to the nearest law enforcement agency.~~Instances of child abuse and/or neglect are to be reported in accordance with state law, including, but not limited to, 10A of Oklahoma Statutes, Section 1-2-101. Any person suspecting child abuse or neglect shall immediately report it to the Oklahoma Department of Human Services (DHS) Hotline at 1-800-522-3511.

317:30-3-65.6. Documentation of Services

Records for ~~EPSDT~~Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screens must contain adequate documentation of services rendered. Such documentation must include the physicians'~~s~~ signature or identifiable initials for every prescription or treatment. Documentation of records may be completed manually or electronically in accordance with guidelines found at OAC 317:30-3-15. Each required element of the age specific screening must be documented with a description of any noted problem, anomaly or concern. In addition, a plan for following necessary diagnostic evaluations, procedures and treatments, must be documented. ~~The OHCA Child Health Provider Manual contains forms that may be used for this purpose.~~

317:30-3-65.7. Vision services

Children and adolescents should receive periodic eye and vision examinations to diagnose and treat any eye disease in its early stages in order to prevent or minimize vision loss and maximize visual abilities.

~~(a) At a minimum, vision services include diagnosis and treatment for defects in vision, including eyeglasses once each 12 months. In addition, payment is made for glasses for children with congenital aphakia or following cataract removal (refer to OAC 317:30-5-2(b)(5) for amount, duration, and scope). Payment is limited to two glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary. The following schedule outlines the services required for vision services adopted by the OHCA.~~

~~(1) Each newborn should have an assessment of the anatomy of the lids, alignment of the eyes and clarity of the ocular media with particular attention to documenting the presence of a normal red reflex. The history should document either a normal birth or other condition such as prematurity.~~

~~(2) Red reflex and external appearance should be repeated and recorded on infants between one and four months of age.~~

~~(3) At six months of age, repeat red reflex and external exam and add an evaluation of ocular alignment with a corneal light reflex test.~~

~~(4) One screen should occur between nine and 12 months to mirror the six month screening.~~

~~(5) One screening from age three to five including alignment and an acuity test e.g., Allen Cards, Snellen chart or HOTV Test in each eye.~~

~~(6) Objective visual acuity testing should be provided at ages five through ten, and once during ages 11 through 18. All other years are subjective by history.~~

~~(b) Interperiodic vision examinations are allowed at intervals outside the periodicity schedule when a vision condition is suspected.~~

(1) At a minimum, vision services include diagnosis and treatment for defects in vision, including eyeglasses once each twelve (12) months. In addition, payment is made for glasses for members with congenital aphakia or following cataract removal (refer to OAC 317:30-5-2(b)(5) for amount, duration, and scope). Payment is limited to only two (2) glasses per year for a member. Any glasses beyond the two (2) glasses limit must be prior authorized and determined to be medically necessary (refer to 317:30-5-432.1 for more information on corrective lenses and optical supplies).

(2) The OHCA recommends that physicians adopt and utilize the American Optometric Association standards for vision screenings and examinations.

317:30-3-65.8. Dental services

(a) At a minimum, dental services include relief of pain and infection; limited restoration of teeth and maintenance of dental health; and oral prophylaxis every 184 days. Dental care includes emergency and preventive services and therapeutic services for dental disease which, if left untreated, may become acute dental problems or may cause irreversible damage to the teeth or supporting structures. Other dental services include inpatient services in an eligible participating hospital, and amalgam ~~composites and posterior amalgam~~composite restorations, pulpotomies, chrome steel crowns, anterior root canals, pulpectomies, band and loop space maintainers, ~~cement bases,~~ acrylic partial and lingual arch bars; other restoration, repair and/or replacement of dental defects after the treatment plan submitted by a dentist has been authorized (refer to ~~OAC~~Oklahoma Administrative Code 317:30-5-696(3) for amount, duration and scope).

(b) Dental screens should begin at the first sign of tooth eruption by the primary care provider and with each subsequent visit to determine if the ~~child~~member needs a referral to a dental provider. Dental examinations by a qualified dental provider should begin ~~before the age of two~~by age one (1)(unless otherwise indicated) and ~~once yearly~~every six (6) months to one (1) year thereafter. Additionally, ~~children~~members should be seen for prophylaxis once every 184 days, if indicated by risk assessment. All other dental services for relief of pain and infection, restoration of teeth and maintenance of dental health should occur as the provider deems necessary.

(c) Separate payment will be made to the member's primary care provider for the application of fluoride varnish during the course of a ~~well child~~child-health screening for members ages ~~6 months to 60 months~~six (6) months to sixty (60) months. Reimbursement is limited to two applications per year by eligible providers who have attended an OHCA-approved training course related to the application of fluoride varnish.

317:30-3-65.9. Hearing services

(a) At a minimum, hearing services include hearing evaluation once every ~~12~~twelve (12) months, hearing aid evaluation if indicated and purchase of a hearing aid when prescribed by a state licensed audiologist who:

(1) holds a certificate of clinical competence from the American Speech and Hearing Association of the American Academy of Audiologists; or

(2) has completed the equivalent educational requirements and work experience necessary for the certificate; or

(3) has completed the academic program and is acquiring supervised work experience necessary for the certificate; and

(4) holds a contract with ~~OHCA~~Oklahoma Health Care Authority (OHCA) to perform such an evaluation and obtains prior authorization for the evaluation.

(b) Interperiodic hearing examinations are allowed at intervals outside the periodicity schedule when a hearing condition is suspected (refer to OAC 317:30-5-676 for amount, duration and scope). The following schedule outlines the services required in the EPSDT/OHCA ~~child Health~~child-health screening program for hearing services adopted by the OHCA.

(1) Birth. Physiologic screen utilizing automated brainstem response testing or ~~transient-evoked~~ otoacoustic emissions testing.

(2) Two (2) to five (5) months. Subjective screens. Question if passed physiologic newborn hearing screen months in both ears in addition to caregiver concerns regarding hearing sensitivity.

(3) Six (6) to twelve (12) months. Infants with ~~JCIH~~Joint Committee on Infant Hearing (JCIH) risk factors are ~~screened~~screened/assessed with physiologic or behavioral ~~months~~ measures ~~including either~~which can include visual reinforcement audiometry, acoustic immittance/reflexes testing, auditory brainstem response testing ~~or~~and/or otoacoustic emissions testing. Infants without risk factors are screened subjectively with~~y~~ auditory behavior development checklist.

(4) ~~18~~Eighteen (18) months. Subjective screen. To include brief questionnaire regarding appropriate speech and language development.

(5) ~~24~~Twenty-four (24) months. ~~Children~~Members with JCIH risk factors ~~screened~~screened/assessed with physiologic or behavioral measures including visual reinforcement audiometry, immittance/reflex testing and/or otoacoustic emissions, or acoustic ~~immittance/reflex testing~~. Subjective screen for all others to include concerns of caregivers and brief questionnaire regarding speech and language development.

(6) Three (3) years. Behavioral or physiologic ~~screen~~screen/assessment ~~including~~which can include either conditioned play audiometry, acoustic immittance testing (including reflexes), pneumatic otoscopy, or otoacoustic emissions.

(7) Four (4) years. Behavioral or physiologic ~~screen~~screen/assessment ~~including~~which can include either

conditioned play audiometry, acoustic immittance testing (including reflexes), or otoacoustic emissions.
(8) Five (4) to six (6) years. Behavioral screen if not completed in school including conventional behavioral pure tone screening.
(9) Eight (8), ten (10) and ~~12~~twelve (12) years. Behavioral screen if not completed in school including conventional behavioral pure tone screening.
(10) ~~15 and 18~~Fifteen (15) and eighteen (18) years. Subjective screening to include concerns regarding school and home communicative performance.

317:30-3-65.10. Periodic and interperiodic screening examinations

(a) **Periodic screening examination.** ~~Periodic screening must be provided in accordance with the periodicity schedule as described in OAC 317:30-3-65.2 following the initial screening.~~ Periodic screenings must be provided in accordance with the recommended American Academy of Pediatrics' Bright Futures' periodicity schedule following the initial screening.

(b) **Interperiodic screening examination.** Interperiodic screenings must be provided when medically necessary to determine the existence of suspected physical or mental illnesses or conditions. This may include, but is not limited to, physical, mental or dental conditions. The screening components must include health and physical history, physical examination, assessment and administration of necessary immunizations, check of nutritional status, appropriate lab and x-ray and anticipatory guidance. The determination of whether an interperiodic screen is medically necessary may be made by a health, developmental or educational professional who comes into contact with the ~~child~~member outside of the formal health care system. Claims for interperiodic screenings must be billed under the appropriate ~~CPT~~Current Procedural Terminology codes on form HCFA-1500 for services that are determined medically necessary.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 73. EARLY INTERVENTION SERVICES

317:30-5-640.1. Periodicity schedule

(a) ~~A complete description of services to be provided at each screening interval is outlined in the Periodicity Schedule found at OAC 317:30-3-65.2.~~The Oklahoma Health Care Authority requires that all physicians providing reimbursable Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screens adopt and

utilize the American Academy of Pediatrics and Bright Futures periodicity schedule.

(b) ~~Medicaid eligible children~~Medicaid-eligible children and adolescents enrolled in SoonerCare are referred to their SoonerCare provider for EPSDT screens. In cases where the SoonerCare provider authorizes the qualified provider of health related services to perform the screen or fails to schedule an appointment within three (3) weeks and a request has been made and documented by the staff of the ~~OSDE or OSDH~~Oklahoma State Department of Education and Oklahoma State Department of Health (OSDH), or the latter's contractors, the OSDH may then furnish the EPSDT ~~child health~~child-health screening and bill it as a fee-for-service activity. Results of the ~~child health~~child-health screening are forwarded to the ~~child's~~member's SoonerCare provider.

PART 103. QUALIFIED SCHOOLS AS PROVIDERS OF ~~HEALTH RELATED~~HEALTH-RELATED SERVICES

317:30-5-1022. Periodicity schedule

(a) The ~~Oklahoma~~ SoonerCare ~~Program~~program has adopted the recommendations of the American Academy of ~~Pediatrics~~Pediatrics' Bright Futures' periodicity schedule for services~~, which include at least the following:~~.

~~(1) Six screenings during the first year of life;~~

~~(2) Two screenings in the second year;~~

~~(3) One screening yearly for ages two through five years;~~

~~(4) One screening every other year for ages six through 20 years~~.

(b) Children and adolescents enrolled in SoonerCare are referred to their SoonerCare provider for services. In cases where the SoonerCare provider authorizes the ~~School~~school to perform the screen or fails to schedule an appointment within three (3) weeks and a request has been made and documented by the ~~School~~school, the ~~School~~school may then furnish the ~~EPSDT~~Early and Periodic Screening, Diagnosis and Treatment ~~child health~~child-health screening and bill it as a fee-for-service activity. Results of the ~~child health~~child-health screening are forwarded to the ~~child's~~member's SoonerCare provider.