Oklahoma Health Care Authority
MEDICAL ADVISORY COMMITTEE

# AGENDA

July 18th, 2019
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 May 16th, 2019: **Medical Advisory Committee Meeting**

III. Public Comments (2 minute limit)

IV. MAC Member Comments/Discussion

V. Financial Report: **Aaron Morris, Chief Financial Officer**

VI. SoonerCare Operations Update: **Marlene Asmussen, Director of Population Care Management**

- **A.** Pharmacy Update: **Burl Beasley, Senior Director of Pharmacy Services**
- **B.** Oklahoma Residency Verification Process: **Melody Anthony, Deputy State Medicaid Director**

VII. Legislative Update: **Audra Cross, Legislative Liaison**

VIII. Access Monitoring Review Plan (AMRP: **Sandra Puebla, Director of Federal & State Authorities**

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

- **A. 19-01 Retroactive Eligibility**
- **B. 19-05 Therapeutic Foster Care Revisions**
- **C. 19-10 American Indian/Alaska Native Cost Sharing Exemption**
- **D. 19-11 Board Organization and Policy Revisions**
- **E. 19-12 High Risk Obstetrical Services (HROB)**

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

XI. Future Meeting:
September 19th
November 21st

XII. Adjourn

Oklahoma Health Care Authority
MEDICAL ADVISORY COMMITTEE
MINUTES of the May 16, 2019 Meeting
4345 N. Lincoln Blvd., Oklahoma City, OK 73105

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

Vice-Chairman Steve Goforth called the meeting to order at 1:00 PM.

***Delegates present were*:** Ms. Debra Billingsly, Dr. Erin Balzer, Dr. Joe Catalano, Mr. Brett Coble, Ms. Wanda Felty, Dr. Don Flinn, Dr. Arlen Foulks, Mr. Steve Goforth, Mr. Mark Jones, Ms. Alyssa Lee, Mr. James Patterson, Dr. J. Daniel Post, Ms. Toni Pratt-Reid, Dr. Jason Rhynes, Dr. Dwight Sublett, Mr. Rick Snyder, Mr. Jeff Tallent, and Mr. William Whited.

**Alternates present were**: Ms. Sarah Baker, Ms. Lois Baer, Ms. Tina Johnson, Mr. Traylor Rains-Sims, and Dr. Mike Talley, providing a quorum.

***Delegates absent without an alternate were*:** Mr. Victor Clay, Dr. Steven Crawford, Ms. Terrie Fritz, Ms. Annette Mays, Dr. Ashley Orynich, and Dr. Raymond Smith.

## II. Approval of the March 14th, 2019 Minutes

Medical Advisory Committee
**The motion to approve the minutes was by Dr. Mike Talley and seconded by Dr. J. Daniel Post and passed unanimously.**

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

Mr. Brian Wilkerson, with the Oklahoma Disability Law Center expressed his concern to the committee regarding agenda item: VIII.B – 19-03 Applied Behavior Analysis (ABA) Services to be added as an EPSDT benefit.
Ms. Jessica Dyer, CEO of Soaring on Hope Pediatric Therapy Center expressed her concerns to the committee regarding agenda item: VIII.B – 19-03 Applied Behavior Analysis (ABA) Services, and provisions for the eligible providers.

## IV. MAC Member Comments/Discussion:

Ms. Mary Brinkley had an inquiry on an out of state company doing certain pharmacy services for the state.
Mr. Burl Beasley replied to her requested stating that we contract with the College of Pharmacy to run our helpdesk, and they contracted with a company called Arine, which provides medication management therapy services as a pilot program. It started January 1st and will conclude in July of this year. The contractor is doing outreach to adult members, with a goal of 1000 members to show some cost savings from medication therapy interventions.

**V. Financial Report:**

Tasha Black, Director of Fiscal Planning

Ms. Black presented the financial report ending in January 2019. OHCA is 1.1% under budget in revenues and 1.5% under budget in expenditures with the result that our budget variance is a positive 10,668,863 dollars. The budget variance is primarily attributed to the following: Medicaid Program Variance is a positive 7.5 million state dollars, and administration is a positive 3.3 million state dollars. Drug Rebate is 2.5 million state dollars under budget. Taxes and Fees, which also included tobacco tax is 3.1 million state dollars under budget, and Medical refunds is .4 million state dollars over budget. For more detailed information, see item 5 in the MAC agenda.

**VI. SoonerCare Operations Update:**

Burl Beasley, Senior Director of Pharmacy Service

Mr. Beasley presented the SoonerCare Operations Update to the committee. He presented information based on data for January of 2019. Patient Centered Medical Home enrollment is at 525,486 which is 4,303 less than the previous month. Sooner Care Traditional has a current enrollment of 231,784 which is 44 less than December. SoonerPlan is down by 793, giving a total number of 28,322. Insure Oklahoma has a total enrollment of 18,754, of which 13,647 are in the Employee Sponsored Plan, and 5,107 are in the individual plan. In total, SoonerCare enrollment is at 804,346 for January, which is a decrease of 5,040.

**VII. Legislative Update:**

MaryAnn Martin, Senior Director of Communications

Ms. Martin gave an update on the legislation activities of interest to OHCA. SB251 was vetoed just the other day which would have had a financial impact on the agency and presented a liability to the state. We will have more updates on the budget for our next meeting as there has been a deal reached just yesterday. It seems from reviewing the bills that have passed that there will be no impacts to providers or any services that the state provides at this time.

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

Sandra Puebla, Director of Federal & State Authorities

A face-to-face tribal consultation regarding the following proposed changes was held on Tuesday, January 8, 2019 in the Charles Ed McFall Boardroom of the Oklahoma Health Care Authority (OHCA). APA work folders 19-02 and 19-03 will be posted for a comment period through May 17, 2019.

**19-02 Certified Community Behavioral Health Clinics (CCBHC) Project —** The proposed revisions will incorporate new rules to sustain the CCBHC project beyond its demonstration period in Oklahoma. The services provided include nine types of behavioral health treatment services, with an emphasis on the provision of 24-hour crisis care, utilization of evidence based practices, care coordination, and integration with physical health. The proposed rules will outline CCBHC member eligibility, provider participation requirements, and program scope.
**Budget Impact: As these rules represent the sustainability plan for a current demonstration project, there are no new immediate costs to the Oklahoma Health Care Authority (OHCA) or the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) for implementation and enforcement of the proposed rule. However, ODMHSAS estimates a FFY 2020 net fiscal impact for CCBHCs, as $35.6M ($23.5M Federal / 12.1M State).**
**The rule change motion to approve was by Mr. Traylor Rains-Sims and seconded by Dr. Erin Balzer and passed unanimously.**

**19-03 Applied Behavior Analysis (ABA) Services —** The proposed revisions will add new language establishing coverage and reimbursement for ABA services as an Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. The proposed language will define scope of service, provider criteria and credentialing requirements, medical necessity, intervention criteria, and extension requests for continued services. Other revisions will involve limited rewriting aimed at clarifying text and updating outdated policy sections.
**Budget Impact: The proposed changes would potentially result in a combined federal and state spending of $11,455,015 total with $4,969,759 in state share for FFY19 and FFY20.**
**The rule change motion to vote was by Dr. J. Daniel Post and seconded by Ms. Sarah Baker.**
**The rule was approved, having 12 votes for yes, and 10 votes for no.**



## IX. New Business: Vice-Chairman Steve Goforth

## X. Future Meeting

July 18th, 2019
September 19th, 2019
November 21st, 2019

## XI. Adjournment

There was no dissent and the meeting was adjourned at 2:05p.m.

# FINANCIAL REPORT

For the Eleven Months Ended May 31, 2019
Submitted to the CEO & Board

- Revenues for OHCA through May, accounting for receivables, were **$3,970,468,676** or **.5% under** budget.
- Expenditures for OHCA, accounting for encumbrances, were **$4,016,512,318** or **.5% under** budget.
- The state dollar budget variance through May is a negative **$195,693.**
- The budget variance is primarily attributable to the following (in millions):

| | | |
|---|---|---|
| **Expenditures:** | | |
| Medicaid Program Variance | | .1 |
| Administration | | 5.6 |
| **Revenues:** | | |
| Drug Rebate | | (1.3) |
| Medical Refunds | | .4 |
| Taxes and Fees | | (5.0) |
| **Total FY 19 Variance** | **$** | **(.2)** |

**ATTACHMENTS**


| | |
|---|---|
| Summary of Revenue and Expenditures: OHCA | 1 |
| Medicaid Program Expenditures by Source of Funds | 2 |
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| Fund 205: Supplemental Hospital Offset Payment Program Fund | 4 |
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| Fund 245: Health Employee and Economy Act Revolving Fund | 6 |
| Fund 250: Belle Maxine Hilliard Breast and Cervical Cancer Treatment Revolving Fund | 7 |

# OKLAHOMA HEALTH CARE AUTHORITY
## Summary of Revenues & Expenditures: OHCA
## SFY 2019, For the Eleven Month Period Ending May 31, 2019

| REVENUES | FY19 Budget YTD | FY19 Actual YTD | Variance | % Over/ (Under) |
|---|---|---|---|---|
| State Appropriations | $ 935,268,137 | $ 935,268,137 | $ - | 0.0% |
| State Appropriations - GME Appropriated Funds | $ 100,873,960 | $ 100,873,960 | $ - | 0.0% |
| Federal Funds | 2,254,774,199 | 2,243,371,194 | (11,403,005) | (0.5)% |
| Tobacco Tax Collections | 45,110,903 | 40,506,909 | (4,603,994) | (10.2)% |
| Quality of Care Collections | 72,673,459 | 71,904,729 | (768,730) | (1.1)% |
| Prior Year Carryover | 20,414,314 | 20,414,314 | - | 0.0% |
| Federal Deferral - Transfer | 4,676,719 | 4,676,719 | - | 0.0% |
| Federal Deferral - Interest | 313,373 | 313,373 | - | 0.0% |
| Drug Rebates | 298,034,156 | 294,477,963 | (3,556,194) | (1.2)% |
| Medical Refunds | 34,249,889 | 35,448,240 | 1,198,351 | 3.5% |
| Supplemental Hospital Offset Payment Program | 210,561,758 | 210,561,758 | - | 0.0% |
| Other Revenues | 12,294,243 | 12,651,381 | 357,137 | 2.9% |
| **TOTAL REVENUES** | **$ 3,989,245,111** | **$ 3,970,468,676** | **$ (18,776,435)** | **(0.5)%** |

| EXPENDITURES | FY19 Budget YTD | FY19 Actual YTD | Variance | % (Over)/ Under |
|---|---|---|---|---|
| **ADMINISTRATION - OPERATING** | **$ 54,650,583** | **$ 44,814,024** | **$ 9,836,559** | **18.0%** |
| **ADMINISTRATION - CONTRACTS** | **$ 106,973,924** | **$ 97,472,386** | **$ 9,501,538** | **8.9%** |
| **MEDICAID PROGRAMS** | | | | |
| Managed Care: | | | | |
| SoonerCare Choice | 36,433,121 | 36,275,989 | 157,132 | 0.4% |
| Acute Fee for Service Payments: | | | | |
| Hospital Services | 869,175,888 | 883,916,269 | (14,740,380) | (1.7)% |
| Behavioral Health | 18,098,705 | 16,210,862 | 1,887,843 | 10.4% |
| Physicians | 380,837,693 | 364,074,820 | 16,762,873 | 4.4% |
| Dentists | 118,932,088 | 119,733,396 | (801,308) | (0.7)% |
| Other Practitioners | 50,037,523 | 48,214,360 | 1,823,163 | 3.6% |
| Home Health Care | 19,857,161 | 22,475,602 | (2,618,442) | (13.2)% |
| Lab & Radiology | 25,153,104 | 23,913,614 | 1,239,490 | 4.9% |
| Medical Supplies | 48,953,711 | 50,173,802 | (1,220,090) | (2.5)% |
| Ambulatory/Clinics | 214,213,675 | 230,903,993 | (16,690,318) | (7.8)% |
| Prescription Drugs | 601,709,778 | 586,097,580 | 15,612,198 | 2.6% |
| OHCA Therapeutic Foster Care | 153,625 | 18,696 | 134,929 | 87.8% |
| Other Payments: | | | | |
| Nursing Facilities | 513,801,204 | 522,310,918 | (8,509,714) | (1.7)% |
| Intermediate Care Facilities for Individuals with Intellectual Disabilities Private | 57,746,391 | 59,309,566 | (1,563,174) | (2.7)% |
| Medicare Buy-In | 163,415,257 | 160,642,425 | 2,772,831 | 1.7% |
| Transportation | 65,764,857 | 63,543,003 | 2,221,854 | 3.4% |
| Money Follows the Person-OHCA | 320,307 | 299,037 | 21,270 | 6.6% |
| Electonic Health Records-Incentive Payments | 5,066,088 | 5,066,088 | - | 0.0% |
| Part D Phase-In Contribution | 99,716,944 | 98,905,549 | 811,395 | 0.8% |
| Supplemental Hospital Offset Payment Program | 473,090,847 | 473,090,847 | - | 0.0% |
| Telligen | 10,034,695 | 8,140,561 | 1,894,134 | 18.9% |
| **Total OHCA Medical Programs** | **3,772,512,661** | **3,773,316,975** | **(804,314)** | **(0.0)%** |
| OHCA Non-Title XIX Medical Payments | 81,934 | 34,974 | 46,960 | 0.0% |
| OHCA Non-Title XIX - GME | 100,873,959 | 100,873,959 | (0) | 0.0% |
| **TOTAL OHCA** | **$ 4,035,093,060** | **$ 4,016,512,318** | **$ 18,580,742** | **0.5%** |
| **REVENUES OVER/(UNDER) EXPENDITURES** | **$ (45,847,950)** | **$ (46,043,643)** | **$ (195,693)** | |

# OKLAHOMA HEALTH CARE AUTHORITY

## Total Medicaid Program Expenditures
## by Source of State Funds
## SFY 2019, For the Eleven Month Period Ending May 31, 2019

| Category of Service | Total | Health Care Authority | Quality of Care Fund | HEEIA | SHOPP Fund | BCC Revolving Fund | Other State Agencies |
|---|---|---|---|---|---|---|---|
| SoonerCare Choice | $ 36,358,024 | $ 36,266,837 | $ - | $ 82,035 | $ - | $ 9,152 | $ - |
| Inpatient Acute Care | 1,080,038,286 | 566,893,793 | 446,130 | 2,931,956 | 354,121,348 | 920,582 | 154,724,478 |
| Outpatient Acute Care | 420,651,474 | 310,405,758 | 38,137 | 4,020,284 | 100,975,425 | 5,211,870 | - |
| Behavioral Health - Inpatient | 48,188,123 | 8,338,414 | - | 403,092 | 16,336,426 | - | 23,110,191 |
| Behavioral Health - Psychiatrist | 9,530,097 | 7,872,448 | - | - | 1,657,648 | - | - |
| Behavioral Health - Outpatient | 15,276,440 | - | - | - | - | - | 15,276,440 |
| Behavioral Health-Health Home | 37,979,667 | - | - | - | - | - | 37,979,667 |
| Behavioral Health Facility- Rehab | 215,574,289 | - | - | - | - | 96,871 | 215,574,289 |
| Behavioral Health - Case Management | 2,504,926 | - | - | - | - | - | 2,504,926 |
| Behavioral Health - PRTF | 43,888,201 | - | - | - | - | - | 43,888,201 |
| Behavioral Health - CCBHC | 59,500,877 | - | | | | | 59,500,877 |
| Residential Behavioral Management | 11,303,604 | - | - | - | - | - | 11,303,604 |
| Targeted Case Management | 65,948,789 | - | - | - | - | - | 65,948,789 |
| Therapeutic Foster Care | 18,696 | 18,696 | - | - | - | - | - |
| Physicians | 427,250,042 | 360,327,121 | 53,259 | 4,719,349 | - | 3,694,439 | 58,455,873 |
| Dentists | 119,776,051 | 119,721,005 | - | 42,655 | - | 12,391 | - |
| Mid Level Practitioners | 2,019,989 | 2,011,056 | - | 8,454 | - | 479 | - |
| Other Practitioners | 46,642,998 | 45,688,883 | 409,167 | 440,174 | - | 104,774 | - |
| Home Health Care | 22,486,307 | 22,467,199 | - | 10,704 | - | 8,403 | - |
| Lab & Radiology | 24,602,863 | 23,707,843 | - | 689,249 | - | 205,771 | - |
| Medical Supplies | 50,384,795 | 47,655,979 | 2,485,571 | 210,994 | - | 32,252 | - |
| Clinic Services | 232,808,504 | 225,025,435 | - | 1,636,065 | - | 246,779 | 5,900,225 |
| Ambulatory Surgery Centers | 5,789,416 | 5,622,739 | - | 157,637 | - | 9,040 | - |
| Personal Care Services | 9,830,566 | - | - | - | - | - | 9,830,566 |
| Nursing Facilities | 522,310,918 | 319,374,809 | 202,935,018 | - | - | 1,091 | - |
| Transportation | 63,506,918 | 60,958,394 | 2,315,093 | 105,046 | - | 128,385 | - |
| IME/DME/GME | 81,103,838 | - | - | - | - | - | 81,103,838 |
| ICF/IID Private | 59,309,566 | 48,534,166 | 10,775,400 | - | - | - | - |
| ICF/IID Public | 13,060,950 | - | - | - | - | - | 13,060,950 |
| CMS Payments | 259,547,974 | 259,136,572 | 411,402 | - | - | - | - |
| Prescription Drugs | 599,767,431 | 583,516,995 | - | 13,669,851 | - | 2,580,585 | - |
| Miscellaneous Medical Payments | 141,131 | 133,230 | - | - | - | 7,901 | - |
| Home and Community Based Waiver | 193,247,996 | - | - | - | - | - | 193,247,996 |
| Homeward Bound Waiver | 72,439,381 | - | - | - | - | - | 72,439,381 |
| Money Follows the Person | 299,037 | 299,037 | - | - | - | - | - |
| In-Home Support Waiver | 22,522,032 | - | - | - | - | - | 22,522,032 |
| ADvantage Waiver | 133,539,959 | - | - | - | - | - | 133,539,959 |
| Family Planning/Family Planning Waiver | 3,910,245 | - | - | - | - | - | 3,910,245 |
| Premium Assistance* | 53,412,804 | - | - | 53,412,804.06 | - | - | - |
| Telligen | 8,140,561 | 8,140,561 | - | - | - | - | - |
| Electronic Health Records Incentive Payments | 5,066,088 | 5,066,088 | - | - | - | - | - |
| **Total Medicaid Expenditures** | **$ 5,079,679,852** | **$ -** | **$ 3,067,183,058** | **$ 219,869,176** | **$ 82,540,351** | **$ 473,090,847** | **$ 13,270,764** | **$ 1,223,822,526** |

* Includes $52,994,201.10 paid out of Fund 245

# OKLAHOMA HEALTH CARE AUTHORITY

**Summary of Revenues & Expenditures:**
**Other State Agencies**
**SFY 2019, For the Eleven Month Period Ending May 31, 2019**

| | FY19 |
|---|---|
| **REVENUE** | **Actual YTD** |
| Revenues from Other State Agencies | $ 524,490,729 |
| Federal Funds | 775,876,122 |
| **TOTAL REVENUES** | **$ 1,300,366,851** |

| **EXPENDITURES** | **Actual YTD** |
|---|---|
| **Department of Human Services** | |
| Home and Community Based Waiver | 193,247,996 |
| Money Follows the Person | - |
| Homeward Bound Waiver | 72,439,381 |
| In-Home Support Waivers | 22,522,032 |
| ADvantage Waiver | 133,539,959 |
| Intermediate Care Facilities for Individuals with Intellectual Disabilities Public | 13,060,950 |
| Personal Care | 9,830,566 |
| Residential Behavioral Management | 6,277,471 |
| Targeted Case Management | 58,036,020 |
| **Total Department of Human Services** | **508,954,375** |
| | |
| **State Employees Physician Payment** | |
| Physician Payments | 58,455,873 |
| **Total State Employees Physician Payment** | **58,455,873** |
| | |
| **Education Payments** | |
| Graduate Medical Education | 43,527,194 |
| Indirect Medical Education | 34,965,572 |
| Direct Medical Education | 2,611,072 |
| **Total Education Payments** | **81,103,838** |
| | |
| **Office of Juvenile Affairs** | |
| Targeted Case Management | 2,149,979 |
| Residential Behavioral Management | 5,026,133 |
| **Total Office of Juvenile Affairs** | **7,176,112** |
| | |
| **Department of Mental Health** | |
| Case Management | 2,504,926 |
| Inpatient Psychiatric Free-standing | 23,110,191 |
| Outpatient | 15,276,440 |
| Health Homes | 37,979,667 |
| Psychiatric Residential Treatment Facility | 43,888,201 |
| Certified Community Behavioral Health Clinics | 59,500,877 |
| Rehabilitation Centers | 215,574,289 |
| **Total Department of Mental Health** | **397,834,590** |
| | |
| **State Department of Health** | |
| Children's First | 555,858 |
| Sooner Start | 1,860,187 |
| Early Intervention | 3,569,881 |
| Early and Periodic Screening, Diagnosis, and Treatment Clinic | 1,515,404 |
| Family Planning | 357,501 |
| Family Planning Waiver | 3,543,490 |
| Maternity Clinic | 964 |
| **Total Department of Health** | **11,403,285** |
| | |
| **County Health Departments** | |
| EPSDT Clinic | 598,878 |
| Family Planning Waiver | 9,254 |
| **Total County Health Departments** | **608,132** |
| | |
| **State Department of Education** | **145,536** |
| **Public Schools** | **1,491,515** |
| **Medicare DRG Limit** | **144,535,167** |
| **Native American Tribal Agreements** | **1,924,791** |
| **Department of Corrections** | **1,633,595** |
| **JD McCarty** | **8,555,715** |
| | |
| **Total OSA Medicaid Programs** | **$ 1,223,822,526** |
| | |
| **OSA Non-Medicaid Programs** | **$ 75,554,128** |
| | |
| **Accounts Receivable from OSA** | **$ (990,197)** |

# OKLAHOMA HEALTH CARE AUTHORITY

## SUMMARY OF REVENUES & EXPENDITURES:

### Fund 205: Supplemental Hospital Offset Payment Program Fund

### SFY 2019, For the Eleven Month Period Ending May 31, 2019

| REVENUES | | FY 19 Revenue |
|---|---|---|
| SHOPP Assessment Fee | | 210,366,014 |
| Federal Draws | $ | 290,755,133 |
| Interest | | 193,460 |
| Penalties | | 2,283 |
| State Appropriations | | (30,200,000) |
| TOTAL REVENUES | $ | 471,116,890 |

| EXPENDITURES | Quarter | Quarter | Quarter | Quarter | | FY 19 Expenditures |
|---|---|---|---|---|---|---|
| Program Costs: | 7/1/18 - 9/30/18 | 10/1/18 - 12/31/18 | 1/1/19 - 3/31/19 | 4/1/19 - 6/30/19 | | |
| Hospital - Inpatient Care | 84,988,728 | 99,052,816 | 83,045,794 | 87,034,010 | $ | 354,121,348 |
| Hospital -Outpatient Care | 25,649,937 | 29,135,930 | 22,823,205 | 23,366,353 | | 100,975,425 |
| Psychiatric Facilities-Inpatient | 3,352,856 | 3,909,783 | 4,421,971 | 4,651,816 | | 16,336,426 |
| Rehabilitation Facilities-Inpatient | 416,290 | 485,439 | 368,383 | 387,537 | | 1,657,648 |
| Total OHCA Program Costs | 114,407,810 | 132,583,968 | 110,659,352 | 115,439,716 | $ | 473,090,847 |
| Total Expenditures | | | | | $ | 473,090,847 |

| CASH BALANCE | | |
|---|---|---|
| | $ | (1,973,957) |

*** Expenditures and Federal Revenue processed through Fund 340

# OKLAHOMA HEALTH CARE AUTHORITY
## SUMMARY OF REVENUES & EXPENDITURES:
## Fund 230: Nursing Facility Quality of Care Fund
## SFY 2019, For the Eleven Month Period Ending May 31, 2019

| REVENUES | Total Revenue | State Share |
|---|---|---|
| Quality of Care Assessment | **$ 71,861,439** | **$ 71,861,439** |
| Interest Earned | **43,290** | **43,290** |
| **TOTAL REVENUES** | **$ 71,904,729** | **$ 71,904,729** |

| EXPENDITURES | FY 19 Total $ YTD | FY 19 State $ YTD | Total State $ Cost |
|---|---|---|---|
| **Program Costs** | | | |
| Nursing Facility Rate Adjustment | $ 199,569,267 | $ 77,120,473 | |
| Eyeglasses and Dentures | 250,330 | 96,756 | |
| Personal Allowance Increase | 3,115,420 | 1,204,167 | |
| Coverage for Durable Medical Equipment and Supplies | 2,485,571 | 960,899 | |
| Coverage of Qualified Medicare Beneficiary | 946,693 | 365,983 | |
| Part D Phase-In | 411,402 | 411,402 | |
| ICF/IID Rate Adjustment | 4,948,935 | 1,912,436 | |
| Acute Services ICF/IID | 5,826,465 | 2,250,087 | |
| Non-emergency Transportation - Soonerride | 2,315,093 | 894,878 | |
| **Total Program Costs** | **$ 219,869,176** | **$ 85,217,082** | **$ 85,217,082** |
| **Administration** | | | |
| OHCA Administration Costs | $ 494,306 | $ 247,153 | |
| DHS-Ombudsmen | 184,199 | 184,199 | |
| OSDH-Nursing Facility Inspectors | 320,646 | 320,646 | |
| Mike Fine, CPA | 18,600 | 9,300 | |
| **Total Administration Costs** | **$ 1,017,751** | **$ 761,298** | **$ 761,298** |
| **Total Quality of Care Fee Costs** | **$ 220,886,927** | **$ 85,978,380** | |
| **TOTAL STATE SHARE OF COSTS** | | | **$ 85,978,380** |

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 2019, For the Eleven Month Period Ending May 31, 2019

| REVENUES | FY 18 Carryover | FY 19 Revenue | Total Revenue |
|---|---|---|---|
| Prior Year Balance | $ 12,902,064 | $ - | $ 6,997,587 |
| State Appropriations | (6,000,000) | - | - |
| Tobacco Tax Collections | - | 33,315,370 | 33,315,370 |
| Interest Income | - | 208,611 | 208,611 |
| Federal Draws | 208,931 | 34,043,858 | 34,043,858 |
| **TOTAL REVENUES** | $ 7,110,995 | $ 67,567,839 | $ 74,565,425 |

| EXPENDITURES | | FY 18 Expenditures | FY 19 Expenditures | Total State $ YTD |
|---|---|---|---|---|
| **Program Costs:** | | | | |
| | Employer Sponsored Insurance | | $ 52,994,201 | $ 52,994,201 |
| | College Students/ESI Dental | | 418,603 | 161,878 |
| **Individual Plan** | | | | |
| | SoonerCare Choice | | $ 79,836 | $ 30,875 |
| | Inpatient Hospital | | 2,914,967 | 1,129,003 |
| | Outpatient Hospital | | 3,922,824 | 1,525,871 |
| | BH - Inpatient Services-DRG | | 388,020 | 149,433 |
| | BH -Psychiatrist | | - | - |
| | Physicians | | 4,652,297 | 1,802,268 |
| | Dentists | | 41,897 | 16,062 |
| | Mid Level Practitioner | | 7,677 | 2,967 |
| | Other Practitioners | | 435,830 | 168,894 |
| | Home Health | | 10,704 | 4,219 |
| | Lab and Radiology | | 679,453 | 262,573 |
| | Medical Supplies | | 209,510 | 81,173 |
| | Clinic Services | | 1,589,502 | 613,142 |
| | Ambulatory Surgery Center | | 157,066 | 60,980 |
| | Prescription Drugs | | 13,458,808 | 5,179,383 |
| | Transportation | | 103,651 | 39,898 |
| | Premiums Collected | | - | (494,418) |
| **Total Individual Plan** | | | $ 28,652,043 | $ 10,572,323 |
| | **College Students-Service Costs** | | $ 475,505 | $ 184,201 |
| **Total OHCA Program Costs** | | | $ 82,540,351 | $ 63,912,604 |
| **Administrative Costs** | | | | |
| | Salaries | $ 24,543 | $ 2,127,814 | $ 2,152,357 |
| | Operating Costs | 9,662 | 126,739 | 136,401 |
| | Health Dept-Postponing | - | - | - |
| | Contract - HP | 79,204 | 787,339 | 866,543 |
| **Total Administrative Costs** | | $ 113,409 | $ 3,041,892 | $ 3,155,301 |
| **Total Expenditures** | | | | $ 67,067,905 |
| **NET CASH BALANCE** | | $ 6,997,587 | | $ 7,497,520 |

# OKLAHOMA HEALTH CARE AUTHORITY

## SUMMARY OF REVENUES & EXPENDITURES:

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

### SFY 2019, For the Eleven Month Period Ending May 31, 2019

| REVENUES | FY 19 Revenue | State Share |
|---|---|---|
| Tobacco Tax Collections | $ 664,925 | $ 664,925 |
| **TOTAL REVENUES** | **$ 664,925** | **$ 664,925** |

| EXPENDITURES | FY 19 Total $ YTD | FY 19 State $ YTD | Total State $ Cost |
|---|---|---|---|
| **Program Costs** | | | |
| SoonerCare Choice | $ 9,152 | $ 2,474 | |
| Inpatient Hospital | 920,582 | 245,899 | |
| Outpatient Hospital | 5,211,870 | 1,406,489 | |
| Inpatient Services-DRG | - | - | |
| Psychiatrist | - | - | |
| TFC-OHCA | - | - | |
| Nursing Facility | 1,091 | 287 | |
| Physicians | 3,694,439 | 1,007,874 | |
| Dentists | 12,391 | 3,320 | |
| Mid-level Practitioner | 479 | 129 | |
| Other Practitioners | 104,774 | 28,202 | |
| Home Health | 8,403 | 2,250 | |
| Lab & Radiology | 205,771 | 55,412 | |
| Medical Supplies | 32,252 | 8,651 | |
| Clinic Services | 246,779 | 66,759 | |
| Ambulatory Surgery Center | 9,040 | 2,414 | |
| Prescription Drugs | 2,580,585 | 696,282 | |
| Transportation | 128,385 | 34,770 | |
| Miscellaneous Medical | 7,901 | 2,092 | |
| **Total OHCA Program Costs** | **$ 13,173,894** | **$ 3,563,304** | |
| **OSA DMHSAS Rehab** | $ 96,871 | 26,144 | |
| **Total Medicaid Program Costs** | **$ 13,270,764** | **$ 3,589,448** | |
| **TOTAL STATE SHARE OF COSTS** | | | **$ 3,589,448** |

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.

# OHCA MAC Meeting
# July 2019
# (April 2019 Data)

## SOONERCARE ENROLLMENT/EXPENDITURES

| Delivery System | | | Enrollment April 2019 | Children April 2019 | Adults April 2019 | Enrollment Change | Total Expenditures April 2019 | PMPM April 2019 |
|---|---|---|---|---|---|---|---|---|
| **SoonerCare Choice Patient-Centered Medical Home** | | | **524,324** | **436,592** | **87,732** | **-5,946** | **$160,739,262** | |
| | *Lower Cost* | *(Children/Parents; Other)* | 482,337 | 423,570 | 58,767 | -5,468 | $114,438,440 | $237 |
| | *Higher Cost* | *(Aged, Blind or Disabled; TEFRA; BCC)* | 41,987 | 13,022 | 28,965 | -478 | $46,300,822 | $1,103 |
| **SoonerCare Traditional** | | | **234,444** | **85,666** | **148,778** | **2,308** | **$182,223,094** | |
| | *Lower Cost* | *(Children/Parents; Other; Q1; SLMB)* | 118,353 | 80,827 | 37,526 | 1,949 | $44,100,965 | $373 |
| | *Higher Cost* | *(Aged, Blind or Disabled; LTC; TEFRA; BCC & HCBS Waiver)* | 116,091 | 4,839 | 111,252 | 359 | $138,122,129 | $1,190 |
| **Insure Oklahoma** | | | **18,819** | **512** | **18,307** | **-5** | **$7,148,060** | |
| | *Employer-Sponsored Insurance* | | 13,492 | 323 | 13,169 | -117 | $4,832,825 | $358 |
| | *Individual Plan* | | 5,327 | 189 | 5,138 | 112 | $2,315,235 | $435 |
| **SoonerPlan** | | | **27,692** | **2,251** | **25,441** | **-824** | **$225,389** | $8 |
| **TOTAL** | | | **805,279** | **525,021** | **280,258** | **-4,467** | **$350,335,805** | |

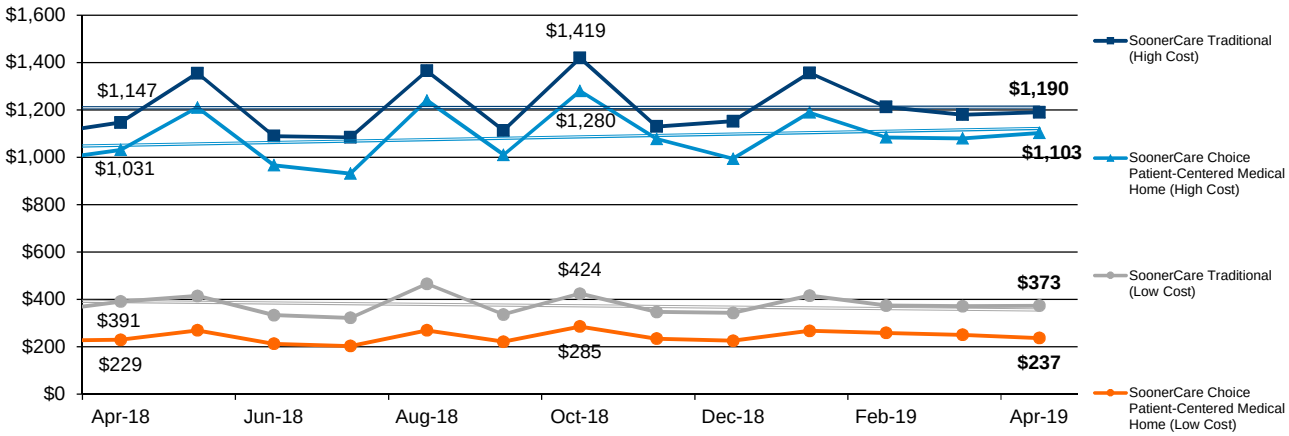
Enrollment totals include all members enrolled during the report month. Members may not have expenditure data. Children are members aged 0 - 20 or for Insure Oklahoma enrolled as Students or Dependents.
Dual Eligibles (Medicare & Medicaid) are in the Traditional delivery system in both the Low Cost (Q1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

**Total In-State Providers: 36,596 (+280)** **(In-State Providers counted multiple times due to multiple locations, programs, types, and specialties)**

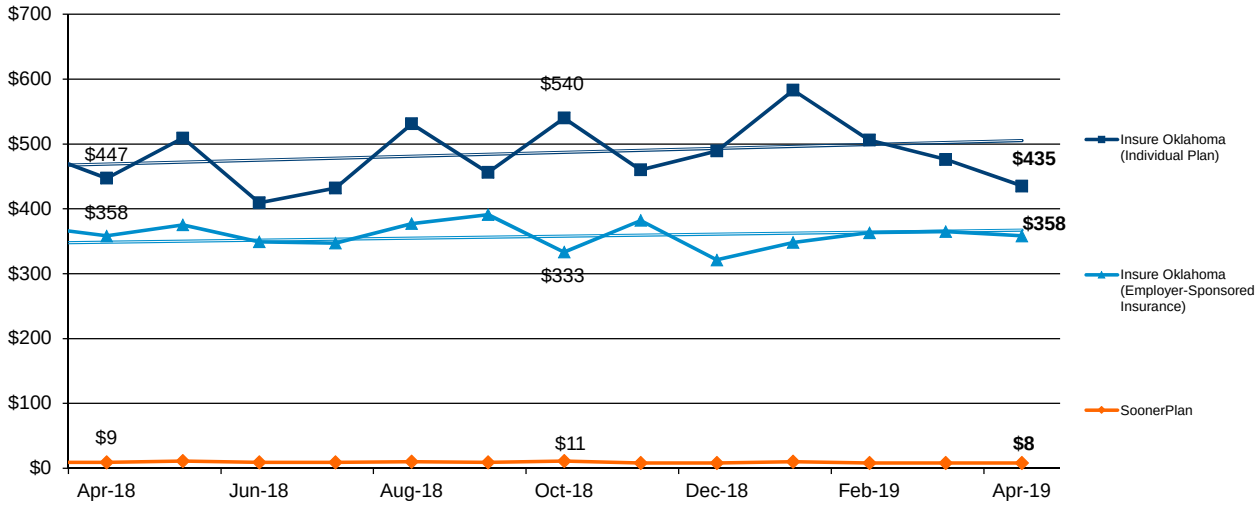
| Physician | Pharmacy | Dentist | Hospital | MH/BH | Optometrist | Extended Care | Total PCPs* | PCMH |
|---|---|---|---|---|---|---|---|---|
| 9,956 | 892 | 1,144 | 153 | 11,293 | 645 | 428 | 7,297 | 2,603 |

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

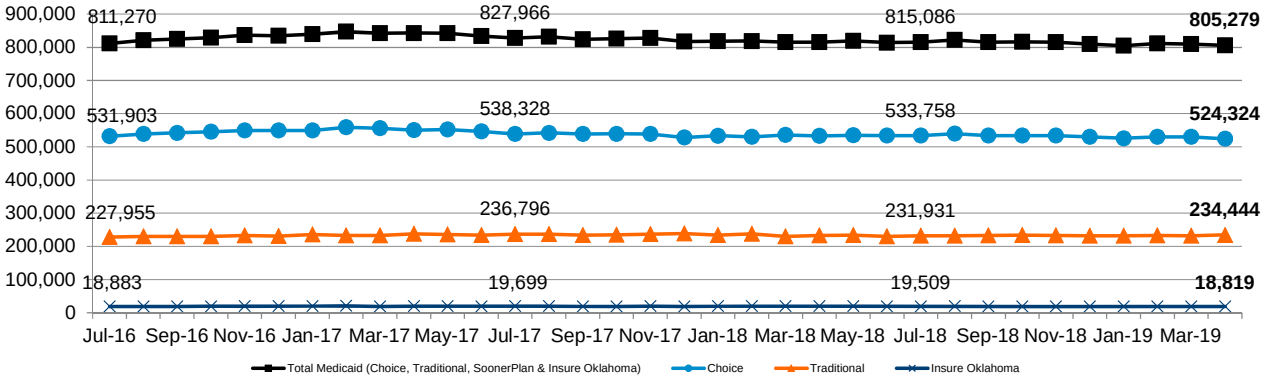
## PER MEMBER PER MONTH COST BY GROUP

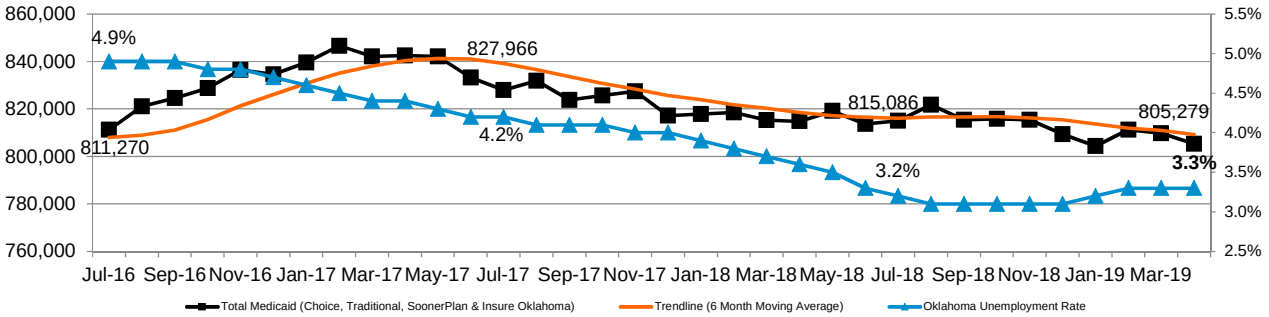



Low Cost includes members qualified under Children/Parents (TANF) and Other; High Cost members qualify under Aged, Blind or Disabled, Oklahoma Cares, TEFRA or a Home and Community-Based Services waiver.



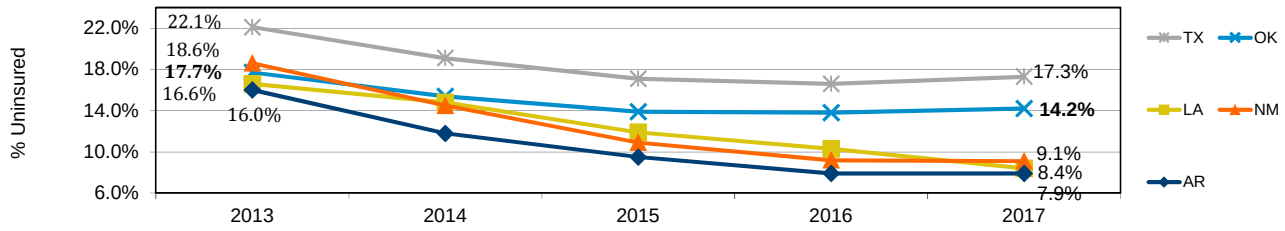
## ENROLLMENT BY MONTH



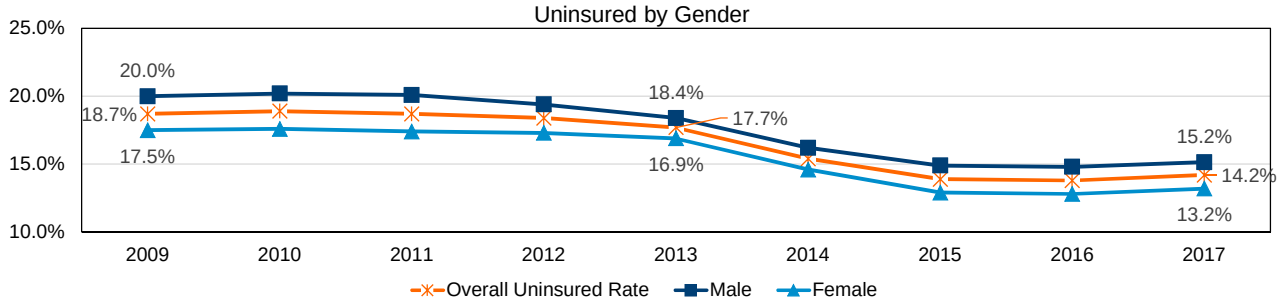



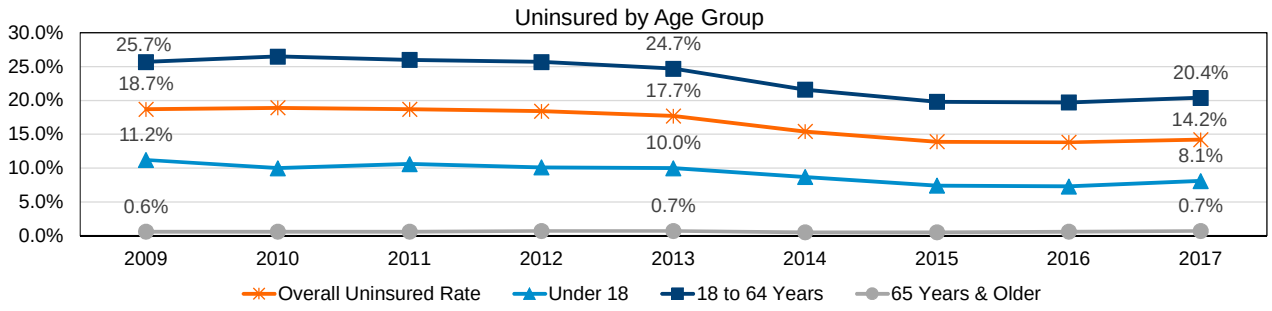

Oklahoma Unemployment Rate is from the Bureau of Labor Statistics 'Local Area Unemployment Statistics' (https://www.bls.gov/lau/) and is seasonally adjusted.
In June 2017 there were changes to the passive renewal system criteria that reduced the number of passively renewed members by 2/3rds.

## OKLAHOMA UNINSURED (CALENDAR YEAR)




AR, LA and NM have expanded Medicaid.




CY 2018 Uninsured will be available around October 2019 once data is released by Census.gov.

# Oklahoma Residency Verification Process

MAC Meeting

July 18, 2019

Melody Anthony, COO

# Work Group Members

## Project Manager, Braden Mitchell

Board Members and Stakeholder

- Chairman Stan Hupfeld
- Dr. Jean Hausheer
- Dr. Laura Shamblin
- Mr. Joe Dorman

SoonerCare Operations

- Becky Pasternik-Ikard, CEO
- Melody Anthony, COO
- Melinda Thomason, Stakeholder Engagement
- Mary Triplet, Member Services
- Efren Herrera, Member Services,
- Carolyn Reconnu Shoffner, RN, Population Care Management
- Ann Nichols, Behavioral Health Services
- Casey Dunham, Provider Services
- LaDawn Fulgenzi, Provider Services

# Work Group Members

Business Enterprises

Derek Lieser, Enrollment Automation and Data Integrity
Halley Kinder, Enrollment Automation and Data Integrity
Chris Dees, Enrollment Automation and Data Integrity
Trish Harland, Electronic Customer Relations
Leslie Sickler, Electronic Customer Relations
Susie Megehee, Business Enterprises
Chris Glenn, Performance and Electronic Processes

Communications

MaryAnn Martin, Senior Director
Shelly Patterson, Director, Community Outreach/Performance and Health Improvement Program
Jo Stainsby, Director, Public Information

# Work Group Members

Legal Division

Maria Maule, JD, Senior Director
Jillian Welch, JD, Deputy General Counsel
Sandra Manzo De Puebla, Federal and State Policy

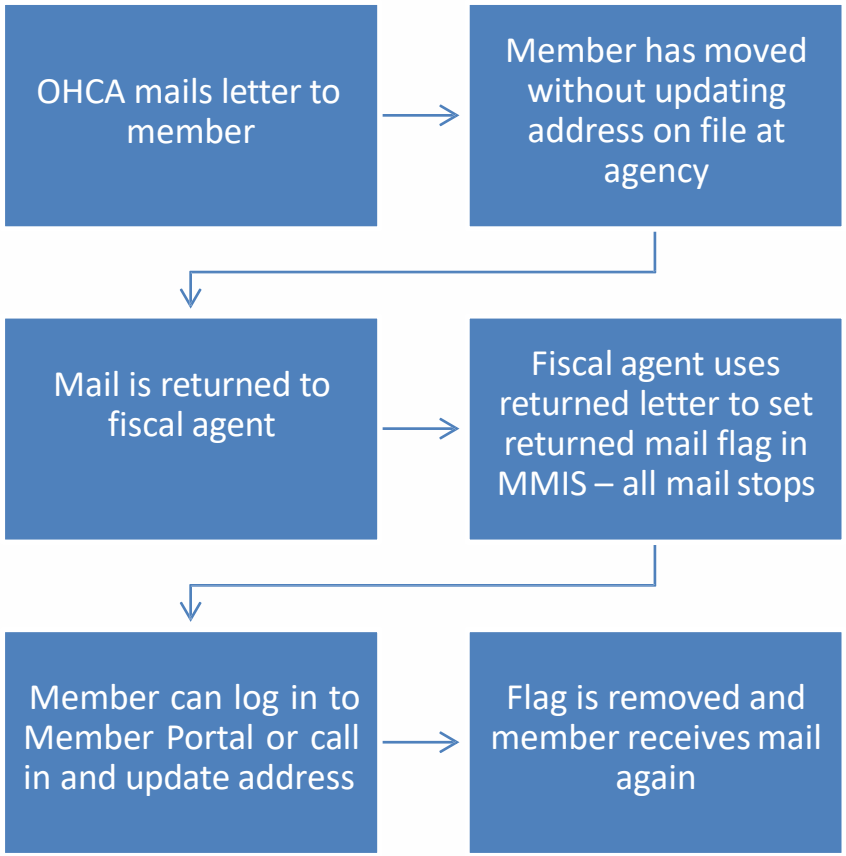
Tribal Government Relations

Johnney Johnson, Associate Director

DXC Technology

Reggie Givens

# Current processes for returned mail:



# Discussion Items

- Current
- Future
- Questions

# Current and Planned New Processes

## Ongoing

- Identify address changes made.
- Hold message with address reminder.
- Develop outbound calling campaign scripts.
- Test outbound calling scripts – July 2019
- Prioritize vulnerable populations.
- Create Agency Partner training plan.
- Other state's insights through Eligibility Technical Advisory Group call.

# Current and Planned New Processes

## Ongoing

- Work with other State Agencies, current partners and agency staff to assist in reaching these members.
  - Attorney General's Office
  - DHS
  - DMH
  - OSDH
  - FQHC
  - ITU
  - Health Access Networks
  - Health Management Program
  - Chronic Care Unit

# Current and Planned New Processes

Ongoing

- Providers
  - Signage given to providers to post at reception/front desk.
  - Create an indicator with eligibility checks in provider portal: “Please ask the member to contact OHCA to update information.”
  - Educational provider webinars – July 11, July 25, Aug 8. Posted on website for future training.

# Additional Planned New Processes

Ongoing

- Change current enrollment to allow us to contact members Authorized Representative.
- We will use outbound calling number that shows “State of Oklahoma.”
- Work with vendor partners to utilize additional resources.
  - Telligen
  - LogistiCare
  - Pharmacy Management Consultants

# Additional Planned New Processes

TBD

- Technical Modifications
  - Make address changes a one click process in Home View.
  - Enhance application to be more mobile friendly.

# Planned New Improvements to Process

TBD

- OHCA Public web page
  - Extract the portion of our existing enrollment video about changing your address.
  - Modify MySoonerCare.org homepage with Quick Links.
  - Direct link to member portal from OHCA homepage.

# Broadening Outreach Now

**Member Services**
**Provider Services**

- Launch outreach calling campaign, prioritizing vulnerable populations.
- Use OHCA member services and other staff, temporary or contracted staff.
- Continue distribution of fliers to providers around the state.

**Communications**
**Provider Services**

- Use data to identify clusters and trends in member location, developing targeted media campaigns and outreach in identified communities.
- Design multilingual fliers for coalitions and workgroups, different public places (libraries, pharmacist reception area, etc.)
- Meet face to face with community partners and advocates statewide.
- Continue social media and digital campaign through member and provider newsletters, social media platforms, strategic website content.

**Member Services**
**Communications**

- Establish ongoing meetings with Agency Partner (organizations with access to "Agency View" enrollment) for continued training. – July 19, July 23, and July 30
- Consider Webinar for community partners and advocates.
- Consider ad campaigns in rural community newspapers and billboards.

# After Rule is Effective

## Planning

- When mail is returned, contact members via letter and email (if available) with 30 days notice of potential closing of eligibility.
- Continue outreach calling campaign, prioritizing vulnerable populations.
- Continue using OHCA member services and other staff, temporary or contracted staff, as indicated.

## TBD

- Future Strategies
  - Robocalls.
  - Texting if permitted under current FCC and HIPAA regulations.

# Questions Comments

Thank you for your support and guidance on this new process.

Melody Anthony, COO
405-522-7360
Melody.Anthony@okhca.org

**Access Monitoring Review Plan (AMRP)**

Federal regulation at 42 CFR 447.203, documentation of access to care and services payments, directs State Medicaid programs to analyze and monitor access to care for Medicaid fee-for-service programs through the Access Monitoring Review Plan (AMRP). Through the AMRP, the State demonstrates access to care by measuring the following: enrollee needs; the availability of care and providers; utilization of services; characteristics of the enrolled members; and estimated levels of provider payment from other payers. The AMRP must be taken through consultation with the Medical Advisory Committee and be published and made available to the public for a period of no less than 30 days prior to being submitted to the Centers for Medicare & Medicaid Services (CMS). The State submitted the initial access monitoring review plan on September 28, 2016 and must submit a revised plan every three years. The AMRP will note any access issues identified during the prior three years and if any issues were identified, the plan will include a corrective action plan. Further, the AMRP includes the State's access to care analyses conducted for State Plan amendments that reduced and/or restructured payment rates that could diminish access to care which were promulgated and approved within the previous three years.

**July MAC**
**Proposed Rule Amendment Summaries**

Face-to-face tribal consultations regarding the following proposed changes were held on Tuesday, January 8, 2019, Tuesday, March 9, 2019, Tuesday, June 18, 2019, and Tuesday, July 2, 2019 in the Charles Ed McFall Boardroom of the Oklahoma Health Care Authority (OHCA).

APA WF # 19-01 will be posted for public comment through July 31, 2019. APA WF # 19-05 will be posted for public comment through August 3, 2019. APA WF # 19-10 will be posted for public comment through July 23, 2019. APA WF # 19-11 will be posted for public comment through August 1, 2019. APA WF # 19-12 will be posted for public comment through August 12, 2019.

**19-01 Retroactive Eligibility —** The proposed revisions amend certification policy for pregnant women and children to allow for a retroactive period of eligibility. Revisions provide that, in addition to certifying an applicant for coverage from the date of certification forward, the applicant may also be certified for coverage for a retroactive period of three months directly prior to the date of application. If the applicant received reimbursable SoonerCare services at any time during the prior three months from certification/date of application and if the applicant would have been eligible for SoonerCare at the time he or she received the services, the member may be eligible for retroactive eligibility coverage. Revisions also specify the requirements that must be met to be eligible for retroactive coverage. Oklahoma had been granted a waiver exemption for retroactive eligibility for children and pregnant women through the 1115(a) waiver; however, in the latest renewal of the waiver, this exemption was removed by the Centers for Medicaid and Medicare Services (CMS), thus mandating the Oklahoma Health Care Authority to extend retroactive eligibility for pregnant women and children. The rule revisions apply to children and pregnant women and do not apply to adult parents/caretaker relatives. The timely filing deadline in Oklahoma Administrative Code (OAC) 317:30-3-11 will still apply to the filing of any retroactive claims.

**Budget Impact: Although it is expected that implementing retroactive eligibility will have a budget impact to the agency it is not possible at this time, to predict how many applicants will be eligible for and receive a retroactive coverage option.**

**19-05 Therapeutic Foster Care (TFC) Revisions —** The proposed revisions will align therapeutic foster care policy with current business practice. Revisions will also add new language establishing a more intensive treatment program for children in DHS and OJA custody known as Intensive Treatment Family Care (ITFC). ITFC is a therapeutic foster care model that addresses children's complex/severe behavioral and emotional health disorders. ITFC utilizes a team approach of professionals including therapists, care coordinators, and foster parents to provide the intensive treatment services in a family care setting. The proposed revisions will define ITFC, member criteria for the provision of ITFC services, provider participation and credentialing requirements, program coverage, and program limitations. Lastly, the proposed revisions will establish reimbursement methodology and applicable rates for ITFC services.

**Budget Impact: The proposed changes would potentially result in an estimated annual total cost for SFY20 of $1,731,183 with a state match of $594,557 and an SFY21 total cost of $2,324,813 with a state match of $768,816. The state share will be paid by the Oklahoma Department of Human Services with the current TFC budget.**

**19-10 American Indian/Alaska Native Cost Sharing Exemption —** The proposed revisions will make Oklahoma's Administrative Code language consistent with the Oklahoma State Plan language and federal regulation at 42 Code of Federal Regulation (CFR) 447.56 (a)(x) regarding cost sharing exemptions.

**Budget Impact: Budget neutral.**

**19-11 Board Organization and Policy Revisions —** The proposed revisions will comply with Oklahoma Senate Bill (SB) 456, which was signed into law on March 13th, 2019 and directed the reorganization of the Oklahoma Health Care Authority (OHCA) Board. The seven-member Board was replaced with a nine-member Board. Further revisions establish that the chair and vice-chair elections are held at the last regular meeting before January 1st of each year. Other revisions are needed to correct outdated language.

**Budget Impact: Budget neutral.**

**19-12 High Risk Obstetrical Services (HROB) —** The proposed revisions will add "family practice physician - obstetrics (FP/OB)" as a new provider type under the enhanced services for medically high risk pregnancies policy. This policy change will address and improve access to care for obstetrical related services in rural Oklahoma. Further revisions will update policy to reflect current business practices.

**Budget Impact: The proposed changes can potentially result in a combined federal and state spending of $154,549.10 total with $52,515.78 in state share for SFY2020.**

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

## SUBCHAPTER 6. SOONERCARE FOR PREGNANT WOMEN AND FAMILIES WITH CHILDREN

## PART 7. CERTIFICATION, REDETERMINATION AND NOTIFICATION

### 317:35-6-60. Certification for SoonerCare for pregnant women and families with children

~~An individual determined eligible for SoonerCare may be certified for a medical service provided on or after the date of certification. The period of certification may not be for a retroactive period unless otherwise prior approved by OHCA. The individual who is categorically needy and related to pregnancy- related services retains eligibility for the period covering prenatal, delivery and postpartum periods without regard to eligibility for other household members in the case. Eligibility during the postpartum period does not apply to women receiving pregnancy-related coverage under Title XXI.~~

(a) **General rules of certification.**

(1) An individual determined eligible for SoonerCare may be certified for a prospective period of coverage on or after the date of certification.

(2) In accordance with 42 Code of Federal Regulations (C.F.R.) § 435.915 and Oklahoma Administrative Code (OAC) 317:35-6-60.2, an individual may also be determined eligible and certified for a retroactive period of coverage during the three month period directly prior to the date of application, if the individual received covered medical services at any time during that period, and would have been eligible for SoonerCare at the time he or she received the services, regardless of whether the individual is alive when application for Medicaid is made. An individual may be eligible for the retroactive period even though ineligible for the prospective period.

(3) The individual who is categorically needy and related to pregnancy-related services retains eligibility for the period covering prenatal, delivery, and postpartum periods without regard to eligibility for other household members in the case. Eligibility during the postpartum period does not apply to women receiving pregnancy-related coverage under Title XXI.

~~(1)~~(b) **Certification as a TANF (cash assistance) recipient.** A categorically needy individual who is determined eligible for TANF is certified effective the first day of the month of TANF eligibility.

~~(2)~~(c) **Certification of non-cash assistance individuals related to the children and parent and caretaker relative groups.** The certification period for the individual related to the children or parent and caretaker relative groups is 12 months. The certification period can be less than 12 months if the individual:

~~(A)~~(1) is certified as eligible in a money payment case during the 12-month period;

~~(B)~~(2) is certified for long-term care during the 12-month period;

~~(C)~~(3) becomes ineligible for SoonerCare after the initial month; or

~~(D)~~(4) becomes financially ineligible.

~~(i)~~(A) If an income change after certification causes the case to exceed the income standard, the case is closed.

~~(ii)~~(B) Individuals, however, who are determined pregnant and financially eligible continue to be eligible for pregnancy-related services through the prenatal, delivery and postpartum period, regardless of income changes. A pregnant individual included in a TANF case which closes continues to be eligible for pregnancy related services through the postpartum period.

~~(3)~~(d) **Certification of individuals related to pregnancy-related services.** The certification period for the individual related to pregnancy-related services will cover the prenatal, delivery and postpartum periods. The postpartum period is defined as the two months following the month the pregnancy ends. Financial eligibility is based on the income received in the first month of the certification period. No consideration is given to changes in income after certification.

~~(4)~~(e) **Certification of newborn child deemed eligible.**

~~(A)~~(1) Every newborn child is deemed eligible on the date of birth for SoonerCare when the child is born to a woman who is eligible for and enrolled in pregnancy-related services as categorically needy. The newborn child is deemed eligible through the last day of the month the newborn child attains the age of one year. The newborn child's eligibility is not dependent on the mother's continued eligibility. The mother's coverage may expire at the end of the postpartum period; however, the newborn child is deemed eligible until age one. The newborn child's eligibility is based on the original eligibility determination of the mother for pregnancy-related services, and consideration is not given to any income or resource changes that occur during the deemed eligibility period.

~~(B)~~(2) The newborn child is deemed eligible for SoonerCare as long as he/she continues to live in Oklahoma. ~~No~~In accordance

with 42 C.F.R. § 435.117, no other conditions of eligibility are applicable, including social security number enumeration, child support referral, and citizenship and identity verification. However, it is recommended that social security number enumeration be completed as soon as possible after the newborn child's birth. It is also recommended that a child support referral be completed, if needed, as soon as possible and sent to the Oklahoma Child Support Services (OCSS) division at ~~OKDHS~~DHS. The referral enables child support services to be initiated.

~~(C)~~(3) When a categorically needy newborn child is deemed eligible for SoonerCare, he/she remains eligible through the end of the month that the newborn child reaches age one. If the child's eligibility is moved from the case where initial eligibility was established, it is required that the newborn receive the full deeming period. The certification period is shortened only in the event the child:

~~(i)~~(A) loses Oklahoma residence; or

~~(ii)~~(B) expires.

~~(D)~~(4) A newborn child cannot be deemed eligible when the mother's only coverage was presumptive eligibility, and continued eligibility was not established.

**317:35-6-60.2. Retroactive eligibility.**

(a) Retroactive eligibility, as outlined in this section, shall be available to pregnant women and/or members under the age of nineteen (19). For retroactive eligibility rules related to other SoonerCare population groups, refer to Oklahoma Administrative Code (OAC) 317:35-7-60(b).

(b) In addition to the period of eligibility specified in Oklahoma Administrative Code (OAC) 317:35-6-60, an applicant, or individuals within the applicant's household, shall be eligible for SoonerCare benefits up to three (3) months prior to the date of application if all of the following requirements are met:

(1) The individual for whom retroactive coverage is being requested would have been eligible for SoonerCare coverage if an application for SoonerCare had been made during the retroactive month.

(A) The individual does not have to be eligible for the month of application to be found eligible for one of the three retroactive months.

(B) The eligibility factors (e.g. income, residency, household composition, etc.) are evaluated separately for each retroactive month for which retroactive eligibility is being requested.

(2) The applicant completes the retroactive eligibility

application form and provides, within six (6) months of the date the services were provided, documentation for verification purposes as requested by SoonerCare.

(3) The individual applying for retroactive coverage states that the individual for whom retroactive coverage is being requested received reimbursable SoonerCare services which were provided by a SoonerCare-contracted provider during the retroactive month.

(4) An applicant cannot be approved for retroactive coverage for a month in which his or her application was previously denied.

(c) Per 42 Code of Federal Regulations (CFR) § 435.915(b), if an applicant is determined to be eligible for retroactive coverage at any time during the requested retroactive month, then coverage will begin on the first (1st) day of the month and be effective for the entire month.

(d) If the applicant is applying for SoonerCare benefits due to pregnancy, then the applicant must have been pregnant during the requested retroactive month.

(e) Regardless of retroactive eligibility being granted, the requirement for the claim to be filed timely, per OAC 317:30-3-11, is still in effect.

(f) Retroactive coverage for SoonerCare health services received during a retroactive month will be secondary to any third-party which has primary responsibility for payment. If the individual eligible for retroactive coverage has already paid for the health services, the provider may refund the payment and bill SoonerCare in accordance with the timely filing requirements in OAC 317:30-3-11.

(g) Retroactive coverage for SoonerCare reimbursable health services that require prior authorization shall not be denied solely because of a failure to secure prior authorization. Medical necessity, however, must be established before reimbursement can be made.

(h) Denials of requests for retroactive eligibility may be appealed in accordance with OAC 317:2-1-2(d)(1)(F).

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

**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**

**PART 83. ~~RESIDENTIAL BEHAVIOR MANAGEMENT SERVICES~~THERAPEUTIC FOSTER CARE**

**317:30-5-740. ~~Eligible providers~~Definitions**

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

~~(1) **Therapeutic foster care (TFC) agencies**. A foster care agency is an agency that provides foster care as defined in the Code of Federal Regulations (CFR) as "24-hour substitute care for children outside their own homes." Therapeutic foster care settings are foster family homes.~~

~~(2) **Therapeutic foster care homes**. Agency-supervised private family homes in which foster parents have been trained to provide individualized, structured services in a safe, nurturing family living environment for children and adolescents with significant emotional or behavioral problems who require a higher level of care than is found in a conventional foster home but do not require placement in a more restrictive setting. Therapeutic foster care homes are considered the least restrictive out-of-home placement for children with severe emotional disorders.~~

~~(b) **TFC Agency Requirements**. Eligible TFC agencies must have:~~

~~(1) current certification from the Oklahoma Department of Human Services (OKDHS) as a child placing agency;~~

~~(2) a contract with the Division of Children and Family Services of the Oklahoma Department of Human Services, or OJA;~~

~~(3) a contract with the Oklahoma Health Care Authority; and~~

~~(4) a current accreditation status appropriate to provide behavioral health services in a foster care setting from:~~

~~(A) The Joint Commission formerly the Joint Commission on Accreditation (JCAHO), or~~

~~(B) the Rehabilitation Accreditation Commission (CARF), or~~

~~(C) the Council on Accreditation (COA), or~~

~~(D) the American Osteopathic Association (AOA).~~

(1) **"Therapeutic foster care (TFC) agency"** means a foster care agency that provides foster care as defined in Public Welfare, 45 Code of Federal Regulation (CFR), Sec. 1355.20 as twenty-four (24) hour substitute care for children and adolescents placed away from their parents or guardians and for whom the title IV-E agency has placement and care responsibility. TFC settings are foster family homes.

(2) **"TFC home"** means an agency-supervised, private family home

in which foster parents have been trained to provide individualized, structured services in a safe, nurturing family-living environment. The children and adolescents receiving services in this setting have moderate behavioral and emotional health needs, and may also present secondary physical, developmental, intellectual, and/or social disorder that is supported alongside the mental health needs. TFC homes are considered the least restrictive out-of-home placement for these children or adolescents.

(3) **"Therapeutic foster care (TFC) model"** means a model in which children and adolescents in the TFC environment receive increased individualized behavioral health and other support services from qualified staff. Because TFC members require exceptional levels of skill, time, and supervision, the number of unrelated children and/or adolescents placed per home is limited; no more than two (2) TFC members may be placed in a home at any one (1) time unless additional cases are specifically authorized by Child Welfare Services (CWS) of the Oklahoma Department of Human Services (DHS), or Oklahoma Office of Juvenile Affairs (OJA).

**317:30-5-740.1. ~~Provider qualifications and requirements~~Eligible providers and requirements**

~~(a) **Therapeutic foster care model.** Children in the TFC environment receive intensive individualized behavioral health and other support services from qualified staff. Because TFC children require exceptional levels of skill, time and supervision, the number of unrelated children placed per home is limited; no more than two TFC children in a home at any one time unless additional cases are specifically authorized by OKDHS, Division of Children and Family Services or OJA.~~

~~(b) **Treatment team.** TFC agencies are primarily responsible for treatment planning and coordination of the child's treatment team. This team is typically composed of an OKDHS or OJA caseworker, the child, the child's parents, others closely involved with the child and family. It also includes the following:~~

~~(1) **Certified Behavioral Health Case Manager II (CM).** A bachelors level team member that may provide support services and case management. In addition to the minimum requirements at OAC 317:30-5-240.3 (c), the CM must have:~~

~~(A) a minimum of one year of experience in providing direct care and/or treatment to children and/or families, and~~

~~(B) have access to weekly consultation with a licensed behavioral health professional or Licensure Candidate.~~

~~(C) CM must also follow requirements at OAC 317:30-5-241.3 for providing psychosocial rehabilitation services.~~

~~(2) **Licensed Behavioral Health Professional (LBHP).** A masters level professional that provides treatment and supervision for~~

the treatment staff to maintain clinical standards of care and provide direct clinical services. In addition to the requirements at OAC 317:30-5-240.3(a) and (b), the LBHP or Licensure Candidate in a TFC setting must demonstrate a general professional or educational background in the following areas:

(A) case management, assessment and treatment planning;

(B) treatment of victims of physical, emotional, and sexual abuse;

(C) treatment of children with attachment disorders;

(D) treatment of children with hyperactivity or attention deficit disorders;

(E) treatment methodologies for emotionally disturbed children and youth;

(F) normal childhood development and the effect of abuse and/or neglect on childhood development;

(G) anger management;

(H) crisis intervention; and

(I) trauma informed methodology.

(3) **Licensed Psychiatrist and/or psychologist.** TFC agencies must provide staff with access to professional psychiatric or psychological consultation as deemed necessary for the planning, implementation and appropriate management of the resident's treatment. See OAC 317:30-5-240.3(a) and OAC 317:25-275.

(4) **Treatment Parent Specialist (TPS).** The TPS serve as integral members of the team of professionals providing services for the child. The TPS receives special training in mental health issues, behavior management and parenting techniques; and implements the in-home portion of the treatment plan with close supervision and support. They provide services for the child, get the child to therapy and other treatment appointments, write daily notes about interventions and attend treatment team meetings. The TPS must be under the supervision of a licensed behavioral health professional of the foster care agency and meet the following criteria:

(A) have a high school diploma or equivalent;

(B) have an employment relationship with the foster care agency as a foster parent complete with OSBI and OKDHS background screening;

(C) completion of therapeutic foster parent training outlined in this section;

(D) have a minimum of twice monthly face to face supervision with the licensed, or under-supervision for licensure, LBHP, independent of the child's family therapy;

(E) have weekly contact with the foster care agency professional staff; and

(F) complete required annual trainings.

(c) **Agency assurances.** The TFC agency must ensure that each

~~individual that renders treatment services (whether employed by or contracted by the agency) meets the minimum provider qualifications for the service. Individuals eligible for direct enrollment must have a contract on file with the Oklahoma Health Care Authority.~~

~~(d) **Policies and Procedures.** Eligible TFC agency providers that are defined in section OAC 317:30-5-740(a) shall have written policies and procedures for the orientation of new staff and foster parents which is reviewed and updated annually, for the following:~~

~~(1) pre-service training of foster parents in treatment methodologies and service needs of emotionally and behaviorally disturbed children;~~

~~(2) treatment of victims of physical, emotional, and sexual abuse;~~

~~(3) treatment of children with attachment disorders;~~

~~(4) treatment of children with hyperactive or attention deficit disorders;~~

~~(5) normal childhood development and the effect of abuse and/or neglect on childhood development;~~

~~(6) treatment of children and families with substance use disorders;~~

~~(7) the Inpatient Mental Health and Substance Abuse Treatment of Minors Act;~~

~~(8) anger management;~~

~~(9) inpatient authorization procedures;~~

~~(10) crisis intervention;~~

~~(11) grief and loss issues for children in foster care;~~

~~(12) the significance/value of birth families to children receiving behavioral health services in a foster care setting; and~~

~~(13) trauma informed methodology.~~

(a) **TFC Agency.** Eligible TFC agencies must have:

(1) Current certification from the Oklahoma Department of Human Services (DHS) as a child placing agency;

(2) A contract with the Child Welfare Division of DHS, or Oklahoma Office of Juvenile Affairs (OJA);

(3) A contract with the Oklahoma Health Care Authority (OHCA); and

(4) A current accreditation status appropriate to provide behavioral health services in a foster care setting from:

(A) The Joint Commission; or

(B) The Commission on Accreditation of Rehabilitative Facilities (CARF); or

(C) The Council on Accreditation (COA).

(b) **Treatment team.** TFC agencies are primarily responsible for treatment planning and coordination of the member's treatment team. This team is typically composed of a DHS or OJA caseworker, the member, the member's foster parent(s), as well as others

closely involved with the member and family, including the biological parents when applicable. It also includes the following:

(1) **Certified behavioral health case manager (CM) II.** A bachelor's level team member that may provide support services and case management. In addition to the minimum requirements at Oklahoma Administrative Code (OAC) 317:30-5-240.3(h)(1), the CM II must:

(A) Have a minimum of one (1) year of experience in providing direct care and/or treatment to children/adolescents and/or families; and

(B) Have access to weekly consultation with a licensed behavioral health professional (LBHP) or licensure candidate.

(C) The CM II must also follow requirements at OAC 317:30-5-241.3 for providing psychosocial rehabilitation (PSR) services.

(2) **Certified alcohol and drug counselor (CADC).** A bachelor's level team member with a current certification as a CADC in the state in which services are provided.

(3) **Licensed behavioral health professional (LBHP) and/or licensure candidate.** An LBHP is a master's level professional that provides treatment and supervises other treatment staff in maintaining clinical standards of care and providing direct clinical services. A licensure candidate is a practitioner actively and regularly receiving board-approved supervision, or extended supervision by a fully-licensed clinician if the board's supervision requirement is met but the individual is not yet licensed. In addition to the requirements at OAC 317:30-5-240.3(a) and (b), the LBHP or licensure candidate in a TFC setting must demonstrate a general professional or educational background in the following areas:

(A) Case management, assessment, and treatment planning;

(B) Treatment of victims of physical, emotional, and sexual abuse;

(C) Treatment of children/adolescents with attachment disorders;

(D) Treatment of children/adolescents with hyperactivity or attention deficit disorders;

(E) Treatment methodologies for emotionally disturbed children/adolescents;

(F) Normal childhood development and the effect of abuse and/or neglect on childhood development;

(G) Anger management;

(H) Crisis intervention; and

(I) Trauma-informed methodology.

(4) **Licensed psychiatrist and/or psychologist.** TFC agencies must provide staff with access to professional psychiatric or

psychological consultation as deemed necessary for the planning, implementation, and appropriate management of the member's treatment. See OAC 317:30-5-240.3(a) and 317:25-7-5.

(5) **Treatment parent specialist (TPS).** The TPS serves as an integral member of the team of professionals providing services for the member. The TPS receives extensive training in diagnosed mental health issues, and behavior management/modification and skill-based parenting techniques; and implements the in-home portion of the treatment plan with close supervision and support. The TPS renders services for the member, provides or arranges suitable transportation for therapy and other treatment appointments, writes daily detailed notes regarding interventions and practical applications of learned skills, and attends treatment team meetings. The TPS must be under the supervision of an LBHP or licensure candidate of the foster care agency and meet the following criteria:

(A) **Qualifications.**

(i) Have a high school diploma or equivalent;

(ii) Have an employment and/or contractual relationship with the foster care agency as a foster parent, and have successfully met all required background screening requirements, including, but not limited to, fingerprint screenings conducted by the Oklahoma State Bureau of Investigation (OSBI) and Federal Bureau of Investigation (FBI), and DHS background screenings;

(iii) Complete the initial thirty-six (36) hours of pre-service training, prior to becoming a TFC parent;

(B) **Responsibilities.**

(i) Have a minimum of twice monthly face-to-face supervision with the licensed, or under-supervision for licensure, LBHP, independent of the member's family therapy;

(ii) Have weekly contact with the foster care agency professional staff;

(iii) Complete the required eighteen (18) hours of in-service training per calendar year; and

(iv) Work with the multidisciplinary team and the member's biological family toward reunification, if appropriate, or other permanency plan.

(c) **Agency assurances.** The TFC agency must ensure that each individual who renders treatment services meets the minimum provider qualifications for the service and, if eligible for direct enrollment, is fully contracted with the OHCA. Additionally, the TFC agency must comply with all state and federal Medicaid law, including, but not limited to, OHCA administrative rules, the Code of Federal Regulations (CFR), and the Oklahoma State Medicaid Plan.

(d) **Policies and procedures.** Eligible TFC agency providers shall have written policies and procedures for the orientation of new

staff and foster parents which is reviewed and updated annually, for the following:

(1) Pre-service training of foster parents in treatment methodologies and service needs of emotionally and behaviorally disturbed children/adolescents;

(2) Treatment of victims of physical, emotional, and sexual abuse;

(3) Treatment of children/adolescents with attachment disorders;

(4) Treatment of children/adolescents with hyperactive or attention deficit disorders;

(5) Normal childhood development and the effect of abuse and/or neglect on childhood development;

(6) Treatment of children/adolescents and families with substance use disorders;

(7) The Inpatient Mental Health and Substance Abuse Treatment of Minors Act;

(8) Anger management;

(9) Inpatient authorization procedures;

(10) Crisis intervention;

(11) Grief and loss issues for children/adolescents in foster care;

(12) The significance/value of birth families to children/adolescents receiving behavioral health services in a foster care setting; and

(13) Trauma-informed methodology.

**317:30-5-740.2. Provider selection**

~~Parents who retain legal custody of a client may select any eligible contractor as the provider of services. In the case of children in the custody of the State of Oklahoma, the State, acting in its custodial role, selects the provider agency.~~Parents who retain legal custody of a TFC child or adolescent may select any eligible TFC agency as the provider of services. In the case of members in the custody of the State of Oklahoma, the State, acting in its custodial role, selects the TFC agency.

**317:30-5-741. Coverage by category**

~~(a) **Adults.** Behavioral health services in therapeutic foster care settings are not covered for adults.~~

~~(b) **Children.** Behavioral health services are allowed in therapeutic foster care settings for certain children and youth as medically necessary. The children and youth receiving services in this setting have special psychological, social and emotional needs, requiring more intensive, therapeutic care than can be found in the traditional foster care setting. The designated children and youth must continually meet medical necessity criteria to be eligible for coverage in this setting.~~

~~(c) **Medical necessity criteria.** Medical necessity criteria is delineated as follows:~~

~~(1) A diagnosis from the most recent edition of "The Diagnostic and Statistical Manual of Mental Disorders" (DSM), with the exception of V codes and adjustment disorders, with a detailed description of the symptoms supporting the diagnosis. Children with a provisional diagnosis may be admitted for a maximum of 30 days. An assessment must be completed by a Licensed Behavioral Health Professional (LBHP) or Licensure Candidate as defined in OAC 317:30-5-240.3(a) and (b) within the 30 day period resulting in a diagnosis from the most recent edition of "the Diagnostic and Statistical Manual of Mental Disorders"(DSM) with the exception of V codes and adjustments disorders, with a detailed description of the symptoms supporting the diagnosis to continue RBMS in a foster care setting.~~

~~(2) Conditions are directly attributed to a mental illness/serious emotional disturbance as the primary need for professional attention.~~

~~(3) It has been determined by the inpatient authorization reviewer that the current disabling symptoms could not have been or have not been manageable in a less intensive treatment program.~~

~~(4) Evidence that the child's presenting emotional and/or behavioral problems prohibit full integration in a family/home setting without the availability of 24 hour crisis response/behavior management and intensive clinical interventions from professional staff, preventing the child from living in a traditional family home.~~

~~(5) The child is medically stable and not actively suicidal or homicidal and not in need of substance abuse detoxification services.~~

~~(6) The legal guardian/parent of the child (OKDHS/OJA if custody child) agrees to actively participate in the child's treatment needs and planning.~~

(a) **Adults.** Behavioral health services in TFC settings are not covered for adults.

(b) **Children.** Behavioral health services are allowed in TFC settings for children and adolescents as medically necessary. The children and adolescents receiving services in this setting have moderate behavioral and emotional health needs, and may also present secondary physical, developmental, intellectual, and/or social disorder that is supported alongside the mental health needs. The designated children and adolescents must continually meet medical necessity criteria to be eligible for coverage in this setting. Requests for behavioral health services in a TFC setting must be prior authorized and may be approved up to a maximum of three (3) month extensions.

(c) **Medical necessity criteria.** In order to satisfy medical necessity criteria, all of the following conditions must be met:

(1) The member must have a diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM-V), with the exception of V codes and adjustment disorders, with a detailed description of the symptoms supporting the diagnosis. Children and adolescents with a provisional diagnosis may receive TFC services for a maximum of thirty (30) days.

(2) An assessment must be completed by a licensed behavioral health professional (LBHP) or licensure candidate as defined in Oklahoma Administrative Code (OAC) 317:30-5-240.3(a) and (b) within the thirty (30) day provisional period described above, that confirms a diagnosis from the DSM-V with the exception of V codes and adjustments disorders, and that includes a detailed description of the symptoms supporting the diagnosis to continue treatment in a TFC setting.

(3) Conditions are directly attributed to moderate behavioral and emotional needs as the primary need for professional attention.

(4) It has been determined by an LBHP that the current disabling symptoms could not have been or have not been manageable in a less intensive treatment program.

(5) Evidence that the members' needs prohibit full integration in a family/home setting without the availability of twenty-four (24) hour crisis response/behavior management and clinical interventions from professional staff, preventing the member from living in a traditional family home.

(6) The member is medically stable and not actively suicidal or homicidal and not in need of substance abuse detoxification services.

(7) The legal guardian [Oklahoma Department of Human Services (DHS)/ Oklahoma Office of Juvenile Affairs (OJA) if custody member] or parent of the member agrees to actively participate in the member's treatment needs and planning.

**317:30-5-742. Description of services**

~~(a) Treatment services must be provided in the least restrictive, non-institutional therapeutic milieu. The foster care setting is restorative in nature, allowing children with emotional and psychological problems to develop the necessary control to function in a less restrictive setting.~~

~~(b) Behavioral health services must include an individual plan of care for each member served. The individual plan of care requirements are set out in OAC 317:30-5-742.2(b)(1). Treatment services in a therapeutic foster care setting may include an array of services listed in (1) - (6) of this subsection as provided in the individual plan of care. Services include, but may not be limited to:~~

~~(1) Individual, family and group therapy;~~
~~(2) Substance abuse/chemical dependency education, prevention, and therapy;~~
~~(3) Psychosocial rehabilitation and support services;~~
~~(4) Behavior management~~
~~(5) Crisis intervention; and~~
~~(6) Case Management.~~

(a) Treatment services must be provided in the least restrictive, non-institutional therapeutic environment. The TFC setting is restorative in nature, allowing children and adolescents with moderate behavioral and emotional health needs who may also have a secondary physical, developmental, intellectual, and/or social disorder that is supported alongside the mental health needs to develop the necessary control to function in a less restrictive setting.

(b) Behavioral health services must include an individual plan of care (IPC) for each member served. The IPC requirements are set out in Oklahoma Administrative Code (OAC) 317:30-5-742.2.

(c) Treatment services in a TFC setting must receive at least one (1) hour of individual, family, and/or group therapy per week, as set forth in OAC 317:30-5-742.2(3). Treatment may also include, but is not limited to, an array of the following services:

(1) Individual, family and group therapy;
(2) Substance abuse/chemical dependency education, prevention, and therapy;
(3) Psychosocial rehabilitation and support services;
(4) Behavior management;
(5) Crisis intervention; and
(6) Case management.

**317:30-5-742.1. Reimbursement**

~~Services provided to a member without a written individual plan of care as described in OAC 317:30-5-742.2(b)(1) will not be reimbursed.~~

(a) TFC services will be paid at the current fee-for-service (FFS) rate. Services provided to a member without a written individual plan of care (IPC) as described in Oklahoma Administrative Code (OAC) 317:30-5-742.2 will not be reimbursed.

(b) Reimbursement for TFC services is not available for the following:

(1) Room and board;
(2) Educational costs;
(3) Supported employment;
(4) Inpatient psychiatric services; and
(5) Respite care.

(c) Case management services are reimbursed to government providers as per the methodology in the approved Oklahoma Medicaid State Plan.

**317:30-5-742.2. Individual plan of care (IPC) ~~and prior authorization of services~~**

~~(a) All behavioral health services must be prior authorized by the designated agent of the Oklahoma Health Care Authority (OHCA) before the service is rendered by an eligible service provider. Without prior authorization, payment is not authorized. Requests for behavioral health services in a foster care setting may be approved for a maximum of three (3) months per extension request.~~

~~(b) All behavioral health services in a foster care setting are provided as a result of an individual assessment of the members needs and documented in the individual plan of care.~~

~~(1)~~**~~Assessment.~~**

~~(A)~~ **~~Definition.~~** ~~Gathering and assessment of historical and current bio-psycho-social information which includes face-to-face contact with the person and/or the person's family or other persons resulting in a written summary report, diagnosis and recommendations. All agencies must assess the medical necessity of each individual to determine the appropriate level of care.~~

~~(B)~~ **~~Qualified professional.~~** ~~This service is performed by an LBHP or Licensure Candidate.~~

~~(C)~~ **~~Limitations.~~** ~~Assessments are compensable on behalf of a member who is seeking services for the first time from the therapeutic foster care 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 child and parent or guardian. The child's level of participation is based on age, developmental and clinical appropriateness. The assessment must include all related diagnoses from the most recent DSM edition. The assessment must contain but is not limited to the following:~~

~~(i) Date, to include month, day and year of the assessment session(s);~~

~~(ii) Source of information;~~

~~(iii) Member's first name, middle initial and last name;~~

~~(iv) Gender;~~

~~(v) Birth date;~~

~~(vi) Home address;~~

~~(vii) Telephone number;~~

~~(viii) Referral source;~~

~~(ix) Reason for referral;~~
~~(x) Person to be notified in case of emergency;~~
~~(xi) Presenting reason for seeking services;~~
~~(xii) Start and stop time for each unit billed;~~
~~(xiii) Dated signature of parent or guardian participating in the face-to-face assessment. Signatures are required for members over the age of fourteen (14);~~
~~(xiv) Bio-Psychosocial information which must include:~~
~~(I) Identification of the member's strengths, needs, abilities and preferences;~~
~~(II) History of the presenting problem;~~
~~(III) Previous psychiatric treatment history, include treatment for psychiatric; substance use; drug and alcohol addiction; and other addictions;~~
~~(IV) Health history and current biomedical conditions and complications;~~
~~(V) Alcohol, drug, and/or other addictions history;~~
~~(VI) Trauma, abuse, neglect, violence, and/or sexual assault history of self and/or others, including Department of Human Services (DHS) involvement;~~
~~(VII) Family and social history including psychiatric, substance use, drug and alcohol addiction, other addictions, and trauma/abuse/neglect;~~
~~(VIII) Educational attainment, difficulties and history;~~
~~(IX) Cultural and religious orientation;~~
~~(X) Vocational, occupational and military history;~~
~~(XI) Sexual history, including HIV, AIDS, and STD at-risk behaviors;~~
~~(XII) Marital or significant other relationship history;~~
~~(XIII) Recreation and leisure history;~~
~~(XIV) Legal or criminal record, including the identification of key contacts, (e.g. attorneys, probation officers);~~
~~(XV) Present living arrangements;~~
~~(XVI) Economic resources; and~~
~~(XVII) Current support system, including peer and other recovery supports.~~
~~(xv) Mental status and Level of Functioning information, including questions regarding but not limited to the following:~~
~~(I) Physical presentation, such as general appearance, motor activity, attention and alertness;~~
~~(II) Affective process, such as mood, affect, manner and attitude;~~
~~(III) Cognitive process, such as intellectual ability, social-adaptive behavior, thought processes, thought~~

content, and memory; and

(IV) All related diagnoses from the most recent addition of the DSM.

(xvi) Pharmaceutical information to include the following for both current and past medications;

(I) Name of medication;

(II) Strength and dosage of medication;

(III) Length of time on the medication; and

(IV) Benefit(s) and side effects of medication.

(xvii) LBHP's interpretation of findings and diagnosis;

(xviii) Dated signature and credentials of the qualified practitioner who performed the face-to-face behavioral assessment. If performed by a licensure candidate, it must be countersigned by the licensed behavioral health professional who is responsible for the member's care.

(2) **Individual plan of care requirement.**

(A) **Signature Requirement.** A written individual plan of care following a comprehensive evaluation for each member must be formulated by the provider agency staff within thirty (30) days of admission with documented input from the member, legal guardian(OKDHS/Office of Juvenile Affairs (OJA) staff), the foster parent (when applicable) and the treatment provider(s). An individual plan of care is not valid until all dated signatures are present, including signatures from the member (if fourteen (14) or over), the legal guardian, the foster parent (when applicable) and the treatment provider(s). If necessary, an individual plan of care may be faxed to a required signatory to have them review, sign and fax it back to the provider before its implementation; however, the provider must obtain the original signature for the clinical file within thirty (30) days. No stamped or photocopied signatures are allowed. This plan must be revised and updated every three (3) months with documented involvement of the legal guardian and resident.

(B) **Individualization.** The individual plan of care must be individualized and take into account the member's age, history, diagnosis, assessed functional levels, culture, and the effect of past and current traumatic experiences in the life of the member. It includes the member's documented diagnosis, appropriate goals, and corresponding reasonable and attainable objectives and action steps within the expected time lines. Each member's individual plan of care is to also address the provider agency's plans with regard to the provision of services. Each plan of care must clearly identify the type of services required to meet the child's treatment needs and frequency over a given period of time.

(C) **Qualified professional.** This service is performed by an LBHP or Licensure Candidate.

(D) **Time requirements.** Individual plan of care updates must be conducted face-to-face and are required every three (3) months during active treatment. However, updates can be conducted whenever it is clinically needed as determined by the qualified practitioner and member.

(E) **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; and

(ix) description of the member's involvement in, and responses to, the treatment plan, and his/her signature and date.

(F) **Amendments.** Amendment of an existing individual plan of care to revise or add goals, objectives, service provider, service type, and service frequency, must be documented in either a scheduled three (3) month plan update or within the existing individual plan of care through an addendum until the review/update is due. Any changes must, prior to implementation, be signed and dated by the member (if fourteen (14) or over), the legal guardian, the foster parent (if applicable), as well as the primary LBHP and any new provider(s). Individual plan of care updates must address the following:

(i) update to the bio-psychosocial assessment, re-evaluation of diagnosis, individual plan of care goals and/ or objectives;

(ii) progress, or lack of, on previous individual plan of care goals and/or objectives;

(iii) a statement documenting a review of the current individual plan of care and an explanation if no changes are to be made to the individual plan of care and a statement addressing the status of identified problem behaviors that lead to placement must be included;

(iv) change in goals and/or objectives (including target dates) based upon member's progress or identification of new need, challenges and problems;

(v) change in frequency and/or type of services provided;

(vi) change in practitioner(s) who will be responsible for providing services on the plan;
(vii) change in discharge criteria;
(viii) description of the member's involvement in, and responses to, the treatment plan, and his/her signature and date.

(3) **Description of Services.** Agency services include:

(A) **Individual, family and group therapy.** See OAC 317:30-5-241.2(a), (b), and (c).

(B) **Crisis/behavior management and redirection.** The provider agency must provide crisis/behavior redirection by agency staff as needed twenty-four (24) hours per day, seven (7) days per week. The agency must ensure staff availability to respond to the residential foster parents in a crisis to stabilize members' behavior and prevent placement disruption. This service is to be provided to the member by an LBHP.

(C) **Discharge planning.** The provider agency must develop a discharge plan for each member. The discharge plan must be individualized, child-specific and include an after care plan that is appropriate to the member's needs, identifies the member's needs, includes specific recommendations for follow-up care and outlines plans that are in place at the time of discharge. The plan for children in parental custody must include, when appropriate, reunification plans with the parent(s)/legal guardian. The plan for children who remain in the custody of the OKDHS or the OJA must be developed in collaboration with the case worker and in place at the time of discharge. The discharge plan is to include at a minimum, recommendations for continued treatment services, educational services, and other appropriate community resources. Discharge planning provides a transition from foster care placement into a lesser restrictive setting within the community.

(D) **Substance use/chemical dependency use therapy.** Substance use/chemical dependency therapy can be provided if a member is identified by diagnosis or documented social history as having emotional or behavioral problems directly related to substance use and/or chemical dependency. The modalities employed are provided in order to begin, maintain and enhance recovery from alcoholism, problem drinking, addiction or nicotine use and addiction. This service is to be provided to the member by an LBHP or Licensure Candidate.

(E) **Substance Use Rehabilitation Services.** Covered substance use rehabilitation services are provided in non-residential settings in regularly scheduled sessions intended for individuals not requiring a more intensive level of care or those who require continuing services

following more intensive treatment regimes. The purpose of substance use rehabilitation services is to begin, maintain, and/or enhance recovery from alcoholism, problem drinking, drug use, drug dependency addiction or nicotine use and addiction. Rehabilitation services may be provided individually or in group sessions, and they take the format of an agency approved curriculum based education and skills training. This service is to be provided to the member by a CM II.

(F) **Psychosocial rehabilitation (PSR).**

(i) **Definition.** PSR services are face-to-face Behavioral Health Rehabilitation services which are necessary to improve the member's ability to function in the community. They are performed to improve the skills and abilities of members to live interdependently in the community, improve self-care and social skills, and promote lifestyle change and recovery practices. Rehabilitation services may be provided individually or in group sessions, and they take the format of an agency approved curriculum based education and skills training.

(ii) **Clinical Restrictions.** This service is generally performed with only the members and the qualified provider, but may include a member and the member's family/support system group that focuses on the member's diagnosis, symptom management, and recovery based curriculum. A member who at the time of service is not able to cognitively benefit from the treatment due to active hallucinations, substance use, or other impairments is not suitable for this service. Family involvement is allowed for support of the member and education regarding his/her recovery, but does not constitute family therapy, which requires a licensed provider.

(iii) **Qualified Practitioners.** CM II, LBHP or a Licensure Candidate and LBHP may perform PSR, following development of an individual plan of care curriculum approved by an LBHP or Licensure Candidate. PSR staff must be appropriately and currently trained in a recognized behavioral/management intervention program such as MANDT or Controlling Aggressive Patient Environment (CAPE) or trauma informed methodology. The CM II must have immediate access to an LBHP who can provide clinical oversight of the CM II and collaborate with the CM II in the provision of services. A minimum of one (1) monthly face-to-face consultation with an LBHP is required.

(iv) **Group Sizes.** The maximum staffing ratio is eight (8) to one (1) for children under the age of eighteen (18).

(v) **Limitations.**

(I) In order to develop and improve the member's community and interpersonal functioning and self-care abilities, PSR services may take place in settings away from the behavioral health agency site as long as the setting protects and assures confidentiality. When this occurs, the qualified provider must be present and interacting, teaching, or supporting the defined learning objectives of the member for the entire claimed time.

(II) PSR services are intended for children with Serious Emotional Disturbance (SED), and children with other emotional or behavioral disorders. Children under age six (6), 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, are not eligible for PSR services.

(III) PSR services are time-limited services designed to be provided over the briefest and most effective period possible and as adjunct (enhancing) interventions to complement more intensive behavioral health therapies. Service limits are based on the member's needs according to the Client Assessment Record (CAR) or other approved tool, the requested placement based on the level of functioning rating, medical necessity, and best practice. Service limitations are designed to help prevent rehabilitation diminishing return by remaining within reasonable age and developmentally appropriate daily limits.

(vi) **Progress Notes.** In accordance with OAC 317:30-5-241.1, the behavioral health individual plan of care developed by the LBHP must include the member's strengths, functional assets, weaknesses or liabilities, treatment goals, objectives and methodologies that are specific and time-limited, and defines the services to be performed by the practitioners and others who comprise the treatment team. When PSR services are prescribed, the plan must address objectives that are specific, attainable, realistic, measurable, and time-limited. The plan must include the appropriate treatment coordination to achieve the maximum reduction of the mental and/or behavioral health disability and to restore the member to their best possible functional level.

(I) Start and stop times for each day attended and the physical location in which the service was rendered;

(II) Specific goal(s) and objectives addressed during the session/group;

~~(III) Type of Skills Training provided each day and/or during the week including the specific curriculum used with member;~~

~~(IV) Member satisfaction with staff intervention(s);~~

~~(V) Progress, or barriers made towards goals, objectives;~~

~~(VI) New goal(s) or objective(s) identified;~~

~~(VII) Dated signature of the qualified provider; and~~

~~(VIII) Credentials of the qualified provider;~~

~~(vii) **Additional documentation requirements.** Documentation of ongoing consultation and/or collaboration with an LBHP or Licensure Candidate related to the provision of PSR services.~~

~~(viii) **Non-Covered Services.** The following services are not considered PSR and are not reimbursable:~~

~~(I) room and board;~~

~~(II) educational costs;~~

~~(III) supported employment; and~~

~~(IV) respite.~~

~~(C) **Social skills redevelopment.** Goal directed activities for each member to restore, retain and improve the self-help, communication, socialization, and adaptive skills necessary to reside successfully in home and community based settings. These will be daily activities that are age appropriate, culturally sensitive and relevant to the goals of the individual plan of care. These may include self-esteem enhancement, violence alternatives, communication skills or other related skill development. This service is to be provided to the member by the Treatment Parent Specialist (TPS). Services rendered by the TPS are limited to one and one half (1.5) hours daily.~~

All behavioral health services in a TFC setting are provided as a result of an individual assessment of the member's needs and documented in the IPC.

(1)**Assessment.**

(A) **Definition.** Gathering and assessment of historical and current bio-psycho-social information which includes face-to-face contact with the member and the member's foster parent(s) or legal guardian or other person, including biological parent(s) when applicable, who have pertinent information about the member resulting in a written summary report, diagnosis, and recommendations. All TFC agencies must assess each individual to determine whether he or she could be an appropriate candidate for TFC services.

(B) **Qualified professional.** This service is performed by a licensed behavioral health professional (LBHP) or licensure candidate.

(C) **Limitations.** Assessments are compensable on behalf of

a member who is seeking services for the first time from the TFC 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 members under the age of eighteen (18), it is performed with the direct, active, face-to-face participation of the member and foster parent(s) or legal guardian or other persons, including biological parent(s) when applicable. The member's level of participation is based on age, developmental, and clinical appropriateness. The assessment must include all related diagnoses from the DSM-V. The assessment must contain, but is not limited to, the following:

(i) Date, to include month, day, and year of the assessment session(s);

(ii) Source of information;

(iii) Member's first name, middle initial, and last name;

(iv) Gender;

(v) Birth date;

(vi) Home address;

(vii) Telephone number;

(viii) Referral source;

(ix) Reason for referral;

(x) Person to be notified in case of emergency;

(xi) Presenting reason for seeking services;

(xii) Start and stop time for each unit billed;

(xiii) Dated signature of foster parent(s) or legal guardian [Oklahoma Department of Human Services (DHS) or Oklahoma Office of Juvenile Affairs (OJA)] or other persons, including biological parents(s) (when applicable) participating in the face-to-face assessment. Signatures are required for members fourteen (14) years of age and over;

(xiv) Bio-psychosocial information which must include:

(I) Identification of the member's strengths, needs, abilities, and preferences;

(II) History of the presenting problem;

(III) Previous psychiatric treatment history, including treatment of psychiatric issues, substance use, drug and alcohol addiction, and other addictions;

(IV) Health history and current biomedical conditions and complications;

(V) Alcohol, drug, and/or other addictions history;

(VI) Trauma, abuse, neglect, violence, and/or sexual assault history of self and/or others, including DHS

involvement;
(VII) Family and social history, including psychiatric, substance use, drug and alcohol addiction, other addictions, and trauma/abuse/neglect;
(VIII) Educational attainment, difficulties, and history;
(IX) Cultural and religious orientation;
(X) Vocational, occupational, and military history;
(XI) Sexual history, including human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), other sexually transmitted diseases (STDs), and at-risk behaviors;
(XII) Marital or significant other relationship history;
(XIII) Recreation and leisure history;
(XIV) Legal or criminal record, including the identification of key contacts (e.g. attorneys, probation officers);
(XV) Present living arrangements;
(XVI) Economic resources; and
(XVII) Current support system, including peer and other recovery supports.

(xv) Mental status and level of functioning information, including, but not limited to, questions regarding the following:
(I) Physical presentation, such as general appearance, motor activity, attention, and alertness;
(II) Affective process, such as mood, affect, manner, and attitude;
(III) Cognitive process, such as intellectual ability, social-adaptive behavior, thought processes, thought content, and memory; and
(IV) All related diagnoses from the DSM-V.

(xvi) Pharmaceutical information for both current and past medications, to include the following:
(I) Name of medication;
(II) Strength and dosage of medication;
(III) Length of time on the medication; and
(IV) Benefit(s) and side effects of medication.

(xvii) LBHP's interpretation of findings and diagnosis; and

(xviii) Dated signature and credentials of the qualified practitioner who performed the face-to-face behavioral assessment. If performed by a licensure candidate, it must be countersigned by the LBHP who is responsible for the member's care.

(2) **IPC requirements.**

(A) **Signature requirement.** A written IPC following a comprehensive evaluation for each member must be formulated by the TFC agency staff within thirty (30) days of admission to the program with documented input from the member, the legal guardian (DHS/ OJA), the foster parent(s), the treatment provider(s), and the biological parent(s) when applicable. An IPC is not valid until all dated signatures are present, including signatures from the member [if fourteen (14) years of age and over], the legal guardian, the foster parent, and the treatment provider (s). This plan must be revised and updated every three (3) months with documented involvement of the legal guardian and member.

(B) **Individualization.** The IPC must be individualized and take into account the member's age, history, diagnosis, assessed functional levels, culture, and the effect of past and current traumatic experiences in the life of the member. It includes the member's documented diagnosis, appropriate goals, and corresponding reasonable and attainable treatment objectives, and action steps within the expected timelines. Each member's IPC needs to address the TFC agency's plans with regard to the provision of services. Each plan of care must clearly identify the type of services required to meet the member's treatment needs and frequency over a given period of time.

(C) **Qualified professional.** This service is performed by an LBHP or licensure candidate.

(D) **Time requirements.** IPC updates must be conducted face-to-face and are required at least every ninety (90) days during active treatment. However, updates can be conducted whenever it is clinically needed, as determined by the qualified practitioner and member.

(E) **Documentation requirements.** Comprehensive and integrated service plan content must identify:

(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 name and credentials of all the practitioners who will be providing and responsible for each service;

(vii) Any needed referrals for service;

(viii) Specific discharge criteria; and

(ix) Member's involvement in, and responses to, the treatment plan, and his/her signature and date [if

fourteen (14) years of age and over].

(F) **Amendments.** Amendment of an existing IPC to revise or add goals, objectives, service provider(s), service type, and service frequency, must be documented in either a scheduled three (3) month plan update or within the existing IPC through an addendum until the review/update is due. Any changes must, prior to implementation, be signed and dated by the member [if fourteen (14) years of age and over], the legal guardian, the foster parent, as well as the primary LBHP and any new provider(s). IPC updates must address the following:

(i) Update to the bio-psychosocial assessment, re-evaluation of diagnosis, and IPC goals and/ or objectives;

(ii) Progress, or lack of, on previous IPC goals and/or objectives;

(iii) A statement documenting a review of the current IPC, and, if no changes are needed, an explanation and a statement addressing the status of the identified problem behavior that led to TFC placement must be included;

(iv) Change in goals and/or objectives (including target dates) based upon member's progress or identification of new needs, 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; and

(viii) Description of the member's involvement in, and responses to, the treatment plan, and his/her signature and date [if fourteen (14) years of age and over].

(3) **Description of services.** Agency services include:

(A) **Individual, family, and/or group therapy.** See Oklahoma Administrative Code (OAC) 317:30-5-241.2(a), (b), and (c). A member must receive one (1) hour of individual, family, and/or group therapy each week that is provided by an LBHP or licensure candidate, and may receive up to two (2) hours each week, if medically needed.

(B) **Crisis intervention.** The provider agency must provide crisis intervention by agency staff as needed twenty-four (24) hours per day, seven (7) days per week. The agency must ensure staff availability to respond to the residential foster parent(s) in a crisis to stabilize a member's behavior and prevent placement disruption. This service is to be provided to the member by an LBHP or a licensure candidate. The licensure candidate must have immediate access to an LBHP who can provide oversight of the licensure candidate and conduct an emergency detention evaluation.

(C) **Discharge planning.** The TFC agency must develop a

discharge plan for each member. The discharge plan must be individualized, member-specific, and include an after care plan that is appropriate to the member's needs, identifies the member's needs, includes specific recommendations for follow-up care, and outlines plans that are in place at the time of discharge. The plan for members in parental custody must include, when appropriate, reunification plans with the parent(s)/legal guardian. The plan for members who remain in the custody of DHS or OJA must be developed in collaboration with the case worker and finalized at the time of discharge. The discharge plan is to include, at a minimum, recommendations for continued treatment services, educational services, and other appropriate community resources. Appointments for outpatient therapy and medication management (when applicable) should be scheduled prior to discharge. Discharge planning provides a transition from TFC placement into a less restrictive setting within the community. Discharge planning is performed in partnership between Child Welfare Services (CWS) of the DHS and an LBHP within the TFC agency.

(D) **Substance use/chemical dependency use therapy.** Substance use/chemical dependency therapy can be provided if a member is identified by diagnosis or documented social history as having emotional or behavioral problems directly related to substance use and/or chemical dependency. The modalities employed are provided in order to begin, maintain, and enhance recovery from problem drinking, alcoholism, nicotine use and addiction, and/or drug use, drug dependency, and/or drug addiction. This service is to be provided to the member by an LBHP or licensure candidate.

(E) **Substance use rehabilitation services.** Covered substance use rehabilitation services are provided in non-residential settings in regularly scheduled sessions intended for individuals not requiring a more intensive level of care or those who require continuing services following more intensive treatment regimes. The purpose of substance use rehabilitation services is to begin, maintain, and/or enhance recovery from problem drinking, alcoholism, nicotine use and addiction, and/or drug use, drug dependency, and/or drug addiction. Rehabilitation services may be provided individually or in group sessions, and they take the format of an agency-approved, curriculum-based education and skills training. This service is to be provided to the member by a certified behavioral health case manager (CM) II, certified alcohol drug counselor (CADC) or LBHP.

(F) **Psychosocial rehabilitation (PSR).**

(i) **Definition.** PSR services are face-to-face behavioral health rehabilitation services which are necessary to

improve the member's ability to function in the community. They are performed to improve the skills and abilities of members to live independently in the community, improve self-care and social skills, and promote lifestyle change and recovery practices. Rehabilitation services may be provided individually or in group sessions, and they take the format of an agency-approved, curriculum-based education, and skills training.

(ii) **Clinical restrictions.** This service is generally performed with only the member and the qualified provider, but may also include a member and the member's family/support system group that focuses on the member's diagnosis, symptom management, and recovery based curriculum. A member who, at the time of service, is not able to cognitively benefit from the treatment due to active hallucinations and/or substance use, or other impairments is not suitable for this service. Family involvement is allowed for support of the member and education regarding his/her recovery, but does not constitute family therapy, which requires an LBHP or licensure candidate.

(iii) **Qualified practitioners.** A CM II, an LBHP, or a licensure candidate may perform PSR, following development of an IPC curriculum approved by an LBHP or licensure candidate. The CM II must have immediate access to an LBHP who can provide clinical oversight of the CM II and collaborate with the CM II in the provision of services. A minimum of one (1) monthly face-to-face consultation with an LBHP is required.

(iv) **Group sizes.** The maximum staffing ratio is eight (8) members to one (1) practitioner for members under the age of twenty-one (21).

(v) **Limitations.**

(I) In order to develop and improve the member's community and interpersonal functioning and self-care abilities, PSR services may take place in settings away from the behavioral health agency site as long as the setting protects and assures confidentiality. When this occurs, the qualified provider must be present and interacting, teaching, or supporting the defined learning objectives of the member for the entire claimed time.

(II) PSR services are intended for children/adolescents with Serious Emotional Disturbance (SED), and children/adolescents with moderate behavioral and emotional health needs who may also have a secondary physical, developmental,

intellectual, and/or social disorder that is supported alongside the mental health needs. Members, ages four (4) and five (5), are not eligible for PSR services unless a prior authorization has been granted by OHCA or its designated agent based on a finding of medical necessity.

(III) PSR services are time-limited services designed to be provided over the briefest and most effective period possible and as adjunct (enhancing) interventions to complement more intensive behavioral health therapies. Service limits are based on the member's needs according to the Client Assessment Record (CAR) or other approved tools. Service limitations are designed to maximize efficacy by remaining within reasonable age and developmentally appropriate daily limits.

(vi) **Progress notes.** In accordance with OAC 317:30-5-241.1, the behavioral health IPC developed by the LBHP or licensure candidate must include the member's strengths, functional assets, weaknesses or liabilities, treatment goals, objectives, and methodologies that are specific and time-limited, and defines the services to be performed by the practitioners and others who comprise the treatment team. When PSR services are prescribed, the plan must address objectives that are specific, attainable, realistic, measurable, and time-limited. The plan must include the appropriate treatment coordination to achieve the maximum reduction of the moderate behavioral and emotional health conditions, and any other secondary physical, developmental, intellectual, and/or social disorder and to restore the member to his or her best possible functional level. Progress notes for PSR services must include:

(I) Start and stop times for each day attended and the physical location in which the service was rendered;

(II) Specific goal(s) and objectives addressed during the session/group;

(III) Type of skills training provided each day and/or during the week including the specific curriculum used with the member;

(IV) Member satisfaction with staff intervention(s);

(V) Progress, towards attaining, or barriers affecting the attainment of, goals and objectives;

(VI) New goal(s) or objective(s) identified;

(VII) Dated signature of the qualified provider; and

(VIII) Credentials of the qualified provider.

(vii) **Additional documentation requirements.** Documentation of ongoing consultation and/or

collaboration with an LBHP or licensure candidate related to the provision of PSR services.

(G) **Therapeutic behavioral services (TBS).** Goal directed social skills redevelopment activities for each member to restore, retain, and improve the self-help, communication, socialization, and adaptive skills necessary to reside successfully in home and community based settings. These will be daily activities that are age appropriate, culturally sensitive, and relevant to the goals of the IPC. These may include self-esteem enhancement, violence alternatives, communication skills, or other related skill development. This service is to be provided to the member by the treatment parent specialist (TPS). Services rendered by the TPS are limited to one and one half (1.5) hours daily.

**317:30-5-743.1. Service ~~Quality Review~~quality review (SQR)**

There will be an ~~on-site Service Quality Review (SQR)~~SQR performed by the ~~OHCA~~Oklahoma Health Care Authority (OHCA) or its designated agent of each ~~Therapeutic Foster Care (TFC)~~TFC agency that provides care to members. The OHCA will designate the members of the SQR ~~Team~~team. This team will consist of at least two (2) team members and will be comprised of ~~Licensed Behavioral Health Professionals and/or Registered Nurses~~licensed behavioral health professionals (LBHPs) and/or registered nurses (RNs). The SQR will consist of a survey of current members receiving services, as well as members for which claims have been filed with OHCA for TFC services. Observation and contact with members may be incorporated. The review includes validation of certain factors, all of which must be met for the services to be compensable. Following the ~~on-site inspection~~review, the SQR ~~Team~~team will report its findings to the TFC agency. The TFC agency will be provided with written notification if the findings of the SQR have resulted in any deficiencies. A copy of the final report will be sent to the TFC agency's accrediting body. Deficiencies found during the SQR may result in a recoupment of the compensation received for that service. The individual plan of care (IPC) is considered to be critical to the integrity of care and treatment and must be completed within the ~~time lines~~timelines designated at ~~OAC~~Oklahoma Administrative Code (OAC) 317:30-5-742.2. If the ~~individual plan of care~~IPC is missing, or it is found that the ~~child~~member did not meet medical necessity criteria at any time, all paid services will be recouped for each day the ~~individual plan of care~~IPC was missing from the date the plan of care was due for completion or the date from which medical necessity criteria was no longer met.

**317:30-5-744. Billing**

(a) Claims must be submitted in accordance with guidelines found

at ~~OAC~~Oklahoma Administrative Code (OAC) 317:30-3-11~~ and~~, 317:30-3-11.1, and 317:30-3-20.
(b) Claims for dually eligible individuals (Medicare/Medicaid) should be filed directly with the ~~OHCA~~Oklahoma Health Care Authority (OHCA).

**317:30-5-745. Documentation of records**

~~All services must be reflected by documentation in the records including the date the service was provided, the beginning and ending time the service was provided, the location in which the service was provided, a description of the resident's response to the service and whether the service provided was an individual, group or family session, group rehabilitative treatment, social skills (re)development, basic living skills (re)development, crisis behavior management and redirection, or discharge planning, and the dated signature with credentials of the person providing the service.~~

Providers must maintain an appropriate records system. Current individual plans of care, case files, and progress notes are maintained in the provider's files during the time the member is receiving services. All services must be reflected by documentation in the records. Documentation of services must include all of the following:

(1) The date the service was provided;
(2) The beginning and ending time the service was provided;
(3) A description of the member's response to the service;
(4) The type of service provided (individual, group, or family session; group rehabilitative treatment; social skills (re)development; basic living skills (re)development; crisis behavior management and redirection; or discharge planning); and
(5) The dated signature with credentials of the person providing the service.

**317:30-5-746. ~~Appeal of Prior Authorization Decision~~Prior authorization and appeal of prior authorization decision**

~~If a denial decision is made, an appeal may be initiated by the member or the member's legal guardian. The denial can be appealed to the Oklahoma Health Care Authority within 20 calendar days of the receipt of the notification of the denial by the OHCA or its designated agent.~~

(a) All behavioral health services must be prior authorized by the Oklahoma Health Care Authority (OHCA) or its designated agent before the service is rendered by an eligible provider. Without prior authorization, payment is not authorized.
(b) If a denial decision is made, an appeal may be initiated by the member or the member's legal guardian. The denial can be appealed to the OHCA within thirty (30) calendar days of the

receipt of the notification of the denial by the OHCA or its designated agent.

## PART 84. INTENSIVE TREATMENT FAMILY CARE

### 317:30-5-750. Definitions.

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

(1) **"Intensive treatment family care (ITFC) agency"** means an agency that provides foster care as defined in Public Welfare, 45 Code of Federal Regulation (CFR), Sec. 1355.20 as twenty-four (24) hour substitute care for children and adolescents placed away from their parents or guardians and for whom the title IV-E agency has placement and care responsibility. ITFC settings are foster family homes.

(2) **"Intensive treatment family care (ITFC) home"** means an agency-supervised, private family home in which foster parents [at least one (1) parent must be a stay-at home parent] have been trained to provide individualized, structured services in a safe, nurturing family-living environment. These services are provided to children and adolescents with severe behavioral and emotional health needs. They may also present a secondary physical, developmental, intellectual, and/or social disorder that is supported alongside the mental health needs of the member. These members require a higher level of care that cannot be provided in the traditional foster care or TFC home. ITFC homes provide the higher level of care needed for these children and adolescents, and help prevent placement in a more restrictive setting, including an inpatient setting.

(3) **"Intensive treatment family care (ITFC) model"** means a model in which children and adolescents in the ITFC environment receive intensive individualized behavioral health and other support services from qualified staff. Because ITFC members require exceptional levels of skill, time, and supervision, the number of unrelated children and adolescents placed per home is limited; no more than one (1) ITFC member may be placed in a home at any one (1) time unless additional cases are specifically authorized by Child Welfare Services (CWS) of the Oklahoma Department of Human Services (DHS), or Oklahoma Office of Juvenile Affairs (OJA).

### 317:30-5-750.1. Eligible providers and requirements

(a) **ITFC agency.** Eligible ITFC agencies must have:

(1) Current certification from the Oklahoma Department of Human services (DHS) as a child placing agency;

(2) A contract with the Child Welfare Division of DHS, or Oklahoma Office of Juvenile Affairs (OJA);

(3) A contract with the Oklahoma Health Care Authority (OHCA);

and

(4) A current accreditation status appropriate to provide behavioral health services in a foster care setting from:

(A) The Joint Commission; or

(B) The Commission on Accreditation of Rehabilitative Facilities (CARF); or

(C) The Council on Accreditation (COA).

(b) **Treatment team.** ITFC agencies are primarily responsible for treatment planning and coordination of the member's treatment team. This team is typically composed of a DHS or OJA caseworker, the member, the member's foster parent(s), as well as others closely involved with the member and family, including the biological parents when applicable. It also includes the following:

(1) **Certified behavioral health case manager (CM) II.** A bachelor's level team member who may provide support services and case management. In addition to the minimum requirements at Oklahoma Administrative Code (OAC) 317:30-5-240.3(h)(1), the CM II must:

(A) Have a minimum of one (1) year of experience in providing direct care and/or treatment to children/adolescents and/or families; and

(B) Have access to weekly consultation with a licensed behavioral health professional (LBHP).

(C) The CM II must also follow requirements at OAC 317:30-5-241.3 for providing psychosocial rehabilitation (PSR) services.

(2) **Certified alcohol and drug counselor (CADC).** A bachelor's level team member with a current certification as a CADC in the state in which services are provided.

(3) **Licensed behavioral health professional (LBHP).** A master's level professional who provides treatment and supervises other treatment staff in maintaining clinical standards of care and providing direct clinical services. In addition to the requirements at OAC 317:30-5-240.3(a), the LBHP in an ITFC setting must demonstrate a general professional or educational background in the following areas:

(A) Case management, assessment, and treatment planning;

(B) Treatment of victims of physical, emotional, and sexual abuse;

(C) Treatment of children/adolescents with attachment disorders;

(D) Treatment of children/adolescents with hyperactivity or attention deficit disorders;

(E) Treatment methodologies for emotionally disturbed children/adolescents;

(F) Normal childhood development and the effect of abuse and/or neglect on childhood development;

(G) Anger management;
(H) Crisis intervention; and
(I) Trauma-informed methodology.
(4) **Licensed psychiatrist and/or psychologist.** ITFC agencies must provide staff with access to professional psychiatric or psychological consultation as deemed necessary for the planning, implementation, and appropriate management of the member's treatment. See OAC 317:30-5-240.3(a) and 317:25-7-5.
(5) **Treatment parent specialist (TPS).** The TPS serves as an integral member of the team of professionals providing services for the children and adolescents. The TPS receives extensive training in diagnosed mental health issues, and behavior management/modification and skill-based parenting techniques; and implements the in-home portion of the treatment plan with close supervision and support. The TPS renders services for the member, provides or arranges suitable transportation for therapy and other treatment appointments, writes daily detailed notes regarding interventions and practical applications of learned skills, and attends treatment team meetings. The TPS must be under the supervision of an LBHP of the ITFC agency and meet the following criteria:
(A) **Qualifications.**
(i) Have a high school diploma or equivalent, and either some post-secondary education and/or a combination of at least two (2) years of personal/professional experience working with children/adolescents with significant needs;
(ii) Have an employment and/or contractual relationship with the ITFC agency as a foster parent, and have successfully met all required background screening requirements, including, but not limited to, fingerprint screenings conducted by the Oklahoma State Bureau of Investigation (OSBI) and Federal Bureau of Investigation (FBI), and DHS background screenings;
(iii) Completed all evidence-informed ITFC foster parent training, as outlined in this section;
(iv) Complete a minimum of twenty (20) hours of required annual continuing education trainings. Six (6) hours of the twenty (20) training hours must be clinical in nature;
(v) Agree to have at least one (1) parent in the ITFC home serve as a full-time, stay-at-home parent in order to sufficiently meet the significant needs of the member placed in the ITFC home; and
(B) **Responsibilities.**
(i) Have a minimum of twice monthly face-to-face supervision with the LBHP, independent of the member's family therapy;
(ii) Have weekly contact with the ITFC agency professional staff;

(iii) Utilize individualized curriculum-based education and support materials with the member to support the member's skill development outside of the clinical setting;

(iv) Agree, by contract with the ITFC agency, to serve the member in his or her ITFC home through completion of the treatment designated on his or her individual plan of care, and without disruption to the service array; and

(v) Work with the multidisciplinary team and the member's biological family toward reunification, if appropriate, or other permanency plan.

(c) **Agency assurances.** The ITFC agency must ensure that each individual who renders treatment services meets the minimum provider qualifications for the service and is fully contracted with the OHCA. Additionally, the ITFC agency must comply with all state and federal Medicaid law, including, but not limited to, OHCA administrative rules, the Code of Federal Regulations (CFR), and the Oklahoma State Medicaid Plan.

(d) **Policies and procedures.** Eligible ITFC agencies shall have written policies and procedures for the orientation of new staff and foster parents which is reviewed and updated annually, for the following:

(1) Pre-service training of foster parents in treatment methodologies and service needs of emotionally and behaviorally disturbed children/adolescents;

(2) Treatment of victims of physical, emotional, and sexual abuse;

(3) Treatment of children/adolescents with attachment disorders;

(4) Treatment of children/adolescents with hyperactive or attention deficit disorders;

(5) Normal childhood development and the effect of abuse and/or neglect on childhood development;

(6) Treatment of children/adolescents and families with substance use disorders;

(7) The Inpatient Mental Health and Substance Abuse Treatment of Minors Act;

(8) Anger management;

(9) Inpatient authorization procedures;

(10) Crisis intervention;

(11) Grief and loss issues for children/adolescents in foster care;

(12) The significance/value of birth families to children/adolescents receiving behavioral health services in a foster care setting; and

(13) Trauma-informed methodology.

**317:30-5-750.2. Provider selection**

Parents who retain legal custody of an ITFC member may select any eligible ITFC agency as the provider of services. In the case of members in the custody of the State of Oklahoma, the State, acting in its custodial role, selects the ITFC agency.

**317:30-5-751. Coverage by category**

(a) **Adults.** Behavioral health services in ITFC settings are not covered for adults.

(b) **Children.** Behavioral health services are allowed in ITFC settings for children and adolescents as medically necessary. The children and adolescents receiving services in this setting have severe behavioral and emotional health needs and may also present a secondary physical, developmental, intellectual, and/or social disorder that is supported alongside the mental health needs. ITFC homes provide the higher level of care needed for these children or adolescents and help prevent placement in an inpatient or more restrictive setting. The designated children and adolescents must continually meet medical necessity criteria to be eligible for coverage in this setting. Requests for behavioral health services in an ITFC setting must be prior authorized and may be approved up to a maximum of three (3) month extensions.

(c) **Medical necessity criteria**. In order to satisfy medical necessity criteria, all of the following conditions must be met:

(1) The member must have a diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM-V), with the exception of V codes and adjustment disorders, with a detailed description of the symptoms supporting the diagnosis. Children and adolescents with a provisional diagnosis may receive ITFC services for a maximum of thirty (30) days.

(2) An assessment must be completed by a licensed behavioral health professional (LBHP) as defined in Oklahoma Administrative Code (OAC) 317:30-5-240.3(a) within the thirty (30) day provisional period described above, that confirms a diagnosis from the DSM-V with the exception of V codes and adjustments disorders, and that includes a detailed description of the symptoms supporting the diagnosis to continue treatment in an ITFC setting.

(3) Conditions are directly attributed to a primary medical diagnosis of a severe behavioral and emotional health need, and may also be attributed to a secondary medical diagnosis of a physical, developmental, intellectual and/or social disorder that is supported alongside the mental health needs.

(4) It has been determined by an LBHP that the current disabling symptoms could not have been or have not been manageable in a less intensive treatment program.

(5) Evidence that the members' needs prohibit full integration in a family/home setting without the availability of twenty-four (24) hour crisis response/behavior management and

intensive clinical interventions from professional staff, preventing the member from living in a traditional or therapeutic foster home.
(6) The member is medically stable and not actively suicidal or homicidal and not in need of substance abuse detoxification services.
(7) The legal guardian [Oklahoma Department of Human Services (DHS)/ Oklahoma Office of Juvenile Affairs (OJA) if custody member] or parent of the member agrees to actively participate in the member's treatment needs and planning.

**317:30-5-752. Description of services**

(a) Treatment services must be provided in the least restrictive, non-institutional therapeutic environment. The ITFC setting is restorative in nature, allowing children and adolescents with severe behavioral and emotional health needs, who may also present a secondary physical, developmental, intellectual, and/or social disorder that is supported alongside the mental health needs, to develop the necessary control to function in a less restrictive setting.
(b) Behavioral health services must include an individual plan of care (IPC) for each member served. The IPC requirements are set out in Oklahoma Administrative Code (OAC) 317:30-5-753.
(c) Treatment services in an ITFC must include at least two (2) hours of individual, family, and/or group therapy per week, as set forth in OAC 317:30-5-753(3). Treatment may also include, but is not limited to, an array of the following services:
(1) Substance abuse/chemical dependency education, prevention, and therapy;
(2) Psychosocial rehabilitation and support services;
(3) Behavior management;
(4) Crisis intervention; and
(5) Case management.

**317:30-5-753. Individual plan of care (IPC) requirements**

All behavioral health services in an ITFC setting are provided as a result of an individual assessment of the member's needs and documented in the IPC.
(1)**Assessment.**
(A) **Definition.** Gathering and assessment of historical and current bio-psychosocial information which includes face-to-face contact with the member and the member's foster parent(s) or legal guardian or other person, including biological parent(s) when applicable, who have pertinent information about the member resulting in a written summary report, diagnosis, and recommendations. All ITFC agencies must assess each individual to determine whether they could be an appropriate candidate for ITFC services.

(B) **Qualified professional.** This service is performed by a licensed behavioral health professional (LBHP).
(C) **Limitations.** Assessments are compensable on behalf of a member who is seeking services for the first time from the ITFC 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 Oklahoma Health Care Authority (OHCA). In the case of members under the age of eighteen (18), it is performed with the direct, active, face-to-face participation of the member and foster parent(s) or legal guardian or other persons, including biological parent(s) when applicable. The member's level of participation is based on age, developmental, and clinical appropriateness. The assessment must include all related diagnoses from the Diagnostic and Statistical Manual of Mental Disorders (DSM-V). The assessment must contain, but is not limited to, the following:

(i) Date, including month, day, and year of the assessment session(s);
(ii) Source of information;
(iii) Member's first name, middle initial, and last name;
(iv) Gender;
(v) Birth date;
(vi) Home address;
(vii) Telephone number;
(viii) Referral source;
(ix) Reason for referral;
(x) Person to be notified in case of emergency;
(xi) Presenting reason for seeking services;
(xii) Start and stop time for each unit billed;
(xiii) Dated signature of foster parent(s) or legal guardian [Oklahoma Department of Human Services (DHS) or Oklahoma Office of Juvenile Affairs (OJA)] or other persons, including biological parent(s) (when applicable) participating in the face-to-face assessment. Signatures are required for members fourteen (14) years of age and over;
(xiv) Bio-psychosocial information, which must include:

(I) Identification of the member's strengths, needs, abilities, and preferences;
(II) History of the presenting problem;
(III) Previous psychiatric treatment history, including treatment of psychiatric issues, substance use, drug and alcohol addiction, and other addictions;

(IV) Health history and current biomedical conditions and complications;
(V) Trauma, abuse, neglect, violence, and/or sexual assault history of self and/or others, including DHS involvement;
(VI) Family and social history, including psychiatric, substance use, drug and alcohol addiction, other addictions, and trauma/abuse/neglect;
(VII) Educational attainment, difficulties, and history;
(VIII) Cultural and religious orientation;
(IX) Vocational, occupational, and military history;
(X) Sexual history, including human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), other sexually transmitted diseases (STDs), and at-risk behaviors;
(XI) Marital or significant other relationship history;
(XII) Recreation and leisure history;
(XIII) Legal or criminal record, including the identification of key contacts (e.g. attorneys, probation officers);
(XIV) Present living arrangements;
(XV) Economic resources; and
(XVI) Current support system, including peer and other recovery supports.

(xv) Mental status and level of functioning information, including, but not limited to, questions regarding the following:
(I) Physical presentation, such as general appearance, motor activity, attention, and alertness;
(II) Affective process, such as mood, affect, manner, and attitude;
(III) Cognitive process, such as intellectual ability, social-adaptive behavior, thought processes, thought content, and memory; and
(IV) All related diagnoses from the DSM-V.

(xvi) Pharmaceutical information for both current and past medications, to include the following;
(I) Name of medication;
(II) Strength and dosage of medication;
(III) Length of time on the medication; and
(IV) Benefit(s) and side effects of medication.

(xvii) LBHP's interpretation of findings and diagnosis; and

(xviii) Dated signature and credentials of the LBHP who performed the face-to-face behavioral assessment.

(2) **IPC requirements.**

(A) **Signature requirement.** A written IPC following a comprehensive evaluation for each member must be formulated by the ITFC agency staff within thirty (30) days of admission to the program with documented input from the member, the legal guardian (DHS/OJA), the foster parent(s), the treatment provider(s), and the biological parent(s) when applicable. An IPC is not valid until all dated signatures are present, including signatures from the member [if fourteen (14) years of age and over], the legal guardian, the foster parent, and the treatment provider(s). This plan must be reviewed every thirty (30) days with documented involvement of the legal guardian and member. The review includes an evaluation of the member's progress in the treatment setting, as well as in other environments, such as home, school, social engagements, etc.

(B) **Individualization.** The IPC must be individualized and take into account the member's age, history, diagnosis, functional levels, culture, and the effect of past and current traumatic experiences in the life of the member. It includes the member's documented diagnosis, appropriate goals, corresponding reasonable and attainable treatment objectives, and action steps within the expected timelines. Each member's IPC needs to address the ITFC agency's plans with regard to the provision of services. Each plan of care must clearly identify the type of services required to meet the member's treatment needs and frequency over a given period of time.

(C) **Qualified professional.** This service is performed by an LBHP.

(D) **Time requirements.** IPC updates must be conducted face-to-face and are required at least every ninety (90) days during active treatment. However, updates can be conducted whenever it is clinically needed, as determined by an LBHP. Updates should reflect changes to treatment based on the members' progress or lack thereof.

(E) **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 name and credentials of all the practitioners who will be providing and responsible for each service;

(vii) Any needed referrals for service;
(viii) Specific discharge criteria; and
(ix) Description of the member's involvement in, and responses to, the treatment plan, and his/her signature and date [if fourteen (14) years of age and older].

(F) **Amendments.** Amendment of an existing IPC to revise or add goals, objectives, service provider(s), service type, and service frequency must be documented in the existing IPC through an addendum until the review/update is due. Any changes must, prior to implementation, be signed and dated by the member [if fourteen (14) years of age and over], the legal guardian, the foster parent, as well as the primary LBHP and any new provider(s). IPC updates must address the following:

(i) Update to the bio-psychosocial assessment, re-evaluation of diagnosis, and IPC goals and/ or objectives;
(ii) Progress, or lack of, on previous IPC goals and/or objectives;
(iii) A statement documenting a review of the current IPC, and, if no changes are needed, an explanation and a statement addressing the status of identified problem behaviors that led to ITFC placement must be included;
(iv) Change in goals and/or objectives (including target dates) based upon member's progress or identification of new needs, 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; and
(viii) Description of the member's involvement in, and responses to, the treatment plan, and his/her signature and date [if fourteen (14) years of age and older].

(3) **Description of services.** Agency services include:

(A) **Individual, family, and/or group therapy.** See OAC 317:30-5-241.2(a), (b), and (c). The number of units of individual, family, and/or group therapy within the ITFC setting differ from the number of units available in the outpatient setting. A member must receive two (2) hours of individual, family, and/or group therapy each week that is provided by an LBHP, and may receive up to three (3) hours each week, if medically needed.

(B) **Crisis intervention.** The provider agency must provide crisis intervention by ITFC agency staff as needed twenty-four (24) hours per day, seven (7) days per week. The agency must ensure staff is available to respond to the ITFC foster parent(s) in a crisis to stabilize a member's behavior and prevent placement disruption. This service is to be provided

to the member by an LBHP.

(C) **Discharge planning.** The ITFC agency must develop a discharge plan for each member. The discharge plan must be individualized, member-specific, and include an after-care plan that is appropriate to the member's needs, identifies the member's needs, includes specific recommendations for follow-up care, and outlines plans that are in place at the time of discharge. The plan for members in parental custody must include, when appropriate, reunification plans with the parent(s)/legal guardian. The plan for members who remain in the custody of DHS or OJA must be developed in collaboration with the case worker and be finalized at the time of discharge. The discharge plan is to include, at a minimum, recommendations for continued treatment services, educational services, and other appropriate community resources. Appointments for outpatient therapy and medication management (when applicable) should be scheduled prior to discharge. Discharge planning provides a transition from ITFC placement into a lesser restrictive setting within the community. Discharge planning is performed in partnership between Child Welfare Services (CWS) of the Oklahoma Department of Human Services (DHS) and an LBHP within the ITFC agency.

(D) **Substance use/chemical dependency use therapy.** Substance use/chemical dependency therapy can be provided if a member is identified by diagnosis or documented social history as having emotional or behavioral problems directly related to substance use and/or chemical dependency. The modalities employed are provided in order to begin, maintain, and/or enhance recovery from problem drinking, alcoholism, nicotine use and addiction, and/or drug use, drug dependency, and/or drug addiction. This service is provided to the member by an LBHP.

(E) **Substance use rehabilitation services.** Covered substance use rehabilitation services are provided in non-residential settings in regularly scheduled sessions intended for individuals not requiring a more intensive level of care or those who require continuing services following more intensive treatment regimes. The purpose of substance use rehabilitation services is to begin, maintain, and/or enhance recovery from problem drinking, alcoholism, nicotine use and addiction, and/or drug use, drug dependency, and/or drug addiction. Rehabilitation services may be provided individually or in group sessions, and they take the format of an agency-approved, curriculum-based education and skills training. This service is provided to the member by a certified behavioral health case manager (CM) II, a certified alcohol drug counselor (CADC), or an

LBHP.

(F) **Psychosocial rehabilitation (PSR).**

(i) **Definition.** PSR services are face-to-face behavioral health rehabilitation services which are necessary to improve the member's ability to function in the community. They are performed to improve the skills and abilities of members to live independently in the community, improve self-care and social skills, and promote lifestyle change and recovery practices. Rehabilitation services may be provided individually or in group sessions, and they take the format of an agency-approved, curriculum-based education and skills training.

(ii) **Clinical restrictions.** This service is generally performed with only the member and the qualified provider, but may also include the member's family/support system group that focuses on the member's diagnosis, symptom management, and recovery-based curriculum. A member who, at the time of service, is not able to benefit from the treatment due to active hallucinations and/or substance use, or other impairment, is not suitable for this service. Family involvement is allowed for support of the member and education regarding his/her recovery, but does not constitute family therapy, which requires an LBHP.

(iii) **Qualified practitioners.** A CM II or an LBHP may perform PSR, following development of an IPC curriculum. The CM II must have immediate access to an LBHP who can provide clinical oversight of the CM II and collaborate with the CM II in the provision of services. A minimum of one (1) monthly face-to-face consultation with an LBHP is required.

(iv) **Group sizes.** The maximum staffing ratio is eight (8) members to one (1) service provider for members under the age of twenty-one (21).

(v) **Limitations.**

(I) In order to develop and improve the member's community and interpersonal functioning and self-care abilities, PSR services may take place in settings away from the behavioral health agency site as long as the setting protects and assures confidentiality. When this occurs, the qualified provider must be present and interacting, teaching, or supporting the defined learning objectives of the member for the entire claimed time.

(II) PSR services are intended for children/adolescents with Serious Emotional Disturbance (SED), and children/adolescents with severe behavioral and emotional health needs who may

also have a secondary physical, developmental, intellectual, and/or social disorder that is supported alongside the mental health needs. Members, ages four (4) and five (5), are not eligible for PSR services unless a prior authorization has been granted by OHCA or its designated agent, based on a finding of medical necessity.

(III) PSR services are time-limited services designed to be provided over the briefest and most effective period possible and as adjunct (enhancing) interventions to complement more intensive behavioral health therapies. Service limits are based on the member's needs according to the Client Assessment Record (CAR) or other approved tools. Service limitations are designed to maximize efficacy by remaining within reasonable age and developmentally appropriate daily limits.

(vi) **Progress notes.** In accordance with OAC 317:30-5-241.1, the behavioral health IPC developed by the LBHP must include the member's strengths, functional assets, weaknesses or liabilities, treatment goals, objectives, and methodologies that are specific and time-limited, and defines the services to be performed by the practitioners and others who comprise the treatment team. When PSR services are prescribed, the plan must address objectives that are specific, attainable, realistic, measurable, and time-limited. The plan must include the appropriate treatment coordination to achieve the maximum reduction of the physical, developmental, emotional, and/or social disorders and to restore the member to his or her best possible functional level. Progress notes for PSR services must include:

(I) Start and stop times for each day attended and the physical location in which the service was rendered;

(II) Specific goal(s) and objectives addressed during the session/group;

(III) Type of skills training provided each day and/or during the week including the specific curriculum used with the member;

(IV) Member satisfaction with staff intervention(s);

(V) Progress towards attaining, or barriers affecting the attainment of, goals and objectives;

(VI) New goal(s) or objective(s) identified;

(VII) Dated signature of the qualified provider; and

(VIII) Credentials of the qualified provider.

(vii) **Additional documentation requirements.** Documentation of ongoing consultation and/or collaboration with an LBHP related to the provision of

PSR services.

(G) **Therapeutic behavioral services (TBS).** Goal-directed social skills redevelopment activities for each member to restore, retain, and improve the self-help, communication, socialization, and adaptive skills necessary to reside successfully in home and community based settings. These will be daily activities that are age appropriate, culturally sensitive, and relevant to the goals of the IPC. These may include self-esteem enhancement, violence alternatives, communication skills, or other related skill development. This service is to be provided to the member by the treatment parent specialist (TPS). Services rendered by the TPS are limited to one and a half (1.5) hours daily.

**317:30-5-754. Service quality review (SQR)**

(a) Providers must maintain an appropriate records system. Current individual plans of care, case files, and progress notes are maintained in the provider's files during the time the member is receiving services. All services must be reflected by documentation in the records. Documentation of services must include all of the following:

(1) The date the service was provided;

(2) The beginning and ending time the service was provided;

(3) A description of the member's response to the service;

(4) The type of service provided (individual, group, or family session; group rehabilitative treatment; social skills (re)development; basic living skills (re)development; crisis behavior management and redirection; or discharge planning); and

(5) The dated signature with credentials of the person providing the service.

(b) There will be an SQR review performed by the Oklahoma Health Care Authority (OHCA) or its designated agent of each ITFC agency that provides care to members. The OHCA will designate the members of the SQR team. This team will consist of at least two (2) team members and will be comprised of licensed behavioral health professionals (LBHPs) and/or registered nurses (RNs). The SQR will consist of a survey of current members receiving services, as well as members for which claims have been filed with OHCA for ITFC services. Observation and contact with members may be incorporated. The review includes validation of certain factors, all of which must be met for the services to be compensable. Following the review, the SQR team will report its findings to the ITFC agency. The ITFC agency will be provided with written notification if the findings of the SQR have resulted in any deficiencies. A copy of the final report will be sent to the ITFC agency's accrediting body. Deficiencies found during the SQR may result in a recoupment of the compensation received for that

service. The individual plan of care (IPC) is considered to be critical to the integrity of care and treatment and must be completed within the timelines designated at Oklahoma Administrative Code (OAC) 317:30-5-753. If the IPC is missing, or it is found that the member did not meet medical necessity criteria at any time, all paid services will be recouped for each day the IPC was missing from the date the plan of care was due for completion or the date from which medical necessity criteria was no longer met.

**317:30-5-755. Billing**

(a) Claims must be submitted in accordance with guidelines found at Oklahoma Administrative Code (OAC) 317:30-3-11, 317:30-3-11.1 and 317:30-3-20.

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

**317:30-5-756. Reimbursement**

(a) ITFC services will be paid at the current fee-for-service (FFS) rate. Services provided to a member without a written individual plan of care (IPC) as described in Oklahoma Administrative Code (OAC) 317:30-5-753 will not be reimbursed.

(b) In the case of a member who needs additional specialized behavioral health services, prior authorization by the Oklahoma Health Care Authority (OHCA) is required. See OAC 317:30-3-31. Only specialized rehabilitation or psychological treatment services to address unique, unusual, or severe symptoms or disorders will be authorized. Documentation must be provided to ensure that services are not duplicative.

(c) If additional services are approved for a member in state custody, the Oklahoma Department of Human Services (DHS), or Oklahoma Office of Juvenile Affairs (OJA) will collaborate with the provider of such services as directed by the OHCA. Any additional specialized behavioral health services provided to members in state custody are funded in the normal manner.

(d) Reimbursement for ITFC services is not available for the following:

(1) Room and board;
(2) Educational costs;
(3) Supported employment;
(4) Inpatient psychiatric services; and
(5) Respite care.

(e) Case management services are reimbursed to government providers as per the methodology in the approved Medicaid State Plan.

**317:30-5-757. Prior authorization and appeal of prior**

**authorization decision**

(a) All behavioral health services must be prior authorized by the Oklahoma Health Care Authority (OHCA) or its designated agent before the service is rendered by an eligible provider. Without prior authorization, payment is not authorized.

(b) If a denial decision is made, an appeal may be initiated by the member or the member's legal guardian. The denial can be appealed to the OHCA within thirty (30) calendar days of the receipt of the notification of the denial by the OHCA or its designated agent.

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

**SUBCHAPTER 3. GENERAL PROVIDER POLICIES**

**PART 1. GENERAL SCOPE AND ADMINISTRATION**

**317:30-3-5. Assignment and Cost Sharing**

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

(1) **"Fee-for-service contract"** means the provider agreement specified in OAC 317:30-3-2. This contract is the contract between the Oklahoma Health Care Authority (OHCA) and medical providers which provides for a fee with a specified service involved.

(2) **"Within the scope of services"** means the set of covered services defined at OAC 317:25-7 and the provisions of the SoonerCare Choice contracts in the SoonerCare Program.

(3) **"Outside of the scope of the services"** means all medical benefits outside the set of services defined at OAC 317:25-7 and the provisions of the SoonerCare Choice contracts in the SoonerCare Program.

(b) **Assignment in fee-for-service.** The OHCA's Medicaid State Plan provides that participation in the medical program is limited to providers who accept, as payment in full, the amounts paid by OHCA plus any deductible, coinsurance, or co-payment required by the State Plan to be paid by the member and make no additional charges to the member or others.

(1) OHCA presumes acceptance of assignment upon receipt of an assigned claim. This assignment, once made, cannot be rescinded, in whole or in part by one party, without the consent of the other party.

(2) Once an assigned claim has been filed, the member must not be billed and the member is not responsible for any balance except the amount indicated by OHCA. The only amount a member may be responsible for is a co-payment, or the member may be responsible for services not covered under the medical programs. In any event, the member should not be billed for charges on an assigned claim until the claim has been adjudicated or other notice of action received by the provider. Any questions regarding amounts paid should be directed to OHCA, Provider Services.

(3) When potential assignment violations are detected, the OHCA will contact the provider to assure that all provisions of the assignment agreement are understood. When there are repeated or

uncorrected violations of the assignment agreement, the OHCA is required to suspend further payment to the provider.

(c) **Assignment in SoonerCare.** Any provider who holds a fee for service contract and also executes a contract with a provider in the SoonerCare Choice program must adhere to the rules of this subsection regarding assignment.

(1) If the service provided to the member is outside of the scope of the services outlined in the SoonerCare Contract, then the provider may bill or seek collection from the member.

(2) In the event there is a disagreement whether the services are in or out of the scope of the contracts referenced in (1) of this subsection, the Oklahoma Health Care Authority shall be the final authority for this decision.

(3) Violation of this provision shall be grounds for a contract termination in the fee-for-service and SoonerCare programs.

(d) **Cost Sharing-Copayment.** Section 1902(a)(14) of the Social Security Act permits states to require certain members to share some of the costs of SoonerCare by imposing upon them such payments as enrollment fees, premiums, deductibles, coinsurance, co-payments, or similar cost sharing charges. OHCA requires a co-payment of some SoonerCare members for certain medical services provided through the fee for service program. A co-payment is a charge which must be paid by the member to the service provider when the service is covered by SoonerCare. Section 1916(e) of the Act requires that a provider participating in the SoonerCare program may not deny care or services to an eligible individual based on such individual's inability to pay the co-payment. A person's assertion of their inability to pay the co-payment establishes this inability. This rule does not change the fact that a member is liable for these charges, and it does not preclude the provider from attempting to collect the co-payment.

(1) Co-payment is not required of the following members:

(A) Individuals under age 21. Each member's date of birth is available on the REVS system or through a commercial swipe card system.

(B) Members in nursing facilities and intermediate care facilities for individuals with intellectual disabilities.

(C) Home and Community Based Service waiver members except for prescription drugs.

(D) ~~Native Americans providing documentation of ethnicity in accordance with OAC 317:35-5-25 who receive items and services furnished by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services~~American Indian and Alaska Native members, as is established in the federally-approved Oklahoma Medicaid State Plan.

(E) Individuals who are categorically eligible for

SoonerCare through the Breast and Cervical Cancer Treatment program.

(F) Individuals receiving hospice care, as defined in section 1905(o) of the Social Security Act.

(2) Co-payment is not required for the following services:

(A) Family planning services. This includes all contraceptives and services rendered.

(B) Emergency services provided in a hospital, clinic, office, or other facility.

(C) Services furnished to pregnant women, if those services relate to the pregnancy or to any other medical condition which may complicate the pregnancy.

(D) Smoking and Tobacco Cessation counseling and products.

(E) Diabetic supplies.

(3) Co-payments are required in an amount not to exceed the federal allowable for the following:

(A) Inpatient hospital stays.

(B) Outpatient hospital visits.

(C) Ambulatory surgery visits including free-standing ambulatory surgery centers.

(D) Encounters with the following rendering providers:

(i) Physicians,

(ii) Advanced Practice Nurses,

(iii) Physician Assistants,

(iv) Optometrists,

(v) Home Health Agencies,

(vi) Certified Registered Nurse Anesthetists,

(vii) Anesthesiologist Assistants,

(viii) Durable Medical Equipment providers, and

(ix) Outpatient behavioral health providers.

(E) Prescription drugs.

(F) Crossover claims. Dually eligible Medicare/SoonerCare members must make a co-payment in an amount that does not exceed the federal allowable per visit/encounter for all Part B covered services. This does not include dually eligible HCBS waiver members.

(4) Medicaid premiums and cost sharing incurred by all individuals in the Medicaid household may not exceed an aggregate limit of five percent of the family's income applied on a monthly basis, as specified by the agency.

# TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

## CHAPTER 1. ADMINISTRATIVE OPERATIONS

## SUBCHAPTER 1. ORGANIZATION AND ADMINISTRATION

### 317:1-1-4. Organization and meetings

(a) The Authority Board consists of ~~seven (7)~~nine (9) members. Section 5007 of Title 63 of the Oklahoma Statutes (O.S.) provides for their appointment and service.

(b) A chair and a ~~Vice-Chair~~vice-chair shall be elected by a majority of the members of the Board. The terms of office of the ~~Chair and Vice-Chair~~chair and vice-chair shall be one (1) year beginning ~~July~~January 1 of each year. A member elected to serve as ~~Chair or Vice-Chair~~chair or vice-chair may be elected to serve more than one (1) term. Elections will be held at the last regular meeting before ~~July~~January 1. However, in the event the last regular meeting before ~~July~~January 1 shall be canceled for any reason, the election may be held at a specially-scheduled meeting or, if it is not possible to schedule a special meeting, at the next ~~regularly-scheduled~~regularly-scheduled meeting. In the event an election ~~can not~~cannot be conducted prior to ~~July~~January 1 of any year, the ~~Chair and Vice-Chair~~chair and vice-chair who are in office ~~June 30~~December 31 shall continue their terms until an election is held.

(c) The chair will preside over meetings and perform other duties as required by the Authority ~~[65:5008(A)]~~.

(d) A majority of the members of the Board shall constitute a quorum for the transaction of business and for taking any official action. Any action or decision of the Board requires an affirmative vote of at least a majority of the members present ~~[63:5007(D)]~~[63 O.S. § 5007(D)].

(e) All meetings of the Authority Board will be conducted in accordance with the Open ~~Meetings~~Meeting Act, ~~Sections 301 through 314 of Title 25 of the Oklahoma Statutes~~25 O.S. §§ 301 - 314.

### 317:1-1-5. Subcommittees and committees [REVOKED]

~~The Chairman may appoint advisory committees. Such appointments shall be in writing and may be changed as needed, upon written notice to all Authority members.~~

### 317:1-1-6. ~~Cancellation~~Emergency cancellation of meetings

The ~~Chairman~~chair, or the vice-chair in the chair's absence, shall have the power to cancel or reschedule any regular or special meeting of the Authority due to anticipated lack of quorum, inclement weather, or other emergency. Notice ~~of cancellation of said meeting~~thereof shall be ~~posted~~filed with the Secretary of State and publicly posted as soon as reasonably possible ~~and in the same manner as the agenda~~.

**317:1-1-7. Minutes of the Authority**

A summary shall be made of all proceedings before the Authority which shall show those members present and absent, all matters considered, all actions taken, and the vote of each member on any motion, and shall be made public~~, as prescribed in OAC 317:1-1-10(e)~~on the Authority's website.

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

**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**

**PART 1. PHYSICIANS**

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

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

(1) prenatal at risk antepartum management;

(2) a combined maximum of five (5) fetal non stress test(s) and biophysical profiles (additional units can be prior authorized for multiple fetuses)with one (1) test per week beginning at ~~32~~thirty-two (32) weeks gestation and continuing to ~~38~~thirty-eight (38) weeks; and

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

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

(1) ~~ACOG~~A comprehensive prenatal assessment from the American College of Obstetricians and Gynecologist (ACOG) or other comparable comprehensive prenatal assessment; and

(2) ~~appropriate~~Appropiate documentation supporting medical necessity from a ~~Board Eligible/Board Certified~~board eligible/board certified Maternal Fetal Medicine (MFM) specialist, ~~or~~a ~~Board Eligible/Board Certified~~board eligible/board certified Obstetrician-Gynecologist (OB-GYN)~~.~~, or a board eligible/board certified Family Practice Physician who has completed an Accreditation Council for Graduate Medical Education (ACGME) approved residency. The medical residency program must include appropriate obstetric training and the physician must be credentialed by the hospital at which they provide obstetrical services in order to perform such services. The documentation must include information identifying and detailing the qualifying high risk condition. Non-MFM obstetrical providers requesting enhanced services are limited to a specific set of diagnoses as outlined on the OHCA Medical Authorizations Unit webpage.

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

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

## PART 3. HOSPITALS

### 317:30-5-42.11. Observation/treatment

(a) Payment is made for the use of a treatment room associated with outpatient observation services. Observation services must be ordered by a physician or other individual authorized by state law. Observation services are furnished by the hospital on the hospital's premises and include use of the bed and periodic monitoring by hospital staff. Observation services must include a minimum of ~~8~~eight (8) hours of continuous care. Outpatient observation services are not covered when they are provided:

(1) On the same day as an emergency department visit.

(2) Prior to an inpatient admission, as those observation services are considered part of the inpatient DRG.

(3) For the convenience of the member, member's family or provider.

(4) When specific diagnoses are not present on the claim.

(5) As part of another service, i.e. for post operative monitoring; recovery after diagnostic testing or concurrently with therapeutic services such as chemotherapy.

(b) Payment is made for observation services in a labor or delivery room. Observation services must include a minimum of eight (8) hours of continuous care. Specific pregnancy-related diagnoses are required. ~~During active labor, a fetal non-stress test is covered in addition to the labor and delivery room charge.~~