Oklahoma Health Care Authority
MEDICAL ADVISORY COMMITTEE
November 12, 2020
1:00 PM – 3:30 PM
Teleconference
OKC, OK

AGENDA

I. Welcome, and Roll Call: **Chairman, Jason Rhynes, O.D.**

Teleconference Participants

Ms. Sarah Baker – WebEx Teleconference	Ms. Debra Billingsley – WebEx Teleconference
Ms. Joni Bruce - WebEx Teleconference	Dr. Joe Catalano – WebEx Teleconference
Mr. Victor Clay - WebEx Teleconference	Dr. Steven Crawford – WebEx Teleconference
Ms. Terrie Fritz - WebEx Teleconference	Ms. Wanda Felty – WebEx Teleconference
Ms. Allison Garrison – WebEx Teleconference	Ms. Lindsay Hanna – WebEx Teleconference
Dr. Lori Holmquist-Day – WebEx Teleconference	Mr. Mark Jones - WebEx Teleconference
Ms. Annette Mays – WebEx Teleconference	Ms. Melissa Miller – WebEx Teleconference
Dr. Daniel Post – WebEx Teleconference	Ms. Toni Pratt-Reid – WebEx Teleconference
Dr. Jason Rhynes - WebEx Teleconference	Ms. Katie Roberts – WebEx Teleconference
Mr. Rick Snyder - WebEx Teleconference	Dr. Dwight Sublett – WebEx Teleconference
Mr. William Whited – WebEx Teleconference	Dr. Whitney Yeates – WebEx Teleconference

II. Action Item: Approval of Minutes of the September 10th, 2020: **Medical Advisory Committee Meeting**

III. Public Comments (2 minute limit)

IV. MAC Member Comments/Discussion

V. Financial Report: **Tasha Black, Senior Director of Financial Services**

VI. SoonerCare Operations Update: **Melinda Thomason, Senior Director for Stakeholder Engagement**

VII. HB2587 Update: **Maria Maule, Director of Legal Services**

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

A. **20-04 Electronic Visit Verification**
B. **20-13 Child Support Cooperation Exemption for Recipients of Indian Health Services**
C. **20-14 Therapy Assistants and Clinical Fellows**

D. 20-15A Residential Substance Use Disorder (SUD) Treatment Coverage
E. 20-15B Residential Substance Use Disorder (SUD) Treatment Coverage
F. 20-16 SUPPORT Act Medication-Assisted Treatment and Opioid Treatment Programs
G. 20-19A Appeals Language Cleanup
H. 20-19B Appeals and Incorrect References Language Cleanup
I. 20-20 Pay-for-Performance (PFP) Program
J. 20-21 Employment Services Offered through Developmental Disabilities Services
K. 20-27 Specialty PRTF Staffing and Admission Revisions

IX. New Business: **Chairman, Jason Rhynes**

A. Election of Chairman and Vice-Chairman

X. Future Meeting:
January 14, 2021
March 11, 2021
May 13, 2021
July 8, 2021
September 9, 2021
November 4, 2021

XI. Adjourn

Oklahoma Health Care Authority
MEDICAL ADVISORY COMMITTEE
MINUTES of the September 10, 2020 Meeting
4345 N. Lincoln Blvd., Oklahoma City, OK 73105

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

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

***Delegates present were*:** Ms. Sarah Baker, Ms. Debra Billingsly, Mr. Victor Clay, Dr. Steven Crawford, Ms. Wanda Felty, Ms. Terrie Fritz, Ms. Allison Garrison, Mr. Steve Goforth, Dr. Lori Holmquist-Day, Ms. Tina Johnson, Mr. Mark Jones, Dr. Craig Kupiec, Ms. Annette Mays, Ms. Melissa Miller, Dr. Daniel Post, Ms. Toni Pratt-Reid, Dr. Jason Rhynes, Dr. Dwight Sublett, Mr. Rick Snyder, Mr. Jeff Tallent, Mr. William Whited, and Dr. Whitney Yeates.

Alternates present were: Ms. Lois Baer providing a quorum.

***Delegates absent without an alternate were*:** Ms. Kristi Blackburn, Dr. Erin Balzer, Dr. Joe Catalano, Mr. Brett Coble, Dr. Arlen Foulks, Mr. James Patterson, and Dr. Raymond Smith.

II. Approval of the July 9th, 2020 Minutes

Medical Advisory Committee
The motion to approve the minutes was by Ms. Annette Mays and seconded by Ms. Debra Billingsley and passed unanimously.

III. Public Comments (2 minute limit):

There were no public comments made at this meeting.

IV. MAC Member Comments/Discussion:

Ms. Debra Billingsley stated we have an exemplary and innovative system for managing Medicaid pharmaceuticals in Oklahoma. OHCA has done a great job insuring that our tax payer's dollars are spent effectively. Colleges and pharmacists have done a great job of helping the staff to help manage the Medicaid population pharmaceuticals. Taking control of the rebate is very helpful but I don't think that will resolve the problem that the other states are encountering. Many of the states are moving their pharmacy benefits in house after West Virginia was able to save $54 million their first year. Ms. Billingsley stated she is concerned with OHCA's capitated rate on a Medicare system.

Mr. Clay stated that as the transition took place from the Advantage waiver program specifically on the incontinence products that have moved over to Title 19 for members of the SoonerCare program for the adults. There has been some things that the OHCA may need to check into to provide a little feedback, but the number of existing patients that were on the Advantage waiver prior to August 1st of this year, 50% of those have been denied. So we are at a 50% approval rate. There are some suggested diagnoses out there but there are some diagnosis that I think are being

over-looked. For instance one patient that has stage IV cancer and is bed-bound, not able to get up, was denied because they did not have one of the assisted diagnoses that were identified in the initial training. CHFS patient as well that's on heavy diuretics that is also in the same situation. Requesting some guidance and possible some additional training for providers out there, so that we can efficiently take care of these people while they transition.

V. Financial Report:

Tasha Black, Senior Director of Financial Services

Ms. Black presented the financial report ending in June, 2020. OHCA is 1.7% under budget in revenues and 2.5% under budget in expenditures with the result that our budget variance is a positive $37,150,306. The budget variance is primarily attributed to the following: Medicaid Program Variance is a positive 30.4 million state dollars, and administration is a positive 5.5 million state dollars. Drug Rebate is 1.3 million state dollars under budget. Taxes and Fees, which also included tobacco tax is 0.6 million state dollars under budget. For more detailed information, see item 5 in the MAC agenda. For more detailed information, see item 5 in the MAC agenda.

VI. SoonerCare Operations Update:

Melinda Thomason, Senior Director for Stakeholder Engagement

Ms. Thomason discussed some program evaluations, along with a preview of the CMS Scorecard. Our Health Management Program (HMP) is currently under our 1115(a) waiver authority, which was mandated by the legislature in 2006, under the Medicaid Reform Act. OHCA implemented the program in 2008, which is administered by our contractor, Telligen. Ms. Thomason spoke briefly discussing the HMP components chronic care unit, and program objectives. For more detailed information, please see item 6 in the MAC agenda.

VIII. Legislative Update:

Christina Foss, Legislative Liaison

Ms. Foss presented a legislative update for the committee members. She discussed some of the interim studies coming up, which include the examination of diabetes standards of care. There will be a study looking at the Open Meetings Act, and the leveraging of technology as we have been doing through this health crisis. OHCA has a few success stories on how we have been able to transition a lot of our workforce to telework. Senator McCortney will be looking at Managed Care and Tribal Health issues, with OHCA in attendance.

IX. Proposed Rule Changes: Presentation, Discussion, and Vote:

Sandra Puebla, Director of Federal & State Authorities

A face-to-face tribal consultation regarding the following proposed change was held on Tuesday, July 7, 2020 in the Charles Ed McFall Boardroom of the Oklahoma Health Care Authority (OHCA).

The following work folder was posted on the OHCA public website for a public comment period.

APA WF # 20-11 Medicare Part C (Medicare Advantage) — AMENDING agency rules at ***Oklahoma Administrative Code (OAC) 317:30-3-25*** will standardize the language in policy regarding the payment of Medicare deductibles, coinsurance, and copays between Medicare Part A, Part B, and Part C.

Budget Impact: Budget neutral

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

X. New Business: Chairman, Jason Rhynes, O.D.

No new business was identified.

XI. Future Meetings

November 12, 2020

XII. **Adjournment**

Chairman Rhynes asked for a motion to adjourn. Motion was provided by Mr. Victor Clay and seconded by Dr. Steven Crawford. There was no dissent and the meeting adjourned at 1:42pm.

OKLAHOMA
Health Care Authority

FINANCIAL REPORT

For the Two Month Period Ending August 31, 2020
Submitted to the CEO & Board

- Revenues for OHCA through August, accounting for receivables, were **$899,587,743** or **5.9% under** budget.
- Expenditures for OHCA, accounting for encumbrances, were **$777,142,485** or **9.6% under** budget.
- The state dollar budget variance through August is a positive **$26,540,211.**
- The budget variance is primarily attributable to the following (in millions):

Expenditures:		
Medicaid Program Variance		28.5
Administration		0.2
Revenues:		
Drug Rebate		(3.6)
Medical Refunds		0.8
Taxes and Fees		0.6
Total FY 21 Variance	**$**	**26.5**

ATTACHMENTS

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures: OHCA
SFY 2021, For the Two Month Period Ending August 31, 2020

REVENUES	FY21 Budget YTD	FY21 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 274,256,490	$ 274,256,490	$ -	0.0%
Federal Funds	577,676,034	531,044,694	(46,631,340)	(8.1)%
Tobacco Tax Collections	7,664,709	8,211,978	547,270	7.1%
Quality of Care Collections	14,045,761	13,824,495	(221,266)	(1.6)%
Prior Year Carryover	-	-	-	0.0%
Federal Deferral - Interest	49,478	49,478	-	0.0%
Rate Preservation Fund	4,092,470	4,092,470	-	0.0%
Drug Rebates	32,924,668	19,837,790	(13,086,878)	(39.7)%
Medical Refunds	6,649,440	9,614,160	2,964,720	44.6%
Supplemental Hospital Offset Payment Program	38,306,422	38,306,422	-	0.0%
GME Federal Disallowance Repayment - OU/OSU	-	-	-	0.0%
Other Revenues	81,382	349,767	268,386	329.8%
TOTAL REVENUES	**$ 955,746,851**	**$ 899,587,743**	**$ (56,159,109)**	**(5.9)%**

EXPENDITURES	FY21 Budget YTD	FY21 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 9,923,913**	**$ 8,766,716**	**$ 1,157,197**	**11.7%**
ADMINISTRATION - CONTRACTS	**$ 23,190,473**	**$ 23,300,349**	**$ (109,875)**	**(0.5)%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	10,833,083	8,334,476	2,498,607	23.1%
Acute Fee for Service Payments:				
Hospital Services	188,763,810	168,407,264	20,356,545	10.8%
Behavioral Health	4,164,820	3,200,991	963,828	23.1%
Physicians	80,449,715	59,790,767	20,658,948	25.7%
Dentists	27,020,983	23,547,402	3,473,581	12.9%
Other Practitioners	9,602,310	8,099,013	1,503,297	15.7%
Home Health Care	5,554,276	5,886,133	(331,857)	(6.0)%
Lab & Radiology	5,455,330	5,126,767	328,563	6.0%
Medical Supplies	9,576,940	10,921,293	(1,344,353)	(14.0)%
Ambulatory/Clinics	47,560,176	43,321,006	4,239,171	8.9%
Prescription Drugs	127,569,811	117,261,961	10,307,850	8.1%
OHCA Therapeutic Foster Care	57,127	69,305	(12,177)	(21.3)%
Other Payments:				
Nursing Facilities	121,908,416	115,564,594	6,343,822	5.2%
Intermediate Care Facilities for Individuals with Intellectual Disabilities Private	11,632,468	11,270,170	362,298	3.1%
Medicare Buy-In	32,205,563	32,326,060	(120,497)	(0.4)%
Transportation	13,990,561	12,319,929	1,670,632	11.9%
Money Follows the Person-OHCA	35,228	41,127	(5,899)	(16.7)%
Electronic Health Records-Incentive Payments	39,754	39,754	-	0.0%
Part D Phase-In Contribution	16,943,721	6,965,439	9,978,282	58.9%
Supplemental Hospital Offset Payment Program	111,361,124	111,361,124	-	0.0%
Telligen	1,912,821	1,220,845	691,976	36.2%
Total OHCA Medical Programs	**826,638,037**	**745,075,421**	**81,562,617**	**9.9%**
OHCA Non-Title XIX Medical Payments	89,382	-	89,382	0.0%
TOTAL OHCA	**$ 859,841,805**	**$ 777,142,485**	**$ 82,699,320**	**9.6%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ 95,905,046**	**$ 122,445,257**	**$ 26,540,211**	

OKLAHOMA HEALTH CARE AUTHORITY

Total Medicaid Program Expenditures
by Source of State Funds
SFY 2021, For the Two Month Period Ending August 31, 2020

Category of Service	Total	Health Care Authority	Quality of Care Fund	HEEIA	SHOPP Fund	BCC Revolving Fund	Other State Agencies
SoonerCare Choice	$ 8,360,969	$ 8,332,983	$ -	$ 26,493	$ -	$ 1,494	$ -
Inpatient Acute Care	276,319,612	105,541,216	81,114	1,219,720	87,121,848	117,885	82,237,828
Outpatient Acute Care	84,426,917	61,356,573	6,934	1,507,476	20,252,392	1,303,542	-
Behavioral Health - Inpatient	11,351,525	1,687,658	-	163,923	3,554,176	-	5,945,768
Behavioral Health - Psychiatrist	1,946,042	1,513,333	-	-	432,709	-	-
Behavioral Health - Outpatient	2,951,078	-	-	-	-	-	2,951,078
Behavioral Health-Health Home	3,062,089	-	-	-	-	-	3,062,089
Behavioral Health Facility- Rehab	27,632,823	-	-	-	-	19,301	27,632,823
Behavioral Health - Case Management	906,200	-	-	-	-	-	906,200
Behavioral Health - PRTF	2,216,623	-	-	-	-	-	2,216,623
Behavioral Health - CCBHC	17,173,392	-					17,173,392
Residential Behavioral Management	3,387,357	-	-	-	-	-	3,387,357
Targeted Case Management	8,232,476	-	-	-	-	-	8,232,476
Therapeutic Foster Care	69,305	69,305	-	-	-	-	-
Physicians	76,103,712	59,209,917	9,683	1,215,218	-	571,167	15,097,728
Dentists	23,568,589	23,545,243	-	21,187	-	2,159	-
Mid Level Practitioners	282,975	277,108	-	5,867	-	-	-
Other Practitioners	7,955,572	7,728,560	74,394	133,667	-	18,950	-
Home Health Care	5,888,401	5,884,328	-	2,268	-	1,805	-
Lab & Radiology	5,335,340	5,095,027	-	208,573	-	31,740	-
Medical Supplies	10,998,833	10,461,886	451,922	77,540	-	7,485	-
Clinic Services	43,152,649	42,157,852	-	618,411	-	40,053	336,333
Ambulatory Surgery Centers	1,155,286	1,121,250	-	32,185	-	1,851	-
Personal Care Services	1,670,670	-	-	-	-	-	1,670,670
Nursing Facilities	115,564,594	75,647,663	39,916,931	-	-	-	-
Transportation	12,287,531	11,731,683	476,869	47,535	-	31,444	-
IME/DME/GME	36,950,916	-	-	-	-	-	36,950,916
ICF/IID Private	11,270,170	9,257,712	2,012,458	-	-	-	-
ICF/IID Public	3,635,552	-	-	-	-	-	3,635,552
CMS Payments	39,291,499	39,220,738	70,760	-	-	-	-
Prescription Drugs	120,896,451	116,809,544	-	3,634,490	-	452,417	-
Miscellaneous Medical Payments	79,933	78,187	-	-	-	1,746	-
Home and Community Based Waiver	38,118,655	-	-	-	-	-	38,118,655
Homeward Bound Waiver	13,569,966	-	-	-	-	-	13,569,966
Money Follows the Person	41,127	41,127	-	-	-	-	-
In-Home Support Waiver	4,369,461	-	-	-	-	-	4,369,461
ADvantage Waiver	31,833,327	-	-	-	-	-	31,833,327
Family Planning/Family Planning Waiver	603,377	-	-	-	-	-	603,377
Premium Assistance*	9,682,945	-	-	9,682,945.07	-	-	-
Telligen	1,220,845	1,220,845	-	-	-	-	-
Electronic Health Records Incentive Payments	39,754	39,754	-	-	-	-	-
Total Medicaid Expenditures	**$ 1,063,604,536**	**$ 588,029,491**	**$ 43,101,066**	**$ 18,597,497**	**$ 111,361,124**	**$ 2,603,040**	**$ 299,931,618**
			-	-	-	-	-

* Includes $9,574,680.50 paid out of Fund 245

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures:
Other State Agencies
SFY 2021, For the Two Month Period Ending August 31, 2020

REVENUE	FY21 Actual YTD
Revenues from Other State Agencies	$ 73,669,181
Federal Funds	219,524,610
TOTAL REVENUES	**$ 293,193,792**

EXPENDITURES	Actual YTD
Department of Human Services	
Home and Community Based Waiver	38,118,655
Money Follows the Person	-
Homeward Bound Waiver	13,569,966
In-Home Support Waivers	4,369,461
ADvantage Waiver	31,833,327
Intermediate Care Facilities for Individuals with Intellectual Disabilities Public	3,635,552
Personal Care	1,670,670
Residential Behavioral Management	2,123,876
Targeted Case Management	7,049,711
Total Department of Human Services	**102,371,217**
State Employees Physician Payment	
Physician Payments	15,097,728
Total State Employees Physician Payment	**15,097,728**
Education Payments	
Graduate Medical Education	-
Indirect Medical Education	36,950,916
Direct Medical Education	-
Total Education Payments	**36,950,916**
Office of Juvenile Affairs	
Targeted Case Management	501,861
Residential Behavioral Management	1,263,481
Total Office of Juvenile Affairs	**1,765,342**
Department of Mental Health	
Case Management	906,200
Inpatient Psychiatric Free-standing	5,945,768
Outpatient	2,951,078
Health Homes	3,062,089
Psychiatric Residential Treatment Facility	2,216,623
Certified Community Behavioral Health Clinics	17,173,392
Rehabilitation Centers	27,632,823
Total Department of Mental Health	**59,887,973**
State Department of Health	
Children's First	-
Sooner Start	233,909
Early Intervention	491,482
Early and Periodic Screening, Diagnosis, and Treatment Clinic	57,696
Family Planning	18,711
Family Planning Waiver	584,667
Maternity Clinic	-
Total Department of Health	**1,386,464**
County Health Departments	
EPSDT Clinic	44,729
Family Planning Waiver	-
Total County Health Departments	**44,729**
State Department of Education	**49,292**
Public Schools	**140,129**
Medicare DRG Limit	**81,472,668**
Native American Tribal Agreements	**-**
Department of Corrections	**-**
JD McCarty	**765,160**
Total OSA Medicaid Programs	**$ 299,931,618**
OSA Non-Medicaid Programs	**$ 14,417,065**
Total Other State Agencies	**$ 314,348,683**
Accounts Receivable from OSA	**$ 21,154,891**

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 205: Supplemental Hospital Offset Payment Program Fund
SFY 2021, For the Two Month Period Ending August 31, 2020

REVENUES		FY 21 Revenue
SHOPP Assessment Fee		38,270,291
Federal Draws	$	80,425,004
Interest		36,131
Penalties		-
State Appropriations		(7,550,000)
TOTAL REVENUES	$	111,181,425

EXPENDITURES	Quarter	Quarter	Quarter	Quarter		FY 21 Expenditures
Program Costs:	7/1/20 - 9/30/20	10/1/20 - 12/31/20	1/1/21 - 3/31/21	4/1/21 - 6/30/21		
Hospital - Inpatient Care	87,121,848				$	87,121,848
Hospital -Outpatient Care	20,252,392					20,252,392
Psychiatric Facilities-Inpatient	3,554,176					3,554,176
Rehabilitation Facilities-Inpatient	432,709					432,709
Total OHCA Program Costs	111,361,124	-	-	-	$	111,361,124
Total Expenditures					$	111,361,124

CASH BALANCE		
	$	(179,699)

*** 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 2021, For the Two Month Period Ending August 31, 2020

REVENUES	Total Revenue	State Share
Quality of Care Assessment	**13,817,224**	**$ 13,817,224**
Quality of Care Penalties	**70,832**	**$ 70,832**
Interest Earned	**7,271**	**7,271**
TOTAL REVENUES	**$ 13,895,327**	**$ 13,895,327**

EXPENDITURES	FY 21 Total $ YTD	FY 21 State $ YTD	Total State $ Cost
Program Costs			
Nursing Facility Rate Adjustment	$ 39,331,890	$ 10,926,399	
Eyeglasses and Dentures	44,301	$ 12,307	
Personal Allowance Increase	540,740	$ 150,218	
Coverage for Durable Medical Equipment and Supplies	451,922	$ 125,544	
Coverage of Qualified Medicare Beneficiary	172,126	$ 47,817	
Part D Phase-In	70,760	$ 19,657	
ICF/IID Rate Adjustment	927,330	$ 257,612	
Acute Services ICF/IID	1,085,128	$ 301,449	
Non-emergency Transportation - Soonerride	476,869	$ 132,474	
Total Program Costs	**$ 43,101,066**	**$ 11,973,476**	**$ 11,973,476**
Administration			
OHCA Administration Costs	$ 96,578	$ 48,289	
DHS-Ombudsmen	-	-	
OSDH-Nursing Facility Inspectors	-	-	
Mike Fine, CPA	-	-	
Total Administration Costs	**$ 96,578**	**$ 48,289**	**$ 48,289**
Total Quality of Care Fee Costs	**$ 43,197,645**	**$ 12,021,765**	
TOTAL STATE SHARE OF COSTS			**$ 12,021,765**

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 2021, For the Two Month Period Ending August 31, 2020

REVENUES	FY 20 Carryover	FY 21 Revenue	Total Revenue
Prior Year Balance	$ 16,831,479		
State Appropriations	-		
Federal Draws - Prior Year	202,345		
Total Prior Year Revenue			17,033,824
Tobacco Tax Collections	-	6,754,101	6,754,101
Interest Income	-	64,366	64,366
Federal Draws	-	6,421,381	6,421,381
TOTAL REVENUES	**$ 17,033,824**	**$ 13,239,848**	**$ 30,273,672**

EXPENDITURES		FY 20 Expenditures	FY 21 Expenditures	Total State $ YTD
Program Costs:				
	Employer Sponsored Insurance		$ 9,574,681	$ 9,574,681
	College Students/ESI Dental		108,265	30,076
Individual Plan				
	SoonerCare Choice		$ 25,671	$ 7,131
	Inpatient Hospital		1,213,612	337,141
	Outpatient Hospital		1,477,082	410,333
	BH - Inpatient Services-DRG		159,681	44,359
	BH -Psychiatrist		-	-
	Physicians		1,191,364	330,961
	Dentists		19,596	5,444
	Mid Level Practitioner		5,867	1,630
	Other Practitioners		130,845	36,349
	Home Health		2,268	630
	Lab and Radiology		202,578	56,276
	Medical Supplies		77,284	21,469
	Clinic Services		596,214	165,628
	Ambulatory Surgery Center		32,185	8,941
	Skilled Nursing		-	-
	Prescription Drugs		3,566,406	990,748
	Transportation		47,168	13,103
	Premiums Collected			(52,936)
Total Individual Plan			**$ 8,747,819**	**$ 2,377,208**
	College Students-Service Costs		**$ 166,732**	**$ 46,318**
Total OHCA Program Costs			**$ 18,597,497**	**$ 12,028,283**
Administrative Costs				
	Salaries	$ -	$ 364,302	$ 364,302
	Operating Costs	3,088	87	3,175
	E&E Development DXC	-	-	-
	Contract - DXC	180,854	-	180,854
Total Administrative Costs		**$ 183,942**	**$ 364,388**	**$ 548,330**
Total Expenditures				**$ 12,576,613**
NET CASH BALANCE		**$ 16,849,882**	**$ 847,176.74**	**$ 17,697,059**

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

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

SFY 2021, For the Two Month Period Ending August 31, 2020

REVENUES	FY 21 Revenue	State Share
Tobacco Tax Collections	$ 134,790	$ 134,790
TOTAL REVENUES	**$ 134,790**	**$ 134,790**

EXPENDITURES	FY 21 Total $ YTD	FY 21 State $ YTD	Total State $ Cost
Program Costs			
SoonerCare Choice	$ 1,494	$ 291	
Inpatient Hospital	117,885	$ 22,929	
Outpatient Hospital	1,303,542	$ 253,539	
Inpatient Services-DRG	-	$ -	
Psychiatrist	-	$ -	
TFC-OHCA	-	$ -	
Nursing Facility	-	$ -	
Physicians	571,167	$ 111,092	
Dentists	2,159	$ 420	
Mid-level Practitioner	0	$ -	
Other Practitioners	18,950	$ 3,686	
Home Health	1,805	$ 351	
Lab & Radiology	31,740	$ 6,173	
Medical Supplies	7,485	$ 1,456	
Clinic Services	40,053	$ 7,790	
Ambulatory Surgery Center	1,851	$ 360	
Prescription Drugs	452,417	$ 87,995	
Transportation	31,444	$ 6,115.95	
Miscellaneous Medical	1,746	$ 339.65	
Total OHCA Program Costs	**$ 2,583,739**	**$ 502,537**	
OSA DMHSAS Rehab	19,301	3,754	
Total Medicaid Program Costs	**$ 2,603,040**	**$ 506,291**	
TOTAL STATE SHARE OF COSTS			**$ 506,291**

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
November 2020
(September 2020 Data)

SOONERCARE ENROLLMENT/EXPENDITURES

Delivery System			Enrollment September 2020	Children September 2020	Adults September 2020	Enrollment Change	Total Expenditures September	PMPM September 2020
SoonerCare Choice Patient-Centered Medical Home			**601,012**	**489,981**	**111,031**	**8,317**	**$175,961,044**	
	Lower Cost	*(Children/Parents; Other)*	558,945	477,156	81,789	8,821	$118,756,828	$212
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC)*	42,067	12,825	29,242	-504	$57,204,217	$1,360
SoonerCare Traditional			**264,586**	**99,669**	**164,917**	**2,612**	**$235,999,261**	
	Lower Cost	*(Children/Parents; Other; Q1; SLMB)*	146,046	94,970	51,076	2,192	$49,198,759	$337
	Higher Cost	*(Aged, Blind or Disabled; LTC; TEFRA; BCC & HCBS Waiver)*	118,540	4,699	113,841	420	$186,800,502	$1,576
Insure Oklahoma			**31,289**	**953**	**30,336**	**1,172**	**$10,516,944**	
	Employer-Sponsored Insurance		14,670	399	14,271	115	$5,156,957	$352
	Individual Plan		16,619	554	16,065	1,057	$5,359,987	$323
SoonerPlan			**39,485**	**1,848**	**37,637**	**892**	**$235,269**	$6
TOTAL (UNDUPLICATED)			**936,353**	**592,451**	**343,921**	**12,993**	**$422,712,518**	

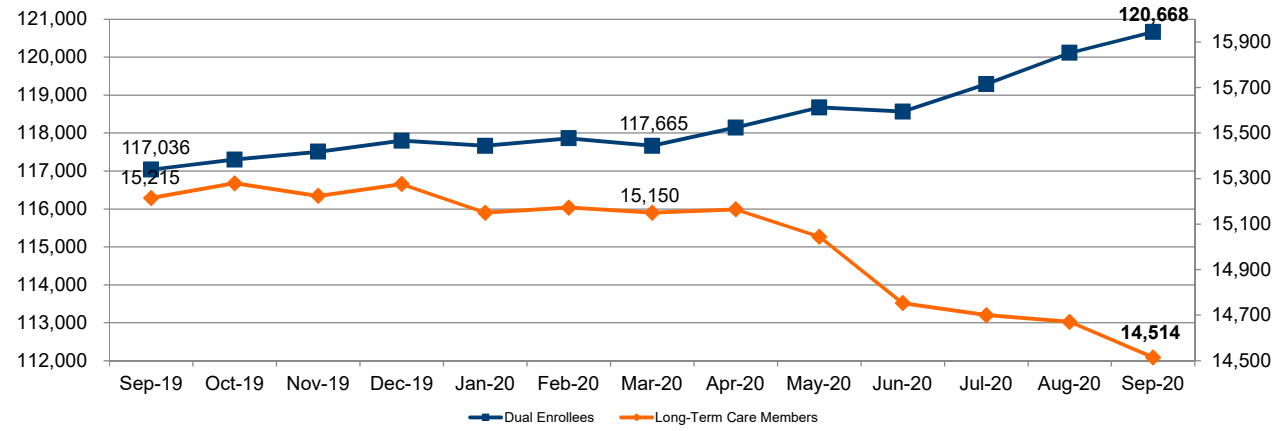
Enrollment totals include all members enrolled during the report month. Members may not have expenditure data. Children are members aged 0 - 20 or for Insure Oklahoma enrolled as Students or Dependents.
Dual Eligibles (Medicare & Medicaid) are in the Traditional delivery system in both the Low Cost (Q1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

Total In-State Providers: 46,385 (+361) **(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
11,034	916	1,267	160	11,215	717	431	8,044	2,832

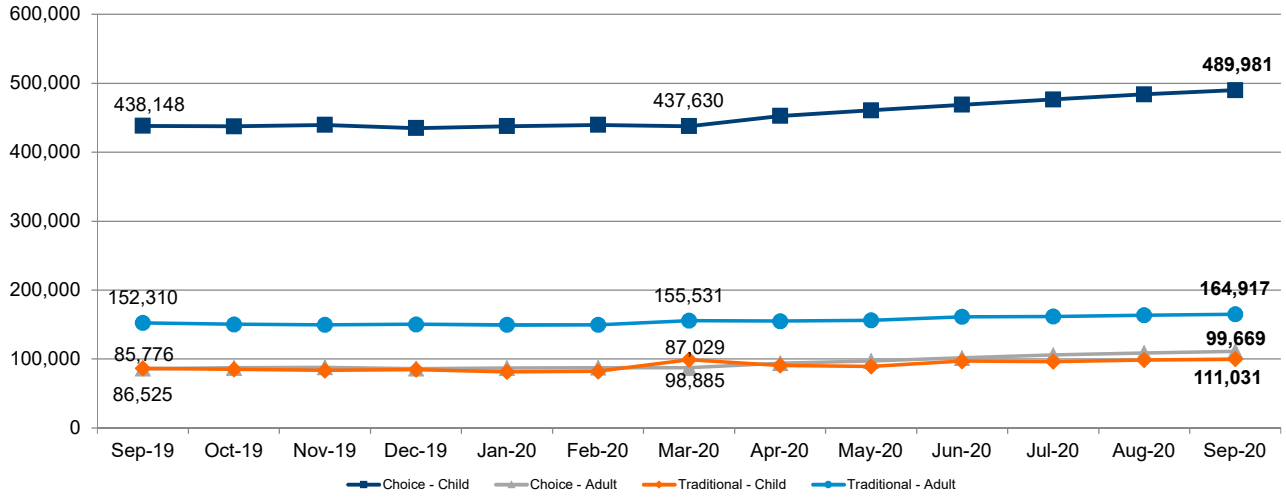
*PCPs consist of all providers contracted as a Certified Registered Nurse Practitioner, Family Practitioner, General Pediatrician, General Practitioner, Internist, General Internist, and Physician Assistant.

DUAL ENROLLEES & LONG-TERM CARE MEMBERS



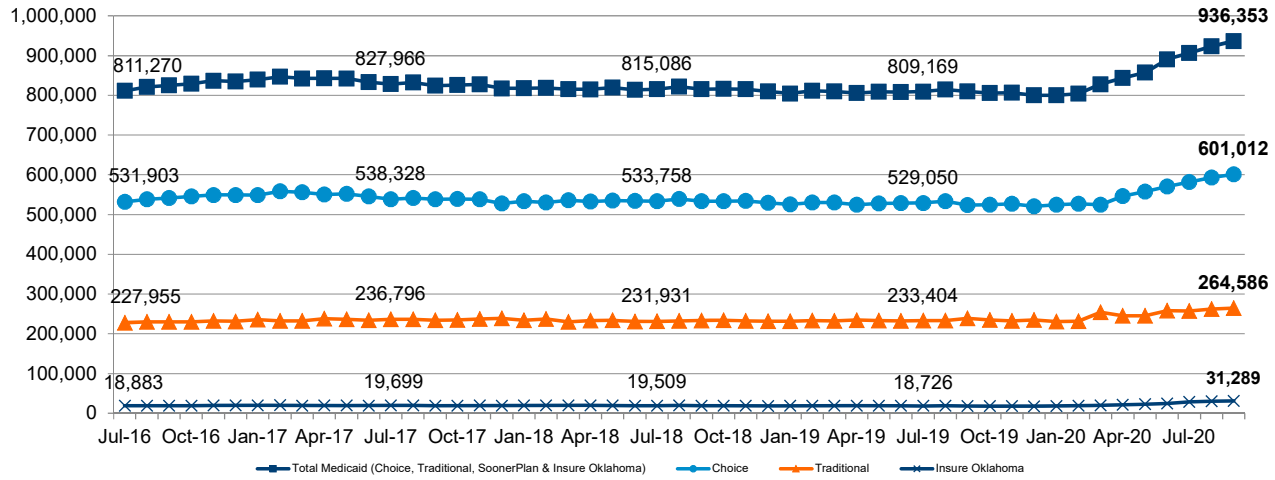
Enrollment increase beginning in March 2020 is due to COVID response to maintain members continuous coverage of care by postponing recertification.

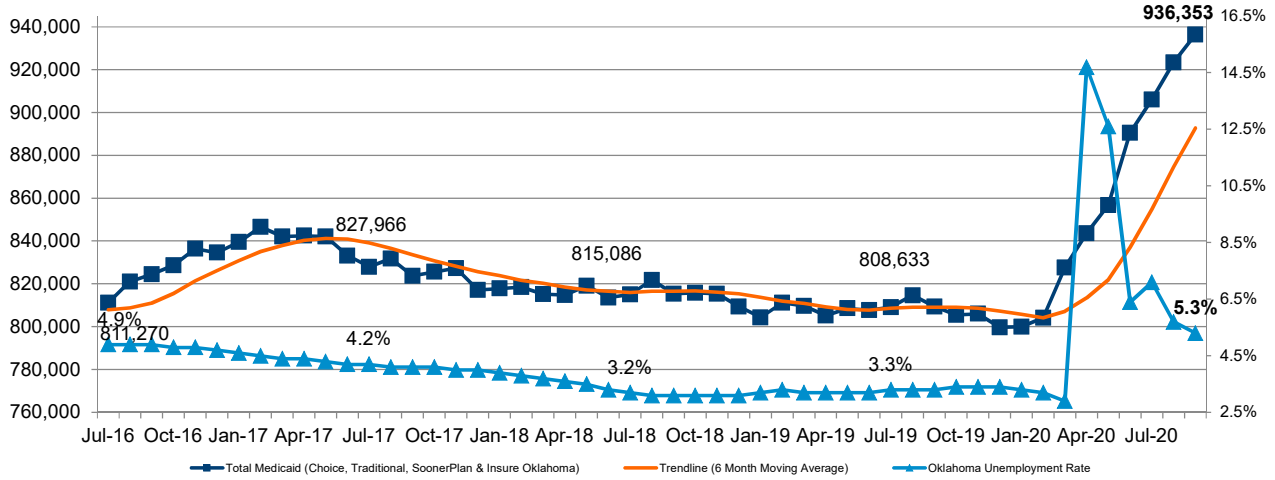
CHILDREN & ADULTS ENROLLMENT



Enrollment increase beginning in March 2020 is due to COVID response to maintain members continuous coverage of care by postponing recertification.

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. Data was extracted on 9/26/2018.
In June 2017 there were changes to the passive renewal system criteria that reduced the number of passively renewed members by 2/3rds.
Enrollment increase beginning in March 2020 is due to COVID response to maintain members continuous coverage of care by postponing recertification.

November MAC
Proposed Rules Amendment Summaries

Tribal consultations regarding the following proposed changes were held on Wednesday, July 11, 2018; Tuesday, November 5, 2019; Tuesday, March 3, 2020; Tuesday, July 7, 2020; Tuesday, September 1, 2020; and Tuesday, November 3, 2020.

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

APA WF # 20-04 Electronic Visit Verification — ADDING agency rules at ***Oklahoma Administrative Code (OAC) 317:30-3-34*** to comply with the 21st Century Cures Act which requires providers of personal care services to utilize an electronic visit verification (EVV) system where visit details are documented in real time. The revisions will require that certain details of the visit including the type of service performed, the individual receiving the service, the date of the service, the location of service delivery, the individual providing the service, and the time the service begins and ends are entered into the EVV system. Further revisions outline personal care provider requirements and claims reimbursement as it applies to EVV use. Finally, revisions will include minor cleanup to fix grammatical and formatting errors.

Budget Impact: Agency staff has determined that the proposed revisions could potentially result in a $150,000 one-time set-up cost (90% match) and another $120,000 (75% match) for operations. Please note that a change to the estimated budget impact may be different upon implementation; however, the 90/75% match ratio will remain the same.

APA WF # 20-13 Child Support Cooperation Exemption for Recipients of Indian Health Services — AMENDING agency rules at ***OAC 317:35-5-7 and 317:35-5-44*** to update policy due to changes in federal regulations which state that a referral for medical support enforcement is not made from the state Medicaid agency to the state child support agency whenever the child is eligible for services through the Indian Health Service and the referral or the case is based solely on services provided through an Indian Health program. The revisions will add an additional instance when cooperation by the parent/caretaker with the state child support agency is not required.

Budget Impact: Budget neutral.

APA WF # 20-14 Therapy Assistants and Clinical Fellows — AMENDING agency rules at ***OAC 317:30-5-290.1, 317:30-5-291, 317:30-5-291.1, 317:30-5-293, 317:30-5-295, 317:30-5-296, 317:30-5-297, 317:30-5-299, 317:30-5-482, 317:30-5-641, 317:30-5-675, 317:30-5-676, 317:30-5-677, 317:30-5-680, and 317:30-5-1023*** to add physical therapy assistants, occupational therapy assistants, speech-language pathology assistants (SLPAs), and speech-language pathology clinical fellows as eligible providers that can render therapy services to SoonerCare members. Additionally, the proposed revisions will outline provider qualifications and other requirements for provision of these therapy services. Finally, revisions will be made to clarify that these providers will be reimbursed at the rate established per the Oklahoma Medicaid State Plan.

Budget Impact: The estimated budget impact, for SFY2021, will be an increase in the total amount of $2,297,680; with $856,116 in state share. The estimated budget impact, for SFY2022, will be an increase in the total amount of $4,595,360; with $1,493,492 in state share.

APA WF # 20-15A Residential Substance Use Disorder (SUD) Treatment Coverage — AMENDING agency rules at ***OAC 317:25-7-13*** to support the changes being made in WF 20-15B, which proposes coverage of residential substance use disorder (SUD) treatment for Medicaid-eligible individuals and removes the eligibility exclusion of members in an institution for mental disease (IMD) under the SoonerCare Choice program. Lastly, the proposed revisions will also remove "family planning" references as the program is terminating due to Medicaid expansion.

Budget Impact: The estimated budget impact for coverage of services provided under the IMD Waiver authority is $12,604,149 total/$6,427,171 state savings (6 months) for SFY2021. The estimated budget impact is $28,003,402 total/$12,854,341 state savings for SFY2022. The estimated budget impact reflect savings for the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) from the movement of state-funded services to Medicaid compensable services.

The estimated budget impact for residential SUD treatment coverage in residential SUD treatment facilities with sixteen (16) beds or less (non-IMDs) is $523,644 total/$275,136 state savings (9 months) for SFY2021. The estimated budget impact is $727,041 total/$370,736 state savings for SFY2022. The estimated budget impact reflect savings for the ODMHSAS from the movement of state-funded services to Medicaid compensable services.

APA WF # 20-15B Residential Substance Use Disorder (SUD) Treatment Coverage — AMENDING agency rules at ***OAC 317:30-5-95, 317:30-5-95.1, 317:30-5-95.42, 317:30-5-96.3, 317:30-5-241.6 and 317:30-5-268*** and ADDING agency rules at ***OAC 317:30-5-95.43 through 317:30-5-95.49*** to add residential substance use disorder (SUD) treatment coverage for Medicaid-eligible adults, ages twenty-one (21) to sixty-four (64), and members under the age of twenty-one (21) in residential SUD treatment facilities with seventeen (17) beds or more and/or residential SUD treatment facilities with sixteen (16) beds or less. Further revisions will outline provider requirements, medical necessity, service plan, and reimbursement policies. Other revisions will involve limited rewriting aimed at clarifying outdated policy sections and removing the institution for mental disease (IMD) exclusion for members, ages twenty-one (21) to sixty-four (64). Lastly, the proposed changes are authorized under 42 CFR 440.130(d) and comply with Oklahoma's 1115(a) IMD for serious mental illness (SMI) and SUD waiver request.

Budget Impact: The budget impact is reflected in APA WF # 20-15A.

APA WF # 20-16 SUPPORT Act Medication-Assisted Treatment and Opioid Treatment Programs — AMENDING agency rules at ***OAC 317:30-5-9*** and ADDING agency rules at ***OAC 317:30-5-241.7*** to comply with the SUPPORT Act, HR 6, Section 1006, and establish coverage and reimbursement of medically necessary medication-assisted treatment (MAT) services and/or medications for SoonerCare members with opioid use disorder (OUD) in opioid treatment programs (OTPs) and within office-based opioid treatment (OBOT) settings.

Budget Impact: The proposed changes to implement substance use disorder coverage in opioid treatment programs may potentially result in an estimated annual total cost of $1,492,594 with a state share of $446,417 for SFY21 and a total cost of $1,992,835 with a state share of $637,907 for SFY22. The state share will be paid by the Oklahoma Department of Mental Health and Substance Abuse Services.

The proposed changes to implement coverage of MAT medications may potentially result in an estimated annual total cost of $1,311,223 with a state share of $392,171 for SFY21 and a total cost of $1,750,679 with a state share of $562,318 for SFY22. The state share will be paid by the Oklahoma Health Care Authority.

APA WF # 20-19A Appeals Language Cleanup — AMENDING agency rules at ***OAC 317:2-1-2, 317:2-1-2.5, 317:2-1-13, and 317:2-1-14*** to replace incorrect rule section references with the appropriate references. Additionally, revisions will remove appeals language for programs that no longer exist and will identify the appropriate appeal form to fill out when filing an appeal. Finally, revisions will include minor cleanup to fix grammatical and formatting errors.

Budget Impact: Budget neutral.

APA WF # 20-19B Appeals and Incorrect References Language Cleanup — AMENDING agency rules at ***OAC 317:30-5-131.2 and 317:30-5-1020*** will replace incorrect rule section references with the appropriate references. Additionally, revisions will remove appeals language for programs that no longer exist and will involve minor cleanup to fix grammatical and formatting errors.

Budget Impact: Budget neutral.

APA WF # 20-20 Pay-for-Performance (PFP) Program — AMENDING agency rules at ***OAC 317:30-5-136.1*** to comply with Oklahoma Senate Bill 280, which directed the Oklahoma Health Care Authority (OHCA) to modify certain provisions related to reimbursement of long-term care facilities. The proposed policy revisions will update the PFP program quality measures to align with the most recent metrics modified by the Centers for Medicare and Medicaid (CMS). Additional changes will specify the timeline in which a nursing facility can submit its quality of care documentation to be eligible for reimbursement each quarter.

Budget Impact: Budget neutral.

APA WF # 20-21 Employment Services Offered through Developmental Disabilities Services — AMENDING agency rules at ***OAC 317:40-7-7 and 317:40-7-15*** to promote small group placements of up to three (3) members in an integrated work site who are paid at more than minimum wage. Policy changes will also create small groups between four (4) to five (5) members in an integrated work site, who may earn less than minimum wage. Additional changes will create provisions to authorize remote supports for individual placements, remove the specific limit that the cost of member's employment services, excluding transportation and state-funded services, cannot exceed limits specified in OKDHS Appendix D-26. Finally, changes will clarify that adult members receiving In-Home Supports Waiver (IHSW) services can access individual placement in job coaching, stabilization, and employment training specialist services not to exceed limits specified in OKDHS Appendix D-26 per Plan of Care year and changes will also clarify/update terminology used. Revisions will also align policy with current practice and correct grammatical errors.

Budget Impact: Budget neutral.

APA WF # 20-27 Specialty PRTF Staffing and Admission Revisions — AMENDING agency rules at ***OAC 317:30-5-95.24*** to update the specialty Psychiatric Residential Treatment Facility (PRTF) staffing ratio from one (1) staff: three (3) members to one (1) staff: four (4) members. Revisions will also clarify inpatient psychiatric admission criteria for members under twenty-one

(21) accessing specialty facilities. The proposed revisions will help support access to specialty providers for children with specialized treatment needs who are most in need of in-state specialty services.

Budget Impact: Budget neutral.

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-34. Electronic visit verification (EVV) system

An EVV system is a telephone-based, computer-based, or other electronic-based system that verifies and documents the time and location of services requiring an in-home visit, including, but not limited to, self-directed services, in accordance with an approved prior authorization or individual plan of care, and pursuant to Title 42 of the United States Code, Section (§) 1396b(l).

(1) **Verification requirements.** An EVV system must verify the following for in-home or community services:

(A) Type of service performed (service code and any applicable modifier);

(B) Date of service;

(C) SoonerCare member identification number of the individual receiving the service;

(D) Unique vendor identification number for the individual providing the service (service provider);

(E) Location where service starts and ends; and

(F) Time the service starts and ends.

(2) **Services requiring EVV system use.** An EVV system must be used for personal care services, as defined by Oklahoma Administrative Code (OAC) 317:35-15-2.

(3) **Services not requiring EVV system use.** When services are provided through home and community-based waivers, EVV is not required if those services are provided in:

(A) Combination with community residential supports, per Oklahoma Administrative Code (OAC) 340:100-5-22.1;

(B) Combination with group home services, per OAC 340:100-6;

(C) Congregate settings where twenty-four (24) hour service is available; or

(D) Settings where the member and service provider live-in the same residence.

(4) **Provider requirements.** Providers are required to use an EVV system. Providers may use the designated statewide EVV system, or their own EVV compliant system. A provider of personal care services using an EVV system must:

(A) Comply with all applicable federal and state laws and regulations, including, but not limited to, HIPAA privacy and security law, as defined in Section 3009 of the Public

Health Service Act; required reporting of abused and/or neglected children, adolescents, and vulnerable adults [Section (§) 1-2-101 of Title 10A of the Oklahoma Statutes (O.S.) and 43A O.S. § 10-104]; and OAC 317:30-3-4.1, Uniform Electronic Transaction Act;

(B) Adopt internal policies and procedures regarding the EVV system;

(C) Ensure that employees are adequately trained on the EVV system's proper use, and make available to them real-time technical resources and support, such as a help desk or call center information;

(D) Ensure employees are adequately trained to properly engage the personal care agency's backup system when the EVV system is not available; and

(E) Ensure that the system:

(i) Accommodates members and service providers with hearing, physical, or visual impairments;

(ii) Accommodates multiple members and/or service providers in the same home or at the same phone number, as well as multiple work shifts per member per day;

(iii) Supports the addition or deletion of members, service providers, and health care services, at any time during the month, as authorized by the Oklahoma Health Care Authority (OHCA) and/or the Oklahoma Department of Human Services (OKDHS);

(iv) Notifies supervisory staff at the personal care agency of any untimely or missed shifts, or any other deviation in scheduled care;

(v) Documents the existence of and justification for all manual modifications, adjustments, or exceptions after the service provider has entered or failed to enter the information in paragraph (1), above; and

(vi) Has the ability to respond to requests for records or documentation in the timeframe and format requested by OHCA.

(F) Be capable of retrieving current and archived data to produce summary reports of the information verified in Paragraph (1), above, as well as the information documented in (3)(E)(vi), above;

(G) Maintain reliable backup and recovery processes that ensure all data is preserved in the event of a system malfunction or disaster situation;

(H) Retain all data regarding the delivery of health care services for a minimum of six (6) years; and

(I) Establish a process to deactivate an employee's access to the EVV or designated system records upon termination of the designated employee's employment.

(4) **Claims reimbursement.** SoonerCare will not pay a claim for reimbursement unless the data is from the EVV system and includes all of the EVV verification requirements [refer to (1)(A through F] of this section:

(A) Corresponds with the health care services for which reimbursement is claimed; and

(B) Is consistent with any approved prior authorization or individual plan of care.

(5) **Program integrity.** Paid claims may be subject to retrospective review and recoupment, as appropriate, in accordance with OAC 317:30-3-2.1.

(6) **Procedures for EVV system failure or EVV system unavailability.** The EVV system provides alternate backup solutions if the automated system is unavailable; however, in the event of the EVV system failure, the provider documents the specified data in paragraph (1), above, in accordance with internal backup policies and procedures. This documentation is sufficient to account for in-home services. The personal care agency's backup procedures are only permitted when the EVV system is unavailable. In the event of EVV system failure, the provider documents time in accordance with internal policies and procedures. This documentation suffices to account for delivered services. Provider agency backup procedures are only permitted when the EVV system is unavailable.

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

SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME

PART 1. DETERMINATION OF QUALIFYING CATEGORICAL RELATIONSHIPS

317:35-5-7. Determining categorical relationship to the children and parent and caretaker relative groups

(a) **Categorical relationship.** All individuals under age nineteen (19) are automatically related to the children's group and further determination is not required. Adults age nineteen (19) or older are related to the parent and caretaker relative group when there is a minor dependent child(ren) in the home and the individual is the parent, or is the caretaker relative other than the parent who meets the proper degree of relationship. A minor dependent child is any child who meets the AFDC eligibility requirements of age and relationship.

(b) **Requirement for referral to the Oklahoma Child Support Services Division (OCSS).** As a condition of eligibility, when both the parent or caretaker and minor child(ren) are receiving SoonerCare and a parent is absent from the home, the parent or caretaker relative must agree to cooperate with OCSS. ~~However, federal regulations provide for a waiver of this requirement when cooperation with OCSS is not in the best interest of the child. OCSS is responsible for making the good cause determination. If the parent or caretaker relative is claiming good cause, he/she cannot be certified for SoonerCare in the parent and caretaker relative group unless OCSS has determined good cause exists. There is no requirement of cooperation with OCSS for child(ren) or pregnant women to receive SoonerCare.~~ However, cooperation with OCSS is not required in the following instances:

(1) OCSS made a good cause determination that cooperation is not in the best interest of the child;

(2) The child is eligible for health care services through the Indian Health Service and the child support case was or would have been opened because of a Medicaid referral based solely on health care services provided through an Indian Health Program, in accordance with 42 C.F.R. § 533.152; or

(3) The SoonerCare application is only for child(ren) and/or pregnant women.

PART 5. COUNTABLE INCOME AND RESOURCES

317:35-5-44. Child/spousal support

The Omnibus Budget Reconciliation Act of 1987 requires the

Oklahoma Department of Human Services to provide Child Support Services to certain families receiving SoonerCare benefits through the Oklahoma Child Support Services Division (OCSS). The families are required to cooperate in assignment of medical support rights except as specified in Oklahoma Administrative Code (OAC) 317:35-5-7(b) In accordance with 42 Code of Federal Regulations (CFR) § 433.152, the Oklahoma Health Care Authority (OHCA) may not refer a case for medical support enforcement when the Medicaid referral is based solely upon health care services provided through an Indian Health Program (as defined at 25 United States Code (U.S.C.) § 1603(12)), including through the Purchased/Referred Care program, to a child who is eligible for health care services from the Indian Health Services (IHS). These families will not be required to cooperate with the OCSS in the assignment of child/spousal support rights. The families involved are those with a minor child(ren) in the home. The child(ren) must be related to the children's, the blind or the disabled groups and have a parent(s) absent from the home. Any support collected on behalf of these families will be paid to them as if they were receiving non-public assistance child support services, with one exception. The exception is regarding child support collected for foster care child(ren) in OKDHS temporary custody. This support is paid to OKDHS Children and Family Services Division (CFSD). The rules in OAC 317:10 are used, with the following exceptions:

(1) In the event the family already has an existing child support case, the only action required is a memo to the appropriate OCSS district office notifying them of the certification.

(2) Prior to October 1, 2013, child/spousal support is always counted as income less any applicable income disregard. This income inclusion applies whether it is redirected to the OCSS or retained by the member. Effective October 1, 2013, see rules regarding financial eligibility for the individual's eligibility group to determine whether child or spousal support is counted as income.

(3) Children who are in custody of OKDHS may be exempt from referral to OCSS. Should the pursuit of the OCSS services be determined to be detrimental to the OKDHS CFSD service plan, an exemption may be approved.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 27. INDEPENDENT ~~LICENSED~~ PHYSICAL THERAPISTS AND PHYSICAL THERAPIST ASSISTANTS

317:30-5-290.1. Eligible providers

~~(a) Eligible physical therapists must be appropriately licensed in the state in which they practice.~~

~~(b) All eligible providers of physical therapy services must have entered into a Provider Agreement with the Oklahoma Health Care Authority to perform physical therapy services.~~

(a) **Physical therapists.**

(1) Must be appropriately licensed in good standing in the state in which they practice and working in accordance with the Oklahoma Physical Therapy Practice Act or other applicable statute(s); and

(2) Entered into a provider agreement with the Oklahoma Health Care Authority (OHCA) to provide physical therapy services.

(b) **Physical therapist assistants.**

(1) Must be working under the supervision of a fully licensed physical therapist;

(2) Must be appropriately licensed in good standing in the state in which they practice and working in accordance with the Oklahoma Physical Therapy Practice Act or other applicable statute(s);

(3) Entered into a provider agreement with the OHCA to provide physical therapy services; and

(4) Provided the name of their OHCA-contracted supervising physical therapist upon enrollment.

317:30-5-291. Coverage by category

Payment is made to registered physical therapists as set forth in this Section.

(1) **Children.** Initial therapy evaluations do not require prior authorization and must be provided by a fully licensed physical therapist. All therapy services following the initial evaluation must be prior authorized for continuation of service. Prior to the initial evaluation, the therapist must have on file a signed and dated prescription or referral for the therapy services from the member's physician or other licensed practitioner of the healing arts. The prescribing or referring provider must be able to provide, if requested, clinical documentation from the member's medical record that supports the medical necessity for the evaluation and referral.

(2) **Adults.** There is no coverage for adults for services rendered by individually contracted providers. Coverage for

adults is permitted in an outpatient hospital setting as described in Oklahoma Administrative Code 317:30-5-42.1.

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

317:30-5-291.1. Payment rates

~~Payment is made in accordance with the current allowable Medicaid fee schedule.~~All physical therapy services are reimbursed per the methodology described in the Oklahoma Medicaid State Plan.

317:30-5-293. Team therapy (Co-treatment)

Therapists, or therapy assistants, working together as a team to treat one (1) or more members cannot ~~each~~ bill separately for the same or different service provided at the same time to the same member.

(1) ~~CPT~~Current Procedural Terminology (CPT) codes are used for billing the services of one (1) therapist or therapy assistant. The therapist cannot bill for his/her services and those of another therapist or a therapy assistant, when both provide the same or different services, at the same time, to the same member.

(2) If multiple therapies (physical therapy, occupational therapy, and/or speech therapy) are provided to one (1) member at the same time, only one (1) therapist can bill for the entire service, or each therapist can divide the service units.

(3) Providers must report the CPT code for the time actually spent in the delivery of the modality requiring constant attendance and therapy services. Pre- and post-delivery services are not to be counted in determining the treatment service time. The time counted must begin when the therapist is directly working with the member to deliver treatment services.

(4) The time counted is the time the member is being treated. If the member requires both a therapist and an assistant, or even two (2) therapists, each service unit of time the member is being treated can count as only one (1) unit of each code. The service units billed must equal the total time the member was receiving actual therapy services. It is not allowable for each therapist or therapy assistant to bill for the entire therapy session. The time the member spends not being treated, for any reason, must not be billed.

PART 28. ~~OCCUPATIONAL THERAPY SERVICES~~OCCUPATIONAL THERAPISTS AND OCCUPATIONAL THERAPY ASSISTANTS

317:30-5-295. Eligible providers

~~(a) Eligible occupational therapists must be appropriately licensed in the state in which they practice.~~

~~(b) All eligible providers of occupational therapy services must~~

~~have entered into a Provider Agreement with the Oklahoma Health Care Authority to perform occupational therapy services.~~

(a) **Occupational therapists.**

(1) Must be appropriately licensed in good standing in the state in which they practice and working in accordance with the Oklahoma Occupational Therapy Practice Act or other applicable statute(s); and

(2) Entered into a provider agreement with the Oklahoma Health Care Authority (OHCA) to provide occupational therapy services.

(b) **Occupational therapy assistants.**

(1) Must be working under the supervision of a fully licensed occupational therapist;

(2) Must be appropriately licensed in good standing in the state in which they practice and working in accordance with the Oklahoma Occupational Therapy Practice Act or other applicable statute(s);

(3) Entered into a provider agreement with the OHCA to provide occupational therapy services; and

(4) Provided the name of their OHCA-contracted supervising occupational therapist upon enrollment.

317:30-5-296. Coverage by category

Payment is made for occupational therapy services as set forth in this Section.

(1) **Children.** Initial therapy evaluations do not require prior authorization and must be provided by a fully licensed occupational therapist. All therapy services following the initial evaluation must be prior authorized for continuation of service. Prior to the initial evaluation, the therapist must have on file a signed and dated prescription or referral for the therapy services from the member's physician or other licensed practitioner of the healing arts. The prescribing or referring provider must be able to provide, if requested, clinical documentation from the member's medical record that supports the medical necessity for the evaluation and referral.

(2) **Adults.** There is no coverage for adults for services rendered by individually contracted providers. Coverage for adults is permitted in an outpatient hospital setting as described in Oklahoma Administrative Code 317:30-5-42.1.

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

317:30-5-297. Payment rates

~~Payment is made in accordance with the current allowable Medicaid fee schedule.~~All occupational therapy services are reimbursed per the methodology described in the Oklahoma Medicaid State Plan.

317:30-5-299. Team therapy (Co-treatment)

Therapists, or therapy assistants, working together as a team to treat one (1) or more members cannot ~~each~~ bill separately for the same or different service provided at the same time to the same member.

(1) ~~CPT~~Current Procedural Terminology (CPT) codes are used for billing the services of one (1) therapist or therapy assistant. The therapist cannot bill for his/her services and those of another therapist or a therapy assistant, when both provide the same or different services, at the same time, to the same member.

(2) If multiple therapies (physical therapy, occupational therapy, and/or speech therapy) are provided to one (1) member at the same time, only one (1) therapist can bill for the entire service, or each therapist can divide the service units.

(3) Providers must report the CPT code for the time actually spent in the delivery of the modality requiring constant attendance and therapy services. Pre- and post-delivery services are not to be counted in determining the treatment service time. The time counted must begin when the therapist is directly working with the member to deliver treatment services.

(4) The time counted is the time the member is being treated. If the member requires both a therapist and an assistant, or even two (2) therapists, each service unit of time the member is being treated can count as only one (1) unit of each code. The service units billed must equal the total time the member was receiving actual therapy services. It is not allowable for each therapist or therapy assistant to bill for the entire therapy session. The time the member spends not being treated, for any reason, must not be billed.

PART 51. HABILITATION SERVICES

317:30-5-482. Description of services

Habilitation services include the services identified in (1) through (15) of this Section. Habilitation services providers must have an applicable agreement with the Oklahoma Health Care Authority (OHCA) to provide Developmental Disabilities Services (DDS) Home and Community-Based Services (HCBS).

(1) **Dental services.** Dental services are provided per Oklahoma Administrative Code (OAC) 317:40-5-112.

(A) **Minimum qualifications.** Dental services providers must have non-restrictive licensure by the Oklahoma State Board of Dentistry to practice dentistry in Oklahoma.

(B) **Description of services.** Dental services include services for maintenance or improvement of dental health as well as relief of pain and infection. These services may include:

(i) ~~an~~An oral examination;

(ii) ~~bite~~Bite-wing X-rays;
(iii) ~~dental~~Dental cleaning;
(iv) ~~topical~~Topical-fluoride treatment;
(v) ~~development~~Development of a sequenced treatment plan that prioritizes:
(I) ~~elimination~~Elimination of pain;
(II) ~~adequate~~Adequate oral hygiene; and
(III) ~~restoration~~Restoration or an improved ability to chew;
(vi) ~~routine~~Routine training of member or primary caregiver regarding oral hygiene; and
(vii) ~~preventive~~Preventive, restorative, replacement, and repair services to achieve or restore functionality provided after appropriate review when applicable, per OAC 317:40-5-112.

(C) **Coverage limitations.** Coverage of dental services is specified in the member's Individual Plan (IP) in accordance with applicable Waiver limits. Dental services are not authorized when recommended for cosmetic purposes.

(2) **Nutrition services.** Nutrition Services are provided per OAC 317:40-5-102.

(3) **Occupational therapy services.**

(A) **Minimum qualifications.** Occupational therapists and occupational therapy assistants must have current, non-restrictive licensure by the Oklahoma Board of Medical Licensure and Supervision. Occupational therapy assistants must be ~~employed~~supervised by occupational therapists~~.~~, per OAC 317:30-5-295 (b) (1).

(B) **Description of services.** Occupational therapy services include evaluation, treatment, and consultation in leisure management, daily living skills, sensory motor, perceptual motor, and mealtime assistance. Occupational therapy services may include the use of occupational therapy assistants, within the limits of the occupational therapist's practice.

(i) Services are:
(I) ~~intended~~Intended to help the member achieve greater independence to reside and participate in the community; and
(II) ~~rendered~~Rendered in any community setting as specified in the member's IP. The IP must include a practitioner's prescription.

(ii) For purposes of this Section, a practitioner is defined as medical and osteopathic physicians, physician assistants, and other licensed health care professionals with prescriptive authority to order occupational therapy services in accordance with the rules and regulations governing the SoonerCare program.

(iii) The provision of services includes a written report or record documentation in the member's record, as

required.

(C) **Coverage limitations.** Payment is made for compensable services to the individual occupational therapist for direct services or for services provided by a qualified occupational therapist assistant, within the occupational therapist's employment. Payment is made in 15-minute units, with a limit of ~~480~~four hundred and eighty (480) units per Plan of Care year. Payment is not allowed solely for written reports or record documentation.

(4) **Physical therapy services.**

(A) **Minimum qualifications.** Physical therapists and physical therapist assistants must have current, non-restrictive licensure with the Oklahoma Board of Medical Licensure and Supervision. The physical therapist must ~~employ~~supervise the physical therapist assistant~~.~~, per OAC 317:30-5-290.1 (b)(1).

(B) **Description of services.** Physical therapy services include evaluation, treatment, and consultation in locomotion or mobility and skeletal and muscular conditioning to maximize the member's mobility and skeletal/muscular well-being. Physical therapy services may include the use of physical therapist assistants, within the limits of the physical therapist's practice.

(i) Services are intended to help the member achieve greater independence to reside and participate in the community. Services are provided in any community setting as specified in the member's IP. The IP must include a practitioner's prescription. For purposes of this Section, practitioners are defined as licensed medical and osteopathic physicians, and physician assistants in accordance with the rules and regulations covering the OHCA SoonerCare program.

~~(ii) For purposes of this Section, a practitioner is defined as a licensed medical and osteopathic physicians, and physician assistants in accordance with the rules and regulations covering the OHCA SoonerCare program.~~

~~(iii)~~(ii) The provision of services includes a written report or record documentation in the member's record, as required.

(C) **Coverage limitations.** Payment is made for compensable services to individual physical therapists for direct services or for services provided by a qualified physical therapist assistant within the physical therapist's employment. Payment is made in 15-minute units with a limit of ~~480~~four hundred and eighty (480) units per Plan of Care year. Payment is not allowed solely for written reports or record documentation.

(5) **Psychological services.**

(A) **Minimum qualifications.** Qualification as a provider of

psychological services requires current, non-restrictive licensure as a psychologist by the Oklahoma State Board of Examiners of Psychologists or licensing board in the state in which service is provided. Psychological technicians who have completed all board certification and training requirements may provide services under a licensed psychologist's supervision.

(B) **Description of services.** Psychological services include evaluation, psychotherapy, consultation, and behavioral treatment. Service is provided in any community setting as specified in the member's IP. The provider must develop, implement, evaluate and revise the Protective Intervention Protocol (PIP) corresponding to the relevant outcomes identified in the member's IP.

(i) Services are:

(I) ~~intended~~Intended to maximize a member's psychological and behavioral well-being; and

(II) ~~provided~~Provided in individual and group formats, with a six-person maximum.

(ii) Approval of services is based upon assessed needs per OAC 340:100-5-51.

(C) **Coverage limitations.**

(i) Payment is made in ~~15~~fifteen (15) minute units. A minimum of ~~15~~fifteen (15) minutes for each individual and group encounter is required.

(ii) Psychological services are authorized for a period, not to exceed twelve (12) months.

(I) Initial authorization must not exceed ~~192~~one hundred and ninety-two (192) units, ~~48~~forty-eight (48) hours of service.

(II) Authorizations may not exceed ~~288~~two hundred and eighty-eight (288) units per plan of care year unless an exception is made by the DDS director of Behavior Support Services or his or her designee.

(III) No more than ~~12~~twelve (12) hours of services, ~~48~~forty-eight (48) units, may be billed for PIP preparation. Any clinical document must be prepared within sixty (60) calendar days of the request. Further, if the document is not prepared, payments are suspended until the requested document is provided.

(IV) When revising a PIP to accommodate recommendations of a required committee review, the provider may bill for only one (1) revision. The time for preparing the revision must be clearly documented and must not exceed four (4) hours.

(6) **Psychiatric services.**

(A) **Minimum qualifications.** Qualification as a psychiatric services provider requires a current, non-restrictive license to practice medicine in Oklahoma. Certification by the

American Board of Psychiatry and Neurology or satisfactory completion of an approved residency program in psychiatry is required.

(B) **Description of services.** Psychiatric services include outpatient evaluation, psychotherapy, medication and prescription management and consultation, and are provided to eligible members. Services are provided in community setting specified in the member's IP.

(i) Services are intended to contribute to the member's psychological well-being.

(ii) A minimum of ~~30~~thirty (30) minutes for encounter and record documentation is required.

(C) **Coverage limitations.** A unit is ~~30~~thirty (30) minutes, with a limit of ~~200~~two hundred (200) units, per Plan of Care year.

(7) **~~Speech/language~~Speech-language pathology services.**

(A) **Minimum qualifications.** Qualification as a ~~speech and/or language~~speech-language pathology services provider requires current, non-restrictive licensure as a ~~speech and/or language~~speech-language pathologist by the Oklahoma Board of Examiners for Speech-Language Pathology and Audiology~~.~~, per OAC 317:30-5-675 (a) (1) through (3).

(B) **Description of services.** Speech therapy includes evaluation, treatment, and consultation in communication and oral motor and/or feeding activities provided to eligible members. Services are intended to maximize the member's community living skills and may be provided in the community setting specified in the member's IP. ~~The IP must include a practitioner's prescription.~~

(i) The IP must include a practitioner's prescription. For purposes of this Section, practitioners are defined as licensed medical and osteopathic physicians, physician assistants, and other licensed professionals with prescriptive authority to order speech and/or language services in accordance with rules and regulations covering the OHCA SoonerCare program.

(ii) A minimum of ~~15~~fifteen (15) minutes for encounter and record documentation is required.

(C) **Coverage limitations.** A unit is ~~15~~fifteen (15) minutes, with a limit of ~~288~~two hundred and eighty-eight (288) units, per Plan of Care year.

(8) **Habilitation training specialist (HTS) services.**

(A) **Minimum qualifications.** Providers must complete the Oklahoma Department of Human Services (DHS) DDS-sanctioned training curriculum. Residential habilitation providers:

(i) ~~are~~Are at least ~~18~~eighteen (18) years of age;

(ii) ~~are~~Are specifically trained to meet members' unique needs;

(iii) ~~were~~Were not convicted of, pled guilty to, or pled

nolo contendere to misdemeanor assault and battery, or a felony, per Section (§) 1025.2 of Title 56 of the Oklahoma Statutes ~~(56 O.S. ' 1025.2)~~(O.S.); unless a waiver is granted, per 56 O.S. ' 1025.2; and

(iv) ~~receive~~Receive supervision and oversight from contracted-agency staff with a minimum of four (4) years of any combination of college-level education or full-time equivalent experience in serving persons with disabilities.

(B) **Description of services.** HTS services include services to support the member's self-care, daily living, and adaptive and leisure skills needed to reside successfully in the community. Services are provided in community-based settings in a manner that contributes to the member's independence, self-sufficiency, community inclusion, and well-being.

(i) Payment is not made for:

(I) ~~routine~~Routine care and supervision normally provided by family; or

(II) ~~services~~Services furnished to a member by a person who is legally responsible per OAC 340:100-3-33.2.

(ii) Family members who provide HTS services must meet the same standards as providers who are unrelated to the member. HTS staff residing in the same household as the member may not provide services in excess of ~~40~~forty (40) hours per week. Members requiring more than ~~40~~forty (40) hours per week of HTS services, must use staff members, who do not reside in the household and are employed by the member's chosen provider agency to deliver the balance of necessary support staff hours. Exceptions may be authorized, when needed, for members who receive services through the Homeward Bound Waiver.

(iii) Payment does not include room and board or maintenance, upkeep, or improvement of the member's or family's residence.

(iv) For members who also receive intensive personal supports (IPS), the member's IP must clearly specify the role of the HTS and person providing IPS to ensure there is no duplication of services.

(v) Review and approval by the DDS plan of care reviewer is required.

(vi) Pre-authorized HTS services accomplish the same objectives as other HTS services, but are limited to situations where the HTS provider is unable to obtain required professional and administrative oversight from an OHCA-approved oversight agency. For pre-authorized HTS services, the service:

(I) ~~provider~~Provider receives DDS area staff oversight; and

(II) ~~must~~Must be pre-approved by the DDS director or his or her designee.

(C) **Coverage limitations.** HTS services are authorized per OAC 317:40-5-110, 317:40-5-111, 317:40-7-13, and 340:100-3-33.1.

(i) A unit is ~~15~~fifteen (15) minutes.

(ii) Individual HTS services providers are limited to a maximum of ~~40~~forty (40) hours per week regardless of the number of members served.

(iii) More than one (1) HTS may provide care to a member on the same day.

(iv) Payment cannot be made for services provided by two (2) or more HTSs to the same member during the same hours of a day.

(v) A HTS may receive reimbursement for providing services to only one (1) member at any given time. This does not preclude services from being provided in a group setting where services are shared among members of the group.

(vi) HTS providers may not perform any job duties associated with other employment including on-call duties, at the same time they are providing HTS services.

(9) **Self Directed HTS (SD HTS).** SD HTS are provided per OAC 317:40-9-1.

(10) **Self Directed Goods and Services (SD GS).** SD GS are provided per OAC 317:40-9-1.

(11) **Audiology services.**

(A) **Minimum qualifications.** Audiologists must have licensure as an audiologist by the Oklahoma Board of Examiners for Speech Pathology and Audiology.

(B) **Description of services.** Audiology services include individual evaluation, treatment, and consultation in hearing to eligible members. Services are intended to maximize the member's auditory receptive abilities. ~~The member's IP must include a practitioner's prescription.~~

(i) The member's IP must include a practitioner's prescription. For purposes of this Section, practitioners are defined as licensed medical and osteopathic physicians, and physician assistants in accordance with rules and regulations covering the OHCA SoonerCare program.

(ii) A minimum of ~~15~~fifteen (15) minutes for encounter and record documentation is required.

(C) **Coverage limitations.** Audiology services are provided in accordance with the member's IP.

(12) **Prevocational services.**

(A) **Minimum qualifications.** Prevocational services providers:

(i) ~~are~~Are at least ~~18~~eighteen (18) years of age;

(ii) ~~complete~~Complete the DHS DDS-sanctioned training curriculum;

(iii) ~~were~~Were not convicted of, pled guilty to, or pled

nolo contendere to misdemeanor assault and battery, or a felony per 56 O.S. '_1025.2, unless a waiver is granted per 56 O.S. '_1025.2; and

(iv) ~~receive~~Receive supervision and oversight by a person with a minimum of four (4) years of any combination of college-level education or full-time equivalent experience in serving persons with disabilities.

(B) **Description of services.** Prevocational services are not available to persons who can be served under a program funded per Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (IDEA) per Section 1401 et seq. of Title 20 of the United States Code.

(i) Prevocational services are learning and work experiences where the individual can develop general, non-job, task-specific strengths that contribute to employability in paid employment in integrated community settings.

(ii) Activities include teaching concepts, such as communicating effectively with supervisors, co-workers, and customers, attendance, task completion, problem solving, and safety. These activities are associated with building skills necessary to perform work.

(iii) Pre-vocational services are delivered for the purpose of furthering habilitation goals that lead to greater opportunities for competitive, integrated employment. All prevocational services are reflected in the member's IP. Documentation must be maintained in the record of each member receiving this service, noting the service is not otherwise available through a program funded under the Rehabilitation Act of 1973 or IDEA.

(iv) Services include:

(I) ~~center~~Center-based prevocational services, per OAC 317:40-7-6;

(II) ~~community~~Community-based prevocational services per, OAC 317:40-7-5;

(III) ~~enhanced~~Enhanced community-based prevocational services per, OAC 317:40-7-12; and

(IV) ~~supplemental~~Supplemental supports, as specified in OAC 317:40-7-13.

(C) **Coverage limitations.** A unit of center-based or community-based prevocational services is one (1) hour and payment is based on the number of hours the member participates in the service. All prevocational services and supported-employment services combined may not exceed $27,000, per Plan of Care year. The services that may not be provided to the same member at the same time as prevocational services are:

(i) HTS;

(ii) Intensive Personal Supports;

(iii) Adult Day Services;

(iv) Daily Living Supports;
(v) Homemaker; or
(vi) ~~therapy~~Therapy services, such as occupational therapy; physical therapy; nutrition, speech, or psychological services; family counseling; or family training, except to allow the therapist to assess the individual's needs at the workplace or to provide staff training, per OAC 317:40-7-6.

(13) **Supported employment.**

(A) **Minimum qualifications.** Supported employment providers:
(i) ~~are~~Are at least ~~18~~eighteen (18) years of age;
(ii) ~~complete~~Complete the DHS DDS-sanctioned training curriculum;
(iii) ~~were~~Were not convicted of, pled guilty to, or pled nolo contendere to misdemeanor assault and battery, or a felony, per ~~Section 1025.2 of Title 56 of the Oklahoma Statutes (O.S. 56 ' 1025.2)~~56 O.S. ' 1025.2 unless a waiver is granted, per 56 O.S.' 1025.5; and
(iv) ~~receive~~Receive supervision and oversight by a person with a minimum of four (4) years of any combination of college-level education or full-time equivalent experience in serving persons with disabilities.

(B) **Description of services.** Supported employment is conducted in a variety of settings, particularly worksites in which persons without disabilities are employed, and includes activities that are outcome based and needed to sustain paid work by members receiving services through HCBS Waivers, including supervision and training. The outcome of supported employment is sustained paid employment at or above minimum wage, but not less than the customary wage and benefit level paid by the employer for the same or similar work performed by individuals without disabilities. The paid employment occurs in an integrated setting in the general workforce in a job that meets personal and career goals.

(i) When supported-employment services are provided at a worksite in which persons without disabilities are employed, payment:
(I) ~~is~~Is made for the adaptations, supervision, and training required by members as a result of their disabilities; and
(II) ~~does~~Does not include payment for the supervisory activities rendered as a normal part of the business setting.

(ii) Services include:
(I) ~~job~~Job coaching per OAC 317:40-7-7;
(II) ~~enhanced~~Enhanced job coaching per OAC 317:40-7-12;
(III) ~~employment~~Employment training specialist services per OAC 317:40-7-8; and
(IV) ~~stabilization~~Stabilization per OAC 317:40-7-11.

(iii) Supported-employment services furnished under HCBS Waivers are not available under a program funded by the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act (IDEA).

(iv) Documentation that the service is not otherwise available under a program funded by the Rehabilitation Act of 1973 or IDEA must be maintained in the record of each member receiving the service.

(v) Federal financial participation (FFP) may not be claimed for incentive payment subsidies or unrelated vocational training expenses, such as:

(I) ~~incentive~~Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;

(II) ~~payments~~Payments passed through to users of supported-employment programs; or

(III) ~~payments~~Payments for vocational training not directly related to a member's supported-employment program.

(C) **Coverage limitations.** A unit is ~~15~~fifteen (15) minutes and payment is made per OAC 317:40-7-1 through 317:40-7-21. All prevocational services and supported-employment services combined cannot exceed $27,000, per Plan of Care year. The DDS case manager assists the member to identify other alternatives to meet identified needs above the limit. The services that may not be provided to the same member, at the same time as supported-employment services are:

(i) HTS;

(ii) Intensive Personal Supports;

(iii) Adult Day Services;

(iv) Daily Living Supports;

(v) Homemaker; or

(vi) ~~therapy~~Therapy services, such as occupational therapy; physical therapy; nutrition, speech, or psychological services, family counseling, or family training, except to allow the therapist to assess the individual's needs at the workplace or to provide staff training.

(14) **Intensive personal supports (IPS).**

(A) **Minimum qualifications.** IPS provider agencies must have a current provider agreement with OHCA and DHS DDS. Providers:

(i) ~~are~~Are at least ~~18~~eighteen (18) years of age;

(ii) ~~complete~~Complete the DHS DDS-sanctioned training curriculum;

(iii) ~~were~~Were not convicted of, pled guilty to, or pled nolo contendere to misdemeanor assault and battery, or a felony, per ~~Section 1025.2 of Title 56 of the Oklahoma Statutes (O.S. 56 ' 1025.2)~~56 O.S. ' 1025.2 unless a

waiver is granted, per 56 O.S.' 1025.2;

(iv) ~~receive~~Receive supervision and oversight by a person with a minimum of four (4) years of any combination of college-level education or full-time equivalent experience in serving persons with disabilities; and

(v) ~~receive~~Receive oversight regarding specific methods to be used with the member to meet the member's complex behavioral or health support needs.

(B) **Description of services.**

(i) IPS:

(I) ~~are~~Are support services provided to members who need an enhanced level of direct support in order to successfully reside in a community-based setting; and

(II) ~~build~~Build upon the level of support provided by a HTS or daily living supports (DLS) staff by utilizing a second staff person on duty to provide assistance and training in self-care, daily living, and recreational and habilitation activities.

(ii) The member's Individual Plan (IP) must clearly specify the role of HTS and the person providing IPS to ensure there is no duplication of services.

(iii) Review and approval by the DDS plan of care reviewer is required.

(C) **Coverage limitations.** IPS are limited to ~~24~~twenty-four (24) hours per day and must be included in the member's IP, per OAC 317:40-5-151 and 317:40-5-153.

(15) **Adult day services.**

(A) **Minimum qualifications.** Adult day services provider agencies must:

(i) ~~meet~~Meet the licensing requirements, per 63 O.S.' 1-873 *et seq*. and comply with OAC 310:605; and

(ii) ~~be~~Be approved by the DHS DDS director and have a valid OHCA contract for adult day services.

(B) **Description of services.** Adult day services provide assistance with the retention or improvement of self-help, adaptive and socialization skills, including the opportunity to interact with peers in order to promote a maximum level of independence and function. Services are provided in a non-residential setting away from the home or facility where the member resides.

(C) **Coverage limitations.** Adult day services are furnished four or more hours per day on a regularly scheduled basis, for one (1) or more days per week. A unit is ~~15~~fifteen (15) minutes for up to a maximum of six (6) hours daily, at which point a unit is one (1) day. All services must be authorized in the member's IP.

PART 73. EARLY INTERVENTION SERVICES

317:30-5-641. Coverage by category

Payment is made for early intervention services as set forth in this Section.

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

(2) **Children.** Payment is made for compensable services rendered by the ~~OSDH~~Oklahoma State Department of Health (OSDH) and its contractors, pursuant to the State's plan for Early Intervention services required under Part C of the ~~IDEIA~~IDEA.

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

(B) **Child health encounter (EPSDT partial screen).** The child health encounter (the EPSDT partial screen) may include a diagnosis and treatment encounter, a follow-up health encounter, or a home visit. A child health encounter may include:

(i) ~~child~~Child health history,

(ii) ~~physical~~Physical examination,

(iii) ~~developmental~~Developmental assessment,

(iv) ~~nutrition~~Nutrition assessment and counseling,

(v) ~~social~~Social assessment and counseling,

(vi) ~~indicated~~Indicated laboratory and screening tests,

(vii) ~~screening~~Screening for appropriate immunizations,

(viii) ~~health~~Health counseling, and

(ix) ~~treatment~~Treatment of common childhood illness and conditions.

(C) **Hearing and Hearing Aid evaluation.** Hearing evaluations must meet guidelines found at ~~OAC 317:30-5-675 and OAC~~ Oklahoma Administrative Code (OAC) 317:30-5-676.

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

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

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

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

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

(i) holds a certificate of clinical competence from ASHA; or

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

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

(F) **Speech language evaluation.** Speech language evaluation must be provided by a ~~state~~fully licensed speech-language pathologist.

(G) **Physical therapy evaluation.** Physical therapy evaluation must be provided by a ~~State~~fully licensed physical therapist.

(H) **Occupational therapy evaluation.** Occupational therapy evaluation must be provided by a ~~State~~fully licensed occupational therapist.

(I) **Psychological evaluation and testing.** Psychological evaluation and testing must be provided by State-licensed, board certified, psychologists.

(J) **Vision testing.** Vision testing examination must be provided by a State licensed Doctor of Optometry (O.D.) or licensed physician specializing in ophthalmology (M.D. or D.O.). At a minimum, vision services include diagnosis and treatment for defects in vision.

(K) **Treatment encounter.** A treatment encounter may occur through the provision of individual, family or group treatment services to infants and toddlers who are identified as having specific disorders or delays in development, emotional or behavioral problems, or disorders of speech, language, vision, or hearing. These types of encounters are initiated following the completion of a diagnostic encounter and subsequent development of the Individual Family Services Plan (IFSP), and may include the following:

(i) **Hearing and Vision Services.** These services include assisting the family in managing the child's vision and/or hearing disorder such as auditory training, habilitation training, communication management, orientation and mobility, and counseling the family. This encounter is designed to assist children and families with management issues that arise as a result of hearing and/or vision loss. These services are usually provided by vision impairment teachers or specialists and orientation specialists, and mobility specialists. These services may be provided in the home or community setting, such as a specialized day care center. Hearing services must be provided by:

(I) a State licensed, Master's Degree, ASHA certified audiologist; or

(II) ~~a State~~A fully licensed, Master's degree, ASHA certified speech-language pathologist; or

(III) ~~an~~An audiologist or speech-language pathologist

who has completed the equivalent educational requirements and work experience necessary for the certificate or has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

~~(ii) **Speech language therapy services.** Speech language therapy services must be provided by a State licensed, speech language pathologist who:~~

~~(I) holds a certificate of clinical competence from ASHA; or~~

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

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

(ii) **Speech-language therapy services.** Speech-language therapy services must be provided by:

(I) A fully licensed, speech-language pathologist who meets the requirements found at OAC 317:30-5-675 (a) (1) through (3);

(II) A licensed speech-language pathology assistant who is working under the supervision of a speech-language pathologist and meets the requirements found at OAC 317:30-5-675 (b) (1) through (4); or

(III) A licensed speech-language pathology clinical fellow, who is working under the supervision of a fully licensed speech-language pathologist and meets the requirements found at OAC 317:30-5-675 (c) (1) through (4).

(iii) **Physical therapy services.** Physical therapy services must be provided by a ~~State~~fully licensed physical therapist or physical therapist assistant, per OAC 317:30-5-290.1.

(iv) **Occupational therapy services.** Occupational therapy may include provision of services to improve, develop or restore impaired ability to function independently and must be provided by a ~~State~~fully licensed occupational therapist or occupational therapy assistant, per OAC 317:30-5-295.

(v) **Nursing services.** Nursing services may include the provision of services to protect the health status of infants and toddlers, correct health problems, and assist in removing or modifying health related barriers and must be provided by a registered nurse or licensed practical nurse under supervision of a registered nurse. Services may include medically necessary procedures rendered in the child's home.

(vi) **Psychological services.** Psychological and counseling

services are planning and managing a program of psychological services, including the provision of counseling or consultation to the family of the infant or toddler, when the service is for the direct benefit of the child and assists the family to better understand and manage the child's disabilities. Psychological services must be provided by a State-licensed psychologist.

(vii) **Psychotherapy counseling services.** Psychotherapy counseling services are the provision of counseling for children and parents. All services must be for the direct benefit of the child. Psychotherapy counseling services must be provided by a State licensed Social Worker, a State Licensed Professional Counselor, a State licensed Psychologist, State licensed Marriage and Family Therapist, or a State licensed Behavioral Practitioner, or under Board Supervision to be licensed in one of the above stated areas.

(viii) **Family Training and Counseling for Child Development.** Family Training and Counseling for Child Development services are the provision of training and counseling regarding concerns and problems in development. Services integrate therapeutic intervention strategies into the daily routines of a child and family in order to restore or maintain function and/or to reduce dysfunction resulting from a mental or physical disability or developmental delay. All services must be for the direct benefit of the child. Family Training and Counseling for Child Development services must be provided by a Certified Child Development Specialist.

(L) **Immunizations.** Immunizations must be coordinated with the Primary Care Physician for those infants and toddlers enrolled in SoonerCare. An administration fee, only, can be paid for immunizations provided by the OSDH.

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

(i) ~~State~~A fully licensed ~~Speech Language Pathologist who:~~speech-language pathologist as listed in OAC 317:30-5-675 (a) (1) through (3);

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

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

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

~~certificate;~~

(ii) ~~State~~A fully licensed ~~Physical Therapist; or~~physical therapist as listed in OAC 317:30-5-290.1 (a); or

(iii) ~~State~~A fully licensed ~~Occupational Therapist~~occupational therapist as listed in OAC 317:30-5-295 (a).

PART 77. ~~SPEECH AND HEARING SERVICES~~ SPEECH-LANGUAGE PATHOLOGISTS, SPEECH-LANGUAGE PATHOLOGY ASSISTANTS, CLINICAL FELLOWS, AND AUDIOLOGISTS

317:30-5-675. Eligible providers

~~(a) Eligible speech and hearing providers must be either state licensed speech/language pathologists or state licensed audiologists who:~~

~~(1) hold a certificate of clinical competence from the American Speech and Hearing Association; or~~

~~(2) have completed the equivalent educational requirements and work experience necessary for the certificate; or~~

~~(3) have completed the academic program and are acquiring supervised work experience to qualify for the certificate.~~

~~(b) All eligible providers of speech and hearing services must have entered into a contract with the Oklahoma Health Care Authority to perform speech and hearing services.~~

(a) **Speech-language pathologist (SLP).**

(1) Must be appropriately licensed in good standing in the state in which they practice and working in accordance with the Speech-Language Pathology and Audiology Licensing Act or other applicable statute(s);

(2) Entered into a Provider Agreement with the Oklahoma Health Care Authority (OHCA) to provide speech-language pathology services; and

(3) Must have one (1) of the following:

(A) Hold the Certificate of Clinical Competence from the American Speech-Language-Hearing Association (ASHA);

(B) Completed the equivalent educational requirements and work experience necessary for the certificate; or

(C) Have completed the academic program and are acquiring supervised work experience to qualify for the certificate.

(b) **Speech-language pathology assistant (SLPA).**

(1) Must be working under the supervision of a fully licensed speech-language pathologist;

(2) Must be appropriately licensed in good standing in the state in which they practice and working in accordance with the Speech-Language Pathology and Audiology Licensing Act or other applicable statute(s);

(3) Entered into a provider agreement with the OHCA to provide speech-language pathology services; and

(4) Provided the name of their OHCA-contracted supervising

speech-language pathologist upon enrollment.

(c) **Clinical fellow.**

(1) Must be working under the supervision of a fully licensed speech-language pathologist;

(2) Must have a clinical fellow license in good standing in the state in which they practice and working in accordance with the Speech-Language Pathology and Audiology Licensing Act or other applicable statute(s);

(3) Entered into a provider agreement with the OHCA to provide speech-language pathology services; and

(4) Provided the name of their OHCA-contracted supervising speech-language pathologist upon enrollment.

(d) **Audiologists.**

(1) Must be appropriately licensed in good standing in the state in which they practice and working in accordance the Speech-Language Pathology and Audiology Licensing Act or other applicable statute(s);

(2) Entered into a provider agreement with the Oklahoma Health Care Authority (OHCA) to provide speech-language pathology and audiology services; and

(3) Must have one (1) of the following:

(A) Hold the Certificate of Clinical Competence from ASHA;

(B) Completed the equivalent educational requirements and work experience necessary for the certificate; or

(C) Have completed the academic program and are acquiring supervised work experience to qualify for the certificate.

317:30-5-676. Coverage by category

Payment is made for speech and hearing services as set forth in this Section.

(1) **Children.** Coverage for children is as follows:

(A) **Preauthorization required.** All therapy services, including the initial evaluation, must be prior authorized. Prior to the initial evaluation, the therapist must have on file a signed and dated prescription or referral for the therapy services from the member's physician or other licensed practitioner of the healing arts. The prescribing or referring provider must be able to provide, if requested, clinical documentation from the member's medical record that supports the medical necessity for the evaluation and referral.

(B) ~~**Speech/Language Services**~~**Speech-language pathology services**. ~~Speech/language therapy services may include speech/language evaluations, individual and group therapy services provided by a state licensed speech/language pathologist.~~

(i) Speech-language pathology services may include speech-language evaluations, individual and group therapy services provided by a fully licensed and certified

speech-language pathologist, a licensed speech-language pathology clinical fellow, and services within the scope of practice of a speech-language pathology assistant as directed by the supervising speech-language pathologist, as listed in Oklahoma Administrative Code (OAC) 317:30-5-675 (a) through (c).

(ii) Initial evaluations must be prior authorized and provided by a fully licensed speech-language pathologist.

(C) **Hearing aids.** Hearing and hearing aid evaluations include pure tone air, bone and speech audiometry by a state licensed audiologist. Payment is made for a hearing aid following a recommendation by a Medical or Osteopathic physician and a hearing aid evaluation by a state licensed audiologist.

(2) **Adults.** There is no coverage for adults for services rendered by individually contracted providers. Coverage for adults is permitted in an outpatient hospital setting as described in ~~30-5-42.1.~~OAC 317:30-5-42.1.

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

317:30-5-677. Payment rates

~~Payment is made in accordance with the current allowable Medicaid fee schedule.~~All speech-language pathology and hearing services are reimbursed per the methodology described in the Oklahoma Medicaid State Plan.

317:30-5-680. Team therapy (Co-treatment)

Therapists, or therapy assistants, working together as a team to treat one (1) or more members cannot ~~each~~ bill separately for the same or different service provided at the same time to the same member.

(1) ~~CPT~~Current Procedural Terminology (CPT) codes are used for billing the services of one (1) therapist or therapy assistant. The therapist cannot bill for his/her services and those of another therapist or a therapy assistant, when both provide the same or different services, at the same time, to the same member.

(2) If multiple therapies (physical therapy, occupational therapy, and/or speech therapy) are provided to one (1) member at the same time, only one (1) therapist can bill for the entire service, or each therapist can divide the service units.

(3) Providers must report the CPT code for the time actually spent in the delivery of the modality requiring constant attendance and therapy services. Pre- and post-delivery services are not to be counted in determining the treatment service time. The time counted must begin when the therapist is directly working with the member to deliver treatment services.

(4) The time counted is the time the member is being treated. If the member requires both a therapist and an assistant, or even two (2) therapists, each service unit of time the member is being treated can count as only one (1) unit of each code. The service units billed must equal the total time the member was receiving actual therapy services. It is not allowable for each therapist or therapy assistant to bill for the entire therapy session. The time the member spends not being treated, for any reason, must not be billed.

PART 103. QUALIFIED SCHOOLS AS PROVIDERS OF HEALTH RELATED SERVICES

317:30-5-1023. Coverage by category

(a) **Adults.** There is no coverage for services rendered to adults twenty-one (21) years of age and older.

(b) **Children.** For non-Individualized Education Program (IEP) medical services that can be provided in a school setting, refer to Part 4, Early and Periodic Screening, Diagnostic and Treatment program, of Oklahoma Administrative Code at 317:30-3-65 through 317:30-3-63.12. Payment is made for the following compensable services rendered by qualified school providers:

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

(A) **Hearing and hearing aid evaluation.** Hearing evaluation includes pure tone air, bone, and speech audiometry. Hearing evaluations must be provided by a ~~state- licensed~~state-licensed audiologist who:

(i) Holds a Certificate of Clinical Competence from the American Speech-Language-Hearing Association (ASHA); or

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

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

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

(i) Holds a Certificate of Clinical Competence from ASHA; or

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

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

(C) **Ear impression (for earmold).** Ear impression (for earmold) includes taking an impression of a member's ear and

providing a finished earmold, to be used with the member's hearing aid as provided by a state-licensed audiologist who:

(i) Holds a Certificate of Clinical Competence from the ASHA; or

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

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

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

(E) **Speech-language evaluation.** Speech-language evaluation is for the purpose of identification of children or adolescents with speech or language disorders and the diagnosis and appraisal of specific speech and language services. Speech-language evaluations must be provided by ~~state-~~a fully licensed speech-language pathologist ~~who:~~as listed in OAC 317:30-5-675 (a) (1) through (3).

~~(i) Holds a Certificate of Clinical Competence from the ASHA; or~~

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

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

(F) **Physical therapy evaluation.** Physical therapy evaluation includes evaluating the student's ability to move throughout the school and to participate in classroom activities and the identification of movement dysfunction and related functional problems. It must be provided by a ~~state-~~fully licensed physical therapist as listed in OAC 317:30-5-290.1 (a) (1) and (2). Physical therapy evaluations must adhere to guidelines found at OAC 317:30-5-291.

(G) **Occupational therapy evaluation.** Occupational therapy evaluation services include determining what therapeutic services, assistive technology, and environmental modifications a student requires for participation in the special education program and must be provided by a ~~state-~~fully licensed occupational therapist~~.~~as listed in OAC 317:30-5-295 (a) (1) and (2). Occupational therapy evaluations must adhere to guidelines found at OAC 317:30-5-

296.

(H) **Evaluation and testing.** Evaluation and testing by psychologists and certified school psychologists are for the purpose of assessing emotional, behavioral, cognitive, or developmental issues that are affecting academic performance and for determining recommended treatment protocol. Evaluation or testing for the sole purpose of academic placement (e.g., diagnosis of learning disorders) is not a compensable service. These evaluations and tests must be provided by a state-licensed, board-certified psychologist or a certified school psychologist certified by the State Department of Education (SDE).

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

(A) **Hearing and vision services.** Hearing and vision services may include provision of habilitation activities, such as: auditory training; aural and visual habilitation training including Braille, and communication management; orientation and mobility; and counseling for vision and hearing losses and disorders. Services must be provided by or under the direct guidance of one (1) of the following individuals practicing within the scope of his or her practice under state law:

(i) ~~state-~~State licensed, master's degree audiologist who:

(I) Holds a Certificate of Clinical Competence from the ASHA; or

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

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

(ii) ~~State-~~Fully licensed, master's degree speech-language pathologist ~~who:~~as listed in OAC 317:30-5-675 (a) (1) through (3).

~~(I) Holds a Certificate of Clinical Competence from the ASHA; or~~

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

~~(III) Has completed the academic program and is acquiring supervised work experience to qualify for the~~

~~certificate; and~~

(iii) Certified orientation and mobility specialists~~; and~~.

(B) **Speech-language therapy services.** Speech-language therapy services include provisions of speech and language services for the habilitation or prevention of communicative disorders. Speech-language therapy services must be provided by or under the direct guidance and supervision of a ~~state-~~fully licensed speech-language pathologist within the scope of his or her practice under state law ~~who:~~ as listed in OAC 317:30-5-675 (a) (1) through (3).

~~(i) Holds a Certificate of Clinical Competence from the ASHA; or~~

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

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

(C) **Physical therapy services.** Physical therapy services are provided for the purpose of preventing or alleviating movement dysfunction and related functional problems that adversely affect the member's education. Physical therapy services must adhere to guidelines found at OAC 317:30-5-291 and must be provided by or under the direct guidance and supervision of a ~~state-~~fully licensed physical therapist; services may also be provided by a licensed physical therapy assistant who has been authorized by the Board of Examiners working under the supervision of a fully licensed physical therapist. ~~The licensed physical therapist may not supervise more than three (3) physical therapy assistants.~~

(D) **Occupational therapy services.** Occupational therapy may include provision of services to improve, develop, or restore impaired ability to function independently. Occupational therapy services must be provided by or under the direct guidance and supervision of a ~~state-~~fully licensed occupational therapist; services may also be provided by ~~an~~a licensed occupational therapy assistant who has been authorized by the Board of Examiners, working under the supervision of a licensed occupational therapist.

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

(F) **Counseling services.** All services must be for the direct benefit of the member. Counseling services must be provided by a state-licensed social worker, a state-licensed

professional counselor, a state-licensed psychologist or SDE-certified school psychologist, a state-licensed marriage and family therapist, or a state-licensed behavioral health practitioner, or under Board supervision to be licensed in one (1) of the above-stated areas.

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

(i) ~~State-licensed speech-language pathologist who:~~Fully licensed speech-language pathologist as listed in OAC 317:30-5-675 (a) (1) through (3).

~~(I) Holds a Certificate of Clinical Competence from the ASHA; or~~

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

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

(ii) ~~State-~~Fully licensed physical therapist as listed in OAC 317:30-5-290.1 (a) (1) and (2); or

(iii) ~~State-~~Fully licensed occupational therapist as listed in OAC 317:30-5-295 (a) (1) and (2).

(H) **Personal care.** Provision of personal care services (PCS) allow students with disabilities to safely attend school. Services include, but are not limited to: dressing, eating, bathing, assistance with transferring and toileting, positioning, and instrumental activities of daily living such as preparing meals and managing medications. PCS also includes assistance while riding a school bus to handle medical or physical emergencies. Services must be provided by registered paraprofessionals that have completed training approved or provided by SDE, or personal care assistants, including LPNs, who have completed on-the-job training specific to their duties. PCS does not include behavioral monitoring. Paraprofessionals are not allowed to administer medication, nor are they allowed to assist with or provide therapy services to SoonerCare members. Tube feeding of any type may only be reimbursed if provided by a RN or LPN. Catheter insertion and Catheter/Ostomy care may only be reimbursed when done by a RN or LPN. All PCS must be prior authorized.

(I) **Therapeutic behavioral services (TBS).** Services are goal-directed activities for each client to restore, retain and improve the self-help, socialization, communication, and adaptive skills necessary to reside successfully in home and

community-based settings. It also includes problem identification and goal setting, medication support, restoring function, and providing support and redirection when needed. TBS activities are behavioral interventions to complement more intensive behavioral health services and may include the following components: basic living and self-help skills; social skills; communication skills; organization and time management; and transitional living skills. This service must be provided by a behavioral health school aide (BHSA) who has a high school diploma or equivalent and has successfully completed training approved by the SDE, and in collaboration with the Oklahoma Department of Mental Health and Substance Abuse Services, along with corresponding continuing education. BHSA must be supervised by a bachelor's level individual with a special education certification. BHSA must have CPR and First Aid certification. Six (6) additional hours of related continuing education are required per year.

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

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 25. SOONERCARE CHOICE

SUBCHAPTER 7. SOONERCARE

PART 3. ENROLLMENT CRITERIA

317:25-7-13. Enrollment ineligibility

Members in certain categories are excluded from participation in the SoonerCare Choice program. All other members may be enrolled in the SoonerCare Choice program and subject to the provisions of this Subchapter. Members excluded from participation in SoonerCare Choice include:

(1) Individuals receiving services in a long-term care facility, in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), or through a Home and Community Based Waiver;

(2) Individuals in the former foster care children's group [see Oklahoma Administrative Code (OAC) 317:35-5-2];

(3) Individuals in benefit programs with limited scope, such as Tuberculosis, ~~Family Planning,~~ or pregnancy only;

(4) Non-qualified or ineligible aliens;

(5) Children in subsidized adoptions;

(6) Individuals who are dually-eligible for SoonerCare and Medicare; and/or

~~(7) Individuals who are in an Institution for Mental Disease (IMD); and/or~~

~~(8)~~ (7) Individuals who have other creditable coverage.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 6. INPATIENT PSYCHIATRIC AND SUBSTANCE USE DISORDER SERVICES

317:30-5-95. General provisions and eligible providers

(a) **Eligible settings for inpatient psychiatric services.** The following individuals may receive SoonerCare-reimbursable inpatient psychiatric services in the following eligible settings:

~~(1) Individuals twenty-one (21) to sixty-four (64) years of age may receive SoonerCare-reimbursable inpatient psychiatric and/or chemical dependency/substance use/detoxification services in a psychiatric unit of a general hospital, provided that such hospital is not an IMD.~~

~~(2) Individuals sixty-five (65) years of age or older may receive SoonerCare-reimbursable inpatient psychiatric services in a psychiatric unit of a general hospital, or in a psychiatric hospital.~~

~~(3)~~ (1) Individuals under twenty-one (21) years of age, in accordance with OAC 317:30-5-95.23, may receive SoonerCare-reimbursable inpatient psychiatric services in a psychiatric unit of a general hospital, a psychiatric hospital, or a PRTF~~.~~; and may receive chemical dependency detoxification/withdrawal management services in a psychiatric unit of a general hospital or in a psychiatric hospital.

(2) Individuals ages twenty-one (21) and older may receive SoonerCare-reimbursable inpatient psychiatric and/or chemical dependency detoxification/withdrawal management services in a psychiatric unit of a general hospital or in a psychiatric hospital.

(b) **Psychiatric hospitals and psychiatric units of general hospitals.** To be eligible for payment under this Part, inpatient psychiatric programs must be provided to eligible SoonerCare members in a hospital that:

(1) Is a psychiatric hospital that:

(A) Successfully underwent a State survey to determine whether the hospital meets the requirements for participation in Medicare as a psychiatric hospital per 42 C.F.R. § 482.60; or

(B) Is accredited by a national organization whose psychiatric accrediting program has been approved by CMS; or

(2) Is a general hospital with a psychiatric unit that:

(A) Successfully underwent a State survey to determine whether the hospital meets the requirements for participation in Medicare as a hospital as specified in 42 C.F.R. Part 482; or

(B) Is accredited by a national accrediting organization whose accrediting program has been approved by CMS; and

(3) Meets all applicable federal regulations, including, but not limited to:

(A) Medicare Conditions of Participation for Hospitals (42 C.F.R. Part 482), including special provisions applying to psychiatric hospitals (42 C.F.R. § 482.60-.62);

(B) Medicaid for Individuals Age 65 or over in Institutions for Mental Diseases (42 C.F.R. Part 441, Subpart C);

(C) Inpatient Psychiatric Services for Individuals under Age 21 in Psychiatric Facilities or Programs (42 C.F.R. Part 441, Subpart D); and/or

(D) Utilization Control [42 C.F.R. Part 456, Subpart C (Utilization Control: Hospitals) or Subpart D (Utilization Control: Mental Hospitals)]; and

(4) Is contracted with the OHCA; and

(5) If located within Oklahoma and serving members under eighteen (18) years of age, is appropriately licensed by the Oklahoma Department of Human Services (OKDHS) as a residential child care facility (10 O.S. §§ 401 to 402) that is providing services as a residential treatment facility in accordance with OAC 340:110-3-168.

(c) **PRTF.** Every PRTF must:

(1) Be individually contracted with OHCA as a PRTF;

(2) Meet all of the state and federal participation requirements for SoonerCare reimbursement, including, but not limited to, 42 C.F.R. § 483.354, as well as all requirements in 42 C.F.R. 483 Subpart G governing the use of restraint and seclusion;

(3) Be appropriately licensed by OKDHS as a residential child care facility (10 O.S. § 401 to 402) that is providing services as a residential treatment facility in accordance with OAC 340:110-3-168;

(4) Be appropriately certified by the State Survey Agency, the Oklahoma State Department of Health (OSDH) as meeting Medicare Conditions of Participation; and

(5) Be accredited by TJC, the Council on Accreditation of Rehabilitation Facilities (CARF), or the Council on Accreditation (COA).

(d) **Out-of-state PRTF.** Any out-of-state PRTF must be appropriately licensed and/or certified in the state in which it does business, and must provide an attestation to OHCA that the PRTF is in compliance with the condition of participation for restraint and seclusion, as is required by federal law. Any out-of-state PRTF must also be accredited in conformance with OAC 317:30-5-95(c)(5).

(e) **Required documents.** The required documents for enrollment for each participating provider can be downloaded from the OHCA's website.

317:30-5-95.1. Medical necessity criteria and coverage for adults

aged twenty-one (21) to sixty-four (64)

(a) **Coverage for adults.** Coverage for adults aged twenty-one (21) to sixty-four (64) is limited to services in a psychiatric unit of a general hospital or in a psychiatric hospital (see ~~Oklahoma Administrative Code (~~OAC~~)~~ 317:30-5-95). Inpatient psychiatric services must be prior authorized in accordance with OAC 317:30-5-41.1. OHCA rules that apply to inpatient psychiatric coverage for adults aged twenty-one (21) to sixty-four (64) are found in Sections OAC 317:30-5-95.1 through 317:30-5-95.10.

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

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

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

(3) It has been determined by the OHCA designated agent that the current disabling symptoms could not have been managed or have not been manageable in a less intensive treatment program.

(4) Adult must be medically stable.

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

(A) Specifically described suicide attempts, suicidal intent, or serious threat by the patient.

(B) Specifically described patterns of escalating incidents of self-mutilating behaviors.

(C) Specifically described episodes of unprovoked significant physical aggression and patterns of escalating physical aggression in intensity and duration.

(D) Specifically described episodes of incapacitating depression or psychosis that result in an inability to function or care for basic needs.

(6) Requires secure twenty-four (24) hour nursing/medical supervision as evidenced by:

(A) Stabilization of acute psychiatric symptoms.

(B) Needs extensive treatment under physician direction.

(C) Physiological evidence or expectation of withdrawal symptoms which require twenty-four (24) hour medical supervision.

(c) **Medical necessity criteria for admission of adults aged twenty-one (21) to sixty-four (64) for inpatient chemical dependency detoxification/withdrawal management.** An inpatient admission of an adult aged twenty-one (21) to sixty-four (64) for ~~chemical dependency/ substance use/ detoxification~~chemical dependency detoxification/withdrawal management must meet the terms and conditions contained in (1), (2), (3), and one of (4)(A) through (D) of this subsection.

(1) Any psychoactive substance dependency disorder described in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) with detailed symptoms supporting the diagnosis and need for medical detoxification, except for cannabis, nicotine, or caffeine dependencies.

(2) Conditions are directly attributable to a substance dependency disorder as the primary need for professional attention (this does not include placement issues, criminal behavior, and/or status offenses).

(3) It has been determined by the OHCA designated agent that the current disabling symptoms could not be managed or have not been manageable in a less intensive treatment program.

(4) Requires secure twenty-four (24) hour nursing/medical supervision as evidenced by:

(A) Need for active and aggressive pharmacological interventions.

(B) Need for stabilization of acute psychiatric symptoms.

(C) Need extensive treatment under physician direction.

(D) Physiological evidence or expectation of withdrawal symptoms which require twenty-four (24) hour medical supervision.

317:30-5-95.42. Service quality review (SQR) of psychiatric facilities and residential substance use disorder (SUD) facilities

(a) The ~~service quality review (SQR)~~SQR conducted by the OHCA or its designated agent meets the utilization control requirements as set forth in 42 C.F.R. Part 456.

(b) There will be an SQR of each in-state psychiatric facility and residential substance use disorder facility that provides services to SoonerCare members which will be performed by the OHCA or its designated agent. Out-of-state ~~psychiatric~~ facilities that provide services to SoonerCare members will be reviewed according to the procedures outlined in the Medical Necessity Manual. Ad hoc reviews may be conducted at the discretion of the agency.

(c) The OHCA will designate the members of the SQR team. The SQR team will consist of one (1) to three (3) team members and will be comprised of LBHPs or registered nurses (RNs).

(d) The SQR will include, but not be limited to, review of facility and clinical record documentation ~~as well as~~and may include observation and contact with members. The clinical record review will consist of ~~those~~ records of members ~~present or listed as~~

~~facility residents at the beginning of the visit~~currently at the facility as well as records of members ~~on~~for which claims have been filed with OHCA for acute, ~~or~~ PRTF, or residential SUD levels of care. The SQR includes validation of compliance with policy, which must be met for the services to be compensable.
(e) Following the SQR, the SQR team will report its findings in writing to the facility. ~~The facility will be provided with written notification if the findings of the review have resulted in any deficiencies.~~ A copy of the final report will be sent to the facility's accrediting agency, as well as the State Survey Agency, if applicable, and any licensing agencies.
(f) Deficiencies identified during the SQR may result in full or partial recoupment of paid claims. The determination of whether to assess full or partial recoupment shall be at the discretion of the OHCA based on the severity of the deficiencies.
(g) Any days during which the facility is determined to be out of compliance with Federal Conditions of Participation, excluding residential SUD facilities, or in which a member does not meet medical necessity criteria ~~will~~may result in full recoupment. Full recoupment may also result from a facility's failure to provide requested documentation within the timeframes indicated on requests for such documents or if the SQR team is denied timely admittance to a facility and/or access to facility records during ~~the~~any on-site portion of the SQR.
(h) Items which may result in full or partial recoupment of paid claims shall include, but not be limited to:

(1) Assessments and evaluations. Assessments and evaluations must be completed, with dated signature(s), by qualified staff within the timeframes outlined in Oklahoma Administrative Code (OAC) 317:30-5-95.6~~ and~~, 317:30-5-95.37~~.~~ and 317:30-5-95.47(1).

(2) Plan of care. Plans of care must be completed, with all required dated signatures within the timeframes described in OAC 317:30-5-95.4~~ and~~, 317:30-5-96.33~~.~~, and 317:30-5-95.47(2).

(3) Certification of need (CON). CONs for psychiatric facilities must be completed by the appropriate team and in the chart within the timeframes outlined in 42 C.F.R. §§ 441.152, 456.160, and 456.481.

(4) Active treatment. Treatment must be documented in the chart at the required frequency by appropriately qualified staff as described in OAC 317:30-5-95.5, 317:30-5-95.7, 317:30-5-95.8, 317:30-5-95.9, 317:30-5-95.10~~ and~~, 317:30-5-95.34~~.~~ and 317:30-5-95.46(b).

(5) Documentation of services. Services must be documented in accordance with OAC 317:30-5-95.5, 317:30-5-95.8, 317:30-5-95.10, 317:30-5-95.41, and 317:30-5-95.47 and 42 C.F.R. §§ 412.27(c)(4) and 482.61. Documentation with missing elements or documentation that does not clearly demonstrate the therapeutic appropriateness and benefit of the service may result in recoupment.

(6) Staffing. Staffing must meet the ratios described in OAC 317:30-5-95.24(b)-(d) & (h) and OAC 317:30-5-95.38 per unit/per shift; and credentialing requirements as outlined in OAC 317:30-5-95.8, 317:30-5-95.9, 317:30-5-95.35, 317:30-5-95.36, 317:30-5-95.46 (b) and 42 C.F.R. §§ 412.27(d), 441.153, 441.156, and 482.62.

(7) Restraint/seclusion. Orders for restraint and seclusion must be completely and thoroughly documented with all required elements as described in OAC 317:30-5-95.39 and 42 C.F.R. § 482.13(e) & (f) and 42 C.F.R. Part 483. Documentation must support the appropriateness and necessity for the use of restraint/seclusion. For PRTFs, documentation must include evidence that staff and resident debriefings occurred as required by OAC 317:30-5-95.39 and 42 C.F.R. Part 483. For residential SUD facilities, restraint may only be used when less restrictive interventions, according to facility policy, have been attempted or when an immediate intervention is required to protect the resident, a staff member, or others. A written incident report must be completed within 24-hours following each use of physical restraint.

(i) If the review findings have resulted in a recoupment, the days and/or services involved will be reported in the notification.

(j) In the event that CMS recoups from OHCA an amount that exceeds the provider's liability for findings described in this Section, the provider will not be held harmless and will be required to reimburse OHCA the total federal amount identified by CMS and/or its designated audit contractor, limited to the amount of the original paid claim less any previously recouped amounts.

(k) Penalties of non-compensable days which are the result of the facility's failure to appropriately provide and document the services described herein, or adhere to applicable accreditation, certification, and/or state licensing standards, are not compensable or billable to the member or the member's family.

(l) Facilities that are determined to owe recoupment of paid claims will have the ability to request a reconsideration of the findings. Details and instructions on how to request a reconsideration will be part of the report documentation sent to the facility.

(m) Facilities that are determined by the SQR process to be out of compliance in significant areas will be required to submit a Corrective Action Plan (CAP) detailing steps being taken to bring performance in line with requirements. Facilities that are required to submit a CAP may be further assessed through a formal, targeted post-CAP review process.

317:30-5-95.43. Residential substance use disorder treatment

(a) **Purpose.** The purpose of sections OAC 317:30-5-95.43 - 317:30-5-95.49 is to establish the procedures and requirements for residential treatment facilities providing substance use disorder services.

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

(1) **"ASAM"** means the American Society of Addiction Medicine.

(2) **"ASAM levels of care"** means the different options for treatment as described below and in the current edition of the ASAM criteria that vary according to the intensity of the services offered. Each treatment option is a level of care.

(A) **"ASAM level 3"** means residential and inpatient services and encompasses ASAM levels 3.1, 3.3, 3.5 and 3.7.

(B) **"ASAM level 3.1"** means clinically managed low-intensity residential services for adolescents and adults. This level of care typically provides at least five (5) hours of clinical services a week and provides a twenty-four (24) hour living support and structure with trained personnel. The corresponding service description for this level of care is halfway house services.

(C) **"ASAM level 3.3"** means clinically managed population-specific high-intensity residential services. This level of care is for adults only and typically offers twenty-four (24) hour care with trained personnel and is designed to accommodate individuals with cognitive or other impairments. The corresponding service description for this level of care is residential treatment for adults with co-occurring disorders.

(D) **"ASAM level 3.5"** means clinically managed medium-intensity residential services for adolescents and clinically managed high-intensity residential services for adults. This level of care provides twenty-four (24) hour care and offers a wide range of therapeutic services. The corresponding service descriptions for this level of care are residential treatment and intensive residential treatment.

(E) **"ASAM level 3.7"** means medically monitored high-intensity inpatient services for adolescents and medically monitored intensive inpatient withdrawal management for adults. This level of care provides twenty-four (24) hour nursing care with physician supervision and medication availability. This level of care is appropriate for individuals withdrawing from alcohol or other drugs with subacute biomedical and emotional, behavioral, or cognitive problems severe enough to require inpatient treatment but for whom hospitalization is not necessary. The corresponding service description for this level of care is medically supervised withdrawal management.

(3) **"ASAM criteria"** means the most recent edition of the American Society of Addiction Medicine's published criteria for admission to treatment, continued services, and discharge.

(4) **"Co-occurring disorder (COD)"** means any combination of mental health symptoms and substance use disorder symptoms or diagnoses that affect a member and are typically determined by

the Diagnostic and Statistical Manual of Mental Disorders (DSM).

(5) **"DSM"** means the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association.

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

(7) **"Service plan"** means the document used during the process by which an LBHP or a licensure candidate and the member together and jointly identify and rank problems, establish agreed-upon immediate short-term and long-term goals, and decide on the treatment process and resources to be utilized.

(8) **"Substance use disorder (SUD)"** means alcohol or drug dependence or psychoactive substance use disorder as defined by the most recent DSM criteria.

(9) **"Therapeutic services"** means professional services during which members engage in identifying, addressing and/or resolving issues identified in the member's service plan.

(10) **"Treatment hours – residential"** means the structured hours in which a member is involved in receiving professional services to assist in achieving recovery.

317:30-5-95.44 Residential substance use disorder - Eligible providers and requirements

(a) Eligible providers shall:

(1) Have and maintain current certification from the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) as a residential level of care provider of substance use disorder (SUD) services, unless exempt from state jurisdiction or an exempted entity as defined in Section 3-415 of Title 43A of the Oklahoma Statutes;

(2) Have a contract with the OHCA;

(3) Have a Certificate of Need, if required by ODMHSAS in accordance with OAC 450:18-17-2 or OAC 450:24-27-2.

(4) Have a current accreditation status appropriate to provide residential behavioral health services from:

(A) The Joint Commission; or

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

(C) The Council on Accreditation (COA).

(b) Providers certified by ODMHSAS as a residential level of care provider of SUD services prior to October 1, 2020 shall have until January 1, 2022 to obtain accreditation as required in (4) above.

(c) Residential treatment facilities providing SUD treatment services to individuals under the age of eighteen (18) must have a residential child care facility license from the Oklahoma Department of Human Services (DHS). Residential treatment facilities providing child care services must have a child care center license from DHS.

317:30-5-95.45. Residential substance use disorder - Coverage by category

(a) **Adults.** Members age twenty-one (21) to sixty-four (64) who meet eligibility and clinical criteria may receive medically necessary residential treatment for SUD.

(1) The member must meet residential level of care as determined through completion of the designated ASAM level of care tool as required in the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) Prior Authorization Manual.

(2) Each presenting member for SUD treatment shall be assessed, according to ASAM criteria, which includes a list of symptoms for all six (6) dimensions and each level of care to determine a clinically appropriate placement in the least restrictive level of care.

(b) **Children.** Coverage for children is the same as adults.

(c) **Individuals with dependent children.** Coverage for individuals with dependent children is the same as adults and/or children.

317:30-5-95.46. Residential substance use disorder - Covered services and medical necessity criteria

(a) In order for the services described in this Section to be covered, individuals shall:

(1) Be diagnosed with a substance use disorder as described in the most recent edition of the DSM; and

(2) Meet residential level of care in accordance with the American Society of Addiction Medicine (ASAM) criteria, as determined by the ASAM level of care determination tool designated by the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS).

(3) For additional medical necessity criteria, refer to the ODMHSAS Prior Authorization Manual available at http://www.odmhsas.org/arc.htm.

(b) Coverage includes the following services:

(1) **Clinically managed low intensity residential services (ASAM Level 3.1).**

(A) **Halfway house services – Individuals age thirteen (13) to seventeen (17).**

(i) **Service description.** This service places a major emphasis on continuing substance use disorder care and community ancillary services in an environment supporting continued abstinence. The facility shall have scheduled services to assess and address the individual needs of each member. Services include, but are not limited to, therapy, rehabilitation services, case management, crisis intervention, and educational support services. Group therapy is limited to a total of six (6) individuals. Rehabilitation services shall not exceed a staffing ratio of eight (8) individuals to one (1) qualified provider.

(ii) **Staffing requirements.** A licensed physician must be

available by telephone twenty-four (24) hours a day, seven (7) days a week. A minimum of two (2) direct care and/or clinical staff must be on-site and awake twenty-four (24) hours a day, seven (7) days a week. Staffing ratios shall not exceed those specified in OAC 340:110-3-153.2. All staff who provide treatment services shall meet qualifications in accordance with the Oklahoma Medicaid State Plan and OAC 450:18.

(iii) **Treatment hours.** A minimum of six (6) treatment hours per week shall be provided.

(B) **Halfway house services – Individuals age eighteen (18) to sixty-four (64).**

(i) **Service description.** This service places a major emphasis on continuing substance use disorder care and community ancillary services in an environment supporting continued abstinence. The facility shall have scheduled services to assess and address the individual needs of each member. Services include, but are not limited to, therapy, rehabilitation services, case management, crisis intervention, peer recovery support services, and educational/vocational support services. Group therapy is limited to a total of eight (8) individuals. Rehabilitation services shall not exceed a staffing ratio of fourteen (14) individuals to one (1) qualified provider.

(ii) **Staffing requirements.** A licensed physician must be available by telephone twenty-four (24) hours a day, seven (7) days a week. Additional clinical and/or direct care staff must be on-site and awake twenty-four (24) hours a day, seven (7) days a week. All staff who provide treatment services shall meet qualifications in accordance with the Oklahoma Medicaid State Plan and OAC 450:18.

(iii) **Treatment hours.** A minimum of six (6) treatment hours per week shall be provided.

(C) **Halfway house services – Individuals with minor dependent children or women who are pregnant.**

(i) **Service description.** This service provides a planned regimen of twenty-four (24) hours, seven (7) days a week, supervised living arrangements, to include professionally directed evaluation, care, and treatment. The facility shall have scheduled services to assess and address the individual needs of each member. Services include, but are not limited to, therapy, rehabilitation services, case management, crisis intervention, peer recovery support services, parenting/ child development services, educational/vocational support services, and other services. Group therapy is limited to a total of eight (8) individuals for adults a total of six (6) individuals for children. Rehabilitation services shall not exceed a

staffing ratio of fourteen (14) individuals to one (1) qualified provider for adults and eight (8) individuals to one (1) qualified provider for children.

(ii) **Staffing requirements.** A licensed physician must be available by telephone twenty-four (24) hours a day, seven (7) days a week. Additional clinical and/or direct care staff must be on-site twenty-four (24) hours a day, seven (7) days a week. All staff who provide treatment services shall meet qualifications in accordance with the Oklahoma Medicaid State Plan and OAC 450:18.

(iii) **Treatment services for dependent children.** Services are available to the child when provided to address the impacts related to the parent's addiction, including, but not limited to, individual and family therapy. Compliance with separate provider qualifications, in accordance with OAC 317:30-5-240.2, is required for other treatment services provided to dependent children by the residential SUD provider. Provision of such treatment services shall be provided in accordance with OAC 317:30-5, Part 21.

(iv) **Treatment hours.** A minimum of six (6) treatment hours per week shall be provided to the individual with minor dependent children and women who are pregnant. Dependent children shall be provided treatment services in accordance with the child's service plan.

(2) **Clinically managed, population specific, high intensity residential services (ASAM Level 3.3).**

(A) **Residential treatment for adults with co-occurring disorders.**

(i) **Service description.** This service provides a planned regimen of twenty-four (24) hours, seven / (7) days a week, structured evaluation, care, and treatment. Daily treatment service shall be provided to assess and address individual needs of the member. Services include, but are not limited to, medication monitoring, therapy, rehabilitation services, crisis intervention, case management, peer recovery support services and educational/vocational support services. Psychiatric and/or psychological and/or mental health evaluations shall be completed on all members. In addition to the requirements in OAC 317:30-5-95.47, the service plan shall address the member's mental health needs and medications. The member's medications shall be re-assessed a minimum of once every thirty (30) days. Group therapy is limited to a total of eight (8) individuals. Rehabilitation services shall not exceed a staffing ratio of fourteen (14) individuals to one (1) qualified provider. Treatment services must address both mental health and SUD needs as identified in the service plan.

(ii) **Staffing requirements.** A licensed psychiatrist must

be available by telephone twenty-four (24) hours a day, seven (7) days a week. Additional staff must be on-site twenty-four (24) hours a day, seven (7) days a week. All staff who provide treatment services shall meet qualifications in accordance with the Oklahoma Medicaid State Plan and OAC 450:18.

(iii) **Treatment hours.** A weekly minimum of twenty-four (24) service hours shall be provided, which shall include a minimum of one (1) hour of therapy and a minimum of seven (7) hours of rehabilitation services. A maximum of seven (7) hours of educational support services may count toward the twenty-four (24) service hours each week.

(3) **Clinically managed medium and high intensity (ASAM Level 3.5).**

(A) **Residential treatment, medium intensity - individuals age thirteen (13) to seventeen (17).**

(i) **Service description.** This service provides a planned regimen of twenty-four (24) hours / seven (7) day a week, professionally directed evaluation, care, and treatment for chemically dependent members. A multidisciplinary team approach shall be utilized in providing daily treatment services to assess and address the individual needs of each member, including but not limited to, therapy, rehabilitation services, case management, crisis intervention, and educational support services. Group therapy is limited to a total of six (6) individuals. Rehabilitation services shall not exceed a staffing ratio of eight (8) individuals to one (1) qualified provider.

(ii) **Staffing requirements.** A licensed physician must be available by telephone twenty-four (24) hours a day, seven (7) days a week. A minimum of two (2) direct care and/or clinical staff must be on-site and awake twenty-four (24) hours a day, seven (7) days a week. Staffing ratios shall not exceed those specified in OAC 340:110-3-153.2. All staff who provide treatment services shall meet qualifications in accordance with the Oklahoma Medicaid State Plan and OAC 450:18.

(iii) **Treatment hours.** A weekly minimum of fifteen (15) treatment hours for members attending academic training and twenty-one (21) treatment hours for members not attending academic training shall be provided. Treatment hours shall include a minimum of ten (10) weekly hours of therapeutic services, including but not limited to, individual, family and group therapy.

(B) **Residential treatment, high intensity – adults.**

(i) **Service description.** This service provides a planned regimen of twenty-four (24) hours / seven (7) day a week, professionally directed evaluation, care, and treatment. Daily treatment service shall be provided to assess and

address individual needs of each member. Services include, but are not limited to, therapy, rehabilitation services, crisis intervention, case management, peer recovery support services, and educational/vocational support services. Group therapy is limited to a total of eight (8) individuals. Rehabilitation services shall not exceed a staffing ratio of fourteen (14) individuals to one (1) qualified provider.

(ii) **Staffing requirements.** A licensed physician must be available by telephone twenty-four (24) hours a day, seven (7) days a week. Additional clinical and/or direct care staff must be on-site twenty-four (24) hours a day, seven (7) days a week. All staff who provide treatment services shall meet qualifications in accordance with the Oklahoma Medicaid State Plan and OAC 450:18.

(iii) **Treatment hours.** A weekly minimum of twenty-four (24) service hours shall be provided, which shall include a minimum of one (1) hour of therapy and a minimum of seven (7) hours of rehabilitation services. A maximum of seven (7) hours of educational support services may count toward the twenty-four (24) service hours each week.

(C) **Intensive residential treatment, high intensity – adults.**

(i) **Service description.** This service provides a planned regimen of twenty-four (24) hours / seven (7) day a week, professionally directed evaluation, care, and treatment. Daily treatment service shall be provided to assess and address individual needs of each member. Services include, but are not limited to, therapy, rehabilitation services, crisis intervention, case management, peer recovery support services, and educational/vocational support services. Group therapy is limited to a total of eight (8) individuals. Rehabilitation services shall not exceed a staffing ratio of fourteen (14) individuals to one (1) qualified provider.

(ii) **Staffing requirements.** A licensed psychiatrist must be available by telephone twenty-four (24) hours a day, seven (7) days a week. Additional clinical and/or direct care staff must be on-site twenty-four (24) hours a day, seven (7) days a week. All staff who provide treatment services shall meet qualifications in accordance with the Oklahoma Medicaid State Plan and OAC 450:18.

(iii) **Treatment hours.** A weekly minimum of thirty-seven (37) service hours shall be provided, which shall include a minimum of four (4) hours of therapy and a minimum of seven (7) hours of rehabilitation services. A maximum of eleven (11) hours of educational support services may count toward the thirty-seven (37) service hours each week.

(D) **Residential treatment for individuals with minor**

dependent children and women who are pregnant.

(i) **Service description.** This service provides a planned regimen of twenty-four (24) hours / seven (7) day a week, professionally directed evaluation, care, and treatment. The facility shall provide substance use disorder treatment services to assess and address individual needs of each member. Services include, but are not limited to, therapy, rehabilitation services, crisis intervention, case management, parenting/child development support services, peer recovery support services, and educational/vocational support services. Group therapy is limited to a total of eight (8) individuals for adults a total of six (6) individuals for children. Rehabilitation services shall not exceed a staffing ratio of fourteen (14) individuals to one (1) qualified provider for adults and eight (8) individuals to one (1) qualified provider for children.

(ii) **Staffing requirements.** A licensed physician must be available by telephone twenty-four (24) hours a day, seven (7) days a week. Additional staff must be on-site twenty-four (24) hours a day, seven (7) days a week. All staff who provide treatment services shall meet qualifications in accordance with the Oklahoma Medicaid State Plan and OAC 450:18.

(iii) **Treatment services for dependent children.** Services are available to the child when provided to address the impacts related to the parent's addiction, including but not limited to individual and family therapy. Compliance with separate provider qualifications, in accordance with OAC 317:30-5-240.2, is required for other treatment services provided to dependent children by the residential SUD provider. Provision of such treatment services shall be provided in accordance with OAC 317:30-5, Part 21.

(iv) **Treatment hours.** A minimum of twenty-four (24) service hours shall be provided to the individual with minor dependent children and women who are pregnant; this requirement may be reduced to a weekly minimum of twenty-one (21) service hours for Temporary Assistance for Needy Families (TANF) recipients. Treatment hours shall include a minimum of one (1) hour of therapy and a minimum of seven (7) hours of rehabilitation services. A maximum of seven (7) hours of educational support services may count toward the required service hours each week. Dependent children shall be provided treatment services in accordance with the child's service plan.

(E) **Intensive residential treatment for individuals with dependent children and women who are pregnant.**

(i) **Service description.** This service provides a planned regimen of twenty-four hours / seven (7) day a week,

professionally directed evaluation, care, and treatment. The facility shall provide substance use disorder treatment services to assess and address individual needs of each member. Services include, but are not limited to, therapy, rehabilitation services, crisis intervention, case management, parenting/child development support services, peer recovery support services, and educational/vocational support services. Group therapy is limited to a total of eight (8) individuals for adults a total of six (6) individuals for children. Rehabilitation services shall not exceed a staffing ratio of fourteen (14) individuals to one (1) qualified provider for adults and eight (8) individuals to one (1) qualified provider for children.

(ii) **Staffing requirements.** A licensed psychiatrist must be available by telephone twenty-four (24) hours a day, seven (7) days a week. Additional clinical and/or direct care staff must be on-site twenty-four (24) hours a day, seven (7) days a week. All staff who provide treatment services shall meet qualifications in accordance with the Oklahoma Medicaid State Plan and OAC 450:18.

(iii) **Treatment services for dependent children.** Services are available to the child when provided to address the impacts related to the parent's addiction, including but not limited to individual and family therapy. Compliance with separate provider qualifications, in accordance with OAC 317:30-5-240.2, is required for other treatment services provided to dependent children by the residential SUD provider. Provision of such treatment services shall be provided in accordance with OAC 317:30-5, Part 21.

(iv) **Treatment hours.** A weekly minimum of thirty-five (35) service hours shall be provided to the individual with minor dependent children and women who are pregnant. Treatment hours shall include a minimum of four (4) hours of therapy and a minimum of seven (7) hours of rehabilitation services. A maximum of eleven (11) hours of educational support services may count toward the thirty-five (35) service hours each week. Dependent children shall be provided treatment services in accordance with the child's service plan.

(4) **Medically monitored high intensity withdrawal management (ASAM Level 3.7).**

(A) **Medically supervised withdrawal management – individuals age thirteen (13) to seventeen (17).**

(i) **Service description and requirements.** This service is provided under the direction of a licensed physician and a licensed registered nurse supervisor, for members who are withdrawing or are intoxicated from alcohol or other drugs. Members shall be assessed as currently experiencing

no apparent medical or neurological symptoms that would require hospitalization. Daily substance use disorder withdrawal management treatment services shall be provided, which include, but are not limited to, taking of vital signs (temperature, pulse, respiration rate, blood pressure), documentation of fluid and food intake a minimum of one (1) time every six (6) hours or more often as indicated by the member's condition. Medications shall be prescribed if needed during withdrawal management. The medications are to include those needed for physical health issues and mental impairment if acquired during the withdrawal process.

(ii) **Staffing requirements.** A licensed physician providing supervision of withdrawal management must be available on site or on call twenty-four (24) hours a day, seven (7) days a week. A licensed nurse must provide twenty-four (24) hours a day, seven (7) days a week monitoring and statutorily approved personnel administer medication. A minimum of two (2) medical and/or clinical/direct care staff must be on-site and awake twenty-four (24) hours a day, seven (7) days a week. Staffing ratios shall not exceed those specified in OAC 340:110-3-153.2.

(B) **Medically supervised withdrawal management – adults.**

(i) **Service description and requirements.** This service is provided under the direction of a licensed physician and a licensed registered nurse supervisor, for members who are withdrawing or are intoxicated from alcohol or other drugs. Members shall be assessed as currently experiencing no apparent medical or neurological symptoms that would require hospitalization. Daily substance use disorder withdrawal management treatment services shall be provided, which include, but are not limited to, taking of vital signs (temperature, pulse, respiration rate, blood pressure), documentation of fluid and food intake a minimum of one (1) time every six (6) hours or more often as indicated by the member's condition. Medications prescribed if needed during withdrawal management. The medications are to include those needed for physical health issues and mental impairment if acquired during the withdrawal process.

(ii) **Staffing requirements.** A licensed physician providing supervision of withdrawal management must be available on site or on call twenty-four (24) hours a day, seven (7) days a week. A licensed nurse must provide twenty-four (24) hours a day, seven (7) days a week monitoring and statutorily approved personnel administer medication.

317:30-5-95.47. Residential substance use disorder - Individualized service plan requirements

All substance use disorder services provided in residential treatment facilities are rendered as a result of an individual assessment of the member's needs and documented in the service plan.

(1) **Assessment.** A biopsychosocial assessment shall be completed to gather sufficient information to assist the member in developing an individualized service plan. The assessment must also list the member's past and current psychiatric medications. The assessment must be completed by an LBHP or licensure candidate. Licensure candidate signatures must be co-signed by a fully-licensed LBHP in good standing.

(A) **Assessments for adolescents.** A biopsychosocial assessment using the Teen Addiction Severity Index (T-ASI) shall be completed. A physical examination shall be conducted by a licensed physician to include, at a minimum, a physical assessment, health history, immunization status, and evaluation of motor development and function, speech, hearing, visual, and language functioning.

(B) **Assessments for adults.** A biopsychosocial assessment using the Addiction Severity Index (ASI) shall be completed.

(C) **Assessments for dependent children.** In accordance with OAC 450:18-7-25, assessments of children (including infants) accompanying their parent into treatment shall include the following items:

(i) Parent-child relationship;
(ii) Physical and psychological development;
(iii) Educational needs;
(iv) Parent related issues; and
(v) Family issues related to the child.

(D) **Assessments for parents/pregnant women.** In accordance with OAC 450:18-7-25, assessments of the parent and/or pregnant women bringing their children into treatment shall include the following items:

(i) Parenting skills;
(ii) Knowledge of age appropriate behaviors;
(iii) Parental coping skills;
(iv) Personal issues related to parenting; and
(v) Family issues as related to the child.

(E) **Assessments for medically supervised withdrawal services.** In accordance with OAC 450:18-13-61, a medical assessment for the appropriateness of placement shall be completed and documented by a licensed physician during the admission process.

(F) **Assessment timeframes.** Biopsychosocial assessments shall be completed within seven (7) days of admission (Refer to OAC 450:18-7-26).

(2) **Service plan.** Pursuant to OAC 450:18-7-81, a service plan shall be completed for each member, including dependent children. The service plan is performed with the active

participation of the member and a support person or advocate, if requested by the member. In the case of children under the age of eighteen (18), it is performed with the participation of the parent or guardian, if allowed by law, and the child as age and developmentally appropriate.

(A) **Service plan development.** The service plan shall:

(i) Be completed by an LBHP or licensure candidate. Licensure candidate signatures must be co-signed by a fully-licensed LBHP in good standing.

(ii) Be initiated by a licensed physician or licensed registered nursing staff for medically supervised withdrawal services.

(iii) Provide the formation of measurable service objectives and reflect ongoing changes in goals and objectives based upon member's progress or preference or the identification of new needs, challenges, and problems.

(iv) Be developed after and based on information obtained in the assessment and includes the evaluation of the assessment information by the clinician and the member.

(v) Have an overall general focus on recovery which, for adults, may include goals like employment, independent living, volunteer work, or training, and for children, may include areas like school and educational concerns and assisting the family in caring for the child in the least restrictive level of care.

(B) **Service plan content**. Service plans must include dated signatures for the member [if over fourteen (14)], the parent/guardian [if under eighteen (18) and allowed by law], and the primary service practitioner. Signatures must be obtained after the service plan is completed. The contents of a service plan shall address the following:

(i) Member strengths, needs, abilities, and preferences;

(ii) Identified presenting challenges, needs, and diagnosis;

(iii) Goals for treatment with specific, measurable, attainable, realistic, and time-limited objectives;

(iv) Type and frequency of services to be provided;

(v) Description of member's involvement in, and response to, the service plan;

(vi) The service provider who will be rendering the services identified in the service plan; and

(vii) Discharge criteria that are individualized for each member and beyond that which may be stated in the ASAM criteria.

(viii) Plans to address the medical stabilization treatment and service needs of each member receiving medically supervised withdrawal management services.

(C) **Service plan updates.** Service plan updates shall occur a minimum of once every thirty (30) days while services are

provided. Service plan updates must include dated signatures for the member [if over fourteen (14)], the parent/guardian [if under eighteen (18) and allowed by law], and the LBHP and licensure candidate. Licensure candidate signatures must be co-signed by a fully-licensed LBHP in good standing. Signatures must be obtained after the service plan is completed. Service plan updates shall address the following:

(i) Progress on previous service plan goals and/or objectives;

(ii) A statement documenting a review of the current service plan and an explanation if no changes are to be made to the service plan;

(iii) Change in goals and/or objectives based upon member's progress or identification of new needs and challenges;

(iv) Change in frequency and/or type of services provided;

(v) Change in staff who will be responsible for providing services on the plan; and

(vi) Change in discharge criteria.

(D) **Service plan timeframes.** Service plans shall be completed within eight (8) days of admission, with the exception of service plans for individuals receiving medically supervised withdrawal management services, which must be completed within three (3) hours of admission.

(3) **Progress notes.** Progress notes shall chronologically describe the services provided, the member's response to the services provided, and the member's progress in treatment.

(A) **Content.** Progress notes shall address the following:

(i) Date;

(ii) Member's name;

(iii) Start and stop time for each timed treatment session or service;

(iv) Signature of the service provider;

(v) Credentials of the service provider;

(vi) Specific service plan needs, goals and/or objectives addressed;

(vii) Services provided to address needs, goals, and/or objectives;

(vii) Progress or barriers to progress made in treatment as it relates to the goals and/or objectives;

(ix) Member (and family, when applicable) response to the session or service provided; and

(x) Any new needs, goals and/or objectives identified during the session or service.

(B) **Frequency.** Progress notes shall be completed in accordance with the following timeframes:

(i) Progress notes for therapy, crisis intervention and case management must be documented in an individual note and reflect the content of each session provided.

(ii) Documentation for rehabilitation services and education groups must include daily member sign-in/sign-out record of member attendance (including date, time, type of service and service focus), and a daily progress note or a summary progress note weekly.

(4) **Transition/discharge planning.** All facilities shall assess each member for appropriateness of discharge from a treatment program. Each member shall be assessed using ASAM criteria to determine a clinically appropriate placement in the least restrictive level of care. Transition/discharge plans and discharge summaries shall be completed by an LBHP or licensure candidate. Licensure candidate signatures must be co-signed by a fully-licensed LBHP in good standing.

(A) **Transition/discharge plans.** Transition/discharge plans shall be developed with the knowledge and cooperation of the member. The transition/discharge plan shall be included in the discharge summary. The discharge plan is to include, at a minimum, recommendations for continued treatment services and other appropriate community resources. Appointments for outpatient therapy and other services, as applicable, should be scheduled prior to discharge from residential care. Development of the transition/discharge plan shall begin no later than two (2) weeks after admission.

(B) **Discharge summary.** The discharge summary shall document the member's progress made in treatment and response to services rendered. A completed discharge summary shall be entered in each member's record within fifteen (15) days of the member completing, transferring, or discontinuing services. The summary must be signed and dated by the staff member completing the summary.

317:30-5-95.48. Staff training

(a) All clinical and direct care staff shall have non-physical intervention training in techniques and philosophies addressing appropriate non-violent interventions for potentially physical interpersonal conflicts, staff attitudes which promote dignity and enhanced self-esteem, keys to effective communication skills, verbal and non-verbal interaction and non-violent intervention within thirty (30) days of being hired with updates each calendar year thereafter.

(b) All staff shall receive training in accordance with OAC 450:18-9-3(f).

317:30-5-95.49. Residential substance use disorder - Reimbursement

(a) In order to be eligible for payment, residential treatment providers of substance use disorder (SUD) services must have an approved provider agreement on file with the OHCA. Through this agreement, the residential provider assures that they are in compliance with all applicable federal and State Medicaid law and

regulations, including, but not limited to, OHCA administrative rules, ODMHSAS administrative rules, and the Oklahoma State Medicaid Plan.
(b) All SUD residential treatment services must be prior authorized by the OHCA or its designated agent before the service is rendered by an eligible provider. Without prior authorization, payment is not authorized.
(c) Covered SUD treatment services for adolescents and adults in SUD residential treatment shall be reimbursed utilizing the per diem rates for each level of care. Separate payment may be made for medications, physician services, and treatment services provided to dependent children in accordance with the Oklahoma Medicaid State Plan.
(d) Treatment services for dependent children accompanying a parent to treatment shall be reimbursed on a fee-for-service basis in accordance with the Oklahoma Medicaid State Plan.

317:30-5-96.3. Methods of payment

(a) **Reimbursement.**

(1) Covered inpatient psychiatric ~~and/or substance use disorder~~chemical dependency detoxification/withdrawal management services will be reimbursed using one (1) of the following methodologies:

(A) Diagnosis related group (DRG);

(B) Cost-based; or

(C) A predetermined per diem payment.

(2) ~~For members twenty-one (21) to sixty-four (64) years of age, payment shall not be made to any inpatient psychiatric facility that qualifies as an IMD, except as provided by OAC 317:30-5-95.23 and 317:30-5-95.11.~~For members twenty-one (21) to sixty-four (64) years of age, payment shall not be made for any inpatient psychiatric episodes over sixty (60) days in a facility that qualifies as an IMD.

(b) **Levels of care.**

(1) **Acute.**

(A) Payment will be made to psychiatric units within general medical surgical hospitals and critical access hospitals utilizing a DRG methodology. [See OAC 317:30-5-41]. Psychiatric professional (physicians and psychologists) services provided in conjunction with the inpatient stay are separately payable from the DRG paid to the hospital;

(B) Payment will be made to psychiatric hospitals utilizing a predetermined statewide per diem payment for all facility services provided during the inpatient stay. Psychiatric professional (physicians and psychologists) services provided in conjunction with the inpatient stay are separately payable from the per diem paid to the hospital. Rates vary for public and private providers.

(2) **Acute II.**

(A) Payment will be made to in-state psychiatric hospitals or inpatient psychiatric programs utilizing a predetermined all-inclusive per diem payment for routine, ancillary, and professional services.

(B) Public facilities will be reimbursed using either the statewide or facility-specific interim rates and settled to total allowable costs as determined by analyses of the cost reports (Form CMS 2552) filed with the OHCA.

(3) **PRTFs.**

(A) A pre-determined per diem payment will be made to private PRTFs with sixteen (16) beds or less for routine services. All other services are separately billable.

(B) A predetermined all-inclusive per diem payment will be made for routine, ancillary, and professional services to private facilities with more than sixteen (16) beds.

(C) Public facilities will be reimbursed using either the statewide or facility-specific interim rates and settled to total allowable costs as determined by analyses of the cost reports (Form CMS 2552) filed with the OHCA.

(c) **Out-of-state services.**

(1) **Border and "border status" placements.** Facilities are reimbursed in the same manner as in-state hospitals or PRTFs. Refer to OAC 317:30-3-90 and 317:30-3-91.

(2) **Out-of-state placements.** In the event comparable services cannot be purchased from an Oklahoma facility and the current payment levels are insufficient to obtain access for the member, the OHCA may negotiate a predetermined, all-inclusive per diem rate for specialty programs/units. An incremental payment adjustment may be made for one (1): one (1) staffing (if clinically appropriate and prior authorized). Payment may be up to, but no greater, than usual and customary charges. The one (1): one (1) staffing adjustment is limited to sixty (60) days annually. Refer to OAC 317:30-3-90 and 317:30-3-91.

(d) **Add-on payments.**

(1) Additional payment shall only be made for services that have been prior authorized by OHCA or its designee and determined to be medically necessary. For medical necessity criteria applicable for the add-on payment(s), refer to the SoonerCare Medical Necessity Criteria Manual for Inpatient Behavioral Health Services found on the OHCA website.

(2) SoonerCare shall provide additional payment for the following services rendered in an Acute II and PRTF, as per the Oklahoma Medicaid State Plan.

(A) **Intensive treatment services (ITS) add-on.** Payment shall be made for members requiring intensive staffing supports.

(B) **Prospective complexity add-on.** Payment shall be made to recognize the increased cost of serving members with a mental health diagnosis complicated with non-verbal communication.

(C) **Specialty add-on.** Payment shall be made to recognize the

increased cost of serving members with complex needs.

(e) **Services provided under arrangement.**

(1) **Health home transitioning services.**

(A) Services for the provision of comprehensive transitional care to existing members are considered to be inpatient psychiatric services, when services exceed and do not duplicate ordinary inpatient discharge planning during the last thirty (30) days of a covered acute or residential stay.

(B) Payment for health home transitioning services provided under arrangement with the inpatient provider will be directly reimbursed to the health home outside of the facility's per diem or DRG rate.

(2) **Case management transitioning services.**

(A) Services for the provision of case management transitioning services to existing members are considered to be inpatient psychiatric services, when services exceed and do not duplicate ordinary inpatient discharge planning during the last thirty (30) days of a covered acute or residential stay.

(B) Payment for case management transitioning services provided under arrangement with the inpatient provider will be directly reimbursed to a qualified community-based provider.

(3) **Evaluation and psychological testing by a licensed psychologist.**

(A) Services for the provision of evaluation and psychological testing by a licensed psychologist to existing members are considered to be inpatient psychiatric services, when services exceed and do not duplicate ordinary inpatient discharge planning during the last thirty (30) days of a covered acute or residential stay.

(B) Payment for evaluation and psychological testing by a licensed psychologist for services provided under arrangement with the inpatient provider will be directly reimbursed to a qualified provider in accordance with the Oklahoma Medicaid State Plan.

PART 21. OUTPATIENT BEHAVIORAL HEALTH AGENCY SERVICES

317:30-5-241.6. Behavioral health targeted case management

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

(1) **Description of behavioral health case management services.** Behavioral health case management services are provided to assist eligible individuals in gaining access to needed medical, social, educational and other services essential to meeting

basic human needs. Services under behavioral health targeted case management are not comparable in amount, duration and scope. The target groups for behavioral health case management services are persons under age twenty-one (21) who are in imminent risk of out-of-home placement for psychiatric or substance abuse reasons or are in out-of-home placement due to psychiatric or substance abuse reasons, and chronically and/or severely mentally ill adults who are institutionalized or are at risk of institutionalization. All behavioral health case management services will be authorized based on established medical necessity criteria.

(A) The behavioral health case manager provides assessment of case management needs, development of a case management care plan, referral, linkage, monitoring and advocacy on behalf of the member to gain access to appropriate community resources. The behavioral health case manager must monitor the progress in gaining access to services and continued appropriate utilization of necessary community resources. Behavioral case management is designed to promote recovery, maintain community tenure, and to assist individuals in accessing services for themselves following the case management guidelines established by ODMHSAS. In order to be compensable, the service must be performed utilizing the Strengths Based model of case management. This model of case management assists individuals in identifying and securing the range of resources, both environmental and personal, needed to live in a normally interdependent way in the community. The focus for the helping process is on strengths, interests, abilities, knowledge and capacities of each person, not on their diagnosis, weakness or deficits. The relationship between the service member and the behavioral health case manager is characterized by mutuality, collaboration, and partnership. Assistive activities are designed to occur primarily in the community, but may take place in the behavioral health case manager's office, if more appropriate.

(B) The provider will coordinate transition services with the member and family (if applicable) by phone or face to face, to identify immediate needs for return to home/community no more than seventy-two (72) hours after notification that the member/family requests case management services. For members discharging from a higher level of care than outpatient, the higher level of care facility is responsible for scheduling an appointment with a case management agency for transition and post discharge services. The case manager will make contact with the member and family (if applicable) for transition from the higher level of care other than outpatient back to the community, within seventy-two (72) hours of discharge, and then conduct a follow-up appointment/contact within seven (7) days. The case manager

will provide linkage/referral to physicians/medication services, psychotherapy services, rehabilitation and/or support services as described in the case management service plan.

(C) Case managers may also provide crisis diversion (unanticipated, unscheduled situation requiring supportive assistance, face to face or telephone, to resolve immediate problems before they become overwhelming and severely impair the individual's ability to function or maintain in the community) to assist member(s) from progression to a higher level of care. During the follow-up phase of these referrals or links, the behavioral health case manager will provide aggressive outreach if appointments or contacts are missed within two (2) business days of the missed appointments. Community/home based case management to assess the needs for services will be scheduled as reflected in the case management service plan, but not less than one (1) time per month. The member/parent/guardian has the right to refuse behavioral health case management and cannot be restricted from other services because of a refusal of behavioral health case management services.

(D) An eligible member/parent/guardian will not be restricted and will have the freedom to choose a behavioral health case management provider as well as providers of other medical care.

(E) In order to ensure that behavioral health case management services appropriately meet the needs of the member and family and are not duplicated, behavioral health case management activities will be provided in accordance with an individualized plan of care.

(F) The individual plan of care must include general goals and objectives pertinent to the overall recovery of the member's (and family, if applicable) needs. Progress notes must relate to the individual plan of care and describe the specific activities to be performed. The individual plan of care must be developed with participation by, as well as, reviewed and signed by the member, the parent or guardian [if the member is under eighteen (18)], the behavioral health case manager, and an LBHP or licensure candidate as defined in OAC 317:30-5-240.3(a) and (b).

(G) SoonerCare reimbursable behavioral health case management services include the following:

(i) Gathering necessary psychological, educational, medical, and social information for the purpose of individual plan of care development.

(ii) Face-to-face meetings with the member and/or the parent/guardian/family member for the implementation of activities delineated in the individual plan of care.

(iii) Face-to-face meetings with treatment or service

providers, necessary for the implementation of activities delineated in the individual plan of care.

(iv) Supportive activities such as non face-to-face communication with the member and/or parent/guardian/family member.

(v) Non face-to-face communication with treatment or service providers necessary for the implementation of activities delineated in the individual plan of care.

(vi) Monitoring of the individual plan of care to reassess goals and objectives and assess progress and or barriers to progress.

(vii) Crisis diversion (unanticipated, unscheduled situation requiring supportive assistance, face to face or telephone, to resolve immediate problems before they become overwhelming and severely impair the individual's ability to function or maintain in the community) to assist member(s) from progression to a higher level of care.

(viii) Behavioral health targeted case management is available to individuals transitioning from institutions to the community [except ~~individuals ages twenty-two (22) to sixty-four (64) who reside in an IMD or~~ individuals who are inmates of public institutions]. Individuals are considered to be transitioning to the community during the last thirty (30) consecutive days of a covered institutional stay. This time is to distinguish case management services that are not within the scope of the institution's discharge planning activities from case management required for transitioning individuals with complex, chronic, medical needs to the community. Transition services provided while the individual is in the institution are to be claimed as delivered on the day of discharge from the institution.

(2) **Levels of case management.**

(A) Standard case management/resource coordination services are targeted to adults with serious mental illness or children with serious emotional disturbance, or who have or are at-risk for mental disorders, including substance use disorders (SUD), and their families, who need assistance in accessing, coordination, and monitoring of resources and services. Services are provided to assess an individual's strengths and meet needs in order to achieve stability in the community. Standard case managers have caseloads of thirty (30) to thirty-five (35) members. Standard case management/resource coordination is limited to twelve (12) units per member per month. Additional units may be authorized up to twenty-five (25) units per member per month if medical necessity criteria for transitional case management are met.

(B) Intensive case management (ICM) is targeted to adults with serious and persistent mental illness in PACT programs. To ensure that these intense needs are met, caseloads are limited to between ten (10) to fifteen (15) members. The ICM shall: be a certified behavioral health case manager II; have a minimum of two (2) years' behavioral health case management experience; have crisis diversion experience; have attended the ODMHSAS six (6) hour ICM training and be available twenty-four (24) hours a day. ICM is limited to fifty-four (54) units per member per month.

(C) Wraparound facilitation case management (WFCM) is targeted to children with significant mental health conditions being treated in a System of Care (SOC) Network who are deemed at imminent risk of out-of-home placement due to psychiatric or SUD reasons and in need of more intensive case management services. It is designed to ensure access to community agencies, services, and people whose functions are to provide the support, training and assistance required for a stable, safe, and healthy community life, and decreased need for higher levels of care. To produce a high fidelity wraparound process, a facilitator can facilitate between eight (8) and ten (10) families. Staff providing WFCM must meet the requirements for the SOC/WFCM. WFCM is limited to fifty-four (54) units per member per month.

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

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

(B) Managing finances;

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

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

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

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

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

(H) Mentoring or tutoring;

(I) Provision of behavioral health case management services to the same family by two (2) separate behavioral health case management agencies;

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

(K) Monitoring financial goals;

(L) Leaving voice or text messages for clients and other failed communication attempts.

(4) **Excluded individuals.** The following SoonerCare members who

are receiving similar services through another method are not eligible for behavioral health case management services without special arrangements with the Oklahoma Department of Human Services (OKDHS), OJA, OHCA or ODMHSAS as applicable, in order to avoid duplication in payment. Services/programs include, but may not be limited to:

(A) Members/families (when applicable) for whom at-risk case management services are available through OKDHS and OJA staff;

(B) Members in out-of-home placement and receiving targeted case management services through staff in a foster care or group home setting, unless transitioning into the community;

(C) Residents of ICF/IIDs and nursing facilities unless transitioning into the community;

(D) Members receiving targeted case management services under a Home and Community Based Services (HCBS) waiver program;

(E) Members receiving services in the health home program;

(F) Members receiving case management through the ADvantage waiver program;

(G) Members receiving targeted case management available through a Certified Community Behavioral Health Center (CCBHC);

(H) Members receiving case management services through Programs of All-Inclusive Care for the Elderly (PACE); or

(I) Members receiving Early Intervention case management (EICM);

(J) Members receiving case management services through certified school-based targeted case management (SBTCM) providers;

(K) Members receiving partial hospitalization services; or

(L) Members receiving MST.

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

(6) **Documentation requirements**. The service plan must include general goals and objectives pertinent to the overall recovery needs of the member. Progress notes must relate to the service plan and describe the specific activities performed. Behavioral health case management service plan development is compensable time if the time is spent communicating with the member and it must be reviewed and signed by the member, the behavioral health case manager, and an LBHP or licensure candidate as defined at OAC 317:30-5-240.3(a) and (b). All behavioral health case management services rendered must be reflected by documentation in the records. In addition to a complete behavioral health case management service, plan documentation of each session must include but is not limited to:

(A) Date;

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

(C) Start and stop times for each service;
(D) Original signature or the service provider [original signatures for faxed items must be added to the clinical file within thirty (30) days];
(E) Credentials of the service provider;
(F) Specific service plan needs, goals, and/or objectives addressed;
(G) Specific activities performed by the behavioral health case manager on behalf of the member related to advocacy, linkage, referral, or monitoring used to address needs, goals, and/or objectives;
(H) Progress and barriers made towards goals, and/or objectives;
(I) Member/family (when applicable) response to the service;
(J) Any new service plan needs, goals, and/or objectives identified during the service; and
(K) Member satisfaction with staff intervention.

(7) **Case management travel time.** The rate for case management services assumes that the case manager will spend some amount of time traveling to the member for the face-to-face service. The case manager must only bill for the actual face-to-face time that they spend with the member and not bill for travel time. This would be considered duplicative billing since the rate assumes the travel component already.

PART 24. CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS

317:30-5-268. Limitations

(a) The following are non-billable opportunities for CCBHCs serving eligible members:
(1) Employment services;
(2) Personal care services;
(3) Childcare
(4) Respite services; and
(5) Care coordination.

(b) The following SoonerCare members are not eligible for CCBHC services:
~~(1) Members receiving care in an IM);~~
~~(2)~~ (1) Members residing in a nursing facility or ICF/IID;
~~(3)~~ (2) Inmates of a public correctional institution; and
~~(4)~~ (3) SoonerCare members being served by a PACE provider.

(c) SoonerCare members receiving services from a CCBHC are not eligible for enrollment in a SoonerCare behavioral health home.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 1. PHYSICIANS

317:30-5-9. Medical services

(a) **Use of medical modifiers.** The ~~Physicians'~~physicians' Current Procedural Terminology (CPT) and the second level ~~HCPCS~~Healthcare Common Procedure Coding System (HCPCS) provide for 2-digit medical modifiers to further describe medical services. Modifiers are used when appropriate.

(b) **Covered office services.**

(1) Payment is made for four (4) office visits (or home) per month per member, for adults ~~(over age 21)~~[over age twenty-one (21)], regardless of the number of physicians involved. Additional visits per month are allowed for services related to emergency medical conditions.

(2) Visits for the purpose of family planning are excluded from the four (4) per month limitation.

(3) Payment is allowed for the insertion and/or implantation of contraceptive devices in addition to the office visit.

(4) Separate payment will be made for the following supplies when furnished during a physician's office visit.

(A) Casting materials;

(B) Dressing for burns;

(C) Contraceptive devices; and

(D) IV ~~Fluids~~fluids.

~~(5) Payment is made for routine physical exams only as prior authorized by the OKDHS and are not counted as an office visit.~~

~~(6)~~(5) Medically necessary office lab and X-rays are covered.

~~(7)~~(6) Hearing exams by physician for members between the ages of ~~21 and 65~~twenty one (21) and sixty five (65) are covered only as a diagnostic exam to determine type, nature and extent of hearing loss.

~~(8)~~(7) Hearing aid evaluations are covered for members under ~~21~~twenty one (21) years of age.

~~(9)~~(8) IPPB (Intermittent Positive Pressure Breathing) is covered when performed in physician's office.

~~(10)~~(9) Payment is made for an office visit in addition to allergy testing.

~~(11)~~(10) Separate payment is made for antigen.

~~(12)~~(11) Eye exams are covered for members between ages ~~21~~twenty one (21) and ~~65~~sixty five (65) for medical diagnosis only.

~~(13)~~(12) If a physician personally sees a member on the same day as a dialysis treatment, payment can be made for a separately identifiable service unrelated to the dialysis.

~~(14)~~(13) Separate payment is made for the following specimen

collections:

(A) Catheterization for collection of specimen; and

(B) Routine ~~Venipuncture~~venipuncture.

~~(15)~~(14) The Professional Component for electrocardiograms, electroencephalograms, electromyograms, and similar procedures are covered on an inpatient basis as long as the interpretation is not performed by the attending physician.

~~(16)~~(15) Cast removal is covered only when the cast is removed by a physician other than the one who applied the cast.

(16) Payment may be made for medication-assisted treatment (MAT) medications prescribed and/or administered by a physician.

(c) **Non-covered office services.**

(1) Payment is not made separately for an office visit and rectal exam, pelvic exam or breast exam. Office visits including one of these types of exams should be coded with the appropriate office visit code.

(2) Payment cannot be made for prescriptions or medication dispensed by a physician in his office.

(3) Payment will not be made for completion of forms, abstracts, narrative reports or other reports, separate charge for use of office or telephone calls.

(4) Additional payment will not be made for mileage.

(5) Payment is not made for an office visit where the member did not keep appointment.

(6) Refractive services are not covered for persons between the ages of ~~21 and 65~~twenty one (21) and sixty five (65).

(7) Removal of stitches is considered part of post-operative care.

(8) Payment is not made for a consultation in the office when the physician also bills for surgery.

(9) Separate payment is not made for oxygen administered during an office visit.

(d) Covered inpatient medical services.

(1) Payment is allowed for inpatient hospital visits for all SoonerCare covered admissions. Psychiatric admissions must be prior authorized.

(2) Payment is allowed for the services of two physicians when supplemental skills are required and different specialties are involved.

(3) Certain medical procedures are allowed in addition to office visits.

(4) Payment for critical care is all-inclusive and includes payment for all services that day. Payment for critical care, first hour is limited to one unit per day.

(e) **Non-covered inpatient medical services.**

(1) For inpatient services, all visits to a member on a single day are considered one service except where specified. Payment is made for only one (1) visit per day.

(2) A hospital admittance or visit and surgery on the same day would not be covered if post-operative days are included in the

surgical procedure. If there are no post-operative days, a physician can be paid for visits.

(3) Drugs administered to inpatients are included in the hospital payment.

(4) Payment will not be made to a physician for an admission or new patient work-up when the member receives surgery in out-patient surgery or ambulatory surgery center.

(5) Payment is not made to the attending physician for interpretation of tests on his own patient.

(f) **Other medical services.**

(1) Payment will be made to physicians providing Emergency Department services.

(2) Payment is made for two (2) nursing facility visits per month. The appropriate CPT code is used.

(3) When payment is made for ~~"Evaluation of arrhythmias" or "Evaluation of sinus node"~~evaluation of arrhythmias or evaluation of sinus node, the stress study of the arrhythmia includes inducing the arrhythmia and evaluating the effects of drugs, exercise, etc. upon the arrhythmia.

(4) When the physician bills twice for the same procedure on the same day, it must be supported by a written report.

PART 21. OUTPATIENT BEHAVIORAL HEALTH AGENCY SERVICES

317:30-5-241.7. Medication-assisted treatment (MAT) services for eligible individuals with opioid use disorder (OUD)

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

(1) **"Medication-assisted treatment (MAT)"** means an evidence-based practice approved by the Food and Drug Administration (FDA) to treat opioid use disorder, including methadone and all biological products licensed under federal law for such purpose. MAT also includes the provision of counseling and behavioral therapy.

(2) **"Office-based opioid treatment (OBOT)"** means a fully contracted SoonerCare provider that renders MAT services in OBOT settings. OBOT providers must have capacity to provide all drugs approved by the FDA for the treatment of opioid use disorder, directly or by referral, including for maintenance, detoxification, overdose reversal, and relapse prevention, and appropriate counseling and other appropriate ancillary services.

(3) **"Opioid treatment program (OTP)"** means a program or provider:

(A) Registered under federal law;

(B) Certified by the Substance Abuse and Mental Health Services Administration (SAMHSA);

(C) Certified by ODMHSAS, unless deemed an exempted entity as defined by federal law;

(D) Registered by the Drug Enforcement Agency (DEA);
(E) Registered by the Oklahoma Bureau of Narcotics and Dangerous Drugs (OBNDD); and
(F) Engaged in opioid treatment of individuals by use of an opioid agonist treatment medication, including methadone.

(4) **"Opioid use disorder (OUD)"** means a cluster of cognitive, behavioral, and physiological symptoms in which the individual continues use of opioids despite significant opioid-induced problems.

(5) **"Phase I"** means a minimum ninety (90) day period in which the member attends the opioid treatment program for observation of medication assisted treatment daily or at least six (6) days a week.

(6) **"Phase II"** means the phase of treatment for members who have been admitted for more than ninety (90) days and who have successfully completed Phase I.

(7) **"Phase III"** means the phase of treatment for members who have been admitted for more than six (6) months and who have successfully completed Phase II.

(8) **"Phase IV"** means the phase of treatment for members who have been admitted for more than nine (9) months and who have successfully completed Phase III.

(9) **"Phase V"** means the phase of treatment for members who have been admitted for more than one (1) year.

(10) **"Phase VI"** means the phase of treatment for members who voluntarily seek medically supervised withdrawal and abstinence from all drugs, including methadone as prescribed. A member may enter this phase at any time in the treatment and rehabilitation process.

(b) **Coverage.** The SoonerCare program provides coverage of medically necessary MAT services in OTPs, including but not limited to, methadone treatment, to eligible individuals with OUD. An OTP must have the capacity to provide the full range of services included in the definition of MAT and must document both medication dosing and supporting behavioral health services, including but not limited to, individual, family and group therapy and rehabilitation services. MAT services and/or medications may also be provided in OBOT settings per OAC 317:30-5-9(b)(17).

(c) **OTP requirements.** Every OTP provider shall:

(1) Have a current contract with the OHCA as an OTP provider;
(2) Hold a certification as an OTP from ODMHSAS, unless deemed an exempted entity as defined by federal law;
(3) Hold a certification from the Substance Abuse and Mental Health Services Administration (SAMHSA);
(4) Be appropriately accredited by a SAMHSA-approved accreditation organization;
(5) Be registered with the DEA and the OBNDD; and
(6) Meet all state and federal opioid treatment standards, including all requirements within OAC 450:70.

(d) **Individual OTP providers.** OTP providers include:

(1) **MAT provider** is a physician, physician's assistant (PA), or advanced practice registered nurse (APRN) who may prescribe, dispense, and administer medications in accordance with state and federal law and the Oklahoma Medicaid State Plan.

(2) **OTP behavioral health services practitioner** is a practitioner that meets the qualifications in OAC 317:30-5-240.3, except for family support and training providers, qualified behavioral therapy aide providers, multi-systemic therapy providers, and case manager I providers, for the provision of outpatient behavioral health services.

(e) **Intake and assessment.** OTPs shall conduct intake and assessment procedures in accordance with OAC 450:70-3-5 through OAC 450:70-3-7.

(f) **Service phases.** In accordance with OAC 450:70-6-17.2 through OAC 450:70-6-17.8, the OTP shall have structured phases of treatment and rehabilitation to support member progress and to establish requirements regarding member attendance and service participation. Treatment requirements for each phase shall include, but not limited to, the following:

(1) During phase I, the member shall participate in a minimum of four (4) sessions of therapy or rehabilitation services per month with at least one (1) session being individual therapy, rehabilitation, or case management.

(2) During phase II the member shall participate in at least two (2) therapy or rehabilitation service sessions per month during the first ninety (90) days, with at least one (1) of the sessions being individual therapy, rehabilitation, or case management. After the initial ninety (90) days in Phase II, the member shall participate in at least one (1) session of individual therapy or rehabilitation service per month.

(3) During phase III, phase IV and phase V, the member shall participate in at least one (1) session of individual therapy, rehabilitation, or case management per month.

(4) During phase VI, the LBHP, licensure candidate or certified alcohol and drug counselor (CADC) determines the frequency of therapy or rehabilitation service sessions with input from the member.

(5) If an OTP is providing MAT medications to members receiving residential substance use disorder services, the required minimum services for the OTP may be delivered by the residential substance use disorder provider. The OTP provider shall document the provision of these services and the provider delivering such services in the member's service plan.

(g) **Service plans.** In accordance with OAC 450:70-3-8, a service plan shall be completed for each member upon completion of the admission evaluation. The service plan shall be based on the patient's presenting problems or diagnosis, intake assessment, biopsychosocial assessment, and expectations of their recovery.

(1) **Service plan development.** Service plans shall be completed by an LBHP or licensure candidate. Service plans completed by a licensure candidate must be co-signed and dated by a fully-licensed LBHP.

(2) **Service plan content.** Service plans shall address, but not limited to, the following:

(A) Presenting problems or diagnosis;

(B) Strengths, needs, abilities, and preferences of the member;

(C) Goals for treatment with specific, measurable, attainable, realistic and time-limited;

(D) Type and frequency of services to be provided;

(E) Dated signature of primary service provider;

(F) Description of member's involvement in, and responses to, the service plan and his or her signature and date;

(G) Individualized discharge criteria or maintenance;

(H) Projected length of treatment;

(I) Measurable long and short term treatment goals;

(J) Primary and supportive services to be utilized with the patient;

(K) Type and frequency of therapeutic activities in which patient will participate;

(L) Documentation of the member's participation in the development of the plan; and

(M) Staff who will be responsible for the member's treatment.

(3) **Service plan updates.** Service plan updates shall be completed by an LBHP or licensure candidate. Service updates completed by a licensure candidate must be co-signed and dated by a fully-licensed LBHP. Service plan review and updates shall occur no less than every six (6) months and shall occur more frequently if required based upon the service phase or certain circumstances:

(A) During phase I, the service plan shall be reviewed and updated a minimum of once monthly.

(B) During phase II, the service plan shall be reviewed and updated a minimum of once every three (3) months.

(C) A service plan review shall be completed for the following situations:

(i) Change in goals and objectives based upon member's documented progress, or identification of any new problem(s);

(ii) Change in primary therapist or rehabilitation service provider assignment;

(iii) Change in frequency and types of services provided;

(iv) Critical incident reports;

(v) Sentinel events; or

(vi) Phase change.

(4) **Service plan timeframes.** Service plans shall be completed by the fourth therapy or rehabilitation service visit after

admission.

(h) **Progress notes.** Progress notes shall be completed in accordance with OAC 317:30-5-248(3).

(i) **Discharge planning.** All members shall be assessed for biopsychosocial appropriateness of discharge from each level of care using ASAM criteria that includes a list of symptoms for all six (6) dimensions and each of the levels of care, to determine a clinically appropriate placement in the least restrictive level of care. This organized process involves a professional determination by an LBHP or licensure candidate for appropriate placement to a specific level of care based on the following symptoms and situations:

(1) Acute intoxication and/or withdrawal potential;

(2) Biomedical conditions and complications;

(3) Emotional, behavioral or cognitive conditions and complications;

(4) Readiness to change;

(5) Relapse, continued use or continued problem potential; and

(6) Recovery/living environment.

(j) **Service exclusions.** The following services are excluded from coverage:

(1) Components that are not provided to or exclusively for the treatment of the eligible individual;

(2) Services or components of services of which the basic nature is to supplant housekeeping or basic services for the convenience of a person receiving covered services;

(3) Telephone calls or other electronic contacts (not inclusive of telehealth);

(4) Field trips, social, or physical exercise activity groups; and

(k) **Reimbursement.** In order to be eligible for payment, OTPs shall:

(1) Have an approved provider agreement on file with the OHCA. Through this agreement, the OTP assures that they are in compliance with all applicable federal and State Medicaid law and regulations, including, but not limited to, OHCA administrative rules, ODMHSAS administrative rules, and the Oklahoma Medicaid State Plan.

(2) Obtain prior authorization for applicable drugs and services by the OHCA or its designated agent before the service is rendered by an eligible provider. Without prior authorization for applicable drugs and services, payment is not authorized.

(3) Record the National Drug Code (NDC) number for each drug used in every encounter at the time of billing.

(3) Be reimbursed pursuant to the methodology described in the Oklahoma Medicaid State Plan.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 2. GRIEVANCE PROCEDURES AND PROCESS

317:2-1-2. Appeals

(a) **Request for appeals.**

(1) For the purpose of calculating the timeframe for requesting an administrative appeal of an agency action, the date on the written notice shall not be included. The last day of the timeframe shall be included, unless it is a legal holiday as defined by Title 25 of the Oklahoma Statutes (O.S.) Section (§) 82.1, or any other day the Oklahoma Health Care Authority (OHCA) is closed or closes early, in which case, the timeframe runs until the close of the next full business day.

(2) An appeals request that an aggrieved member or provider sends via mail is deemed filed on the date that the agency receives it.

(b) **Member process overview.**

(1) The appeals process allows a member to appeal a decision relating to program benefits. Examples are decisions involving medical services, prior authorizations for medical services, or discrimination complaints.

(2) In order to initiate an appeal, the member must file a LD-1 (Member Complaint/Grievance Form) within thirty (30) calendar days of the date the OHCA sends written notice of its action, in accordance with Oklahoma Administrative Code (OAC) 317:2-1-2(a), above, or, in matters in which a formal notice is not sent by the agency, within thirty (30) days of the date on which the member knew or should have known the facts or circumstances serving as the basis for appeal.

(3) If the LD-1 form is not received timely, the administrative law judge (ALJ) will cause to be issued a letter stating the appeal will not be heard. In the case of tax warrant intercept appeals, if the LD-1 form is not received by OHCA within the timeframe pursuant to 68 O.S. § 205.2, OHCA similarly will cause to be issued a letter stating the appeal will not be heard because it is untimely.

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

(5) OHCA will advise members that if assistance is needed in reading or completing the grievance form, arrangements will be made to provide such assistance.

(6) Upon receipt of the member's appeal, a fair hearing before the ALJ will be scheduled. The member will be notified in writing of the date and time of the hearing. The member must appear at the hearing, either in person or telephonically. Requests for a telephone hearing must be received in writing on

OHCA's LD-4 (Request for Telephonic Hearing) form no later than ten (10) calendar days prior to the scheduled hearing date. Telephonic hearing requests will only be granted by the OHCA's chief executive officer (CEO) or his/her designee, at his/her sole discretion, for good cause shown, including, for example, the member's physical condition, travel distances, or other limitations that either preclude an in-person appearance or would impose a substantial hardship on the member.

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

(8) Member appeals are ordinarily decided within ninety (90) days from the date on which the member's timely request for a fair hearing is received, unless:

(A) The appellant was granted an expedited appeal pursuant to OAC 317:2-1-2.5;

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

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

(D) The appellant filed a request for an appeal of a denied step therapy exception request, pursuant to OAC 317:2-1-18.

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

(c) **Provider process overview.**

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

(2) All provider appeals are initially heard by the OHCA ALJ under OAC 317:2-1-2(d)(2).

(A) In order to initiate an appeal, a provider must file the appropriate LD form within thirty (30) calendar days of the date the OHCA sends written notice of its action, in accordance with OAC 317:2-1-2(a), above. LD-2 forms should be used for Program Integrity audit appeals; LD-3 forms are to be used for all other provider appeals.

(B) Except for OHCA Program Integrity audit appeals, if the appropriate LD form is not received timely, the ALJ will cause a letter to be issued stating that the appeal will not be heard.

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

(D) Unless otherwise limited by OAC 317:2-1-7 or 317:2-1-13, the ALJ's decision is appealable to OHCA's CEO.

(d) **ALJ jurisdiction.** The ALJ has jurisdiction of the following matters:

(1) **Member appeals.**

(A) Discrimination complaints regarding the SoonerCare program;

(B) Appeals which relate to the scope of services, covered services, complaints regarding service or care, enrollment, disenrollment, and reenrollment in the SoonerCare Program;

(C) Fee-for-service appeals regarding the furnishing of services, including prior authorizations;

(D) Appeals which relate to the tax warrant intercept system through the OHCA. Tax warrant intercept appeals will be heard directly by the ALJ. A decision will be rendered by the ALJ within twenty (20) days of the hearing;

(E) Proposed administrative sanction appeals pursuant to OAC 317:35-13-7. Proposed administrative sanction appeals will be heard directly by the ALJ. A decision by the ALJ will ordinarily be rendered within twenty (20) days of the hearing before the ALJ. This is the final and only appeals process for proposed administrative sanctions;

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

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

(H) Appeals which relate to a requested step therapy protocol exception as provided by 63 O.S. § 7310.

(2) **Provider appeals.**

(A) Whether Pre-admission Screening and Resident Review (PASRR) was completed as required by law;

(B) Denial of request to disenroll member from provider's SoonerCare Choice panel;

(C) Appeals by long-term care facilities for administrative penalty determinations as a result of findings made under OAC 317:30-5-131.2(b)(5)(B) and (d)(8);

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

(E) Drug rebate appeals;

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

(G) Oklahoma Electronic Health Records Incentive program appeals related only to incentive payments, incentive payment amounts, provider eligibility determinations, and

demonstration of adopting, implementing, upgrading, and meaningful use eligibility for incentives;

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

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

~~(J)~~(I) Appeals from any adjustment made to a long-term care facility's cost report pursuant to OAC 317:30-5-132, including any appeal following a request for reconsideration made pursuant to OAC 317:30-5-132.1.

317:2-1-2.5. Expedited appeals

(a) An Appellant may request an expedited hearing, if the time otherwise permitted for a hearing as described in Oklahoma Administrative Code (OAC) 317:2-1-2(~~a~~b)(8) could jeopardize the Appellant's life or health or ability to attain, maintain, or regain maximum function. Any request for expedited consideration should be made to the Administrative Law Judge (ALJ), with a copy to the Oklahoma Health Care Authority (OHCA) Legal division and shall be ruled upon within three (3) working days of the date of the request. The request shall specify the reason for the appeal and the specific basis for the Appellant's assertion that a delay will jeopardize the Appellant's life or health.

(b) If the ALJ determines that an expedited hearing is warranted, he or she shall:

(1) Schedule the matter for hearing pursuant to OAC 317:2-1-5. Telephonic hearings may be scheduled as appropriate under the particular facts of the case; and

(2) Issue a preliminary or final decision as expeditiously as possible, but no later than three (3) working days the close of the expedited hearing.

(c) If the ALJ determines that the request does not meet the criteria for expedited consideration, he or she shall:

(1) Schedule the appeal for hearing within the ordinary timeframe, in accordance with OAC 317:2-1-2(~~a~~b)(8); and

(2) Notify the Appellant of the denial orally or through a written notice as described in OAC 317:35-5-66. If oral notification is provided, the ALJ shall issue a written notification within three (3) calendar days of the denial.

317:2-1-13. Appeal to the chief executive officer

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 9. LONG-TERM CARE FACILITIES

317:30-5-131.2. Quality of care fund requirements and report

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

(1) **"Annualize"** means that the calculations, including, for example, total patient days, gross revenue, or contractual allowances and discounts, is divided by the total number of applicable days in the relevant time period.

(2) **"Direct-Care Staff"** means any nursing or therapy staff who provides direct, hands-on care to residents in a nursing facility and intermediate care facility for individuals with intellectual disabilities pursuant to Section 1-1925.2 of Title 63 of the Oklahoma Statutes, pursuant to OAC 310:675-1 et seq., and as defined in subsection (c) of this Section.

(3) **"Major Fraction Thereof"** means an additional threshold for direct-care-staff-to-resident ratios at which another direct-care staff person(s) is required due to the peak in-house resident count exceeding one-half of the minimum direct-care-staff-to-resident ratio pursuant to Section 1-1925.2 of Title 63 of the Oklahoma Statutes.

(4) **"Nursing Facility and Intermediate Care Facility for Individuals with Intellectual Disabilities"** means any home, establishment, or institution or any portion thereof, licensed by the Oklahoma State Department of Health (OSDH) as defined in Section 1-1902 of Title 63 of the Oklahoma Statutes.

(5) **"Peak In-House Resident Count"** means the maximum number of in-house residents at any point in time during the applicable shift.

(6) **"Quality of Care Fee"** means the fee assessment created for the purpose of quality care enhancements pursuant to Section 2002 of Title 56 of the Oklahoma Statutes upon each nursing facility and intermediate care facility for individuals with intellectual disabilities licensed in this state.

(7) **"Quality of Care Fund"** means a revolving fund established in the State Treasury pursuant to Section 2002 of Title 56 of the Oklahoma Statutes.

(8) **"Quality of Care Report"** means the monthly report developed by the Oklahoma Health Care Authority (OHCA) to document the staffing ratios, total patient gross receipts, total patient days, and minimum wage compliance for specified staff for each

nursing facility and intermediate care facility for individuals with intellectual disabilities licensed in the state.

(9) **"Service Rate"** means the minimum direct-care-staff-to-resident rate pursuant to Section 1-1925.2 of Title 63 of Oklahoma Statutes and pursuant to OAC 310:675-1 et seq.

(10) **"Staff Hours Worked by Shift"** means the number of hours worked during the applicable shift by direct-care staff.

(11) **"Staffing Ratios"** means the minimum direct-care-staff-to-resident ratios pursuant to Section 1-1925.2 of Title 63 of the Oklahoma Statutes and pursuant to OAC 310:675-1 et seq.

(12) **"Total Gross Receipts"** means all cash received in the current Quality of Care Report month for services rendered to all residents in the facility. Receipts should include all Medicaid, Medicare, private pay, and insurance including receipts for items not in the normal per diem rate. Charitable contributions received by the nursing facility are not included.

(13) **"Total Patient Days"** means the monthly patient days that are compensable for the current monthly Quality of Care Report.

(b) **Quality of care fund assessments.**

(1) The OHCA was mandated by the Oklahoma Legislature to assess a monthly service fee to each licensed nursing facility in the state. The fee is assessed on a per patient day basis. The amount of the fee is uniform for each facility type. The fee is determined as six percent (6%) of the average total gross receipts divided by the total days for each facility type.

(2) Annually, the Nursing Facilities Quality of Care Fee shall be determined by using the daily patient census and patient gross receipts report received by the OHCA for the most recent available twelve months and annualizing those figures. Also, the fee will be monitored to never surpass the federal maximum.

(3) The fee is authorized through the Medicaid State Plan and by the Centers for Medicare and Medicaid Services regarding waiver of uniformity requirements related to the fee.

(4) Monthly reports of Gross Receipts and Census are included in the monthly Quality of Care Report. The data required includes, but is not limited to, the Total Gross Receipts and Total Patient Days for the current monthly report.

(5) The method of collection is as follows:

(A) The OHCA assesses each facility monthly based on the reported patient days from the Quality of Care Report filed two months prior to the month of the fee assessment billing. As defined in this subsection, the total assessment is the fee times the total days of service. The OHCA notifies the facility of its assessment by the end of the month of the Quality of Care Report submission date.

(B) Payment is due to the OHCA by the 15th of the following month. Failure to pay the amount by the 15th or failure to have the payment mailing postmarked by the 13th will result in a debt to the State of Oklahoma and is subject to penalties of 10 percent (10%) of the amount and interest of 1.25 percent (1.25%) per month. The Quality of Care Fee must be submitted no later than the 15th of the month. If the 15th falls upon a holiday or weekend (Saturday-Sunday), the fee is due by 5 p.m., Central Standard Time (CST), of the following business day (Monday-Friday).

(C) The monthly assessment, including applicable penalties and interest, must be paid regardless of any appeals action requested by the facility. If a provider fails to pay the OHCA the assessment within the time frames noted on the second invoice to the provider, the assessment, applicable penalty, and interest will be deducted from the facility's payment. Any change in payment amount resulting from an appeals decision will be adjusted in future payments. Adjustments to prior months' reported amounts for gross receipts or patient days may be made by filing an amended part C of the Quality of Care Report.

(D) The Quality of Care fee assessments excluding penalties and interest are an allowable cost for OHCA cost reporting purposes.

(E) The Quality of Care fund, which contains assessments collected including penalties and interest as described in this subsection and any interest attributable to investment of any money in the fund, must be deposited in a revolving fund established in the State Treasury. The funds will be used pursuant to Section 2002 of Title 56 of the Oklahoma Statutes.

(c) **Quality of care direct-care-staff-to resident-ratios.**

(1) All nursing facilities and intermediate care facilities for individuals with intellectual disabilities (ICFs/IID) subject to the Nursing Home Care Act, in addition to other state and federal staffing requirements, must maintain the minimum direct-care-staff-to-resident ratios or direct-care service rates as cited in Section 1-1925.2 of Title 63 of the Oklahoma Statutes and pursuant to OAC 310:675-1 et seq.

(2) For purposes of staff-to-resident ratios, direct-care staff are limited to the following employee positions:

(A) Registered Nurse;

(B) Licensed Practical Nurse;

(C) Nurse Aide;

(D) Certified Medication Aide;

(E) Qualified Intellectual Disability Professional (ICFs/IID only);

(F) Physical Therapist;
(G) Occupational Therapist;
(H) Respiratory Therapist;
(I) Speech Therapist; and
(J) Therapy Aide/Assistant.

(3) The hours of direct care rendered by persons filling non-direct care positions may be used when those persons are certified and rendering direct care in the positions listed in OAC 317:30-5-131.2(c)(2) when documented in the records and time sheets of the facility.

(4) In any shift when the direct-care-staff-to-resident ratio computation results in a major fraction thereof, direct-care staff is rounded to the next higher whole number.

(5) To document and report compliance with the provisions of this subsection, nursing facilities and ICFs/IID must submit the monthly Quality of Care Report pursuant to subsection (e) of this Section.

(d) **Quality of care reports.** All nursing facilities and intermediate care facilities for individuals with intellectual disabilities must submit a monthly report developed by the OHCA, the Quality of Care Report, for the purposes of documenting the extent to which such facilities are compliant with the minimum direct-care-staff-to-resident ratios or direct-care service rates.

(1) The monthly report must be signed by the preparer and by the owner, authorized corporate officer, or administrator of the facility for verification and attestation that the reports were compiled in accordance with this section.

(2) The owner or authorized corporate officer of the facility must retain full accountability for the report's accuracy and completeness regardless of report submission method.

(3) Penalties for false statements or misrepresentation made by or on behalf of the provider are provided at 42 U.S.C. Section 1320a-7b.

(4) The Quality of Care Report must be submitted by 5 p.m. (CST) on the 15th of the following month. If the 15th falls upon a holiday or a weekend (Saturday-Sunday), the report is due by 5 p.m. (CST) of the following business day (Monday - Friday).

(5) The Quality of Care Report will be made available in an electronic version for uniform submission of the required data elements.

(6) Facilities must submit the monthly report through the OHCA Provider Portal.

(7) Should a facility discover an error in its submitted report for the previous month only, the facility must provide to the Long-term Care Financial Management Unit written notification with adequate, objective, and substantive documentation within five business days following the submission deadline. Any

documentation received after the five business day period will not be considered in determining compliance and for reporting purposes by the OHCA.
(8) An initial administrative penalty of $150.00 is imposed upon the facility for incomplete, unauthorized, or non-timely filing of the Quality of Care Report. Additionally, a daily administrative penalty will begin upon the OHCA notifying the facility in writing that the report was not complete or not timely submitted as required. The $150.00 daily administrative penalty accrues for each calendar day after the date the notification is received. The penalties are deducted from the Medicaid facility's payment. For 100 percent (100%) private pay facilities, the penalty amount(s) is included and collected in the fee assessment billings process. Imposed penalties for incomplete reports or non-timely filing are not considered for OHCA cost reporting purposes.
(9) The Quality of Care Report includes, but is not limited to, information pertaining to the necessary reporting requirements in order to determine the facility's compliance with subsections (b) and (c) of this Section. Such reported information includes, but is not limited to: total gross receipts, patient days, available bed days, direct care hours, Medicare days, Medicaid days, number of employees, monthly resident census, and tenure of certified nursing assistants, nurses, directors of nursing, and administrators.
(10) Audits may be performed to determine compliance pursuant to subsections (b), and (c) of this Section. Announced/unannounced on-site audits of reported information may also be performed.
(11) Direct-care-staff-to-resident information and on-site audit findings pursuant to subsection (c), will be reported to the OSDH for their review in order to determine "willful" non-compliance and assess penalties accordingly pursuant to Title 63 Section 1-1912 through Section 1-1917 of the Oklahoma Statutes. The OSHD informs the OHCA of all final penalties as required in order to deduct from the Medicaid facility's payment. Imposed penalties are not considered for OHCA Cost Reporting purposes.
~~(12) If a Medicaid provider is found non-compliant pursuant to subsection (d) based upon a desk audit and/or an on-site audit, for each hour paid to specified staff that does not meet the regulatory minimum wage of $6.65, the facility must reimburse the employee(s) retroactively to meet the regulatory wage for hours worked. Additionally, an administrative penalty of $25.00 is imposed for each non-compliant staff hour worked. For Medicaid facilities, a deduction is made to their payment. Imposed penalties for non-compliance with minimum wage~~

~~requirements are not considered for OHCA cost reporting purposes.~~

~~(13)~~(12) Under OAC 317:2-1-2, long-term care facility providers may appeal the administrative penalty described in (b)(5)(B) and ~~(e)(8) and (e)(12)~~(d)(8) of this section.

~~(14)~~(13) Facilities that have been authorized by the OSDH to implement flexible staff scheduling must comply with OAC 310:675-1 et seq. The authorized facility is required to complete the flexible staff scheduling section of Part A of the Quality of Care Report. The owner, authorized corporate officer, or administrator of the facility must complete the flexible staff scheduling signature block, acknowledging their OSDH authorization for flexible staff scheduling.

PART 103. QUALIFIED SCHOOLS AS PROVIDERS OF HEALTH RELATED SERVICES

317:30-5-1020. General provisions

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

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

(1) Except for those services, referenced in ~~Oklahoma Administrative Code (OAC)~~OAC 317:30-5-1023(b)(~~4~~2)(H), a plan of care that meets the requirements of OAC 317:30-5-1020(b), above, shall serve as a prior medical authorization for the purpose of providing medically necessary and appropriate school-based services to students.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) The Oklahoma Health Care Authority offers approximately forty (40) different types of administrative appeals. Some of the appeals are appealable to the chief executive officer (CEO) and some are not. The following appeals may be heard by the CEO following the decision of an administrative law judge:

(1) Appeals under Oklahoma Administrative Code (OAC) 317:2-1-2(d)(1)(A) to (d)(1)(H), with the exception of subsection (d)(1)(E); and

(2) Appeals under OAC 317:2-1-2(d)(2)(A) to (d)(2)(I), with the exceptions of subsections ~~(d)(2)(F) and (G)~~ (d)(2)(D),(E),(F),(G), and (I).~~; and~~

~~(3) Appeals under 317:2-1-10.~~

(b) Appeals to the CEO must be filed with the OHCA within thirty (30) days of the date of the Order, or decision by OHCA.

(c) No new evidence may be presented to the CEO.

(d) Appeals to the CEO under (a) of this Section may be filed by the provider, member, or agency. The CEO will ordinarily render decisions within sixty (60) days of the receipt of the appeal.

317:2-1-14. Contract award protest process

Suppliers who respond to a solicitation issued and awarded by the Authority pursuant to 74 Oklahoma Statutes (O.S.) § 85.5 (~~T~~N) may protest the award of a contract under such solicitation.

(1) A supplier shall submit written notice to the OHCA Legal Division of a protest of an award of a contract by OHCA within ten (10) business days of contract award. The protest shall state supplier facts and reasons for protest.

(2) The OHCA Legal Division shall review the supplier's protest and contract award documents. Written notice of the decision to sustain or deny the supplier's protest will be sent to the supplier within ten (10) business days of receipt of supplier's written notice.

(3) If the OHCA Legal Division denies the supplier's protest, the supplier may request a hearing to administratively resolve the matter within thirty (30) calendar days of receipt of the written denial by filing a form ~~LD-2~~LD-3 with the Docket Clerk.

(4) The process afforded the supplier will be the process found at Oklahoma Administrative Code 317:2-1-2(c).

(5) The Administrative Law Judge's decision will constitute the final administrative decision of the Oklahoma Health Care Authority.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 9. LONG-TERM CARE FACILITIES

317:30-5-136.1. Pay-for-Performance (PFP) program

(a) **Purpose.** The ~~Pay-for-Performance (PFP)~~PFP program was established through Oklahoma State Statute, Title 56, Section 56-1011.5 as amended. PFP's mission is to enhance the quality of life for target citizens by delivering effective programs and facilitating partnerships with providers and the community they serve. The program has a full commitment to the very best in quality, service and value which will lead to measurably improved quality outcomes, healthier lifestyles~~;~~, greater satisfaction and confidence for our members.

(b) **Eligible ~~Providers.~~providers.** Any Oklahoma long-term care nursing ~~facilities~~facility that ~~are~~is licensed and certified by the Oklahoma State Department of Health (OSDH) ~~and accommodate SoonerCare members at their facility~~ as defined in Oklahoma Administrative Code (OAC) 317:30-5-120.

(c) **Quality measure care criteria.** To maintain status in the PFP program, each nursing facility shall submit documentation as it relates to program metrics ~~(below)~~ quarterly or upon the request of the Oklahoma Health Care Authority (OHCA). The program metrics can be found on the OHCA's PFP website or on PFP/Quality of Care (QOC) data collection portal. If any quality metric, listed below, is substituted or removed by Centers of Medicare and Medicaid Services (CMS), an alternative quality metric may be chosen. For the period beginning October 1, 2019 and until changed by amendment, qualifying facilities participating in the PFP program have the potential to earn an average of the five dollars ($5.00) quality incentive per Medicaid patient per day. Facility(s) baseline is calculated annually and will remain the same for the twelve (12) month period. Facility(s) will meet or exceed five-percent (5%) relative improvement or the ~~Centers for Medicare and Medicaid Services~~CMS' national average each quarter for the following metrics:

(1) Decrease percent of high risk/unstageable pressure ulcers for ~~long stay~~long-stay residents.

(2) Decrease percent of unnecessary weight loss for ~~long stay~~long-stay residents.

(3) Decrease percent of use of anti-psychotic medications for ~~long stay~~long-stay residents.

(4) Decrease percent of urinary tract infection for ~~long stay~~long-stay residents.

(d) **Payment.** Payment to long-term care facilities for meeting the metrics will be awarded quarterly. A facility may earn a minimum of ~~$1.25~~one dollar and twenty-five cents ($1.25) per Medicaid patient per day for each qualifying metric. A facility receiving a deficiency of "I" or greater related to a targeted quality measure in the program is disqualified from receiving an award related to that measure for that quarter.

(1) **Distribution of ~~Payment.~~payment.** OHCA will notify the PFP facility of the quality reimbursement amount on a quarterly basis.

(2) **Penalties.** Facilities shall have performance review(s) and provide documentation upon request from OHCA to maintain program compliance. Program payments will be withheld from facilities that fail to submit the requested documentation within fifteen (15) business days of the request.

(3) **Timeframe.** To qualify for program reimbursement by meeting a specific quality measure, facilities are required to provide metric documentation within thirty (30) days after the end of each quarter to the Oklahoma Health Care Authority.

(e) **Appeals.** Facilities can file an appeal with the Quality Review Committee and in accordance, with the grievance procedures found at OAC 317:2-1-2(c) and ~~317:2-1-16.~~317:2-1-17.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 40. DEVELOPMENTAL DISABILITIES SERVICES

SUBCHAPTER 7. EMPLOYMENT SERVICES THROUGH HOME AND COMMUNITY-BASED SERVICES WAIVERS

317:40-7-7. Job coaching services

(a) Job coaching services:

(1) ~~are~~Are pre-planned, documented activities related to the member's identified employment outcomes that include training at the work site and support by provider agency staff who have completed ~~DDSD~~Developmental Disabilities Services (DDS) sanctioned training, per ~~OAC~~Oklahoma Administrative Code (OAC) 340:100-3-38.2;

(2) ~~promote~~Promote the member's capacity to secure and maintain integrated employment at a job of the member's choice paying at or more than minimum wage, or working to achieve minimum wage;

(3) ~~provide~~Provide active participation in paid work. Efforts are made in cooperation with employers to adapt normal work environments to fit the needs of members through the maintenance of an active relationship with the business;

(4) ~~are~~Are available for individual and group placements.

(A) Individual placement is:

(i) ~~one~~One (1) member receiving job coaching services who:

(I) ~~works~~Works in an integrated job setting;

(II) ~~is~~Is paid at or more than minimum wage;

(III) ~~does~~Does not receive services from a job coach who is simultaneously responsible for continuous job coaching for a group;

(IV) ~~is~~Is employed by a community employer or provider agency; and

(V) ~~has~~Has a job description that is specific to the member's work~~; and~~.

(ii) ~~authorized~~Authorized when on-site supports by a certified job coach are provided more than ~~20%~~twenty percent (20%) of the member's compensable work time. Job coaching services rate continues until a member reaches ~~20%~~twenty percent (20%) or less job coach intervention for four (4) consecutive weeks, at which time stabilization services begin~~.~~ and;

(iii) Authorized through remote supports per Health Insurance Portability and Accountability Act (HIPAA) compliant technology, when the Personal Support Team (Team) has an approved remote supports risk assessment.

(B) ~~Group~~Small group placement is~~ two to eight members receiving continuous support in an integrated work site, who may earn less than minimum wage ; and~~:

(i) Two (2) to three (3) members receiving continuous support in an integrated work site who are paid at, or more than, minimum wage; or

(ii) Four (4) to five (5) members receiving continuous support in an integrated work site, who may earn less than minimum wage.

(5) ~~are~~Are based on the amount of time for which the member is compensated by the employer, except per OAC 317:40-7-11.

(b) For members in individual placements, the ~~Personal Support Team (Team):~~Team:

(1) ~~evaluates~~Evaluates the need for job coaching services at least annually; and

(2) ~~documents~~Documents a plan for fading job coaching services as the member's independence increases.

(c) When the member receives commensurate compensation, employment goals include, but are not limited to, increasing:

(1) ~~productivity;~~Productivity;

(2) ~~work quality;~~Work quality;

(3) ~~independence;~~Independence;

(4) ~~minimum wage opportunities; and~~Minimum wage opportunites; and

(5) ~~competitive work opportunities.~~Competitive work opportunites.

317:40-7-15. Service requirements for employment services through Home and Community-Based Services (HCBS) Waivers

(a) The Oklahoma~~ Department of~~ Human Services ~~(DHS)~~(OKDHS) Developmental Disabilities Services (DDS) case manager, the member, the member's family or, when applicable, the member's legal guardian, and the member's provider develop a preliminary plan of services including the:

(1) ~~site~~Site and amount of the services offered;

(2) ~~types~~Types of services to be delivered; and

(3) ~~expected~~Expected outcomes.

(b) To promote community integration and inclusion, employment services are delivered in non-residential sites.

(1) Employment services through HCBS waivers cannot be reimbursed when those services occur in the residence or property of the member or provider-paid staff, including garages and sheds, whether or not the garage or shed is attached to the home~~ or not~~.

(2) No exceptions to Oklahoma Administrative Code (OAC) 317:40-7-15(b) are authorized except when a home-based business is established and supported through~~ the~~ Oklahoma~~ Department of~~

Rehabilitation Services ~~(OKDRS).~~(DRS). Once ~~OKDRS~~DRS stabilization services end, DDS stabilization services are then utilized.

(c) The service provider is required to notify the DDS case manager in writing when the member:

(1) ~~is~~Is placed in a new job;

(2) ~~loses~~Loses his or her job. A personal support team (Team) meeting must be held when the member loses the job;

(3) ~~experiences~~Experiences significant changes in the community-based or employment schedule; or

(4) ~~is~~Is involved in critical and non-critical incidents per OAC 340:100-3-34.

(d) The provider submits a DHS Provider Progress Report, per OAC 340:100-5-52, for each member receiving services.

(e) The cost of a member's employment services, excluding transportation and state-funded services ~~per OAC 340:100-17-30,~~ cannot exceed ~~$27,000~~limits set forth in OKDHS Appendix D-26, Developmental Disabilities Services Rates Schedule, per Plan of Care (POC) year.

(f) Each member receiving HCBS is supported in opportunities to seek employment and work in competitive integrated settings. When the member is not employed in a competitive integrated job, the Team identifies outcomes, ~~and/or~~ action steps, or both, to create opportunities that move the member toward competitive integrated employment.

(g) Each member receiving residential supports, per OAC 340:100-5-22.1, or group-home services is employed for thirty (30) hours per week or receives a minimum of thirty (30) hours of employment services each week, excluding transportation to and from his or her residence.

(1) Thirty (30) hours of employment service each week may be a combination of community-based services, center-based services, employment training specialist (ETS) intensive training services, stabilization services, or job coaching services. Center-based services cannot exceed fifteen (15) hours per week for members receiving services through the Homeward Bound Waiver.

(2) When the member does not participate in thirty (30) hours per week of employment services, the Team:

(A) ~~documents~~Documents the outcomes and/or action steps to create a pathway that moves toward employment activities;

(B) ~~describes~~Describes a plan to provide a meaningful day in the community; or

(C) ~~increases~~Increases the member's employment activities to thirty (30) hours per week.

(h) Adult members receiving In-Home Supports waiver services can access individual placement in job coaching, stabilization, and

employment training specialist services not to exceed limits specified in OKDHS Appendix D-26, per POC year.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 6. INPATIENT PSYCHIATRIC SERVICES

317:30-5-95.24. Prior authorization of inpatient psychiatric services for individuals under twenty-one (21)

(a) All inpatient psychiatric services for members under twenty-one (21) years of age must be prior authorized by the OHCA or its designated agent. All inpatient Acute, Acute II, and PRTF services will be prior authorized for an approved length of stay. Admission requirements for services must be provided in accordance with 42 C.F.R. Part 441 and 456. Additional information will be required for SoonerCare-compensable approval on enhanced treatment units or in special population programs.

(b) Unit staffing ratios shall always meet the requirements in OAC 317:30-5-95.24 (c), (d) and (h). The facility cannot use staff that is also on duty in other units of the facility in order to meet the unit staffing ratios. Patients shall be grouped for accommodation by gender, age, and treatment needs. At a minimum, children, adolescent, and adult treatment programs shall be separate with distinct units for each population. A unit is determined by separate and distinct sleeping, living, and treatment areas often separated by walls and/or doors. A unit that does not allow clear line of sight due to the presence of walls or doors is considered a separate unit. Each individual unit shall have assigned staff to allow for appropriate and safe monitoring of patients and to provide active treatment.

(c) In Acute and Acute II settings, at least one (1) registered nurse (RN) must be on duty per unit at all times, with additional RNs to meet program needs. RNs must adhere to Oklahoma State Department of Health (OSDH) policy at OAC 310:667-15-3 and 310:667-33-2(a)(3).

(d) Acute, non-specialty Acute II, and non-specialty PRTF programs require a staffing ratio of one (1) staff: six (6) patients during routine waking hours and one (1) staff: eight (8) patients during time residents are asleep with twenty-four (24) hour nursing care supervised by an RN for management of behaviors and medical complications. For PRTF programs, at a minimum, a supervising RN must be available by phone and on-site within one (1) hour. If the supervising RN is off-site, then an RN or licensed practical nurse (LPN) must be on-site to adhere to a twenty-four (24) hour nursing care coverage ratio of one (1) staff: thirty (30) patients during routine waking hours and one (1) staff: forty (40) patients during time residents are asleep.

(e) Specialty treatment at Acute II or PRTF is a longer-term treatment that requires a higher staff-to-member ratio because of

the need for constant, intense, and immediate reinforcement of new behaviors to develop an understanding of the behaviors. The environment of specialized residential treatment centers requires special structure and configuration (e.g., sensory centers for autistic members) and specialized training for the staff in the area of the identified specialty. The physician will see the child at least one (1) time a week.

(f) An Acute II or PRTF will not be considered a specialty treatment program for SoonerCare without prior approval of the OHCA behavioral health unit.

(g) A treatment program that has been approved as a specialized treatment program must maintain medical records that document the degree and intensity of the psychiatric care delivered to the members.

(h) Criteria for classification as a specialty Acute II or PRTF will require a staffing ratio of one (1) staff: ~~three (3)~~four (4) patients at a minimum during routine waking hours and one (1) staff: six (6) patients during time residents are asleep with twenty-four (24) hour nursing care supervised by a RN for management of behaviors and medical complications. The specialty Acute II or PRTF will be a secure unit, due to the complexity of needs and safety considerations. ~~Admissions will be restricted to members who meet the medical necessity criteria for the respective level of care and also meet at least two (2) or more of the following:~~

~~(1) Have failed at other levels of care or have not been accepted by other non-specialty levels of care;~~

~~(2) Have behavioral, emotional, and cognitive problems requiring secure treatment that includes one (1) staff: one (1) patient, one (1) staff: two (2) patients, or one (1) staff: three (3) patients staffing due to the member being a danger to themselves and others, for impairments in socialization problems, communication problems, and restricted, repetitive, and stereotyped behaviors. These symptoms must be severe and intrusive enough that management and treatment in a less restrictive environment places the member and others in danger but, do not meet acute medical necessity criteria. These symptoms must be exhibited across multiple environments and must include at least two (2) or more of the following:~~

~~(A) Marked impairments in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction;~~

~~(B) Inability to regulate impulse control with frequent displays of aggression or other dangerous behavior toward self and/or others regularly;~~

~~(C) Failure to develop peer relationships appropriate to developmental level;~~

~~(D) Lack of spontaneously seeking to share enjoyment, interests, or achievements with other people;~~

~~(E) Lack of social or emotional reciprocity;~~

~~(F) Lack of attachment to caretakers;~~
~~(G) Require a higher level of assistance with activities of daily living requiring multiple verbal cues at least fifty (50) percent of the time to complete tasks;~~
~~(H) Delay, or total lack of, the development of spoken language which is not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime;~~
~~(I) Marked impairment in individuals with adequate speech in the ability to initiate or sustain a conversation with others;~~
~~(J) Stereotyped and repetitive use of language or idiosyncratic language;~~
~~(K) Lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level;~~
~~(L) Encompassing preoccupation with one (1) or more stereotyped and restricted pattern and interest that is abnormal in intensity of focus;~~
~~(M) Inflexible adherence to specific, nonfunctional routines or rituals;~~
~~(N) Stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting or complex whole body movements); and/or~~
~~(O) Persistent occupation with parts of objects;~~

~~(3) Member is medically stable, but has co-morbid medical conditions which require specialized medical care during treatment; and/or~~

~~(4) Has full-scale IQ below forty (40) (profound intellectual disability).~~

(i) Admissions to a specialty Acute II or PRTF will be restricted to members who meet the medical necessity criteria at OAC 317:30-5-95.29 for the respective level of care and also meet the following criteria:

(1) Have failed at other levels of care or have not been accepted by other non-specialty levels of care; and

(2) Have an intellectual disability and/or developmental disability that meets at least one (1) of the following criteria:

(A) Intellectual disability characterized by a full-scale IQ of seventy (70) or less; or

(B) Developmental disability characterized by significant functional impairment, such as delayed or total lack of spoken language, inability to independently perform two (2) or more activities of daily living requiring multiple verbal cues at least fifty percent (50%) of the time to complete tasks, inability to regulate impulse control with frequent displays of aggression or other dangerous behavior toward self and/or others regularly, or other impairments requiring specialty care, subject to approval by OHCA.

~~(i)~~ (j) Non-authorized inpatient psychiatric services will not be

SoonerCare compensable.

~~(j)~~ (k) The OHCA, or its designated agent, will prior authorize all services for an approved length of stay based on the medical necessity criteria described in OAC 317:30-5-95.25 through 317:30-5-95.30.

~~(k)~~ (l) For out-of-state placement policy, refer to OAC 317:30-3-89 through 317:30-3-92. A prime consideration for placements will be proximity to the family or guardian in order to involve the family or guardian in active treatment, including discharge and reintegration planning. Out-of-state facilities are responsible for insuring appropriate medical care, as needed under SoonerCare provisions, as part of the per-diem rate.

~~(l)~~ (m) Inpatient psychiatric services in all psychiatric units of general hospitals, psychiatric hospitals, and PRTFs are limited to the approved length of stay. OHCA, or its designated agent, will approve lengths of stay using the current OHCA Behavioral Health medical necessity criteria as described in OAC 317:30-5-95.25 through OAC 317:30-5-95.30. The approved length of stay applies to both facility and physician services.