

OKLAHOMA HEALTH CARE AUTHORITY  
REGULARLY SCHEDULED BOARD MEETING  
March 10, 2011 at 1:00 P.M.  
Oklahoma Health Care Authority  
2401 NW 23<sup>rd</sup>, Suite 1-A  
Ponca Conference Room  
Oklahoma City, Oklahoma

**A G E N D A**

**Items to be presented by Lyle Roggow, Chairman**

1. Call To Order/Determination of Quorum
2. Action Item - Approval of January 13, 2011 OHCA Board Minutes

**Item to be presented by Mike Fogarty, Chief Executive Officer**

3. Discussion Item - Chief Executive Officer's Report
  - a) Financial Update - Carrie Evans, Chief Financial Officer
  - b) Medicaid Director's Update - Garth Splinter, M.D.
  - c) Legislative Update - Nico Gomez, Deputy Chief Executive Officer
  - d) SoonerCare Prenatal Update - Tobacco Settlement Endowment Trust (TSET)  
Shelly Patterson, Director of Child Health Unit

**Item to be presented by Chairman Roggow**

4. Discussion Item - Reports to the Board by Board Committees
  - a) Audit/Finance Committee - Member Miller
  - b) Legislative Committee - Member McFall
  - c) Rules Committee - Sandra Langenkamp

**Item to be presented by Howard Pallotta, Director of Legal Services**

5. Announcement of Conflicts of Interest Panel Recommendations for all action items regarding this board meeting.

**Item to be presented by Cindy Roberts, Deputy Chief Executive Officer**

6. Action Item - Consideration and Vote of agency recommended rulemaking pursuant to Article I of the Administrative Procedures Act

**Adoption of Permanent Rules as required by the Administrative Procedures Act.**

**The following rules HAVE previously been approved by the Board and have Gubernatorial approval under Emergency rulemaking. These rules have been REVISED for Permanent Rulemaking.**

- 6.a-1 AMENDING Agency rules at OAC 317:30-5-660.1, 30-5-660.4, 30-5-661.1, 30-5-661.5, 30-5-664.5, 30-5-664.7, and 30-5-664.10 to revise contracting requirements for Federally Qualified Health Centers (FQHC); clarify Health Center enrollment requirements for services rendered in a school setting; revise the definition of core services to include services rendered by Licensed Behavioral Health Professionals as authorized under the FQHC

State Plan pages; and clarify general reimbursement requirements for FQHC's. **(Reference APA WF # 10-04)**

- 6.a-2** AMENDING agency rules at OAC 317:45-1-3, 45-3-2, 45-5-1, 45-5-2, 45-7-2, 45-7-3, 45-7-6, 45-7-8, 45-9-1, 45-9-2, 45-9-7, 45-11-1, 45-11-2, 45-11-10 through 45-11-13, 45-11-20, 45-11-21, 45-11-23, 45-11-27, 45-11-28 to clarify and expand on definitions of College Student, Employee and Employer within the Insure Oklahoma program; clarify procedures for credits and adjustments for employers participating in the program; require college students to submit current course schedules to prove full-time status; add Ultraviolet Treatment-Actinotherapy and Private Duty Nursing as non-covered services; clarify that no standard deduction for work related expenses may be made for self-employed individuals; require that approved individuals notify OHCA of any changes in household status and income, that might impact eligibility, within 30 calendar days of the change; and to clean up references to the Oklahoma Administrative Code to comply with APA formatting requirements. **(Reference APA WF # 10-08)**
- 6.a-3** AMENDING Agency rules at OAC 317:50-1-3 to revise eligibility requirements for the Medically Fragile Waiver to allow individuals with intellectual disabilities. **(Reference APA WF # 10-13)**
- 6.a-4** AMENDING agency rules at OAC 317:30-5-276 and 30-5-281 to revise psychologist rules to update provider requirements, terminology and to require prior authorization of services for all services provided except the initial assessment and/or crisis intervention. **(Reference APA WF # 10-15)**
- 6.a-5** AMENDING Agency rules at OAC 317:30-5-241.1 to reflect behavioral health assessments and service plan development may only be provided by licensed behavioral health professionals. Currently, bachelor level Certified Alcohol and Drug Counselors (CADCs) may perform substance abuse assessments in accordance with their Licensure Act. Due to accreditation standard requirements for Assessments, all outpatient agencies are required to conduct full bio-psycho-social assessments by a licensed Masters level professional. As a result, ODMHSAS and OHCA collaboratively agreed to restrict the realm of behavioral health assessments to licensed behavioral health professionals and disallow the use of CADCs for substance abuse assessments. **(Reference APA WF # 10-18)**
- 6.a-6** AMENDING Agency rules at OAC 317:30-5-556 and 30-5-560 to clarify that Private Duty Nursing (PDN) is available to eligible individuals in their primary residence and to remove the requirement that treatment plans for (PDN) be updated and signed by the member's physician annually. **(Reference APA WF # 10-23)**
- 6.a-7** AMENDING Agency rules at OAC 317:30-5-241 to refer to the Behavioral health provider reference tool as the Behavioral Health Manual rather than the Behavioral Health Billing Manual. **(Reference APA WF # 10-29)**
- 6.a-8** AMENDING Agency rules at OAC 317:30-5-241.2 to revise the definition of Partial Hospitalization Services to require that the services are reasonable and necessary for the diagnosis and active treatment of the member's condition, are reasonably expected to improve or maintain the member's condition and are

provided in accordance with the Code of Federal Regulations.  
(Reference APA WF # 10-53)

- 6.a-9** AMENDING Agency rules at OAC 317:30-3-5 to exempt from SoonerCare cost sharing requirements, Native Americans who have provided documentation of ethnicity and receive items and services furnished by the Indian Health Service, Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U's) or through referral under contract health services. (Reference APA WF # 10-56)
- 6.a-10** AMENDING Agency rules at OAC 317:30-5-700 and 30-5-700.1 to clarify eligibility requirements for SoonerCare Orthodontic services; clarify provider requirements for General or Pediatric dental practitioners who have completed at least 200 certified hours of continuing education in the field of orthodontics practice; and remove references to Relative Value Units (RVU's) as well as other minor formatting revisions. (Reference APA WF # 10-58)
- 6.a-11** AMENDING Agency rules at OAC 317:30-5-78 to allow for a new pricing benchmark, Wholesale Acquisition Cost (WAC), in the event that the Average Wholesale Price (AWP) is no longer published by OHCA's pharmacy pricing vendor. Rules are also revised to reflect the change in pricing methodology for injectable drugs that are submitted through the pharmacy system. (Reference APA WF # 10-62)
- 6.a-12** AMENDING Agency rules at OAC 317:35-5-25 to revise SoonerCare eligibility rules so that only new certified birth certificates will be accepted as verification of citizenship for Puerto Ricans who are using their birth certificate as proof of citizenship and whose eligibility for benefits will be determined for the first time on or after October 1, 2010. This rule change does not prohibit Puerto Ricans from using other forms of citizenship verification; it only applies to the use of birth certificates. When the applicant has not yet received his or her new certified birth certificate, reasonable opportunity to obtain citizenship verification will be afforded to the applicant. These changes are made pursuant to CMS guidance. (Reference APA WF # 10-63)

The following rules HAVE previously been reviewed by the Board DO NOT have Gubernatorial approval under Emergency rulemaking. These rules have been REVISED for Permanent Rulemaking.

- 6.a-13** AMENDING Agency rules at OAC 317:30-5-660.5, 30-5-661.4 and 30-5-664.3 to clarify reimbursement for certain Licensed Behavioral Health Professionals in Federally Qualified Health Centers (FQHC). Additionally, revisions are made to reflect contracting and reimbursement requirements for covered services in FQHC and school settings. Policy revisions are needed to make certain LBHP's who provide behavioral health services in FQHC's are reimbursed appropriately. Revisions are also needed to identify behavioral health services that are permissible in FQHC's and school settings. These revisions ensure that the reimbursement rates for services rendered in FQHC's comply with cost based reimbursement accounting principles thereby eliminating payment errors and guarding the Agency's Federal Financial Participation (FFP) from being at risk. (Reference APA WF # 10-04)

The following rules HAVE previously been approved by the Board and have Gubernatorial approval under Emergency Rulemaking.

- 6.a-14** AMENDING agency rules at OAC 317:30-5-740, 30-5-740.1, 30-5-741, 30-5-742, 30-5-742.1, 30-5-742.2, 30-5-743.1, 30-5-744 and 30-5-745, and REVOKING agency rules at 30-5-743 to change outpatient behavioral health reimbursement methodology for services provided in therapeutic foster care settings from an all inclusive per diem payment to fee-for-service. The requirement of "unbundling" per diem rates has been an ongoing trend for CMS and this change more closely aligns our reimbursements with CMS preferences and requirements. **(Reference APA WF # 10-02)**
- 6.a-15** AMENDING Agency rules at OAC 317:30-5-660.3, 30-5-661.7 and REVOKING 30-5-664.11 to clarify the allowable places of services where Federally Qualified Health Center providers are eligible to be reimbursed the Prospective Payment System (PPS) rate for services rendered. Revisions also revoke references to outdated policies and practices. **(Reference APA WF # 10-04)**
- 6.a-16** AMENDING Agency rules at OAC 317:45-1-1, 45-1-2, 45-1-4, 45-3-1, 45-7-1, 45-7-4, 45-7-5, 45-7-7, 45-9-3, 45-9-4, 45-9-6, 45-9-8, 45-11-22, 45-11-24 through 45-11-26 to expand the Insure Oklahoma ESI and IP programs. Expansions include incorporating Oklahoma children through 18 years of age whose household income is from 185 up to and including 300 percent of the Federal Poverty Level. The inclusion of children into the program will be phased in over a period of time as determined by the OHCA. In addition, revisions will expand the current Insure Oklahoma ESI and IP program guidelines to include employees and working adults whose family income does not exceed 250 percent of the Federal Poverty Level. The increase from 200 to 250 percent of the FPL will be phased in over a period of time as determined by the OHCA. These revisions comply with Sections 1009.2 and 1010.1 of Title 56 of Oklahoma Statutes. This expansion to the Insure Oklahoma program will help increase access to healthcare for Oklahomans thereby reducing the amount of uncompensated care provided by healthcare providers. **(Reference APA WF # 10-08)**
- 6.a-17** AMENDING agency rules at OAC 317:10-1-1, 10-1-2, 10-1-3, 10-1-4, 10-1-12 and 10-1-16, and REVOKING agency rules at 10-1-5, 10-1-6, 10-1-7, 10-1-8, 10-1-9, 10-1-10, 10-1-11, 10-1-15, 10-1-17, 10-1-18, 10-1-18.1, 10-1-18.2, 10-1-19 and 10-1-20 to better coordinate and comply with new purchasing rules and regulations from the Oklahoma Department of Central Services (DCS). Proposed revisions will: (1) incorporate updated procedures corresponding to higher purchasing thresholds; (2) allow OHCA subject matter experts to make purchases in house without DCS approval, pursuant to 74 Okla. Stat. § 85.5(T); (3) provide for the appeals process on these purchases to be handled by OHCA; (4) remove unnecessary language; and (5) update policy to reflect changes in the internal purchasing manual. **(Reference APA WF # 10-09)**
- 6.a-18** ADDING Agency rules at OAC 317:50-1-1, 50-1-2, and 50-1-4 through 50-1-16 to include provisions for a new Home and Community based Waiver Program providing non-institutional long-term care for individuals requiring skilled nursing or hospital level of care. These individuals' needs exceed the service capacity of the current Advantage waiver and therefore require

additional funding and waiver authority to be adequately served. Creation of the Medically Fragile Waiver will result in a more appropriate service delivery mechanism for this fragile population thereby increasing quality and continuity of care. **(Reference APA WF # 10-13)**

- 6.a-19** ADDING agency rules to OAC 317:25-9-1 through 25-9-3 to implement a pilot program to pay Health Access Networks to coordinate and improve the quality of care for SoonerCare members. Rules are needed to establish provider requirements and billing guidelines for HAN's which are not-for-profit, administrative entities that work with SoonerCare providers to coordinate and improve the quality of care for our members. Contracted HAN's will be paid a \$5.00 per member per month fee in order to enhance the development of comprehensive medical homes for SoonerCare Choice members. **(Reference APA WF # 10-14)**
- 6.a-20** AMENDING agency rules at OAC 317:30-5-275, 30-5-278, and ADDING agency rules at 30-5-280, 30-5-282 and 30-5-283 to allow direct reimbursement to licensed masters level behavioral health professionals who, under current rules, are only allowed to provide services in agency settings. Allowing direct contracting with these providers will help increase specialist access, decrease use of ER and inpatient psych, and increase crisis intervention. This revision will also divert psychiatric residential treatment center usage due to LBHPs being more accessible throughout the state. **(Reference APA WF # 10-15)**
- 6.a-21** AMENDING agency rules at OAC 317:35-9-15 and 35-19-4 to remove policy directing OKDHS to conduct the fair hearings in the estate recovery process for individuals in nursing facilities, ICFs/MR or other medical institutions. Current policy conflicts with the Agency's enabling statutes which provide that the OHCA shall conduct the hearings. **(Reference APA WF # 10-16)**
- 6.a-22** REVOKING Agency rules at OAC 317:30-5-586.1 and 30-5-589, and AMENDING Agency rules at OAC 317:30-5-595 through 30-5-596 to remove language that allows reimbursement for behavioral health case managers' travel time to and from meetings for the purpose of development or implementation of the individual plan of care. Current policy conflicts with the Agency's State Plan reimbursement methodology which includes travel time as a component of the case management rate. Additionally, rules are revised to revoke sections that were previously combined with other areas of policy. **(Reference APA WF # 10-19)**
- 6.a-23** AMENDING Agency rules at OAC 317:30-5-1091 and 30-5-1098 to clarify that smoking and tobacco use cessation counseling is a covered SoonerCare service for the Native American population through the Indian Health Service, Tribally Operated Programs and Urban Indian Clinics (I/T/U's). **(Reference APA WF # 10-20)**
- 6.a-24** AMENDING Agency rules at OAC 317:30-5-1023 and 30-5-1027 to add a new provider type "Behavior Health School Aide" and service description "Therapeutic Behavioral Services". Currently schools are being allowed to include behavior interventions as a personal care service. This rule change is needed to help better define and separate behavioral interventions that do not appropriately fall within the description of personal care services. **(Reference APA WF # 10-22)**

- 6.a-25** AMENDING agency rules at OAC 317:30-5-555, 30-5-557 through 30-5-559 and 30-5-560.1 to provide clarification for Private Duty Nursing prior authorization requests. Revisions clarify that providers should submit the required OHCA forms and documentation along with the treatment plan when requesting the prior authorization for private duty nursing. Revisions also provide additional flexibility for OHCA to conduct a preliminary telephonic interview with members prior to arranging a personal visit. The additional flexibility in allowing the telephonic interview will provide an opportunity for OHCA to ensure medical necessity prior to arranging the personal home visit. Additional revisions include general policy cleanup as it relates to these sections. **(Reference APA WF # 10-23)**
- 6.a-26** AMENDING Agency rules at OAC 317:30-5-211.5 to provide guidance regarding the delivery of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS). Rules provide clarification and guidelines for product refills and reorders, including expected utilization patterns, member contact, and timelines. Rules also provide additional guidance with regard to products which are supplied and delivered via mail and the appropriate way for providers to bill for such items. Additional revisions include clarification to the provider cost of delivery and additional language to clarify OHCA's intent on DMEPOS supplier maintenance with regard to equipment-related services. **(Reference APA WF # 10-24)**
- 6.a-27** ADDING Agency rules at OAC 317:25-7-7 to include procedures and guidelines related to primary care provider (PCP) referrals under the Patient Centered Medical Home model. The PCP referral process is clearly defined, including the appropriate use of OHCA administrative referrals. Rules further explain provider expectations and provide guidelines regarding PCP referrals, medical necessity, medical record documentation, and OHCA administrative referrals. These revisions continue to strengthen the OHCA medical home and SoonerCare Choice program. **(Reference APA WF # 10-25)**
- 6.a-28** AMENDING Agency rules at OAC 317:30-3-2.1 to allow providers the option of requesting OHCA to perform a full-scope audit or utilize an extrapolation method to determine overpayments, if during a review a sample indicates an error rate greater than 10 percent of paid claims. If the full-scope audit produces an error rate less than the initial error rate, OHCA will bear the cost of the full-scope audit. However, if it produces an error rate equal to or greater than that of the initial audit, the provider will be responsible for the cost of the full-scope audit and repayment of the identified overpayment resulting from the review method chosen. **(Reference APA WF # 10-26)**
- 6.a-29** ADDING Agency rules at OAC 317:30-5-293, 30-5-299 and 30-5-680 to provide guidance with regard to team therapy. Physical, occupational, and speech therapy rules will clarify that when multiple therapists, or therapy assistants, work together as a team to treat one or more SoonerCare members, each therapist or assistant cannot bill separately for the same or different service provided at the same time to the same member. Additionally, rules will provide clarification with regard to billing, multiple therapies, delivery of service, and determining the time counted for service units and codes. **(Reference APA WF # 10-27)**

- 6.a-30** AMENDING agency rules at OAC 317:30-3-24 and 35-5-43 to reflect changes in third party liability recovery procedures necessitated by the Agency's implementation of Online Enrollment. In 2007, the OHCA received a Transformation Grant through the Centers for Medicare and Medicaid Services (CMS) to develop a web based online application and eligibility determination system in order to improve the ease and efficiency of enrollment. The Online Enrollment process allows potential members to apply for SoonerCare electronically. Because OHCA will assume responsibility for determining eligibility for certain groups of individuals under SoonerCare through this process, rules regarding Third Party Liability are in need of revision to update procedures to be followed by both OKDHS and OHCA employees. **(Reference APA WF # 10-28 A & B)**
- 6.a-31** AMENDING Agency rules at OAC 317:30-5-240,30-5-240.1 through 30-5-240.3, 30-5-241.2, 30-5-241.3, 30-5-241.5, and 30-5-248 to clarify the definition and credential requirements of a Behavioral Health Rehabilitation Specialists (BHRS).Current policy conflicts with Oklahoma Department of Mental Health Substance Abuse Services (ODMHSAS) definition and credential requirements. Additionally, rules are revised to clean up discrepancies between OHCA and ODMHSAS policy for consistency. **(Reference APA WF # 10-29)**
- 6.a-32** AMENDING Agency rules at OAC 317:30-5-95, 30-5-95.4 through 30-5-95.6, 30-5-95.8 through 30-5-95.10, 30-5-95.13 through 30-5-95.16, 30-5-95.18 through 30-5-95.20, 30-5-95.22 through 30-5-95.40, 30-5-95.42, 30-5-96.2 through 30-5-96.4, and 30-5-96.7 to modify Residential Treatment Center (RTC) requirements for Community Based transitional level of care. Modifications allow the requirements to be less restrictive as a step-down from standard RTC. By reducing the treatment requirements for the Community Based Transitional level of care, this allows facilities to step down that member to a lower level of RTC care and focus on transitioning the member back to the community, which supports RTC diversion. Additionally, rules are revised to add the Child and Adolescent Level of Care Utilization System (CALOCUS) to be used when determining level of care. Other revisions include removing medical necessity from policy and directing providers to reference the OHCA Behavioral Health Provider Manual. **(Reference APA WF # 10-30)**
- 6.a-33** ADDING Agency rules at OAC 317:2-1-14 to provide for an appeals process for purchasing decisions made internally at OHCA, pursuant to 74 Okla. Stat., §85.5(T). These revisions are needed to provide immediate consistency and clarity within agency purchasing rules. **(Reference APA WF # 10-31)**
- 6.a-34** ADDING Agency rules at OAC 317:45-13-1 to add dental services requirements and benefits for children in the Insure Oklahoma Program. The Oklahoma Health Care Authority (OHCA), as a requirement of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), will provide dental services to children who qualify for the Insure Oklahoma Individual Plan (IP). Rules will include requirements and benefits for direct dental coverage. The benefits extended to children will include class A, B, C, orthodontic care, and emergency dental services. All dental services for children will follow the American Academy of Pediatric Dentistry (AAPD) periodicity schedule. **(Reference APA WF # 10-32)**

- 6.a-35** ADDING Agency rules at OAC 317:50-5-1 through 50-5-16 to include language allowing for a new Home and Community Based Services Waiver program known as Sooner Seniors. The Sooner Seniors Waiver is targeted to members who are age 65 or older, have a clinically documented degenerative disease process and have been transitioned from a nursing facility to a home and community based setting through the Living Choice demonstration program. The new home and community based waiver program allows SoonerCare members improved quality of life by providing medically necessary institutional services in a home setting. The program is more cost effective than institutionalized care; therefore a substantial savings will be realized over time through operation of this Waiver. **(Reference APA WF # 10-40)**
- 6.a-36** ADDING Agency rules at OAC 317:50-3-1 through 50-3-16 to include language allowing for a new Home and Community Based Services Waiver program known as My Life, My Choice. The My Life, My Choice Waiver is targeted to members who are 20 to 64 years of age, are physically disabled and have been transitioned from a nursing facility to a home and community based setting through the Living Choice demonstration program. The new home and community based waiver program allows SoonerCare members improved quality of life by providing medically necessary institutional services in a home setting. The program is more cost effective than institutionalized care; therefore a substantial savings will be realized over time through operation of this Waiver. **(Reference APA WF # 10-41)**
- 6.a-37** AMENDING Agency rules at OAC 317:35-23-2 to revise eligibility criteria for individuals transitioning from an institution to a home and community based setting through the Living Choice Demonstration. A recent change in federal law reduce the institutional stay requirement from six months to 90 days and the required period of Medicaid eligibility from 30 days to 1 day. **(Reference APA WF # 10-43)**
- 6.a-38** AMENDING Agency rules at OAC 317:2-1-2, 2-1-5, 2-1-6, 2-1-7, and 2-1-13 to comply with Section 1011.9 of Title 56 of Oklahoma Statutes. These revisions allow for the recoupment of overpayments due to identified errors determined not to be fraudulent only after a provider has had the opportunity to exercise the right to an appeal that includes a hearing conducted by an administrative law judge appointed by the Oklahoma Attorney General. Rules also clarify that a provider has the right to participate in the hearing and to be represented by legal counsel. Revisions also grant the Administrative Law Judge (ALJ) jurisdiction over provider appeals related to the Oklahoma Electronic Health Records Incentive Payment Program. Appeals' rules are also revised to add the responsibility of hearing members' grievances relating to Online Enrollment eligibility determinations. **(Reference APA WF # 10-45)**
- 6.a-39** ADDING Agency rules at OAC 317:30-3-28 to establish program criteria and guidelines for the new Oklahoma Electronic Health Records Incentive Payment Program, which will begin January 2011 and is authorized by the American Recovery and Reinvestment Act of 2009. The rules provide a basic governing structure for the program, including the delineation of eligible providers and eligible hospitals, patient volume requirements, and incentive payment processes. **(Reference APA WF # 10-49)**



**6.a-40** AMENDING agency rules at OAC 317:30-5-42.16 and 30-5-532 to allow hospice services to be available to children eligible for SoonerCare without forgoing any other service for treatment of the underlying terminal conditions. Families are no longer required to elect hospice services in lieu of standard SoonerCare services that have the objective to treat or cure the terminal illness. Additional revisions include allowing nurse practitioners to recertify the continuation of hospice services. The revisions ensure Agency compliance with Public Laws 111-148 and 111-152. **(Reference APA WF # 10-54)**

**6.a-41** AMENDING Agency rules at OAC 317:30-5-72.1, 30-5-77, and 30-5-78.1 to include the coverage of non-prescription EPSDT products offered through the pharmacy point of sale system and exempt I/T/U facilities from prior authorization requirements for brand name drugs. **(Reference APA WF # 10-62)**

**The following rules HAVE NOT previously been reviewed by the Board.**

**6.a-42** AMENDING agency rules at OAC 317:30-3-59, 30-3-60, 30-5-2 and 30-5-9 to insure OHCA rules are consistent with reimbursement practices and make coverage rules more consistent throughout policy. Specifically, rules are revised to be consistent with the Centers for Medicare and Medicaid Services (CMS) regarding the elimination of office and inpatient consultation codes. Additional revisions include general policy cleanup as it relates to these sections. **(Reference APA WF # 10-11)**

**6.a-43** ADDING agency rules at OAC 317:30-5-211.19 to set guidelines for quality assurances and safeguards. Rules set guidelines related to DMEPOS quality standards, manufacturer standards, member education, maintenance and repair of products, safety and infection control, and provider contact and follow-up services. **(Reference APA WF # 10-34)**

**6.a-44** ADDING agency rules at OAC 317:30-3-29 to clarify the criteria used to review and revise provider fee schedules. Rules clarify that provider fee schedules may be revised based on efficiency, budget considerations, economy, and quality of care. Rules provide guidelines related to fee schedule updates and provider notifications of such updates. Rules also provide guidance related to public notice of significant proposed changes in methods and standards for setting provider payment rates for services. **(Reference APA WF # 10-36)**

**6.a-45** AMENDING agency rules at OAC 317:35-21-1 through 35-21-6, 35-21-8 through 35-21-9, 35-21-11 through 35-21-13, 2-1-1, and ADDING Agency rules at OAC 317:35-21-14 to add a provision for medical eligibility review by the OHCA. The medical review will ensure that the original screening has properly indentified the woman as eligible for further testing or treatment. The rule revision further clarifies that income is a requirement for eligibility through SoonerCare, clarifies the meaning of "in need of treatment" and adds to policy that medical and financial eligibility appeals for applicants will be handled through the OHCA. **(Reference APA WF # 10-37 A & B)**

**6.a-46** ADDING agency rules at OAC 317:30-3-30 to establish provider signature requirements. For medical review purposes, the OHCA will require that all services provided and/or ordered be authenticated by the author. The method used shall be a hand written signature, electronic signature, or signature

attestation statement. Stamp signatures are not acceptable. Rules are revised to be consistent with the Centers for Medicare and Medicaid Services (CMS) regarding such provider signature requirements. **(Reference APA WF # 10-39)**

- 6.a-47** REVOKING agency rules at OAC 317:30-3-20.1 to update pharmacy provider appeals rules in order to bring them in line with current practice. Current pharmacy provider appeals rules refer to processes that no longer take place. **(Reference APA WF # 10-44)**
- 6.a-48** AMENDING agency rules at OAC 317:30-5-24 to update coverage guidelines to include positron emission tomography (PET) and computed tomography (CT/CTA). **(Reference APA WF # 10-50)**
- 6.a-49** AMENDING agency rules at OAC 317:30-5-336.10 to clarify fixed wing air ambulance services. The action is to remove the prior authorization requirement in order to concur with OHCA current claims process that requires an authorization of medical necessity. **(Reference APA WF # 10-52)**
- 6.a-50** AMENDING Agency rules at OAC 317:30-5-763 to include a re-evaluation and approval of additional hospice services within the ADvantage waiver. The ADvantage waiver is a Home and Community Based Services program that allows individuals qualifying for SoonerCare long term care institutional services to live in a home or community based setting. Hospice is a service provided to SoonerCare members within the waiver, and currently has no authorization limits. Rules are revised to include a re-authorization process after the initial 6 months of hospice care. A re-evaluation of the member will be performed and additional hospice care authorized for a period not to exceed 60 days. A re-evaluation will be performed every 60 days until the member no longer requires hospice. **(Reference APA WF # 10-55 A)**
- 6.a-51** AMENDING Agency rules at OAC 317:30-5-65.8, 30-5-695, 30-5-696, 30-5-698 through 30-5-699, to ensure consistency throughout policy. Additionally, rules are revised to allow reimbursement to primary care providers for application of fluoride varnish to the gums and teeth of children ages 12 months to 42 months during a well-child visit. Reimbursement is limited to two applications per year. **(Reference APA WF # 10-58)**
- 6.a-52** AMENDING agency rules at OAC 317:30-3-43, 30-5-122, 30-5-412, 35-9-4, 35-9-5, 35-9-45, 40-1-1, 40-5-8, 40-5-40, 40-5-55, 40-5-59, 40-5-100, 40-5-103, 40-5-113, 40-7-5, 40-7-7, 40-7-15, 40-7-21, 40-9-1 and REVOKING Agency rules at OAC 317:35-9-5.1 to clarify policy for: eligibility for services in an ICF/MR and HCBS waiver for persons with mental retardation and related conditions, screening process for in-home supports providers, back-up plan provisions for specialized foster care members and allowance for natural supports within the specialized foster care member's home. Clarification is also provided on training requirements for providers of job coaching services and the limits on goods and services provided through Self-Direction. Additionally policy is revised to clarify provider qualifications for assistive technology devices, and the procurement review/approval process for assistive technology devices. Further policy revisions include clarification of transportation provider responsibilities, services not covered and limits on the types of adapted transportation allowable.

Lastly, policy is revised to include clarification of family training provider qualifications and coverage limitations. **(Reference APA WF # 10-59 A, B, & C)**

- 6.a-53** AMENDING agency rules at OAC 317:30-3-4.1 to clarify requirements when documenting electronic health records. **(Reference APA WF # 10-60)**
- 6.a-54** AMENDING agency rules at OAC 317:30-5-210 to clarify OHCA's DMEPOS provider criteria. DMEPOS providers must meet Medicare accreditation standards unless the OHCA grants an exemption based on CMS exemptions, the provider is a government-owned entity, or at a provider's request. Revisions clarify that DMEPOS providers be located within the State of Oklahoma, unless the OHCA provides an exception to this requirement. Additionally, DMEPOS providers must comply with Medicare DMEPOS Supplier Standards as specified in 42 C.F.R. 424.57(c). **(Reference APA WF # 10-61)**
- 6.a-55** AMENDING Agency rules at OAC 317:30-5-72, 30-5-77.3 to allow for a prior authorization for a third brand name prescription if determined to be medically necessary by OHCA and if the member has not already utilized their six covered prescriptions for the month. Additional revisions include general policy cleanup as it relates to these sections. **(Reference APA WF # 10-62)**
- 6.a-56** AMENDING agency rules at OAC 317:35-5-41.6, 35-5-41.9, 35-5-42 and 35-10-26 to clarify OHCA's treatment of Individual Indian Money (IIM) Accounts as a converted resource. Funds and property held in IIM Accounts will no longer be used in an eligibility test. References to per capita payments are removed and the period in which money disbursed from IIM accounts can be counted as a resource is revised. **(Reference APA WF # 10-65)**
- 6.a-57** AMENDING agency rules at OAC 317:30-5-1076 to clarify and to bring the language in line with current reimbursement practices and rules. **(Reference APA WF # 10-66)**
- 6.a-58** AMENDING agency rules at OAC 317:30-3-3 and ADDING Agency rules at OAC 317:30-5-575, 30-5-576, 30-5-577, and 30-5-578 to add clarification and differentiate between provider group and clinic contracts. Provider groups are business entities in which one or more individual providers practice. Provider clinics are facilities or distinct parts of facilities used for the diagnosis and treatment of outpatients. Provider clinics are limited to organizations serving specialized treatment requirements or distinct groups. Clinics must have a specialized contract with the Oklahoma Health Care Authority (OHCA). These rules allow the OHCA to effectively distinguish between provider business entities and treatment facilities during the contracting process. **(Reference APA WF # 10-67)**
- 6.a-59** AMENDING agency rules at OAC 317:30-3-27 to clarify that all services and/or networks be allowed and approved at the OHCA's discretion to ensure medical necessity. **(Reference APA WF # 10-68)**
- 6.a-60** AMENDING agency rules at OAC 317:35-17-3, 35-17-4, and 35-17-16 to remove language approving ADvantage services when services exceed the established cost cap. Additionally, waitlist procedures are revised to prohibit entry into the waiver at 90% of capacity, rather than the current 102% of capacity and all

exceptions to the waitlist procedure are eliminated. Lastly, language is revised to state that OKDHS performs all eligibility determinations rather than the Advantage Administration (AA).  
**(Reference APA WF # 10-69)**

**6.a-61** ADDING agency rules at OAC 317:30-3-39 and AMENDING agency rules at OAC 317:30-3-40 through 30-3-41 to include general information about three new Waivers operated by the OHCA, the Medically Fragile Waiver, the My Life My Choice Waiver and the Sooner Seniors Waiver. **(Reference APA WF # 10-71)**

**6.a-62** AMENDING Agency rules at OAC 317:35-5-6 and 35-5-6.1 to clarify that pregnant women have thirty (30) days within application submission to provide medical proof of pregnancy in order to continue receiving SoonerCare benefits. Previous policy allowed a period of ten (10) days for submission of pregnancy verification. **(Reference APA WF # 10-77)**

**Item to be presented by Beth VanHorn, Director of Legal Operations**

- 7. a) Action Item - Consideration and Vote for Authorization to Expend Funds to increase the Hewlett Packard(HP) Contract for the Development and Implementation of the Medicaid Management Information System
- b) Action Item - Consideration and Vote for Authorization to Expend Funds to increase the Fox Systems Contract for Consultant Services for Medicaid Management Information System
- c) Action Item - Consideration and Vote for Authorization for Expenditure of Funds for Legal Representation Covington & Burling, LLP
- d) Action Item - Consideration and Vote for Authority for Expenditure of Funds Behavioral Health Utilization Management Services

**Item to be presented by Chairman Roggow**

- 8. Discussion Item - Proposed Executive Session as Recommended by the Director of Legal Services and Authorized by the Open Meetings Act, 25 Okla. Stat. § 307(B)(1),(4)and(7)

**Status of pending suits and claims**

- 1. Assoc. for Direct Care Trainers v. OHCA CJ-08-4237(OK County)
- 2. Choices v. OHCA CJ-09-22901(Garfield County)
- 3. Morris v. OKDHS 10-6241 (10<sup>th</sup> Circuit)
- 4. Harper v. OHCA 5:10 cv 00514-R(Western District)
- 5. Gohl v. Jones 108,993 (Supreme Ct. Okla.)

9. New Business

10. **ADJOURNMENT**

**NEXT BOARD MEETING  
April 14, 2011  
Oklahoma Health Care Authority  
Oklahoma City, OK**

MINUTES OF A REGULARLY SCHEDULED BOARD MEETING  
OF THE HEALTH CARE AUTHORITY BOARD

January 13, 2011

Held at Oklahoma Health Care Authority  
Oklahoma City, OK

Manner and Time of Notice of Meeting: A public notice was placed on the front door of the Oklahoma Health Care Authority on January 11, 2011.

Pursuant to a roll call of the members, a quorum was declared to be present, and Chairman Roggow called the meeting to order at 1:00PM.

BOARD MEMBERS PRESENT:

Vice Chairman Armstrong, Member McVay, Member Bryant, Member Miller, Member Langenkamp, Member McFall, and Chairman Roggow

OTHERS PRESENT:

Ron Graham, OUCOP  
Lynn White, OHA  
Mike Van Pelt, LogistiCare  
Justin Martino, eCapitol

OTHERS PRESENT:

Charles Brodt, HPES  
Steven Feist, LogistiCare  
John Marinelli, LogistiCare

DISCUSSION AND POSSIBLE VOTE ON APPROVAL OF BOARD MINUTES OF THE REGULARLY SCHEDULED BOARD MEETING HELD DECEMBER 9, 2010

The Board routinely reviews and approves a synopsis of all its meetings. The full-length recordings of the meetings of the Board are retained at the Board Offices and may be reviewed upon written request.

MOTION:

Member McFall moved for approval of the December 9, 2010 board minutes as published. Member Langenkamp seconded.

FOR THE MOTION:

Vice Chairman Armstrong, Member Bryant, Member Miller, Member Langenkamp, Member McFall, and Chairman Roggow

BOARD MEMBER ABSTAIN:

Member McVay

Mr. Fogarty stated that Vickie Kersey, Director of Purchasing, has done an exceptional job during the 16 years at this agency. Vickie was the 3<sup>rd</sup> employee of this agency with other years at the State Health Department and Commission on Oklahoma Health Care. During the transition from Lincoln Plaza her efficiency in performing the move was quite admirable and commendable. Mr. Fogarty recognized Ms. Kersey as the recipient of the OHCA's Director's Award.

FINANCIAL UPDATE

Carrie Evans, Chief Financial Officer

Ms. Evans stated that Revenues for OHCA through November, accounting for receivables, were **\$1,559,642,364** or **(1.8%) under** budget. The

expenditures for OHCA, accounting for encumbrances, were **\$1,337,227,397** or **2.8% under** budget. The state dollar budget variance through November is **\$10,015,060 positive**. Ms. Evans noted that the prior year carryover was reduced by **\$10,000,000** due to the Office of State Finance redistribution of State Fiscal Stabilization Funds.

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

<b>Expenditures:</b>	
Medicaid Program Variance	10.7
Administration	2.5
<b>Revenues:</b>	
Prior Year-Reduction	(10.0)
Taxes and Fees	1.6
Drug Rebate	2.4
Overpayments/Settlements	2.8
<b>Total FY 11 Variance</b>	<b>\$ 10.0</b>

**MEDICAID DIRECTOR'S UPDATE**

Garth Splinter, MD

Dr. Splinter reported on the following 4 statistical items, SoonerCare Choice Patient Centered Medical Home; SoonerCare Traditional; SoonerPlan; and Insure Oklahoma. He noted there was slow growth in the programs. At some point in the future, we will do a breakdown in those 4 categories with a comparison of the sub-categories. On page 2 the total provider count looks good but we have had a decrease in the in-state dental providers which is probably normal fluctuation. He noted that Oklahoma was the first in the nation to make an EHR payment to physicians. There were 4 members (CEO Fogarty, Mr. Kimble, Ms. Harding and myself) from the agency who went to Durant and presented the incentive payments to 2 Osteopathic Physicians. CMS had a film crew there and OFMQ was there and will be using the film in promotional items. Dr. Splinter noted that he and Mr. Calabro had traveled to New Mexico last week to present to the Legislators the history of the agency and talked about all the activities on HIT.

**ITEM 4.b.1 - CESAREAN SECTION SURGICAL PROCEDURE QUALITY INITIATIVE**

Sylvia Lopez, MD

Dr. Lopez presented the Cesarean Section Quality Initiative. She reported on the concerns; the SoonerCare percent of C-Sections; Primary C-Section Rates; Primary C-Section vs. Vaginal Deliveries; Potential Harms; the Goal; and Process Phase I and Phase II.

**ITEM 4C/LEGISLATIVE UPDATE**

Nico Gomez, Deputy Chief Executive Officer

Mr. Gomez stated that the Legislative Update will be on a regular basis until the end of session. Next month the summary list will be more complete with OHCA Request Bills. Mr. Gomez noted that the state of the state address will be on February 7. He said that there had been a meeting with the Office of State Finance discussing the budget for 2010, 2011, and 2012. The theme is reduction of services for members. This year there are 28 freshmen in the House and 8 freshmen in the Senate that we will have to make knowledgeable about the agency. The budget meeting with the House Committee is scheduled on January 31, and the Senate on February 2. He discussed the take home packet consisting of the Fast Facts, Public relations activities, Oklahoma First in National Health article and Online Enrollment. He informed members that the Community Action Agency (KIBOIS) in Stigler has purchased 5 computers to be put in kiosks' for members to enroll online. Next month we will have a one page document highlighting Oklahoma uniqueness.

Mr. Fogarty reported on making a move of some of OHCA employees to the Farmers space at the south end of the mall. We are working on permanent space and will have some news soon. He discussed Insure Oklahoma's modest change of increasing to 210% of the Federal Poverty Level which is funded by the tobacco tax. We have remained flat in growth with about 32,000 members for the last 6 months. Hopefully, by raising the income standard levels from 200% to 220% we will be able to cover the maximum of 35,000 members.

**ITEM 5/PROGRAM INTEGRITY UPDATE**

Kelly Shropshire, Director of Program Integrity and Accountability

Mr. Shropshire stated that the Payment Error Rate Measurement (PERM) began in 2002 to gauge the error rate of Medicaid claims payments. He then presented the on-going federal initiatives, the Medicare-Medicaid Data Matching Program (Medi-Medi); Medicaid Integrity Contractor Audits (MICs); and the Medicaid Recovery Audit Contractors (RACs). He also noted that in a study of 17 states recently reviewed, the Centers for Medicare & Medicaid Services utilized the Payment Error Rate Measurement (PERM) initiative to assess error rates, and found Oklahoma's to be the lowest at 1.2 percent with the national average about 8.9 percent. This rate showed that almost 99% of the time, Oklahoma was accurate in whom and how we paid for services. It also shows that our providers are billing correctly and OHCA is providing services to those who are qualified for the program.

**ITEM 6/ADVISORY GROUPS AND TASK FORCES UPDATE**

Terrie Fritz, External Relations Coordinator

Ms. Fritz presented a presentation on OHCA's ongoing efforts to improve stakeholder input. Stakeholder input is critical to optimal policy development and quality services. Today's focus is on OHCA's advisory councils and task forces. She then discussed the different aspects of the Medical Advisory Committee (MAC) and the Drug Utilization Review Board (DUR); Behavioral Health Advisory Council; Perinatal Advisory Task Force (PATF); Child Health Advisory Task Force (CHATF); Medical Advisory Task Force (MAT); Durable Medical Equipment Advisory Council

(DAC); Long Term Care Quality Initiative Council; Living Choice Advisory Committee; Dental Task Force; and the Member Advisory Task Force. Ms. Fritz stated that OHCA also hosts and participates in other events with the goal of obtaining input and improving communication with stakeholders and partners.

**ITEM 7/REPORTS TO THE BOARD BY BOARD COMMITTEES**

Chairman Roggow

Audit/Finance Committee

Member Miller

Member Miller stated the Audit/Finance Committee met and had a long and interesting discussion. The legislators will be facing difficult problems this session. He noted that if we have to make a 5% cut it would be a catastrophe requiring us to cut providers by 15%. He noted that our account receivables were still in good standing.

Legislative Committee

Member McFall

Legislative Committee met and had a long discussion regarding the upcoming session. Mr. McFall stated OHCA does a great job, and has made great accomplishments in the short 16 years in existence.

**ITEM 8 - ANNOUNCEMENTS OF CONFLICTS OF INTEREST PANEL RECOMMENDATIONS FOR ALL ACTION ITEMS REGARDING THIS BOARD MEETING**

Howard Pallotta, General Counsel

Mr. Pallotta stated the Conflict of Interest Panel met and found no conflicts with Item 9.

Mr. Pallotta stated the Conflict of Interest Panel met and found no conflicts with Item 9a, 9b, and 9c.

**ITEM 9/CONSIDERATION AND BOTE REGARDING RECOMMENDATIONS MADE BY THE DRUG UTILIZATION REVIEW BOARD UNDER 63 OKLAHOMA STATUTES § 5030.3**

Nancy Nesser, PharmD.JD, Pharmacy Director

Dr. Nesser presented the following recommendations for approval:

- 9.a The Drug Utilization Review Board recommends all prescriptions for Suboxone<sup>®</sup> (buprenorphine/ naloxone) tablets and film or Subutex<sup>®</sup> (buprenorphine), and their generic equivalents if available, require prior authorization.
- 9.b The Drug Utilization Review Board recommends prior authorization of Metozolv<sup>®</sup> (metoclopramide) ODT with the following criteria:
  1. FDA-approved diagnosis of gastro esophageal reflux disease in adults not responding to conventional therapy, or acute and recurrent diabetic gastro paresis in adults.
  2. Must provide a clinical reason why the member cannot use the regular formulation of metoclopramide tablets or syrup.
  3. Therapy will be approved for a period of not more than 12 weeks.
  4. Quantity limit of 120 tablets for 30 days.



9.c The Drug Utilization Review Board recommends placing prior authorization requirements on medications used to treat Alzheimer's Disease.

1. Prior Authorization of special formulation products including oral solutions, patches, extended release formulations, or other convenience formulations with the following approval criteria:
  - a. Member must have a documented reason why the special formulation is clinically necessary over the regular formulation
2. Application of Age Restriction for ages 0-50 with the following approval criteria
  - a. FDA approved diagnosis

MOTION:

Member McFall moved for approval of 9a, 9b, and 9c as presented. Member Bryant seconded.

FOR THE MOTION:

Vice Chairman Armstrong, Member McVay, Member Bryant, Member Miller, Member Langenkamp, Member McFall, and Chairman Roggow

**ITEM 10- DISCUSSION ITEM - PROPOSED EXECUTIVE SESSION AS RECOMMENDED BY THE DIRECTOR OF LEGAL SERVICES AND AUTHORIZED BY THE OPEN MEETINGS ACT, 25 OKLA. STATE. §307(B)(1),(4)&(7)**

Howard Pallotta, General Counsel

MOTION:

Vice Chairman Armstrong moved for executive session. Member McFall seconded.

FOR THE MOTION:

Vice Chairman Armstrong, Member McVay, Member Bryant, Member Miller, Member Langenkamp, Member McFall, and Chairman Roggow

NEW BUSINESS:

None

**ADJOURNMENT**

MOTION:

Vice Chairman Armstrong moved for adjournment. Member McVay seconded.

FOR THE MOTION:

Vice Chairman Armstrong, Member McVay, Member Bryant, Member Miller, Member Langenkamp, Member McFall, and Chairman Roggow



## FINANCIAL REPORT

For the Seven Months Ended January 31, 2011

Submitted to the CEO & Board

March 10, 2011

- Revenues for OHCA through January, accounting for receivables, were **\$2,002,846,976** or **(1.9%) under** budget.
- Expenditures for OHCA, accounting for encumbrances, were **\$1,903,220,234** or **3% under** budget.
- The state dollar budget variance through January is **\$20,411,868 positive**.
- The prior year carryover was reduced by **\$10,000,000** due to the Office of State Finance redistribution of State Fiscal Stabilization Funds.
- The budget variance is primarily attributable to the following (in millions):

<b>Expenditures:</b>	
Medicaid Program Variance	16.9
Administration	5.3
<b>Revenues:</b>	
Prior Year-Reduction	(10.0)
Taxes and Fees	1.7
Drug Rebate	5.0
Overpayments/Settlements	1.5
<b>Total FY 11 Variance</b>	<b>\$ 20.4</b>

### ATTACHMENTS

Summary of Revenue and Expenditures: OHCA	1
Medicaid Program Expenditures by Source of Funds	2
Other State Agencies Medicaid Payments	3
Fund 230: Quality of Care Fund Summary	4
Fund 245: Health Employee and Economy Act Revolving Fund	5
Fund 250: Belle Maxine Hilliard Breast and Cervical Cancer Treatment Revolving Fund	6
Fund 255: OHCA Medicaid Program Fund	7

**OKLAHOMA HEALTH CARE AUTHORITY**  
**Summary of Revenues & Expenditures: OHCA**  
**Fiscal Year 2011, for the Seven Months Ended January 31, 2011**

REVENUES	FY11 Budget YTD	FY11 Actual YTD	Variance	% Over/ (Under)
State Appropriations	\$ 498,494,365	\$ 498,494,365	\$ -	0.0%
Federal Funds	1,178,563,971	1,130,793,442	(47,770,529)	(4.1)%
Tobacco Tax Collections	32,680,883	33,144,544	463,661	1.4%
Quality of Care Collections	29,419,260	30,640,101	1,220,841	4.1%
Prior Year Carryover	45,663,786	35,663,786	(10,000,000)	(21.9)%
HEEIA Fund Transfer	30,000,000	30,000,000	-	0.0%
Federal Deferral - Interest	105,585	105,585	-	0.0%
Drug Rebates	89,677,918	103,938,750	14,260,832	15.9%
Medical Refunds	25,768,839	29,903,259	4,134,420	16.0%
Other Revenues	10,696,625	10,372,956	(323,669)	(3.0)%
Stimulus Funds Drawn	99,790,188	99,790,188	-	0.0%
<b>TOTAL REVENUES</b>	<b>\$ 2,040,861,421</b>	<b>\$ 2,002,846,976</b>	<b>\$ (38,014,445)</b>	<b>(1.9)%</b>

EXPENDITURES	FY11 Budget YTD	FY11 Actual YTD	Variance	% (Over)/ Under
<b>ADMINISTRATION - OPERATING</b>	<b>\$ 25,803,391</b>	<b>\$ 21,560,526</b>	<b>\$ 4,242,865</b>	<b>16.4%</b>
<b>ADMINISTRATION - CONTRACTS</b>	<b>\$ 69,416,204</b>	<b>\$ 64,208,320</b>	<b>\$ 5,207,884</b>	<b>7.5%</b>
<b>MEDICAID PROGRAMS</b>				
<u>Managed Care:</u>				
SoonerCare Choice	17,632,461	15,859,497	1,772,964	10.1%
<u>Acute Fee for Service Payments:</u>				
Hospital Services	518,175,716	511,340,827	6,834,888	1.3%
Behavioral Health	162,957,131	163,220,116	(262,986)	(0.2)%
Physicians	242,716,065	230,642,484	12,073,580	5.0%
Dentists	93,976,518	85,365,098	8,611,420	9.2%
Other Practitioners	31,686,532	34,046,989	(2,360,457)	(7.4)%
Home Health Care	12,347,169	12,619,197	(272,028)	(2.2)%
Lab & Radiology	27,875,862	27,932,308	(56,446)	(0.2)%
Medical Supplies	30,293,005	27,044,301	3,248,704	10.7%
Ambulatory Clinics	54,339,680	45,200,217	9,139,463	16.8%
Prescription Drugs	210,190,715	195,133,680	15,057,035	7.2%
Miscellaneous Medical Payments	17,310,041	17,423,598	(113,557)	(0.7)%
OHCA TFC	-	1,253,235	(1,253,235)	0.0%
<u>Other Payments:</u>				
Nursing Facilities	281,892,833	284,166,173	(2,273,341)	(0.8)%
ICF-MR Private	31,552,388	32,125,845	(573,457)	(1.8)%
Medicare Buy-In	78,101,401	79,325,313	(1,223,912)	(1.6)%
Transportation	15,832,777	15,851,478	(18,701)	(0.1)%
HIT-Incentive Payments	-	63,750	(63,750)	0.0%
Part D Phase-In Contribution	39,457,278	38,837,280	619,998	1.6%
<b>Total OHCA Medical Programs</b>	<b>1,866,337,570</b>	<b>1,817,451,388</b>	<b>48,886,182</b>	<b>2.6%</b>
OHCA Non-Title XIX Medical Payments	89,382	-	89,382	0.0%
<b>TOTAL OHCA</b>	<b>\$ 1,961,646,547</b>	<b>\$ 1,903,220,234</b>	<b>\$ 58,426,313</b>	<b>3.0%</b>
<b>REVENUES OVER/(UNDER) EXPENDITURES</b>	<b>\$ 79,214,874</b>	<b>\$ 99,626,742</b>	<b>\$ 20,411,868</b>	

**OKLAHOMA HEALTH CARE AUTHORITY**  
**Total Medicaid Program Expenditures**  
**by Source of State Funds**  
**Fiscal Year 2011, for the Seven Months Ended January 31, 2011**

Category of Service	Total	Health Care Authority	Quality of Care Fund	HEEIA	Medicaid Program Fund	BCC Revolving Fund	Other State Agencies
SoonerCare Choice	\$ 16,104,208	\$ 15,846,149	\$ -	\$ 244,711	\$ -	\$ 13,348	\$ -
Inpatient Acute Care	517,668,635	350,592,312	283,901	7,143,383	28,551,344	2,476,634	128,621,063
Outpatient Acute Care	134,808,387	126,024,126	24,269	5,371,750	-	3,388,242	-
Behavioral Health - Inpatient	70,180,028	67,179,923	-	3,585	-	6,033	2,990,488
Behavioral Health - Outpatient	5,483,593	5,438,418	-	-	-	-	45,174
Behavioral Health Facility- Rehab	119,165,788	90,494,595	-	263,799	-	100,929	28,306,464
Behavioral Health - Case Management	218	149	-	-	-	69	-
Residential Behavioral Management	13,042,090	-	-	-	-	-	13,042,090
Targeted Case Management	42,298,047	-	-	-	-	-	42,298,047
Therapeutic Foster Care	1,253,235	1,253,235	-	-	-	-	-
Physicians	258,912,315	190,576,091	33,892	7,451,327	34,131,606	5,900,894	20,818,504
Dentists	85,378,030	80,866,855	-	12,931	4,423,719	74,524	-
Other Practitioners	34,339,892	33,216,428	260,379	292,903	537,379	32,802	-
Home Health Care	12,619,197	12,585,413	-	-	-	33,784	-
Lab & Radiology	29,700,988	27,042,505	-	1,768,679	-	889,803	-
Medical Supplies	27,392,261	25,396,185	1,585,404	347,960	-	62,712	-
Ambulatory Clinics	52,450,437	44,797,010	-	985,237	-	403,206	6,264,984
Personal Care Services	7,369,106	-	-	-	-	-	7,369,106
Nursing Facilities	284,166,173	181,556,356	79,192,709	-	23,387,214	29,894	-
Transportation	15,851,478	14,398,464	1,411,933	-	35,449	5,631	-
GME/IME/DME	68,000,509	-	-	-	-	-	68,000,509
ICF/MR Private	32,125,845	26,332,805	5,303,242	-	489,798	-	-
ICF/MR Public	44,888,032	-	-	-	-	-	44,888,032
CMS Payments	118,162,593	116,618,302	1,544,292	-	-	-	-
Prescription Drugs	204,229,733	168,616,543	-	9,096,053	25,043,684	1,473,452	-
Miscellaneous Medical Payments	17,423,608	16,535,322	-	10	808,545	79,732	-
Home and Community Based Waiver	90,251,547	-	-	-	-	-	90,251,547
Homeward Bound Waiver	51,588,595	-	-	-	-	-	51,588,595
Money Follows the Person	2,798,421	-	-	-	-	-	2,798,421
In-Home Support Waiver	14,197,809	-	-	-	-	-	14,197,809
ADvantage Waiver	106,305,722	-	-	-	-	-	106,305,722
Family Planning/Family Planning Waiver	4,083,915	-	-	-	-	-	4,083,915
Premium Assistance*	30,480,604	-	-	30,480,604	-	-	-
HIT Grant Incentive Payments	63,750	63,750	-	-	-	-	-
<b>Total Medicaid Expenditures</b>	<b>\$ 2,512,784,790</b>	<b>\$ 1,595,430,939</b>	<b>\$ 89,640,021</b>	<b>\$ 63,462,932</b>	<b>\$ 117,408,739</b>	<b>\$ 14,971,689</b>	<b>\$ 631,870,470</b>

\* Includes \$30,344,111.62 paid out of Fund 245

# OKLAHOMA HEALTH CARE AUTHORITY

## Summary of Revenues & Expenditures:

### Other State Agencies

Fiscal Year 2011, for the Seven Months Ended January 31, 2011

REVENUE	FY11 Actual YTD
Revenues from Other State Agencies	\$ 242,665,587
Federal Funds	410,729,579
<b>TOTAL REVENUES</b>	<b>\$ 653,395,166</b>
EXPENDITURES	Actual YTD
<b>Department of Human Services</b>	
Home and Community Based Waiver	\$ 90,251,547
Money Follows the Person	2,798,421
Homeward Bound Waiver	51,588,595
In-Home Support Waivers	14,197,809
ADvantage Waiver	106,305,722
ICF/MR Public	44,888,032
Personal Care	7,369,106
Residential Behavioral Management	10,335,489
Targeted Case Management	33,783,848
<b>Total Department of Human Services</b>	<b>361,518,569</b>
<b>State Employees Physician Payment</b>	
Physician Payments	20,818,504
<b>Total State Employees Physician Payment</b>	<b>20,818,504</b>
<b>Education Payments</b>	
Graduate Medical Education	28,600,000
Graduate Medical Education - PMTC	2,466,870
Indirect Medical Education	28,813,252
Direct Medical Education	8,120,387
<b>Total Education Payments</b>	<b>68,000,509</b>
<b>Office of Juvenile Affairs</b>	
Targeted Case Management	1,629,876
Residential Behavioral Management - Foster Care	22,079
Residential Behavioral Management	2,684,522
Multi-Systemic Therapy	45,174
<b>Total Office of Juvenile Affairs</b>	<b>4,381,651</b>
<b>Department of Mental Health</b>	
Targeted Case Management	98
Hospital	2,990,488
Mental Health Clinics	28,306,464
<b>Total Department of Mental Health</b>	<b>31,297,050</b>
<b>State Department of Health</b>	
Children's First	1,211,956
Sooner Start	1,273,963
Early Intervention	3,228,734
EPSDT Clinic	1,184,009
Family Planning	39,197
Family Planning Waiver	4,021,633
Maternity Clinic	57,756
<b>Total Department of Health</b>	<b>11,017,248</b>
<b>County Health Departments</b>	
EPSDT Clinic	513,388
Family Planning Waiver	23,085
<b>Total County Health Departments</b>	<b>536,473</b>
<b>State Department of Education</b>	
Public Schools	84,514
Medicare DRG Limit	2,359,020
Native American Tribal Agreements	126,423,905
Department of Corrections	3,235,867
JD McCarty	57,886
	2,139,272
<b>Total OSA Medicaid Programs</b>	<b>\$ 631,870,469</b>
<b>OSA Non-Medicaid Programs</b>	<b>\$ 40,991,318</b>
<b>Accounts Receivable from OSA</b>	<b>\$ 19,466,621</b>

**OKLAHOMA HEALTH CARE AUTHORITY**  
**SUMMARY OF REVENUES & EXPENDITURES:**  
**Fund 230: Nursing Facility Quality of Care Fund**  
**Fiscal Year 2011, for the Seven Months Ended January 31, 2011**

REVENUES	Total Revenue	State Share
Quality of Care Assessment	\$ 30,611,518	\$ 30,611,518
Interest Earned	28,583	28,583
<b>TOTAL REVENUES</b>	<b>\$ 30,640,101</b>	<b>\$ 30,640,101</b>

EXPENDITURES	FY 11 Total \$ YTD	FY 11 State \$ YTD	Total State \$ Cost
<b>Program Costs</b>			
NF Rate Adjustment	\$ 76,994,849	\$ 27,094,487	
Eyeglasses and Dentures	168,040	59,133	
Personal Allowance Increase	2,029,820	714,294	
Coverage for DME and supplies	1,585,404	557,904	
Coverage of QMB's	602,441	211,999	
Part D Phase-In	1,544,292	1,544,292	
ICF/MR Rate Adjustment	2,835,639	997,861	
Acute/MR Adjustments	2,467,603	868,349	
NET - Soonerride	1,411,933	496,859	
<b>Total Program Costs</b>	<b>\$ 89,640,021</b>	<b>\$ 32,545,179</b>	<b>\$ 32,545,179</b>
<b>Administration</b>			
OHCA Administration Costs	\$ 307,395	\$ 153,698	
DHS - 10 Regional Ombudsman	-	-	
OSDH-NF Inspectors	127,878	127,878	
Mike Fine, CPA	3,500	1,750	
<b>Total Administration Costs</b>	<b>\$ 438,774</b>	<b>\$ 283,326</b>	<b>\$ 283,326</b>
<b>Total Quality of Care Fee Costs</b>	<b>\$ 90,078,795</b>	<b>\$ 32,828,505</b>	
<b>TOTAL STATE SHARE OF COSTS</b>			<b>\$ 32,828,505</b>

Note: Expenditure amounts are for informational purposes only. Actual payments are made from Fund 340. Revenues deposited into the fund are transferred 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  
Fiscal Year 2011, for the Seven Months Ended January 31, 2011**

<b>REVENUES</b>	<b>FY 10 Carryover</b>	<b>FY 11 Revenue</b>	<b>Total Revenue</b>
Prior Year Balance	\$ 45,276,770	\$ -	\$ 7,227,416
State Appropriations	(30,000,000)		
Tobacco Tax Collections	-	27,260,285	27,260,285
Interest Income	-	761,992	761,992
Federal Draws	383,873	17,467,275	17,467,275
All Kids Act	(8,000,000)	-	-
<b>TOTAL REVENUES</b>	<b>\$ 7,660,643</b>	<b>\$ 45,489,552</b>	<b>\$ 52,716,969</b>

<b>EXPENDITURES</b>	<b>FY 10 Expenditures</b>	<b>FY 11 Expenditures</b>	<b>Total \$ YTD</b>
<b>Program Costs:</b>			
Employer Sponsored Insurance		\$ 30,344,112	\$ 30,344,112
ESI-College Students		136,493	136,493
<b>Individual Plan</b>			
SoonerCare Choice		\$ 239,419	\$ 84,252
Inpatient Hospital		7,088,681	2,494,507
Outpatient Hospital		5,321,794	1,872,739
BH - Inpatient Services		3,585	1,261
BH Facility - Rehabilitation Services		213,843	75,251
Physicians		7,390,481	2,600,710
Dentists		12,916	4,545
Other Practitioners		287,571	101,196
Home Health		-	-
Lab and Radiology		1,747,606	614,983
Medical Supplies		346,929	122,084
Ambulatory Clinics		977,166	343,865
Prescription Drugs		9,023,196	3,175,263
Miscellaneous Medical		10	3
Premiums Collected		-	(1,252,851)
<b>Total Individual Plan</b>		<b>\$ 32,653,196</b>	<b>\$ 10,237,809</b>
<b>College Students-Service Costs</b>		<b>\$ 279,679</b>	<b>\$ 98,419</b>
<b>Total Program Costs</b>		<b>\$ 63,413,479</b>	<b>\$ 40,816,832</b>
<b>Administrative Costs</b>			
Salaries	\$ 22,395	\$ 808,650	\$ 831,045
Operating Costs	117,115	63,786	180,901
Health Dept-Postponing	29,637	-	29,637
Contract - HP	264,080	1,014,426	1,278,505
<b>Total Administrative Costs</b>	<b>\$ 433,227</b>	<b>\$ 1,886,862</b>	<b>\$ 2,320,088</b>
<b>Total Expenditures</b>			<b>\$ 43,136,921</b>
<b>NET CASH BALANCE</b>	<b>\$ 7,227,416</b>		<b>\$ 9,580,048</b>

# OKLAHOMA HEALTH CARE AUTHORITY

## SUMMARY OF REVENUES & EXPENDITURES:

**Fund 250: Belle Maxine Hilliard Breast and Cervical Cancer Treatment Revolving Fund  
Fiscal Year 2011, for the Seven Months Ended January 31, 2011**

REVENUES	FY 11 Revenue	State Share
Tobacco Tax Collections	\$ 544,043	\$ 544,043
<b>TOTAL REVENUES</b>	<b>\$ 544,043</b>	<b>\$ 544,043</b>

EXPENDITURES	FY 11 Total \$ YTD	FY 11 State \$ YTD	Total State \$ Cost
<b>Program Costs</b>			
SoonerCare Choice	\$ 13,348	\$ 3,288	
Inpatient Hospital	2,476,634	609,995	
Outpatient Hospital	3,388,242	834,524	
Inpatient Free Standing	6,033	1,486	
MH Facility Rehab	100,929	24,859	
Case Mangement	69	17	
Nursing Facility	29,894	7,363	
Physicians	5,900,894	1,453,390	
Dentists	74,524	18,355	
Other Practitioners	32,802	8,079	
Home Health	33,784	8,321	
Lab & Radiology	889,803	219,158	
Medical Supplies	62,712	15,446	
Ambulatory Clinics	403,206	99,310	
Prescription Drugs	1,473,452	362,911	
Transportation	5,631	1,387	
Miscellaneous Medical	79,732	19,638	
<b>Total Program Costs</b>	<b>\$ 14,971,689</b>	<b>\$ 3,687,527</b>	<b>\$ 3,687,527</b>
<b>TOTAL STATE SHARE OF COSTS</b>			<b>\$ 3,687,527</b>

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



**OKLAHOMA HEALTH CARE AUTHORITY**  
**SUMMARY OF REVENUES & EXPENDITURES:**  
**Fund 255: OHCA Medicaid Program Fund**  
**Fiscal Year 2011, for the Seven Months Ended January 31, 2011**

<b>REVENUES</b>	<b>FY 11 Total Revenue</b>	<b>FY 11 State Share</b>
Tobacco Tax Collections	\$ 32,600,501	\$ 32,600,501
<b>TOTAL REVENUES</b>	<b>\$ 32,600,501</b>	<b>\$ 32,600,501</b>

<b>EXPENDITURES</b>	<b>FY 11 Total \$ YTD</b>	<b>FY 11 State \$ YTD</b>	<b>Total State \$ Cost</b>
<b>Program Costs:</b>			
Adult Dental Services	\$ 4,423,719	\$ 1,556,707	
Remove Hospital Day Limit	6,914,425	2,433,186	
Hospital Rate Increase - Statewide Median +2%	9,937,256	3,496,921	
Increase Physician Visits from 2 to 4 per Month	285,274	100,388	
Increase Physician Office Visits/OB Visits to 90% of Medicare	16,398,137	5,770,504	
Increase Emergency Room Physician Rates to 90% of Medicare	7,763,672	2,732,036	
Pay 50% of Medicare Crossover - Physician/Ambulance/OP	11,030,447	3,881,614	
Nursing Facility 7% Rate Increase	18,730,071	6,591,112	
Enhanced Drug Benefit for Adults 3 + 3	13,506,698	4,753,007	
Enhanced Drug Benefit for Waiver Adults 3 + 10	11,536,986	4,059,866	
TEFRA Services	6,496,002	2,285,943	
SoonerRide	35,449	12,475	
Replace NSGO Medicare DRG Limit Revenues	10,350,601	3,642,376	
<b>Total Program Costs</b>	<b>\$ 117,408,739</b>	<b>\$ 41,316,135</b>	<b>\$ 41,316,135</b>
<b>TOTAL STATE SHARE OF COSTS</b>			<b>\$ 41,316,135</b>

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

# SoonerCare Programs

## January 2011 Data for March 2011 Board Meeting

### SOONERCARE ENROLLMENT/EXPENDITURES

Delivery System	Monthly Enrollment Average SFY2010	Enrollment January 2011	Total Expenditures January 2011	Average Dollars Per Member Per Month January 2011
<b>SoonerCare Choice Patient-Centered Medical Home</b>	435,958	446,743	\$102,473,664	
<i>Lower Cost</i> (Children/ Parents; Other)		401,245	\$68,461,246	\$171
<i>Higher Cost</i> (Aged, Blind or Disabled; TEFRA; BCC)		45,498	\$34,012,418	\$748
<b>SoonerCare Traditional</b>	219,646	240,973	\$180,006,439	
<i>Lower Cost</i> (Children/ Parents; Other)		135,890	\$59,020,942	\$434
<i>Higher Cost</i> (Aged, Blind or Disabled; TEFRA; BCC & HCBS Waiver)		105,083	\$120,985,497	\$1,151
<b>SoonerPlan</b>	23,255	31,207	\$323,947	\$10
<b>Insure Oklahoma</b>	28,594	32,075	\$8,771,116	
<i>Employer-Sponsored Insurance</i>	17,857	19,241	\$4,309,656	\$224
<i>Individual Plan</i>	10,736	12,834	\$4,461,460	\$348
<b>TOTAL</b>	<b>707,453</b>	<b>750,998</b>	<b>\$291,575,166</b>	

The enrollment totals above include all members enrolled during the report month; therefore, some members may not have expenditure data. Custody expenditures are excluded. Non-member specific expenditures of \$22,761,457 are excluded.

<b>Net Enrollee Count Change from Previous Month Total</b>	<b>(737)</b>
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Please note some Child/Parent member eligibility was extended during the September Online Enrollment transition period. Therefore, we are continuing to experience a decrease in enrollment.

<b>New Enrollees</b>	<b>19,476</b>
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### Opportunities for Living Life (OLL) (subset of data above)

Qualifying Group	Age Group	Enrollment
Aged/Blind/Disabled	Child	17,642
Aged/Blind/Disabled	Adult	130,599
Other	Child	41
Other	Adult	19,305
PACE	Adult	78
TEFRA	Child	381
Living Choice	Adult	124
<b>OLL Enrollment</b>		<b>168,170</b>

The "Other" category includes DDS State, PKU, Q1, Q2, Refuge, SLM, Soon-to-be Sooner (STS) and TB members.

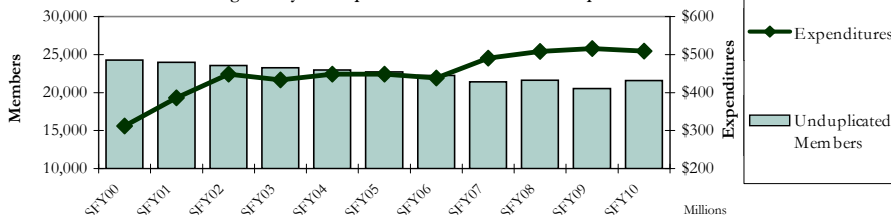
Medicare and SoonerCare	Monthly Average SFY2010	Enrolled January 2011
<b>Dual Enrollees</b>	<b>100,143</b>	<b>104,062</b>

	Monthly Average SFY2010	Enrolled January 2011
<b>Long-Term Care Members</b>	<b>15,820</b>	<b>15,727</b>
Child	37	89
Adult	15,783	15,638

PER MEMBER PER MONTH  
**\$3,072**

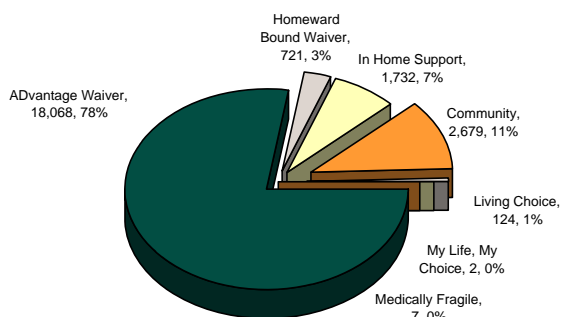
<b>SFY2010 Long-Term Care</b>
Statewide LTC Occupancy Rate - 69.8%
SoonerCare funded LTC Bed Days 68.6%
Data as of September 2010

Standard SoonerCare Nursing Facility - Unduplicated Members and Total Expenditure Trends



Data as of Oct. 15, 2010. Figures do not include intermediate care facilities for the mentally retarded (ICF/MR).

### Waiver Enrollment Breakdown Percent



**Advantage Waiver** - Serves frail elderly individuals age 65 or older and adults age 21 and older with physical disabilities who would otherwise require placement in a nursing facility.

**Community** - serves individuals 3 years of age and older who have mental retardation and certain persons with related conditions who would otherwise require placement in an intermediate care facility for the mentally retarded (ICF/MR).

**Homeward Bound Waiver** - Designed to serve the needs of individuals with mental retardation or "related conditions" who are also members of the Plaintiff Class in Homeward Bound et al. v. The Hissom Memorial Center, et al, who would otherwise qualify for placement in an ICF/MR.

**In Home Support** - Serves the needs of individuals 3 years of age and older with mental retardation who would otherwise require placement in an ICF/MR.

**Living Choice** - Promotes community living for people of all ages who have disabilities or long-term illnesses.

**Medically Fragile** - This program serves qualifying individuals who meet hospital or skilled nursing facility level of care.

**My Life, My Choice** - This program is for adults with physical disabilities who transitioned to the community under the Living Choice program.

# SoonerCare Programs

## SOONERCARE CONTRACTED PROVIDER INFORMATION

Provider Counts	Monthly Average SFY2010	Enrolled January 2011
<b>Total Providers</b>	<b>28,000</b>	<b>28,277</b>
	<i>In-State</i> 19,563	20,278
	<i>Out-of-State</i> 8,437	7,999

Program	% of Capacity Used
SoonerCare Choice	41%
SoonerCare Choice I/T/U	13%
Insure Oklahoma IP	3%

Select Provider Type Counts	<i>In-State Monthly Average SFY2010</i>	<i>In-State Enrolled January 2011*</i>	Total Monthly Average SFY2010	Total Enrolled January 2011
Physician	5,884	6,410	10,664	11,597
Pharmacy	874	899	1,168	1,228
Mental Health Provider	915	932	983	968
Dentist	793	783	893	878
Hospital	159	187	790	723
Licensed Behavioral Health Practitioner	N/A	486	N/A	505
Extended Care Facility	394	389	395	389

Above counts are for specific provider types and are not all-inclusive.

Total Primary Care Providers	4,072	4,312	6,063	6,227
Patient-Centered Medical Home	1,339	1,452	1,360	1,477

Including Physicians, Physician Assistants and Advance Nurse Practitioners.

\*Items shaded above represent a 10% or more increase (green) or decrease (red) from the previous fiscal year's average.

## ELECTRONIC HEALTH RECORDS (EHR) INCENTIVE STATISTICS

The Electronic Health Records Incentive Program is a federal program that offers major financial support to assist certain providers to adopt (acquire and install), implement (train staff, deploy tools, exchange data), upgrade (expand functionality or interoperability) or meaningfully use certified EHR technology.

As of January 31, 2011

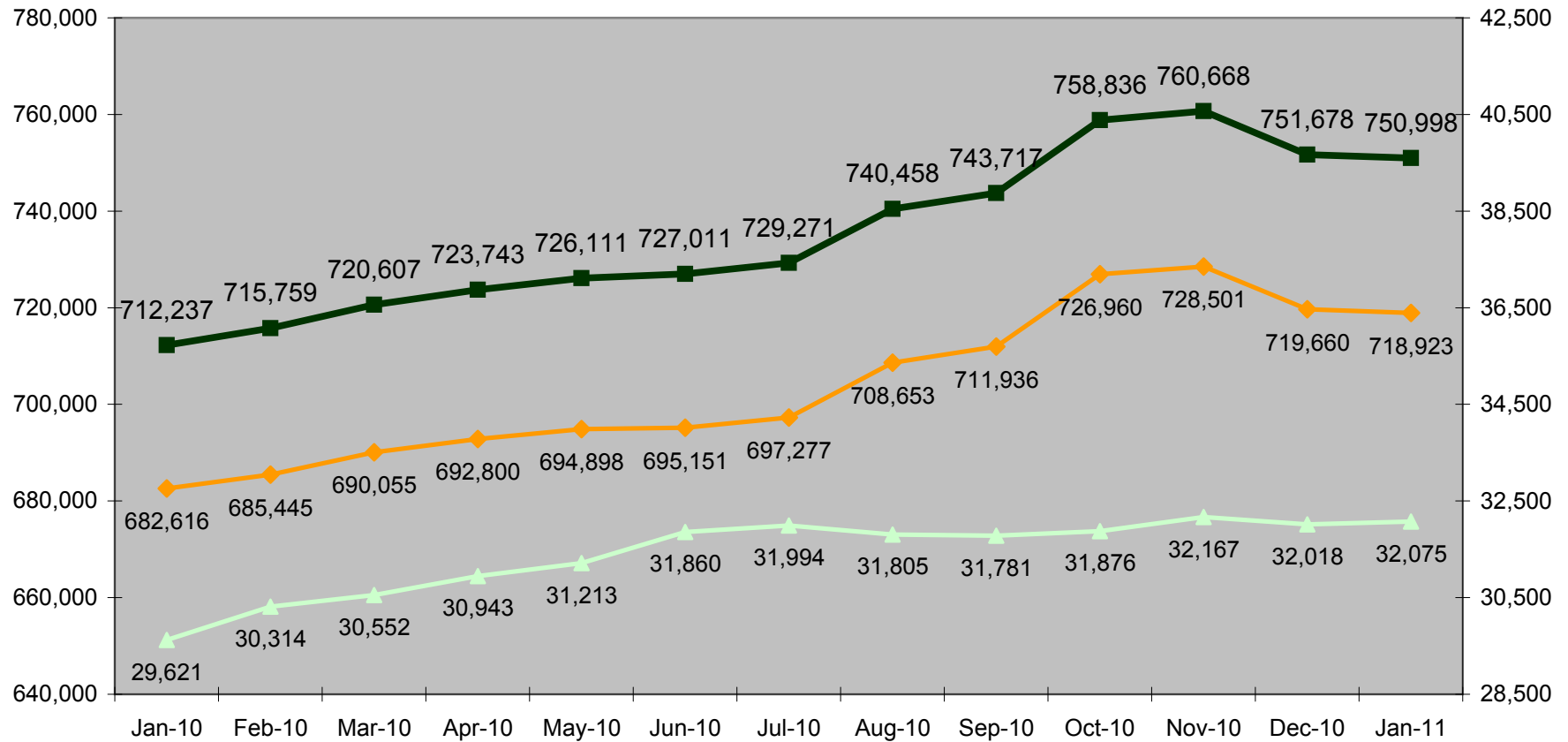
\* OHCA made payments to 9 providers

- 7 Eligible Professionals and 2 Eligible Hospitals (Eastern Oklahoma Medical Center and McCurtain Memorial Hospital)

\* Total Payments made: \$1,628,689

- \$148,750 to Eligible Professionals and \$1,479,939 to Eligible Hospitals

## SoonerCare and Insure Oklahoma Enrollment January 2010 through January 2011



Online Enrollment was implemented in September 2010. SoonerCare enrollment was extended for some cases to allow for the transition to the new system. Beginning in December 2010, the extended cases are closing if the renewal process isn't completed. Data is valid as of 2/14/2011 and is subject to change.



# OHCA BOARD MEETING

## MARCH 10, 2011 OHCA BOARD MEETING

### OHCA REQUEST BILLS:

- SB 0412 – Sen. Bill Brown – Prohibits Commercial Insurance Companies From Charging Fees to Process SoonerCare Secondary Claims
- SB 0676 – Sen. Clark Jolley – Allows Administrative Sanctions to Medicaid Recipients Who Abuse the State Medicaid Program

After the February deadlines and as of noon Wednesday, March 02, 2011, the Oklahoma Legislature is currently tracking a total of 1,777 bills. OHCA is currently tracking 132 bills. They are broken down as follows:

- |                                   |    |
|-----------------------------------|----|
| • OHCA Request                    | 02 |
| • Direct Impact & Agency Interest | 78 |
| • Appropriations                  | 06 |
| • Employee Interest               | 46 |

### SENATE AND HOUSE REMAINING DEADLINES

- |                |   |
|----------------|---|
| March 3, 2011  | Deadline for Reporting Double-Assigned Senate Bills from 2 <sup>nd</sup> Committee and<br>Deadline for Reporting House Bills and Joint Resolutions from House<br>Committees |
| March 17, 2011 | Deadline for Third Reading of a Bill in the House of Origin (House/Senate)  |
| March 31, 2011 | Deadline for Reporting Double-Assigned House Bills from 1st Committee   |
| April 7, 2011  | Deadline for Reporting Single Assigned House Bills in Senate Committees   |
| April 14, 2011 | Deadline for Reporting Double-Assigned House Bills from 2 <sup>nd</sup> Committee and<br>Deadline for Reporting Senate Bills and Joint Resolutions from House<br>Committees |
| April 28, 2011 | Deadline for Third Reading of Bills in Opposite Chamber   |
| May 27, 2011   | Sine Die of the first session of the 53rd Legislature   |

A Legislative Bill Tracking Report will be included in your handout at the board Meeting.

# SoonerQuit

## Prenatal Tobacco Cessation



Shelly Patterson, MPH  
OHCA Board Meeting  
March 10, 2011



# “SoonerQuit”

- Official Trademark Name

  - SoonerCare tobacco cessation services and programs

- Partnership Initiatives with TSET

  - SoonerQuit for Women
  - SoonerQuit Prenatal



# SoonerQuit Prenatal

Goal:

Improve birth outcomes for Oklahoma babies by reducing tobacco use among pregnant SoonerCare members





# Why the Need?

## 2006-New Mothers in OK-

- Over 30% smoked prior to pregnancy
- 1 in 5 continued into third trimester
- Most likely to smoke throughout pregnancy:
  - Lower education levels
  - Unmarried
  - SoonerCare members
- Nearly 60% resumed smoking shortly after delivery



# Adverse Health Outcomes

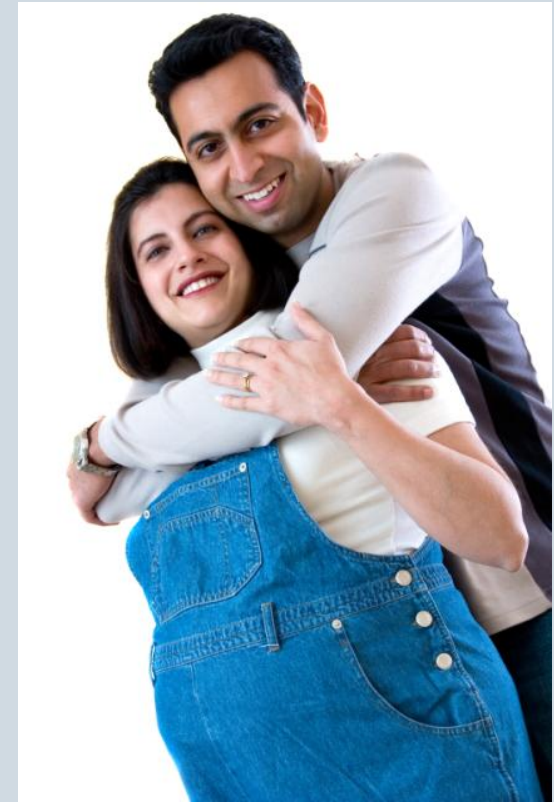
Smoking during pregnancy is associated with higher rates of:

- Preterm labor
- Low birth weight
- Stillbirth
- Neonatal and maternal mortality
- Increased infant/child morbidities



# SoonerCare & Pregnancy

- 64% of women delivering in OK received health care services through SoonerCare
- 19% births with complications
- Average costs for complicated delivery is over 1.5 times the costs of uncomplicated



# Partners

- OHCA
- Tobacco Settlement Endowment Trust
- OK State Department of Health
- OK Tobacco Helpline
- Iowa Foundation for Medical Care
- Pacific Health Policy Group
- Perinatal Advisory Taskforce



THE PACIFIC HEALTH POLICY GROUP

# Funding



- Grant Funding from TSET  
\$700,000
- Federal Medicaid  
administrative match  
\$700,000
- Total Funding over 3 years  
\$1.4 million

# Objectives

Increase prenatal care provider:

- Knowledge and use of best practices for tobacco cessation
- Rate of inquiry about tobacco use status of pregnant patients
- Routine use of 5A's tobacco cessation counseling
- Rate of referrals to the Oklahoma Tobacco Helpline

# Methods

## □ **Practice Facilitation by IFMC**

Hands-on help to prenatal care providers in implementing tobacco cessation best practices into daily routine

## □ **Tobacco Cessation Outreach**

Increase provider knowledge of best practices for tobacco cessation & SoonerCare tobacco cessation counseling benefits



# Practice Facilitation

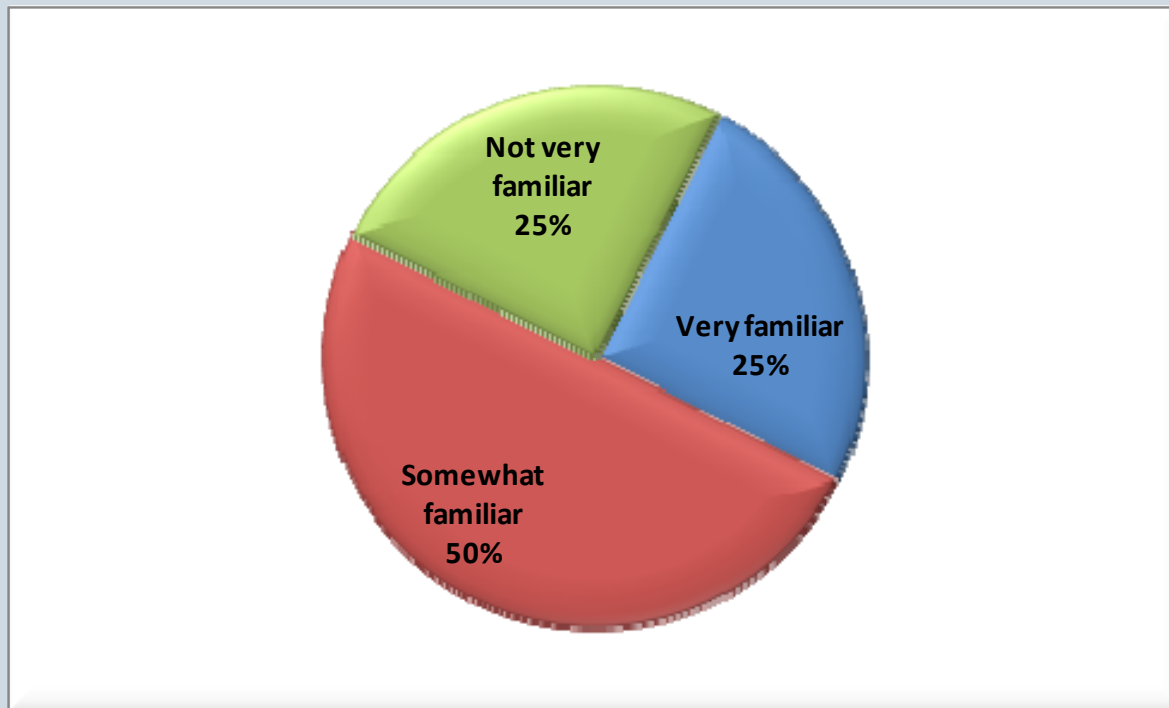
- April-December 2010
  - Initiated with 18 providers
  - 10 OKC Providers
  - 8 Tulsa Providers
- 2011 PF
  - Initiate with additional 24-30
  - OU OKC Women's Clinics
  - OU Tulsa Women's Clinics





# Targeting the Need

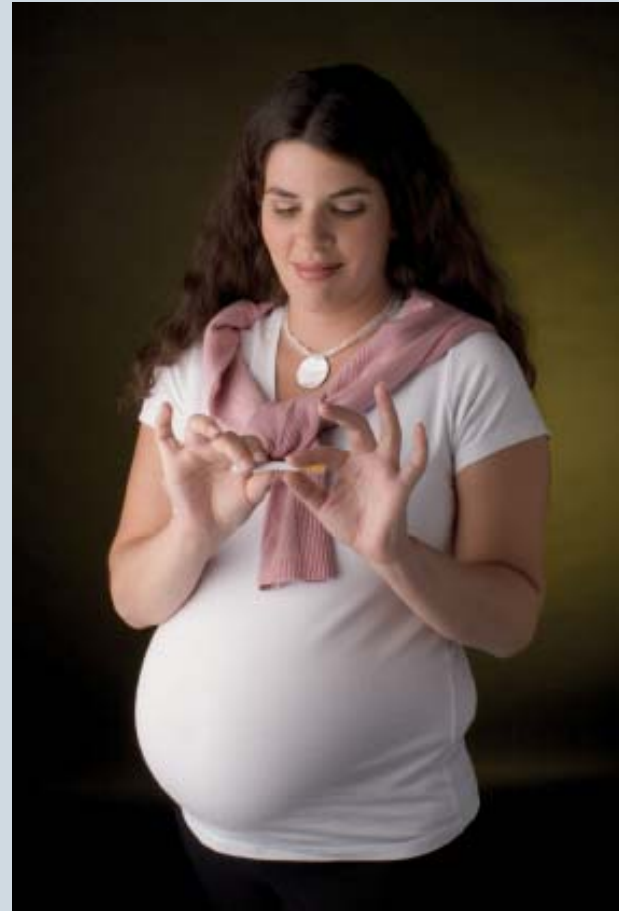
## Provider Familiarity with 5A's Method for Tobacco Cessation



- Targets most significant barriers to intervention
- Offers assistance in areas considered of greatest importance to providers

# Good Things...

- Quit Kits
- Poster Presentation
- Success Stories
- Check Presentation



Questions?

6.a-1 **TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY**  
**CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**  
Subchapter 5. Individual Providers and Specialties  
Part 75. Federally Qualified Health Centers  
317:30-5-660.1. [AMENDED]  
317:30-5-660.4. [AMENDED]  
317:30-5-661.1. [AMENDED]  
317:30-5-661.5. [AMENDED]  
317:30-5-664.5. [AMENDED]  
317:30-5-664.7. [AMENDED]  
317:30-5-664.10. [AMENDED]  
**(Reference APA WF # 10-04)**

**SUMMARY:** Rules are amended to revise contracting requirements for Federally Qualified Health Centers (FQHC); clarify Health Center enrollment requirements for services rendered in a school setting; revise the definition of core services to include services rendered by Licensed Behavioral Health Professionals as authorized under the FQHC State Plan pages; and clarify general reimbursement requirements for FQHC's.

**BUDGET IMPACT:** Agency staff has determined that these revisions will be budget neutral.

**MEDICAL ADVISORY COMMITTEE:** The Medical Advisory Committee considered the proposed rule revisions on March 9, 2011 and recommended Board approval.

**AUTHORITY:** The Oklahoma Health Care Authority Board; the Oklahoma Health Care Authority Act, and Sections 5003 through 5016 of Title 63 of the Oklahoma Statutes.

**PUBLIC HEARING:** A public hearing was held on February 22, 2011. The revised language is being made to address providers' written and oral comments on this subject.

**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY**  
**CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**  
**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**  
**PART 75. FEDERALLY QUALIFIED HEALTH CENTERS**

**317:30-5-660.1. Health Center multiple sites contracting**

(a) Health Centers may contract as SoonerCare Traditional providers and as a PCP/CM under SoonerCare Choice (Refer to OAC 317:25-7-5).

(b) Health Centers are required to submit a list of all entities affiliated or owned by the Center including any programs that do not have Health Center status, along with all OHCA provider numbers.

(c) Payment for FQHC services is based on a Prospective Payment System (PPS). (Refer to OAC 317:30-5-664.10) In order to be eligible for reimbursement under this method for covered services, in traditional primary care settings, each site must submit an approval copy of the Health Resource and Service Administration (HRSA) Notice of Grant Award Authorization for Public Health Services Funds under Section 330, (or a copy of the letter from CMS designating the facility as a "Look Alike" FQHC) and a copy of the Medicare certification number, at the time of enrollment.

**317:30-5-660.4. Health Center enrollment requirements for school-based health**

### services in a school setting

(a) ~~For the provision of school-based health~~ Physical and behavioral health services provided in accordance with the Individuals with Disabilities Education Act (IDEA) and pursuant to an Individual Education Plan (IEP) or Individual Family Service Plan (IFSP) are the responsibility of the school district. (not a health care delivery site), Health Centers must be contracted with a qualified school provider. contract with the school district and invoice the school district for services rendered. (Refer to OAC 317:30-5-1020 through 30-5-1027). Reimbursement is made directly to the school.

(b) ~~Payment may be made for FQHC services to Health Centers that have a health care delivery site in a school setting (i.e., the school has no responsibility /no contract with OHCA and a parental authorization must be on file)~~ that have a school-based health center that meets the definition of Section 2110(c)(9) of the Social Security Act.

### **317:30-5-661.1. Health Center core services**

Health Center "core" services include:

- (1) Physicians' services and services and supplies incident to a physician's services;
- (2) Services of advanced practice nurse (APNs), physician assistants (PAs), certified nurse midwives (CNMs), or specialized advanced practice nurse practitioners;
- (3) Services and supplies incident to the services of APNs, nurse midwives, and PAs;
- (4) Visiting nurse services to the homebound;
- (5) ~~Mental health professional services~~ Behavior health professional services as authorized under the FQHC State Plan pages and services and supplies incident to the services of MHPs thereto;
- (6) Preventive primary care services;
- (7) Preventive primary dental services.

### **317:30-5-661.5. Health Center preventive primary care services**

(a) Preventive primary care services are those health services that:

- (1) a Health Center is required to provide as preventive primary health services under section 330 of the Public Health Service Act;
- (2) are furnished by or under the direct supervision of an APN, PA, CNMW, specialized advanced practice nurse practitioner, MHP licensed psychologist, LCSW, ~~or~~ a physician, or other approved health care professional as authorized in the FQHC state plan pages;
- (3) are furnished by a member of the Health Center's health care staff who is an employee of the Center or provides services under arrangements with the Center; and
- (4) includes only drugs and biologicals that cannot be self-administered.

(b) Preventive primary care services which may be paid for when provided by Health Centers include:

- (1) medical social services;
- (2) nutritional assessment and referral;
- (3) preventive health education;
- (4) children's eye and ear examinations;
- (5) prenatal and post-partum care;
- (6) perinatal services;
- (7) well child care, including periodic screening (refer to OAC 317:30-3-65);
- (8) immunizations, including tetanus-diphtheria booster and influenza vaccine;
- (9) voluntary family planning services;

- (10) taking patient history;
- (11) blood pressure measurement;
- (12) weight;
- (13) physical examination targeted to risk;
- (14) visual acuity screening;
- (15) hearing screening;
- (16) cholesterol screening;
- (17) stool testing for occult blood;
- (18) dipstick urinalysis;
- (19) risk assessment and initial counseling regarding risks;
- (20) tuberculosis testing for high risk patients;
- (21) clinical breast exam;
- (22) referral for mammography;
- (23) thyroid function test; and
- (24) dental services (specified procedure codes).

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

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

(1) Services provided by an independently CLIA certified and enrolled laboratory.

(2) Radiology services including nuclear medicine and diagnostic ultrasound services.

(3) Venipuncture for lab tests is considered part of the encounter and cannot be billed separately. When a ~~client~~ member is seen at the clinic for a lab test only, use the appropriate CPT code. A visit for "lab test only" is not considered a Center encounter.

(4) Durable medical equipment or medical supplies not generally provided during the course of a Center visit such as diabetic supplies. However, gauze, band-aids, or other disposable products used during an office visit are considered as part of the cost of an encounter and cannot be billed separately under SoonerCare.

(5) Supplies and materials that are administered to the member are considered a part of the physician's or other health care practitioner's service.

(6) Drugs or medication treatments provided during a clinic visit are included in the encounter rate. For example, a ~~client~~ member has come into the Center with high blood pressure and is treated at the Center with a hypertensive drug or drug samples provided to the Center free of charge are not reimbursable services and are included in the cost of an encounter. Prescriptions are not included in the encounter rate and must be billed through the pharmacy program by a qualified enrolled pharmacy.

(7) Administrative medical examinations and report services;

(8) Emergency services including delivery for pregnant members that are eligible under the Non-Qualified (ineligible) provisions of OAC 317:35-5-25;

(9) Family planning services provided to individuals enrolled in the Family Planning Waiver;

(10) Optometry and podiatric services other than for dual eligible for Part B of Medicare;

~~(10) (11) Other services that are not defined in this rule or the State Plan.~~

(b) In addition, the following limitations and requirements apply to services provided by Health Centers:

(1) Physician services are not covered in a hospital.

~~(2) Encounters for PCP/CM covered capitated services provided to eligible~~

~~SoonerCare Choice members enrolled in the Health Center's panel (except family planning services or HIV/AIDS prevention services) are not reimbursed as an encounter. However, PCP/CM covered services are included in the PPS wrap around/reconciliation process (refer to OAC 317:30-5-664.11 for specific details).~~

~~(3) (2) Behavioral health case management and psychosocial rehabilitation services are limited to Health Centers enrolled under the provider requirements in OAC 317:30-5-240, 317:30-5-585, and 317:30-5-595 and contracted with OHCA as an outpatient behavioral health agency.~~

~~(4) Behavioral health services are limited to those services furnished to members at or on behalf of the Health Center.~~

### **317:30-5-664.7. Dental services provided by Health Centers**

~~(a) Covered medically necessary preventive dental services provided to adults and children are considered core services.~~

~~(b) (a) **Adults.** The Health Center core service benefit to adults is intended to provide services requiring immediate treatment, relief of pain and/or extraction and is not intended to restore teeth. For scope of services for individuals eligible under other program categories, refer to OAC 317:30-5-696. Core Services services are limited to treatment for conditions such as:~~

- ~~(1) Acute infection;~~
- ~~(2) Acute abscesses;~~
- ~~(3) Severe tooth pain; and~~
- ~~(4) Tooth re-implantation, when clinically appropriate.~~

~~(c) Other medically necessary dental services which are not considered to be preventive may be billed by the Health Center utilizing the current SoonerCare fee schedule.~~

~~(b) **Children.** Medically necessary dental services for children are covered.~~

~~(c) **Exclusions and Limitations.** Other medically necessary dental services which are not considered core services may be billed by the Health Center utilizing the current SoonerCare fee schedule.~~

~~(1) Smoking and tobacco use cessation is a covered service for adults and children and is separately reimbursable. Refer to OAC 317:30-5-2.~~

~~(2) Refer to OAC 317:30-5-695 for other specific coverage, exclusions and prior authorization requirements.~~

~~(d) Health Centers must submit all claims for SoonerCare reimbursement for dental services on the American Dental Association (ADA) form.~~

### **317:30-5-664.10. Health Center reimbursement**

~~(a) In accordance with Section 702 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000, effective January 1, 2002, reimbursement is provided for core services and other health services at a Health Center facility-specific Prospective Payment System (PPS) rate per visit (encounter) determined according to the methodology described in OAC 317:30-5-664.12.~~

~~(b) As claims/encounters are filed, reimbursement for SoonerCare Choice members is made for all medically necessary covered primary care services (that are not included in the SoonerCare capitation payment, if applicable) and other approved health services at the current rate for that CPT/HCPSC code PPS rate.~~

~~(c) As claims are filed, reimbursement for SoonerCare Traditional members is made for all medically necessary covered primary care and other health services at the PPS rate.~~

~~(d) (c) The originating site facility fee for telemedicine services is not a Federally Qualified Health Center (FQHC) service. When a FQHC serves as the originating site, the originating site facility fee is paid separately from the center's all-inclusive rate. Refer to OAC 317:30-3-27 for other specific~~

coverage and exclusion requirements.

(d) Primary and preventive behavioral health services rendered by health care professionals authorized in the FQHC approved state plan pages will be reimbursed at the PPS encounter rate.

(e) Vision services provided by Optometrists within the scope of their licensure for non dual eligible members and allowed under the Medicaid State Plan are reimbursed pursuant to the SoonerCare fee-for-service fee schedule.



~~CHAPTER 45. INSURE OKLAHOMA/OKLAHOMA EMPLOYER AND EMPLOYEE  
PARTNERSHIP FOR INSURANCE COVERAGE~~

Subchapter 1. General Provisions

317:45-1-3. [AMENDED]

Subchapter 3. Insure Oklahoma/~~O-Epic~~ Carriers

317:45-3-2. [AMENDED]

Subchapter 5. Insure Oklahoma/~~O-Epic~~ Qualified Health Plans

317:45-5-1. [AMENDED]

317:45-5-2. [AMENDED]

Subchapter 7. Insure Oklahoma/~~O-Epic~~ ESI Employer Eligibility

317:45-7-2. [AMENDED]

317:45-7-3. [AMENDED]

317:45-7-6. [AMENDED]

317:45-7-8. [AMENDED]

Subchapter 9. Insure Oklahoma/~~O-Epic~~ ESI Employee Eligibility

317:45-9-1. [AMENDED]

317:45-9-2. [AMENDED]

317:45-9-7. [AMENDED]

Subchapter 11. Insure Oklahoma/~~O-Epic~~ IP

Part 1. Individual Plan Providers

317:45-11-1. [AMENDED]

317:45-11-2. [AMENDED]

Part 3. Insure Oklahoma/~~O-Epic~~ IP Member Health Care Benefits

317:45-11-10. [AMENDED]

317:45-11-11. [AMENDED]

317:45-11-12. [NEW]

317:45-11-13. [NEW]

Part 5. Insure Oklahoma/~~O-Epic~~ IP Member Eligibility

317:45-11-20. [AMENDED]

317:45-11-21. [AMENDED]

317:45-11-23. [AMENDED]

317:45-11-27. [AMENDED]

317:45-11-28. [AMENDED]

**(Reference APA WF # 10-08)**

**SUMMARY:** Rules are revised to expand the Insure Oklahoma ESI and IP programs. Expansions include incorporating Oklahoma children through 18 years of age whose household income is from 185 up to and including 300 percent of the Federal Poverty Level. The inclusion of children into the program will be phased in over a period of time as determined by the OHCA. In addition, revisions will expand the current Insure Oklahoma ESI and IP program guidelines to include employees and working adults whose family income does not exceed 250 percent of the Federal Poverty Level. The increase from 200 to 250 percent of the FPL will be phased in over a period of time as determined by the OHCA. These revisions comply with Sections 1009.2 and 1010.1 of Title 56 of Oklahoma Statutes. This expansion to the Insure Oklahoma program will help increase access to health care for Oklahomans thereby reducing the amount of uncompensated care provided by health care providers.

**BUDGET IMPACT:** State dollars used to fund the expansion of the Insure Oklahoma Program will be provided from the unused funds from the HEEIA Revolving Fund, in an amount not to exceed \$8,000,000.00

**MEDICAL ADVISORY COMMITTEE:** The Medical Advisory Committee considered the proposed rule revisions on March 25, 2010 and recommended Board

approval.

**AUTHORITY:** The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; Sections 1009.2 and 1010.1 of Title 56 of Oklahoma Statutes

**PUBLIC HEARING:** A public hearing was held on February 22, 2011. No comments were received before, during, or after the hearing.

**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY**  
**CHAPTER 45. ~~INSURE OKLAHOMA/OKLAHOMA EMPLOYER AND EMPLOYEE~~**  
**~~PARTNERSHIP FOR INSURANCE COVERAGE~~**  
**SUBCHAPTER 1. GENERAL PROVISIONS**

**317:45-1-3. Definitions**

The following words or terms, when used in this Chapter, will have the following meanings unless the context clearly indicates otherwise:

**"Carrier"** means:

(A) an insurance company, insurance service, insurance organization, or group health service, which is licensed to engage in the business of insurance in the State of Oklahoma and is subject to State law which regulates insurance, or Health Maintenance Organization (HMO) which provides or arranges for the delivery of basic health care services to enrollees on a prepaid basis, except for copayments or deductibles for which the enrollee is responsible, or both and is subject to State law which regulates Health Maintenance Organizations (HMOs);

(B) a Multiple Employer Welfare Arrangement (MEWA) licensed by the Oklahoma Insurance Department;

(C) a domestic MEWA exempt from licensing pursuant to Title 36 O.S., Section 634(B) that otherwise meets or exceeds all of the licensing and financial requirements of MEWAs as set out in Article 6A of Title 36; or

(D) any entity organized pursuant to the Interlocal Cooperation Act, Section 1001 et seq. of Title 74 of the Oklahoma Statutes as authorized by Title 36 Section 607.1 of the Oklahoma Statutes and which is eligible to qualify for and hold a certificate of authority to transact insurance in this State and annually submits on or before March 1st a financial statement to the Oklahoma Insurance Department in a form acceptable to the Insurance Commissioner covering the period ending December 31st of the immediately preceding fiscal year.

**"Child Care Center"** means a facility licensed by OKDHS which provides care and supervision of children and meets all the requirements in ~~OAC~~ 340:110-3-1 through ~~OAC~~ 340:110-3-33.3.

**"College Student"** means an Oklahoma resident between the age of 19 through 22 that is a full-time student ~~at an Oklahoma~~ in an accredited and OHCA approved University or College in the State of Oklahoma.

**"Dependent"** means the spouse of the approved applicant and/or child under 19 years of age or his or her child 19 years through 22 years of age who is attending an Oklahoma qualified institution of higher education and relying upon the insured employee or member for financial support.

**"Eligibility period"** means the period of eligibility extending from an approval date to an end date.

**"Employee"** means a person who works for an employer in exchange for earned income. This includes the owners of a business. All employees and employers

must be in compliance with all OESC requirements to be eligible for the program.

"Employer" means the business entity that pays earned income to employees. All employees and employers must be in compliance with all OESC requirements to be eligible for the program.

"Employer Sponsored Insurance" means the program that provides premium assistance to qualified businesses for approved applicants.

"EOB" means an Explanation of ~~Benefits~~ Benefit.

"Explanation of Benefit" means a statement issued by a carrier that indicates services rendered and financial responsibilities for the carrier and Insure Oklahoma/~~O-EPIC~~ member.

"Full-time Employment" means a normal work week of 24 or more hours.

"Full-time Employer" means the employer who employs an employee for 24 hours or more per week to perform work in exchange for wages or salary.

"Gross Household Income" or "Annual Gross Household Income" means the countable income (earned or unearned) that is computed pursuant to OHCA's waiver and/or state plan using rules found in 317:35.

"Individual Plan" means the safety net program for those qualified individuals who do not have access to Insure Oklahoma/~~O-EPIC~~ ESI.

"Insure Oklahoma/~~O-EPIC~~" means a health plan purchasing strategy in which the State uses public funds to pay for a portion of the costs of health plan coverage for eligible populations.

"Insure Oklahoma/~~O-EPIC~~ IP" means the Individual Plan program.

"Insure Oklahoma/~~O-EPIC~~ ESI" means the Employer Sponsored Insurance program.

"Member" means an individual enrolled in the Insure Oklahoma/~~O-EPIC~~ ESI or IP program.

"OESC" means the Oklahoma Employment Security Commission.

"OHCA" means the Oklahoma Health Care Authority.

"OKDHS" means the Oklahoma Department of Human Services.

"PCP" means Primary Care Provider.

"PEO" or "Professional Employer Organization" means any person engaged in the business of providing professional employer services. A person engaged in the business of providing professional employer services shall be subject to registration under the Oklahoma Professional Employer Organization Recognition and Registration Act as provided in Title 40, Chapter 16 of Oklahoma Statutes, Section 600.1 et.seq.

"Primary Care Provider" means a provider under contract ~~to~~ with the Oklahoma Health Care Authority to provide primary care services, including all ~~medically necessary~~ medically necessary referrals.

"Premium" means a monthly payment to a carrier for health plan coverage.

~~"QHP" means Qualified Health Plan.~~

"Qualified Health Plan" means a health plan that has been approved by the OHCA for participation in the Insure Oklahoma/~~O-EPIC~~ program.

"Qualifying Event" means the occurrence of an event that permits individuals to join a group health plan outside of the "open enrollment period" and/or that allows individuals to modify the coverage they have had in effect. Qualifying events are defined by the employer's health plan and meet federal requirements under Public Law 104-191 (HIPAA), and 42 U.S.C. 300bb-3.

"State" means the State of Oklahoma, acting by and through the Oklahoma Health Care Authority ~~or its designee.~~

~~"TPA" means the Third Party Administrator.~~

~~"Third Party Administrator" means the entity contracted by the State to provide the administration of the Insure Oklahoma/Oklahoma Employer and Employee Partnership for Insurance Coverage program.~~

## SUBCHAPTER 3. INSURE OKLAHOMA/~~O-EPIC~~ CARRIERS

### 317:45-3-2. Audits

Carriers are subject to audits related to health plan qualifications. These audits may be conducted periodically to determine if ~~QHPs continue~~ each qualified health plan continues to meet all requirements as defined in ~~OAC~~ 317:45-5-1.

## SUBCHAPTER 5. INSURE OKLAHOMA/~~O-EPIC~~ QUALIFIED HEALTH PLANS

### 317:45-5-1. Qualified Health Plan requirements

(a) Participating ~~QHPs~~ qualified health plans must offer, at a minimum, benefits that include:

- (1) hospital services;
- (2) physician services;
- (3) clinical laboratory and radiology;
- (4) pharmacy; ~~and~~
- (5) office visits-;
- (6) well baby/well child exams;
- (7) age appropriate immunizations as required by law; and
- (8) emergency services as required by law.

(b) The health plan, if required, must be approved by the Oklahoma Insurance Department for participation in the Oklahoma market. All health plans must share in the cost of covered services and pharmacy products in addition to any negotiated discounts with network providers, pharmacies, or pharmaceutical manufacturers. If the health plan requires co-payments or deductibles, the co-payments or deductibles cannot exceed the limits described in this subsection.

(1) An annual in-network out-of-pocket maximum cannot exceed ~~an amount that is established by OHCA. This amount includes any non-pharmacy, annual deductible amount for in-network services~~ \$3,000 per individual, excluding separate pharmacy deductibles.

(2) Office visits cannot require a co-payment exceeding \$50 per visit.

(3) Annual in-network pharmacy deductibles cannot exceed \$500 per individual.

(c) ~~QHPs may~~ Qualified health plans will provide an EOB, an expense summary, or required documentation for paid ~~or~~ and/or denied claims subject to member co-insurance or member deductible calculations. If an EOB is provided it The required documentation must contain, at a minimum, the:

- (1) provider's name;
- (2) patient's name;
- (3) date(s) of service;
- (4) code(s) and/or description(s) indicating the service(s) rendered, the amount(s) paid or the denied status of the claim(s);
- (5) reason code(s) and description(s) for any denied service(s); ~~and~~
- (6) amount due and/or paid from the patient or responsible party-; and
- (7) provider network status (in-network or out-of-network provider).

### 317:45-5-2. Closure criteria for health plans

Eligibility for the carrier's health plans ends when:

(1) changes are made to the design or benefits of the QHP health plan such that it no longer meets the requirements for QHPs to be considered a qualified health plan. Carriers are required to report to OHCA any changes in health plans potentially affecting ~~its~~ their qualification for participation in the program not less than 90 days prior to the effective date of such change(s).

- (2) the carrier no longer meets the definition set forth in ~~OAC~~ 317:45-1-3.
- (3) the health plan is no longer an available product in the Oklahoma market.
- (4) the health plan fails to meet or comply with all requirements for a ~~QHP~~ qualified health plan as defined in ~~OAC~~ 317:45-5-1.

## SUBCHAPTER 7. INSURE OKLAHOMA/~~O-EPIC~~ ESI EMPLOYER ELIGIBILITY

### 317:45-7-2. Employer eligibility determination

Eligibility for employers is determined ~~by the TPA~~ using the eligibility requirements listed in ~~OAC~~ 317:45-7-1. An employer determined eligible for Insure Oklahoma/~~O-EPIC~~ is approved for up to a 12 month period. The eligibility period begins on the first day of the month following the date of approval. The eligibility period ends the last day of the 12th month. The eligibility period will renew automatically unless the employer's eligibility has been closed (refer to ~~OAC~~ 317:45-7-8). ~~The TPA notifies the employer of the eligibility decision for employer and employees.~~ Employers will be notified of their eligibility decision.

### 317:45-7-3. Employer cost sharing

Employers are responsible for a portion of the eligible employee's monthly health plan premium as defined in ~~OAC~~ 317:45-7-1. ~~Employers are not required to contribute to an eligible dependent's coverage.~~

### 317:45-7-6. Credits and adjustments

When an overpayment ~~has occurred~~ occurs, the employer must immediately refund report the TPA, ~~by check, to the attention of the Finance Division erroneous payment.~~ The TPA system has the capability of automatic credits and debits. ~~When an erroneous payment occurs, that results in an overpayment, an automatic recoupment is made to the employer's account against monies owed to the employer on behalf of their employee(s). When such an overpayment(s) occurs, an automatic recoupment is made to the employer's account against future reimbursements. If the employer is not expecting future reimbursements, either by termination from the program or inactivity, the employer must repay any and all overpayments that are outstanding to the OHCA.~~

### 317:45-7-8. Closure

Eligibility provided under the Insure Oklahoma/~~O-EPIC~~ ESI program may end during the eligibility period when:

- (1) the employer no longer meets the eligibility requirements in ~~OAC~~ 317:45-7-1;
- (2) the employer fails to pay premiums to the carrier;
- (3) the employer fails to provide an invoice verifying the monthly health plan premium has been paid; or
- (4) an audit indicates a discrepancy that makes the employer ineligible.

## SUBCHAPTER 9. INSURE OKLAHOMA/~~O-EPIC~~ ESI EMPLOYEE ELIGIBILITY

### 317:45-9-1. Employee eligibility requirements

(a) ~~Employee applications are submitted to the TPA~~ Employees must complete and submit the OHCA required forms and application to be considered for participation in the program.

(b) The eligibility determination ~~is~~ will be processed within 30 days from the date the application is received ~~by the TPA.~~ The employee ~~is~~ will be notified in writing of the eligibility decision.

(c) All eligible employees described in this ~~Section are enrolled in their Employer's QHP~~ section must be enrolled in their employer's qualified health plan. Eligible employees must:

(1) ~~have a countable~~ have an annual gross household income at or below 200% 250 percent of the Federal Poverty Level (FPL). The increase from 200 to 250 percent of the FPL will be phased in over a period of time as determined by the Oklahoma Health Care Authority. The standard deduction for work related expenses such as income tax payments, Social Security taxes, and transportation to and from work, is \$240 per each full-time or part-time employed member;

(2) be a US citizen or alien as described in ~~OAC~~ 317:35-5-25;

(3) be Oklahoma residents;

(4) provide social security number for all household members;

(5) not be receiving benefits from ~~SoonerCare/Medicare~~ SoonerCare or Medicare;

(6) be employed with a qualified employer at a business location in Oklahoma;

(7) be age 19 through age 64 or an emancipated minor;

(8) be eligible for enrollment in the employer's ~~QHP~~ qualified health plan;

(9) not have full-time employment with any employer who does not meet the eligible employer guidelines listed in ~~OAC~~ 317:45-7-1(a)(1)-(2); ~~and~~

(10) select one of the ~~QHPs~~ qualified health plans the employer is offering-; ~~and~~

(11) provide in a timely manner any and all documentation that is requested by the Insure Oklahoma program by the specified due date.

(d) An employee's dependents are eligible when:

(1) the employer's health plan includes coverage for dependents;

(2) the employee is eligible;

(3) if employed, the spouse may not have full-time employment with any employer who does not meet the eligible employer guidelines listed in ~~OAC~~ 317:45-7-1(a)(1)-(2); and

(4) the dependents are enrolled in the same health plan as the employee.

(e) If an employee or their dependents are eligible for multiple ~~QHPs~~ qualified health plans, each may receive a subsidy under only one health plan.

(f) Dependent college students must enroll under their parents and all annual gross household income (including parent income) must be included in determining eligibility. Independent college students may apply on their own without parent income included in the household. College student status as dependent or independent is determined by the student's current Free Application for Federal Student Aid (FAFSA). College students must also provide a copy of their current student schedule to prove full-time student status.

(g) Dependent children in families whose annual gross household income is from 185 up to and including 300 percent of the Federal Poverty Level may be eligible. The inclusion of children into the Insure Oklahoma program will be phased in over a period of time as determined by the OHCA. No other deductions or disregards apply.

(1) Children found to be eligible for SoonerCare may not receive coverage through Insure Oklahoma.

(2) Children are not eligible for Insure Oklahoma if they are a member of a family eligible for employer-sponsored dependent health insurance coverage under any Oklahoma State Employee Health Insurance Plan.

(3) Children who already have coverage through another source must undergo, or be excepted from, a six month uninsured waiting period prior to becoming eligible for Insure Oklahoma. Exceptions to the waiting period may include:

(A) the cost of covering the family under the ESI plan meets or exceeds ten percent of the annual gross household income. The cost of coverage includes premiums, deductibles, co-insurance, and co-payments;

(B) loss of employment by a parent which made coverage available;

(C) affordable ESI is not available; "affordable" coverage is defined by the OHCA annually using actuarially sound rates established by the Oklahoma State and Education Employee Group Insurance Board (OSEEGIB);

or

(D) loss of medical benefits under SoonerCare.

(h) ESI approved individuals must notify the OHCA of any changes, including household status and income, that might impact individual and/or dependent eligibility in the program within 30 calendar days of the change.

### **317:45-9-2. Employee eligibility period**

(a) Employee eligibility is contingent upon the employer's program eligibility.

(b) The employee's eligibility is determined ~~by the TPA~~ using the eligibility requirements listed in ~~OAC~~ 317:45-9-1.

(c) If the employee is determined eligible, he/she is approved for a period not greater than 12 months. ~~The length of the eligibility period is based on the remaining number of months the employer has left in its eligibility period.~~

(d) The employee's eligibility period begins on the first day of the month following the date of approval.

### **317:45-9-7. Closure**

(a) Employer and employee eligibility are tied together. If the employer is no longer eligible, then the associated employees enrolled under that employer are also ineligible. Employees are mailed a notice 10 days prior to closure of eligibility.

(b) The employee's certification period may be terminated when:

(1) termination of employment, either voluntary or involuntary, occurs;

(2) the employee moves out-of-state;

(3) the covered employee dies;

(4) the employer ends its contract with the ~~QHP~~ qualified health plan;

(5) the employer's eligibility ends;

(6) an audit indicates a discrepancy that makes the employee or employer ineligible;

(7) the employer is terminated from the program;

(8) the employer fails to pay the premium;

(9) the ~~QHP~~ qualified health plan or carrier ~~is no longer qualified~~ no longer meets the requirements set forth in this Chapter;

(10) the employee becomes eligible for ~~Medicaid/Medicare~~ SoonerCare or Medicare;

(11) the employee or employer reports ~~to the OHCA or the TPA~~ any change affecting eligibility;

(12) the employee is no longer listed as a covered person on the employer's health plan invoice; ~~or~~

(13) the employee requests closure; or

(14) the employee no longer meets the eligibility criteria set forth in this Chapter.

## PART 1. INDIVIDUAL PLAN PROVIDERS

### 317:45-11-1. Insure Oklahoma/~~O-EPIC~~ Individual Plan providers

Insure Oklahoma/~~O-EPIC~~ Individual Plan (IP) providers must comply with existing SoonerCare rules found at ~~OAC~~ 317:25 and ~~OAC~~ 317:30. In order to receive reimbursement, the IP provider:

- (1) must enter into a SoonerCare contract; and
- (2) must complete Insure Oklahoma/~~O-EPIC~~ IP addendum if provider wants to provide primary care services as a PCP.

### 317:45-11-2. Insure Oklahoma/~~O-EPIC~~ IP provider payments

Payment for covered benefits rendered to Insure Oklahoma/~~O-EPIC~~ IP members, ~~as shown in OAC 317:45-11-10 and not listed as a non covered service in OAC 317:45-11-11,~~ is made to contracted Insure Oklahoma/~~O-EPIC~~ IP healthcare providers for medical and surgical services within the scope of OHCA's medical programs, provided the services are medically necessary as defined in ~~OAC~~ 317:30-3-1(f).

- (1) Coverage of certain services requires prior authorization ~~as shown in OAC 317:45-11-10~~ and may be based on a determination made by a medical consultant in individual circumstances;
- (2) The decision to charge a ~~copayment~~ co-payment for a missed visit is at the provider's discretion;
- (3) The provider may collect the member's ~~co-pay~~ co-payment in addition to the SoonerCare reimbursement for services provided; and
- (4) The provider may refuse to see members based on their inability to pay their ~~co-pay~~ co-payment.

## PART 3. INSURE OKLAHOMA/~~O-EPIC~~ IP MEMBER HEALTH CARE BENEFITS

### 317:45-11-10. Insure Oklahoma/~~O-EPIC~~ IP adult benefits

(a) All IP adult benefits are subject to rules delineated in ~~OAC~~ 317:30 except as specifically set out in this Section. The scope of IP adult benefits described in this Section ~~are~~ is subject to specific non-covered services listed in ~~OAC~~ 317:45-11-11.

(b) A PCP referral is required to see any other provider with the exception of the following services:

- (1) behavioral health services;
- (2) prenatal and obstetrical supplies and services, meaning prenatal care, delivery and 60 days of postpartum care;
- (3) family planning supplies and services, meaning an office visit for a comprehensive family planning evaluation, including obtaining a Pap smear;
- (4) women's routine and preventive health care services;
- (5) emergency medical condition as defined in ~~OAC~~ 317:30-3-1; and
- (6) services delivered to American Indians at Indian Health Service, tribal, or urban Indian clinics.

(c) IP covered adult benefits for in-network services, limits, and applicable co-payments are listed in this subsection. In addition to the benefit-specific limits, there is a maximum lifetime benefit of \$1,000,000. Dependent children coverage is found at 317:45-11-12. Children are not held to the maximum lifetime benefit. Coverage includes:

- (1) Anesthesia / Anesthesiologist Standby. Covered in accordance with ~~OAC~~ 317:30-5-7. Eligible services are covered for covered illness or surgery including services provided by a Certified Registered Nurse Anesthetist (CRNA) or Anesthesiologist Assistant (AA).
- (2) Blood and Blood Products. Processing, storage, and administration of blood and blood products in inpatient and outpatient settings.
- (3) Chelation Therapy. Covered for heavy metal poisoning only.



(4) Diagnostic X-ray, including Ultrasound. Covered in accordance with ~~OAC~~ 317:30-5-22(b)(2). PCP referral is required. Standard radiology (X-ray or Ultrasound): \$0 co-pay. Specialized scanning and imaging (MRI, MRA, PET, or CAT Scan); \$25 co-pay per scan.

(5) Emergency Room Treatment, services and supplies for treatment in an emergency. Contracted provider services are subject to a \$30 co-pay per occurrence. The emergency room co-pay will be waived if the member is admitted to the hospital or death occurs before admission.

(6) Inpatient Hospital Benefits. Covered in accordance with ~~OAC~~ 317:30-5-41, 317:30-5-47 and 317:30-5-95; \$50 co-pay per admission.

(7) Preventive Office Visit. For services of evaluation and medical management (wellness exam); one visit per year with a \$10 co-pay. This visit counts as an office visit.

(8) Office Visits/Specialist Visits. Covered in accordance with ~~OAC~~ 317:30-5-9, 317:30-5-10, and 317:30-5-11. For services of evaluation and medical management; up to four visits are covered per month; PCP referral required for specialist visits; \$10 co-pay per visit.

(9) Outpatient Hospital/Facility Services.

(A) Includes hospital surgery services in an approved outpatient facility including outpatient services and diagnostic services. Prior authorization required for certain procedures; \$25 co-pay per visit.

(B) Therapeutic radiology or chemotherapy on an outpatient basis without limitation to the number of treatments per month for persons with proven malignancies or opportunistic infections; \$10 co-pay per visit.

(C) Physical, Occupational and Speech Therapy services. Coverage is limited to one evaluation/re-evaluation visit (unit) per discipline per calendar year and 15 visits (units) per discipline per date of service per calendar year; \$10 co-pay per visit.

(10) Maternity (Obstetric). Covered in accordance with ~~OAC~~ 317:30-5-22. Nursery care paid separately under eligible child; \$50 inpatient hospital co-pay.

(11) Laboratory/Pathology. Covered in accordance with ~~OAC~~ 317:30-5-20; \$0 co-pay.

(12) Mammogram (Radiological or Digital). Covered in accordance with ~~OAC~~ 317:30-5-901; \$0 co-pay.

(13) Immunizations. Covered in accordance with ~~OAC~~ 317:30-5-2.

(14) Assistant Surgeon. Covered in accordance with ~~OAC~~ 317:30-5-8.

(15) Dialysis, Kidney dialysis, and services and supplies, either at home or in a facility; \$0 co-pay.

(16) Oral Surgery. Services are limited to the removal of tumors or cysts; Inpatient Hospital \$50 or Outpatient Hospital/Facility; \$25 co-pay applies.

(17) Behavioral Health (Mental Health and Substance Abuse) Treatment (Inpatient). Covered in accordance with ~~OAC~~ 317:30-5-95.1; \$50 co-pay per admission.

(18) Behavioral Health (Mental Health and Substance Abuse) Treatment (Outpatient).

(A) Agency services. Covered in accordance with ~~OAC~~ 317:30-5-241 and 317:30-5-596; \$10 co-pay per visit.

(B) Individual provider services. Licensed Behavioral Health Professionals (LBHPs) are defined as follows for the purpose of Outpatient ~~Mental~~ Behavioral Health Services and Outpatient Substance Abuse Treatment:

(i) Allopathic or Osteopathic Physicians with a current license and board certification in psychiatry or board eligible in the state in

which services are provided, or a current resident in psychiatry practicing as described in ~~OAC~~ 317:30-5-2.

(ii) Practitioners with a license to practice in the state in which services are provided or those actively and regularly receiving board approved supervision, and extended supervision by a fully licensed clinician if board's supervision requirement is met but the individual is not yet licensed, to become licensed by one of the licensing boards listed in (I) through (VI) below. The exemptions from licensure under ~~59 §1353(4) and (5)~~ 59 Okla. Stat. §1353(4) and (5), 59 §1903(C) and (D), 59 §1925.3(B) and (C), and 59 §1932(C) and (D) do not apply to Outpatient Behavioral Health Services.

- (I) Psychology,
- (II) Social Work (clinical specialty only),
- (III) Professional Counselor,
- (IV) Marriage and Family Therapist,
- (V) Behavioral Practitioner, or
- (VI) Alcohol and Drug Counselor.

(iii) Advanced Practice Nurse (certified in a psychiatric mental health specialty), licensed as a registered nurse with a current certification of recognition from the board of nursing in the state in which services are provided.

(iv) A Physician's Assistant who is licensed in good standing in this state and has received specific training for and is experienced in performing mental health therapeutic, diagnostic, or counseling functions.

(v) LBHPs must have a valid Insure Oklahoma contract in order to bill for services rendered.

(vi) LBHP services require prior authorization and are limited to 8 therapy services per month per member and 8 testing units per year per member; \$10 co-pay per visit.

(19) Durable Medical Equipment and Supplies. Covered in accordance with ~~OAC~~ 317:30-5-210 through 317:30-5-218. A PCP referral and prior authorization is required for certain items. DME/Supplies are covered up to a \$15,000 annual maximum; exceptions from the annual DME limit are diabetic supplies, oxygen, home dialysis, and parenteral therapy; \$5 co-pay for durable/non-durable supplies and \$25 co-pay for durable medical equipment.

(20) Diabetic Supplies. Covered in accordance with ~~OAC~~ 317:30-5-211.15; not subject to \$15,000 annual DME limit; \$5 co-pay per prescription.

(21) Oxygen. Covered in accordance with ~~OAC~~ 317:30-5-211.11 through 317:30-5-211.12; not subject to \$15,000 annual DME limit; \$5 co-pay per month.

(22) Pharmacy. Covered in accordance with ~~OAC~~ 317:30-5-72.1 and 317:30-5-72. Prenatal vitamins and smoking cessation products do not count against monthly prescription limits; \$5/\$10 co-pay per prescription.

(23) Smoking Cessation Products. Products do not count against monthly prescription limits. Covered in accordance with ~~OAC~~ 317:30-5-72.1; \$5/\$10 co-pay per product.

(24) Nutrition Services. Covered in accordance with ~~OAC~~ 317:30-5-1076; \$10 co-pay per visit.

(25) External Breast Prosthesis, Bras and Prosthetic Garments. Covered in accordance with ~~OAC~~ 317:30-5-211.13; \$25 co-pay per prosthesis.

(26) Surgery. Covered in accordance with ~~OAC~~ 317:30-5-8; \$50 co-pay per inpatient admission and \$25 co-pay per outpatient visit.

(27) Home Dialysis. Covered in accordance with ~~OAC~~ 317:30-5-211.13; not subject to \$15,000 annual DME limit; \$0 co-pay.

(28) Parenteral Therapy. Covered in accordance with ~~OAC~~ 317:30-5-211.14; not subject to \$15,000 annual DME limit; \$25 co-pay per month.

- (29) Family Planning Services and Supplies, including Sterilizations. Covered in accordance with ~~OAC~~ 317:30-3-57; \$0 co-pay.
- (30) Home Health Medications, Intravenous (IV) Therapy and Supplies. Covered in accordance with ~~OAC~~ 317:30-5-211.15 and 317:30-5-42.16(b)(3).
- ~~(31) Ultraviolet Treatment Actinotherapy.~~
- ~~(32) (31) Fundus photography.~~
- ~~(33) (32) Perinatal dental care for pregnant women. Covered in accordance with ~~OAC~~ 317:30-5-696; \$0 co-pay.~~

### **317:45-11-11. Insure Oklahoma/~~O-EPIC~~ IP adult non-covered services**

Certain health care services are not covered in the Insure Oklahoma/~~O-EPIC~~ IP adult benefit package listed in ~~OAC~~ 317:45-11-10. These services include, but are not limited to:

- (1) ~~services that the member's PDP or Insure Oklahoma/O-EPIC does not consider~~ not considered medically necessary;
- (2) any medical service when the member refuses to authorize release of information needed to make a medical decision;
- (3) organ and tissue transplant services;
- (4) weight loss intervention and treatment including, but not limited to, bariatric surgical procedures or any other weight loss surgery or procedure, drugs used primarily for the treatment of weight loss including appetite suppressants and supplements, and/or nutritional services prescribed only for the treatment of weight loss;
- (5) procedures, services and supplies related to sex transformation;
- (6) supportive devices for the feet (orthotics) except for the diagnosis of diabetes;
- (7) cosmetic surgery, except as medically necessary and as covered in ~~OAC~~ 317:30-3-59(19);
- (8) over-the-counter drugs, medicines and supplies except contraceptive devices and products, and diabetic supplies;
- (9) experimental procedures, drugs or treatments;
- (10) dental services (preventive, basic, major, orthodontia, extractions or services related to dental accident) except for pregnant women and as covered in ~~OAC~~ 317:30-5-696;
- (11) vision care and services (including glasses), except services treating diseases or injuries to the eye;
- (12) physical medicine including chiropractic, ~~acupuncture and osteopathic manipulation and acupuncture~~ therapy;
- (13) hearing services;
- (14) transportation [~~emergent emergency~~ emergent emergency or ~~non-emergent non-emergency~~ non-emergent non-emergency (air or ground)];
- (15) rehabilitation (inpatient);
- (16) cardiac rehabilitation;
- (17) allergy testing and treatment;
- (18) home health care with the exception of medications, intravenous (IV) therapy, supplies;
- (19) hospice regardless of location;
- (20) Temporomandibular Joint Dysfunction (TMD) (TMJ);
- (21) genetic counseling;
- (22) fertility evaluation/treatment/and services;
- (23) sterilization reversal;
- (24) Christian Science Nurse;
- (25) Christian Science Practitioner;
- (26) skilled nursing facility;
- (27) long-term care;
- (28) stand by services;
- (29) thermograms;

- (30) abortions (for exceptions, refer to ~~OAC~~ 317:30-5-6);
- (31) services of a Lactation Consultant;
- (32) services of a Maternal and Infant Health Licensed Clinical Social Worker; ~~and~~
- (33) enhanced services for medically high risk pregnancies as found in ~~OAC~~ 317:30-5-22.1-;
- (34) ultraviolet treatment- actinotherapy; and
- (35) private duty nursing.

### **317:45-11-12. Insure Oklahoma IP children benefits**

(a) IP covered child benefits for in-network services, limits, and applicable co-payments are listed in this Subsection. All IP benefits are subject to rules delineated in 317:30 except as specifically set out in this Section. All services provided must be medically necessary as defined in 317:30-3-1(f). The scope of IP child benefits described in this Section is subject to specific non-covered services listed in 317:45-11-13. Dependent children are not held to the maximum lifetime benefit of \$1,000,000. Coverage includes:

- (1) Ambulance services. Covered as medically necessary; \$50 co-pay per occurrence; waived if admitted.
- (2) Blood and blood products. Processing, storage, and administration of blood and blood products in inpatient and outpatient settings.
- (3) Chelation therapy. Covered for heavy metal poisoning only.
- (4) Chemotherapy and radiation therapy. Covered as medically necessary; \$10 co-pay per visit.
- (5) Clinic services including renal dialysis services. Covered as medically necessary; \$0 co-pay for dialysis services; \$10 co-pay per office visit.
- (6) Diabetic supplies. One glucometer, one spring-loaded lancet device, two replacement batteries per year - 100 glucose strips and lancets per month; not included in DME \$15,000 max/year; \$5 co-pay per billable service. Additional supplies require prior authorization.
- (7) Diagnostic X-ray services. Covered as medically necessary; \$25 co-pay per scan for MRI, MRA, PET, CAT scans only.
- (8) Dialysis. Covered as medically necessary.
- (9) Durable medical equipment and supplies. Covered as medically necessary with \$15,000 annual maximum; \$5 co-pay per item for durable/non-durable supplies; \$25 co-pay per item for DME.
- (10) Emergency department services. Covered as medically necessary; \$30 co-pay per occurrence; waived if admitted.
- (11) Family planning services and supplies. Birth control information and supplies; pap smears; pregnancy tests.
- (12) Home health services. Home health visits limited to 36 visits per year, prior authorization required, includes medications IV therapy and supplies; \$10 co-pay per visit, appropriate pharmacy and DME co-pays will apply.
- (13) Hospice services. Covered as medically necessary, prior authorization required; \$10 co-pay per visit.
- (14) Immunizations. Covered as recommended by ACIP; \$0 co-pay.
- (15) Inpatient hospital services (acute care only). Covered as medically necessary; \$50 co-pay per admission.
- (16) Laboratory services. Covered as medically necessary.
- (17) Psychological testing. Psychological, neurological and development testing; outpatient benefits per calendar year, prior authorization required issued in four unit increments - not to exceed eight units/hours per testing set; \$0 co-pay.
- (18) Mental health/substance abuse treatment-outpatient. All outpatient benefits require prior authorization. Outpatient benefits limited to 48

visits per calendar year. Additional units as medically necessary; \$10 co-pay per outpatient visit.

(19) Mental health/substance abuse treatment-inpatient. Acute, detox, partial, and residential treatment center (RTC) with 30 day max per year, 2 days of partial or RTC treatment equals 1 day accruing to maximum. Additional units as medically necessary; \$50 co-pay per admission. Requires prior authorization.

(20) Nurse midwife services. Covered as medically necessary for pregnancy-related services only; \$0 co-pay.

(21) Nutrition services. Covered as medically necessary; \$10 co-pay.

(22) Nutritional support. Covered as medically necessary; not included in DME \$15,000 max/year. Parenteral nutrition covered only when medically necessary; \$25 co-pay.

(23) Other medically necessary services. Covered as medically necessary.

(24) Oral surgery. Covered as medically necessary and includes the removal of tumors and cysts; \$25 co-pay for outpatient; \$50 co-pay for inpatient hospital.

(25) Outpatient hospital services. Covered as medically necessary and includes ambulatory surgical centers and therapeutic radiology or chemotherapy on an outpatient basis without limitation to the number of treatments per month for children with proven malignancies or opportunistic infections; \$25 co-pay per visit; \$10 co-pay per visit for therapeutic radiology or chemotherapy.

(26) Oxygen. Covered as medically necessary; not included in DME \$15,000 max/year; \$5 co-pay per month.

(27) PCP visits. Blood lead screen covered as medically necessary. Hearing services limited to one outpatient newborn screening. Well baby/well child exams follow recommended schedule to age 19; \$0 co-pay for preventive visits and well baby/well child exams; \$10 co-pay for all other visits.

(28) Physical, occupational, and speech therapy. Covered as medically necessary; prior authorization required; \$10 co-pay per visit.

(29) Physician services, including preventive services. Covered as medically necessary; \$0 co-pay for preventive visits; \$10 co-pay for all other visits.

(30) Prenatal, delivery and postpartum services. Covered as medically necessary; \$0 co-pay for office visits; \$50 co-pay for delivery.

(31) Prescription drugs and insulin. Limited to six per month; generic preferred. Prenatal vitamins and smoking cessation products do not count toward the six prescription limit; \$5-\$10 co-pay.

(32) Smoking cessation products. Limited coverage; 90-day supply; products do not count against prescription drug limit; \$5-\$10 co-pay.

(33) Specialty clinic services. Covered as medically necessary; \$10 co-pay.

(34) Surgery. Covered as medically necessary; \$25 co-pay for outpatient facility; \$50 co-pay for inpatient hospital.

(35) Tuberculosis services. Covered as medically necessary; \$10 co-pay per visit.

(36) Ultraviolet treatment-actinotherapy. Covered as medically necessary; prior authorization required after one visit per 365 sequential days; \$5 co-pay.

(b) A PCP referral is required to see any other provider with the exception of the following services:

(1) behavioral health services;

(2) prenatal and obstetrical supplies and services, meaning prenatal care, delivery and 60 days of postpartum care;

- (3) family planning supplies and services, meaning an office visit for a comprehensive family planning evaluation, including obtaining a Pap smear;
- (4) women's routine and preventive health care services;
- (5) emergency medical condition as defined in 317:30-3-1; and
- (6) services delivered to American Indians at Indian Health Service, tribal, or urban Indian clinics.

### **317:45-11-13. Insure Oklahoma IP children non-covered services**

Certain health care services are not covered in the Insure Oklahoma IP benefit package for children listed in 317:45-11-12. These services include, but are not limited to:

- (1) services not considered medically necessary;
- (2) any medical service when the member refuses to authorize release of information needed to make a medical decision;
- (3) organ and tissue transplant services;
- (4) weight loss intervention and treatment including, but not limited to, bariatric surgical procedures or any other weight loss surgery or procedure, drugs used primarily for the treatment of weight loss including appetite suppressants and supplements, and/or nutritional services prescribed only for the treatment of weight loss;
- (5) procedures, services and supplies related to sex transformation;
- (6) supportive devices for the feet (orthotics) except for the diagnosis of diabetes;
- (7) cosmetic surgery, except as medically necessary and as covered in 317:30-3-59(19);
- (8) over-the-counter drugs, medicines and supplies except contraceptive devices and products, and diabetic supplies;
- (9) experimental procedures, drugs or treatments;
- (10) transportation [non-emergency (air or ground)];
- (11) rehabilitation (inpatient);
- (12) cardiac rehabilitation;
- (13) allergy testing and treatment;
- (14) Temporomandibular Joint Dysfunction (TMD) (TMJ);
- (15) genetic counseling;
- (16) fertility evaluation/treatment/and services;
- (17) sterilization reversal;
- (18) Christian Science Nurse;
- (19) Christian Science Practitioner;
- (20) skilled nursing facility;
- (21) long-term care;
- (22) stand by services;
- (23) thermograms;
- (24) abortions (for exceptions, refer to 317:30-5-6);
- (25) donor transplant expenses;
- (26) tubal ligations and vasectomies; and
- (27) private duty nursing.

## **PART 5. INSURE OKLAHOMA/~~O-EPIC~~ IP MEMBER ELIGIBILITY**

### **317:45-11-20. Insure Oklahoma/~~O-EPIC~~ IP eligibility requirements**

(a) ~~Employees~~ Working adults not eligible to participate in an employer's ~~QHP~~ qualified health plan, employees of non-participating employers, self-employed, unemployed seeking work, ~~and~~ workers with a disability, and qualified college students may apply for the Individual Plan. Applicants cannot obtain IP coverage if they are eligible for ESI. Applicants, unless a qualified college student, must be engaged in employment as defined under

state law, must be considered self-employed as defined under federal and/or state law, or must be considered unemployed as defined under state law.

(b) The eligibility determination ~~is~~ will be processed within 30 days from the date the complete application is received by the TPA. The applicant ~~is~~ will be notified in writing of the eligibility decision.

(c) In order to be eligible for the IP, the applicant must:

(1) choose a valid PCP according to the guidelines listed in ~~OAC~~ 317:45-11-22, at the time they make application;

(2) be a US citizen or alien as described in ~~OAC~~ 317:35-5-25;

(3) be an Oklahoma resident;

(4) provide social security numbers for all household members;

(5) be not currently enrolled in, or have an open application for, ~~SoonerCare/Medicare~~ SoonerCare or Medicare;

(6) be age 19 through 64 or an emancipated minor;

(7) make premium payments by the due date on the invoice; ~~and~~

(8) not have full-time employment with any employer who does not meet the eligible employer guidelines listed in ~~OAC~~ 317:45-7-1(a)(1)-(2); ~~and~~

(9) be not currently covered by a private health insurance policy or plan; ~~and~~

(10) provide in a timely manner any and all documentation that is requested by the Insure Oklahoma program by the specified due date.

(d) If employed and working for an approved Insure Oklahoma/~~O~~ EPIC employer who offers a ~~QHP~~ qualified health plan, the applicant must meet the requirements in subsection (c) of this Section and:

(1) have annual gross household income at or below 200% 250 percent of the Federal Poverty Level. The increase from 200 to 250 percent of the FPL will be phased in over a period of time as determined by the Oklahoma Health Care Authority.

(2) be ineligible for participation in their employer's ~~QHP~~ qualified health plan due to number of hours worked.

(3) have received notification from Insure Oklahoma/~~O~~ EPIC indicating their employer has applied for Insure Oklahoma/~~O~~ EPIC and has been approved.

(e) If employed and working for an employer who ~~doesn't~~ does not offer a ~~QHP~~ qualified health plan, the applicant must meet the requirements in subsection (c) of this Section and have ~~a countable~~ an annual gross household income at or below 200% 250 percent of the Federal Poverty Level. The increase from 200 to 250 percent of the FPL will be phased in over a period of time as determined by the Oklahoma Health Care Authority. The standard deduction for work related expenses such as income tax payments, Social Security taxes, and transportation to and from work, is \$240 per each full-time or part-time employed member.

(f) If self-employed, the applicant must meet the requirements in subsection (c) of this Section and:

(1) must have an annual gross household income at or below 200% 250 percent of the Federal Poverty Level. The increase from 200 to 250 percent of the FPL will be phased in over a period of time as determined by the Oklahoma Health Care Authority. No standard deduction for work related expenses such as income tax payments, Social Security taxes, and transportation to and from work may be made for self-employed individuals. Allowable Deductions for work related expenses for self-employed individuals, with the exception of the standard deduction, are found at 317:35-10-26(b)(1);

(2) verify self-employment and income by providing the most recent federal tax return with all supporting schedules and copies of all 1099 forms; ~~and~~

(3) ~~verify current income by providing appropriate supporting documentation; ~~and~~~~

(4) must not be employed by any full-time employer who meets the eligibility requirements in OAC 317:45-7-1(a)(1)-(2) (3) must not have full-time employment with any employer who does not meet the eligible employer guidelines listed in 317:45-7-1(a)(1)-(2).

(g) If unemployed seeking work, the applicant must meet the requirements in subsection (c) of this Section and the following:

(1) Applicant must have an annual gross household income at or below 200% 250 percent of the Federal Poverty Level. The increase from 200 to 250 percent of the FPL will be phased in over a period of time as determined by the Oklahoma Health Care Authority. In determining income, payments of regular unemployment compensation in the amount of \$25 per week ending June 30, 2010 and any amount of emergency unemployment compensation paid through May 31, 2010, will not be counted, as authorized under the American Recovery and Reinvestment Tax Act of 2009.

(2) Applicant must verify eligibility by providing a most recent copy of their monetary OESC determination letter and a most recent copy of at least one of the following:

- (A) OESC eligibility letter,
- (B) OESC weekly unemployment payment statement, or
- (C) bank statement showing state treasurer deposit.

(h) If working with a disability, the applicant must meet the requirements in subsection (c) of this Section and:

(1) Applicant must have an annual gross household income at or below 200% 250 percent of the Federal Poverty Level based on a family size of one+ and. The increase from 200 to 250 percent of the FPL will be phased in over a period of time as determined by the Oklahoma Health Care Authority.

(2) Applicant must verify eligibility by providing a copy of their:

- (A) ticket to work, or
- (B) ticket to work offer letter.

(i) IP approved individuals must notify the OHCA of any changes, including household status and income, that might impact individual and/or dependent eligibility in the program within 30 calendar days of the change.

### **317:45-11-21. Dependent eligibility**

(a) If the spouse of an Insure Oklahoma/~~O-EPIC~~ IP approved individual is eligible for Insure Oklahoma/~~O-EPIC~~ ESI, they must apply for Insure Oklahoma/~~O-EPIC~~ ESI. Spouses cannot obtain Insure Oklahoma/~~O-EPIC~~ IP coverage if they are eligible for Insure Oklahoma/~~O-EPIC~~ ESI.

(b) The employed or self-employed spouse of an approved applicant must meet the guidelines listed in ~~OAC~~ 317:45-11-20(a) through (g) to be eligible for Insure Oklahoma/~~O-EPIC~~ IP.

(c) The dependent of an applicant approved according to the guidelines listed in ~~OAC~~ 317:45-11-20(h) does not become automatically eligible for Insure Oklahoma/~~O-EPIC~~ IP.

(d) The applicant and the dependents' eligibility are tied together. If the applicant no longer meets the requirements for Insure Oklahoma/~~O-EPIC~~ IP, then the associated dependent enrolled under that applicant is also ineligible.

(e) Dependent college students must enroll under their parents and all annual gross household income (including parent income) must be included in determining eligibility. Independent college students may apply on their own without parent income included in the household. College student status as dependent or independent is determined by the student's current Free Application for Federal Student Aid (FAFSA). College students must also provide a copy of their current student schedule to prove full-time student status.



(f) Dependent children in families whose annual gross household income is from 185 up to and including 300 percent of the Federal Poverty Level may be eligible. The inclusion of children into the Insure Oklahoma program will be phased in over a period of time as determined by the OHCA. No other deductions or disregards apply.

(1) Children found to be eligible for SoonerCare may not receive coverage through Insure Oklahoma.

(2) Children are not eligible for Insure Oklahoma if they are a member of a family eligible for employer-sponsored dependent health insurance coverage under any Oklahoma State Employee Health Insurance Plan.

(3) Children who already have coverage through another source must undergo, or be excepted from, a six month uninsured waiting period prior to becoming eligible for Insure Oklahoma. Exceptions to the waiting period may include:

(A) the cost of covering the family under the ESI plan meets or exceeds 10 percent of the annual gross household income. The cost of coverage includes premiums, deductibles, co-insurance, and co-payments;

(B) loss of employment by a parent which made coverage available;

(C) affordable ESI is not available; "affordable" coverage is defined by the OHCA annually using actuarially sound rates established by the Oklahoma State and Education Employee Group Insurance Board (OSEEGIB);  
or

(D) loss of medical benefits under SoonerCare.

(g) IP approved individuals must notify the OHCA of any changes, including household status and income, that might impact individual and/or dependent eligibility in the program within 30 calendar days of the change.

### **317:45-11-23. Employee eligibility period**

(a) The rules in this subsection apply to applicants eligible according to ~~OAC~~ 317:45-11-20(a) through (e).

(1) The employee's coverage period begins only after receipt of the premium payment.

(A) If the application is received and approved before the 15th of the month, eligibility begins the first day of the second consecutive month. If the application is not received or approved before the 15th of the month, eligibility begins the first day of the 3rd consecutive month. (Examples: An application is received and approved on January 14<sup>th</sup> and the premium is received before February 15<sup>th</sup>, eligibility begins March 1<sup>st</sup>; or an application is received and approved January 15<sup>th</sup> and the premium is received on March 15<sup>th</sup>, eligibility begins April 1<sup>st</sup>.)

(B) If premiums are paid early, eligibility still begins as scheduled.

(2) Employee eligibility is contingent upon the employer meeting the program guidelines.

(3) The employee's eligibility is determined ~~by the TPA~~ using the eligibility requirements listed in ~~OAC~~ 317:45-9-1 or ~~OAC~~ 317:45-11-20(a) through (e).

(4) If the employee is determined eligible for Insure Oklahoma/~~O-EPIC~~ IP, he/she is approved for a period not greater than 12 months. ~~The length of the eligibility period is based on the remaining number of months the employer has left in its eligibility period as defined in OAC 317:45-7-1, 317:45-7-2 and 317:45-7-8.~~

(b) The rules in this subsection apply to applicants eligible according to ~~OAC~~ 317:45-11-20(a) through (c) and ~~OAC~~ 317:45-11-20(f) through (h).

(1) The applicant's eligibility is determined ~~by the TPA~~ using the eligibility requirements listed in ~~OAC~~ 317:45-11-20(a) through (c) and ~~OAC~~ 317:45-11-20(f) through (h).

(2) If the applicant is determined eligible for Insure Oklahoma/~~O-EPIC~~ IP, he/she is approved for a period not greater than 12 months.

(3) The applicant's eligibility period begins only after receipt of the premium payment.

(A) If the application is received and approved before the 15th of the month, eligibility begins the first day of the second consecutive month. If the application is not received or approved before the 15th of the month, eligibility begins the first day of the 3rd consecutive month. (Examples: An application is approved on January 14<sup>th</sup> and the premium is received before February 15<sup>th</sup>, eligibility begins March 1<sup>st</sup>; or an application is approved January 15<sup>th</sup> and the premium is received on March 15<sup>th</sup>, eligibility begins April 1<sup>st</sup>.)

(B) If premiums are paid early, eligibility still begins as scheduled.

### **317:45-11-27. Closure**

(a) Members are mailed a notice 10 days prior to closure of eligibility.

(b) The employer and employees' eligibility are tied together. If the employer no longer meets the requirements for Insure Oklahoma/~~O-EPIC~~ then eligibility for the associated employees enrolled under that employer are also ineligible.

(c) The employee's certification period may be terminated when:

(1) the member requests closure;

(2) the member moves out-of-state;

(3) the covered member dies;

(4) the employer's eligibility ends;

(5) an audit indicates a discrepancy that makes the member or employer ineligible;

(6) the employer is terminated from Insure Oklahoma/~~O-EPIC~~;

(7) the member fails to pay the amount due within 60 days of the date on the bill;

(8) the ~~OMP~~ qualified health plan or carrier ~~is no longer qualified~~ no longer meets the requirements set forth in this chapter;

(9) the member begins receiving ~~SoonerCare/Medicare~~ SoonerCare or Medicare benefits;

(10) the member begins receiving coverage by a private health insurance policy or plan; ~~or~~

(11) the member or employer reports ~~to the OHCA or the TPA~~ any change affecting eligibility-; or

(12) the member no longer meets the eligibility criteria set forth in this Chapter.

(d) This subsection applies to applicants eligible according to ~~OAC~~ 317:45-11-20(a) through (c) and 317:45-11-20(f) through (h). The member's certification period may be terminated when:

(1) the member requests closure;

(2) the member moves out-of-state;

(3) the covered member dies;

(4) the employer's eligibility ends;

(5) an audit indicates a discrepancy that makes the member or employer ineligible;

(6) the member fails to pay the amount due within 60 days of the date on the bill;

(7) the member becomes eligible for ~~SoonerCare/Medicare~~ SoonerCare or Medicare;

(8) the member begins receiving coverage by a private health insurance policy or plan; ~~or~~

(9) the member or employer reports ~~to the OHCA or the TPA~~ any change affecting eligibility;i or

(10) the member no longer meets the eligibility criteria set forth in this Chapter.

### **317:45-11-28. Appeals**

(a) Member appeal procedures based on denial of eligibility due to income are described at ~~OAC~~ 317:2-1-2.

~~(b) Member appeals related to premium payments and/or out-of-pocket expenses are made to the TPA. If the member disagrees with the TPA's findings, reconsideration of the finding may be made to the OHCA. The decision of the OHCA is final.~~

~~(c) Employee appeals regarding out-of-pocket expenses are made to the TPA. If the employee disagrees with the TPA's findings, reconsideration of the finding may be made to the OHCA. The decision of the OHCA is final~~ Member appeals regarding out-of-pocket medical expense reimbursements may be made to the OHCA. The OHCA may request documentation to support the out-of-pocket appeal. The decision of the OHCA is final.

CHAPTER 50. HOME AND COMMUNITY BASED SERVICES WAIVERS

Subchapter 1. Medically Fragile Waiver Services

317:50-1-3. [AMENDED]

(Reference APA WF # 10-13)

**SUMMARY:** Medically Fragile Waiver Services rules are revised to change eligibility requirements for the Program to allow individuals with intellectual disabilities.

**BUDGET IMPACT:** Agency staff has determined that these revisions will be budget neutral.

**MEDICAL ADVISORY COMMITTEE:** The Medical Advisory Committee considered the proposed rule revisions on March 9, 2011, and recommended Board approval.

**AUTHORITY:** The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes

**PUBLIC HEARING:** A public hearing was held on February 22, 2011. No comments were received before, during, or after the hearing.

**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY**

**CHAPTER 50. HOME AND COMMUNITY BASED SERVICES WAIVERS**

**SUBCHAPTER 1. MEDICALLY FRAGILE WAIVER SERVICES**

**317:50-1-3. Medically Fragile Program overview**

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

(1) To receive Medically Fragile Waiver services, individuals must meet the following criteria:

(A) be 19 years of age or older;

(B) have a chronic medical condition which results in prolonged dependency on medical care for which daily skilled intervention is necessary and is characterized by one or more of the following:

(i) a life threatening condition characterized by reasonably frequent periods of acute exacerbation which requires frequent medical supervision and/or physician consultation and which, in the absence of such supervision or consultation, would require hospitalization;

(ii) require frequent time consuming administration of specialized treatments which are medically necessary;

(iii) be dependent on medical technology such that without the technology, a reasonable level of health could not be maintained.

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

(A) meet service eligibility criteria [see OAC 317:50-1-3(d)]; and

(B) meet program eligibility criteria [see OAC 317:50-1-3(e)].

(b) Home and Community Based Waiver Services are outside the scope of state plan Medicaid services. The Medicaid waiver allows the OHCA to offer certain Home and Community Based services to an annually capped number of persons who are categorically needy (refer to OKDHS form 08AX001E, Schedule VIII. B. 1) and without such services would be institutionalized.

(c) Services provided through the Medically Fragile Waiver are:

- (1) case management;
- (2) respite;
- (3) adult day health care;
- (4) environmental modifications;
- (5) specialized medical equipment and supplies;
- (6) physical therapy, occupational therapy, respiratory therapy, speech therapy or consultation;
- (7) advanced supportive/restorative assistance;
- (8) skilled nursing;
- (9) home delivered meals;
- (10) hospice care;
- (11) medically necessary prescription drugs within the limits of the waiver;
- (12) personal care (state plan), Medically Fragile Waiver personal care;
- (13) Personal Emergency Response System (PERS);
- (14) Self Direction; and
- (15) SoonerCare medical services within the scope of the State Plan.

(d) A service eligibility determination is made using the following criteria:

- (1) an open Medically Fragile Waiver Program waiver slot, as authorized by the waiver document approved by the Centers for Medicare and Medicaid Services (CMS), is available to assure federal participation in payment for services to the member. If it is determined that all Medically Fragile Waiver slots are filled, the member cannot be certified as eligible for Medically Fragile Waiver services and the member's name is placed on a waiting list for entry as an open slot becomes available. Medically Fragile Waiver slots and corresponding waiting lists, if necessary, are maintained.
- (2) the member is in the Medically Fragile Waiver targeted service group. The target group is an individual who is age 19 or older with a physical disability and may also have mental retardation or a cognitive impairment.
- (3) the individual does not pose a physical threat to self or others as supported by professional documentation.
- (4) members of the household or persons who routinely visit the household, as supported by professional documentation, do not pose a threat of harm or injury to the individual or other household visitors.

(e) The Medically Fragile Waiver program eligibility determination is made through the service plan approval process. The following criteria are used to make the determination that an individual is not eligible:

- (1) if the individual's needs as identified by UCAT and other professional assessments cannot be met through Medically Fragile Waiver program services, SoonerCare State Plan services and other formal or informal services. The State, as part of the waiver program approval authorization, assures CMS that each waiver member's health, safety, or welfare can be maintained in their home. If an individual's identified needs cannot be met through provision of Medically Fragile Waiver program or SoonerCare State Plan services and other formal or informal services are not in place or immediately available to meet those needs, the individual's health, safety or welfare in their home cannot be assured.
- (2) if the individual poses a physical threat to self or others as supported by professional documentation.
- (3) if other members of the household or persons who routinely visit the

household who, as supported by professional documentation, pose a threat of harm or injury to the individual or other household visitors.

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

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

(f) Professional documentation is provided to support the recommendation for redetermination of program eligibility. The service providers continue providing services according to the service plan as provider safety permits until the member is removed from the Medically Fragile Waiver program. As a part of the procedures requesting redetermination of program eligibility, the OHCA will provide technical assistance to the Provider for transitioning the member to other services.

(g) Individuals determined ineligible for Medically Fragile Waiver program services are notified in writing of the determination and of their right to appeal the decision.

6.a-4 **TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY**  
**CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**  
Subchapter 5. Individual Providers and Specialties  
Part 25. Psychologists  
317:30-5-276. [AMENDED]  
Part 26. Licensed Behavioral Health Professionals  
317:30-5-281. [AMENDED]  
(Reference APA WF # 10-15)

**SUMMARY:** Psychologist rules are revised to update provider requirements, terminology and to require prior authorization of services for all services provided except the initial assessment, health and behavior codes and/or crisis intervention. Revisions require LBHPs and Psychologist to complete a customer data core (CDC) assessment sheet to receive reimbursement for services. The CDC data enables OHCA to review quality of service.

**BUDGET IMPACT:** Agency staff has determined that these revisions are budget neutral.

**MEDICAL ADVISORY COMMITTEE:** The Medical Advisory Committee considered the proposed rule revisions on March 25, 2010, and recommended Board approval.

**AUTHORITY:** The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes

**PUBLIC HEARING:** A public hearing was held on January 19, 2011. No comments were received before, during, or after the hearing.

**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY**  
**CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**  
**PART 25. PSYCHOLOGISTS**

**317:30-5-276. Coverage by category**

(a) **Outpatient Behavioral Health Services.** Outpatient behavioral health services are covered for children as set forth in this Section and following the requirements as defined in the OHCA BH Provider Manual, unless specified otherwise, and when provided in accordance with a documented individualized service plan medical record, developed to treat the identified behavioral health and/or substance abuse disorder(s).

(1) All services are to be for the goal of improvement of functioning, independence, or well being of the member. The services and treatment plans are to be recovery focused, trauma and co-occurring specific. The member must be able to actively participate in the treatment. Active participation means that the member must have sufficient cognitive abilities, communication skills, and short-term memory to derive a reasonable benefit from the treatment.

(2) All outpatient BH services will require authorization through OHCA, or its designated agent, following established medical necessity criteria. Providers are required to follow these criteria and guidelines under the OHCA BH Provider Manual. OHCA does retain final administrative review over both prior authorization and review of services as required by 42 CFR 431.10.

(3) Unauthorized services will not be SoonerCare compensable, unless designated by OHCA.

~~(a)~~ (b) Adults. There is no coverage for adults for services by a psychologist.

~~(b)~~ (c) Children. Coverage for children includes the following services (all services, except Initial or Level of Care Assessment, health and behavior codes and/or Crisis Intervention services, require authorization by OHCA, or its designated agent):

~~(1) Psychiatric Diagnostic Interview Examination (PDIE). The interview and assessment is defined as a face to face interaction with the member. Psychiatric diagnostic interview examination includes a history, mental status, and a disposition, and may include communication with family or other sources, ordering and medical interpretation of laboratory or other medical diagnostic studies. Only one PDIE is allowable per provider. If there has been a break in service over a six month period, then an additional unit can be prior authorized by OHCA, or their designated agent.~~ Bio-Psycho-Social Assessments. Psychiatric Diagnostic Interview Examination (PDIE) initial assessment or Level of Care Assessment. The interview and assessment is defined as a face-to-face interaction with the member. Psychiatric diagnostic interview examination includes a history, mental status, and a disposition, and may include communication with family or other sources, ordering and medical interpretation of laboratory or other medical diagnostic studies. Only one PDIE is allowable per provider per member. If there has been a break in service over a six month period, then an additional unit of PDIE can be prior authorized by OHCA, or their designated agent.

~~(2) Individual and/or Interactive psychotherapy in an outpatient setting including an office, ~~or~~ clinic, or other confidential setting. The services may be performed at the residence of the member if it is demonstrated that it is clinically beneficial, or if the member is unable to go to a clinic or office. Individual psychotherapy is defined as a one to one treatment using a widely accepted modality or treatment framework suited to the individual's age, developmental abilities and diagnosis. It may include specialized techniques such as biofeedback or hypnosis.~~

~~(3) Family Psychotherapy is performed in an outpatient setting limited to an office, clinic, or member's residence~~ other confidential setting. Family therapy is a face-to-face interaction between a therapist and the patient/family to facilitate emotional, psychological or behavioral changes and promote communication and understanding. Family therapy must be provided for the benefit of a SoonerCare eligible child as a specifically identified component of an individual treatment plan.

~~(4) Group and/or Interactive Group psychotherapy in an outpatient setting must be performed in the psychologist's office, clinic, or other confidential setting. Group therapy is a face to face interaction between a therapist and two or more unrelated patients (though there may be siblings in the same group, just not siblings only) to facilitate emotional, psychological, or behavioral changes. All group therapy records must indicate group size. Maximum total group size is eight~~ six patients for children four years of age up to the age of 18. Groups 18-20 year olds can include eight individuals. Group therapy must be provided for the benefit of a SoonerCare eligible child four years of age or older as a specifically identified component of an individual treatment plan. Multi-family group therapy size is limited to eight family units.

~~(5) Psychological, Developmental, Neuropsychological, Neurobehavioral Testing is clinically appropriate and allowable when an accurate diagnosis and determination of treatment needs is needed. Assessment/Evaluation and testing is provided by a psychological technician of a psychologist or a LBHP utilizing tests selected from currently accepted assessment test batteries. For assessments conducted in a school setting, the Oklahoma~~



State Department of Education requires that a licensed supervisor sign the assessment. ~~Four~~ Eight hours/units of testing per patient (over the age of two), per provider is allowed ~~without prior~~ with authorization every 12 months. In circumstances where it is determined that further testing is medically necessary, and or needed for specialty testing, additional hours/units may be prior authorized by the OHCA or designated agent based upon medical necessity and consultation review. ~~In circumstances where there is a clinical need for specialty testing, then more hours/units of testing can be authorized.~~ Test results must be reflected in the service plan or medical record. The service must clearly document the need for the testing and what the testing is expected to achieve. Any testing performed for a child under three must be prior authorized. Testing units must be billed on the date the testing, interpretation, scoring, and/or reporting was performed and supported by documentation.

~~(6) Payment for therapy services provided by a psychologist to any one member is limited to five sessions/units per month without prior authorization. In circumstances where it is determined that further sessions/units are medically necessary, then more sessions/units can be prior authorized by the Oklahoma Health Care Authority or their designated agent. A maximum of 12 sessions/units of therapy and testing services per day per provider are allowed. Health and Behavior codes B behavioral health services are available only to chronically and severely medically ill children.~~

~~(7) A child who is being treated in an acute inpatient setting can receive separate Psychological services as the inpatient per diem is for "non-physician" services only. Crisis intervention services for the purpose of stabilization and hospital diversion as clinically appropriate.~~

~~(8) A child receiving Residential Behavioral Management in a foster home, also known as therapeutic foster care, or a child receiving Residential Behavioral Management in a group home, also known as therapeutic group home, may not receive individual, group or family counseling or psychological testing without prior authorization by the OHCA or its designated agent. Payment for therapy services provided by a psychologist to any one member is limited to eight sessions/units per month. All units/sessions, except the Initial or Level of Care Assessments or Crisis Intervention must be authorized by the OHCA or its designated agent. A maximum of 12 sessions/units of therapy and testing services per day per provider are allowed. Case Management services are considered an integral component of the behavioral health services listed above.~~

~~(9) A child who is being treated in an acute psychiatric inpatient setting can receive separate Psychological services as the inpatient per diem is for "non-physician" services only.~~

~~(10) A child receiving Residential Behavioral Management in a foster home, also known as therapeutic foster care, or a child receiving Residential Behavioral Management in a group home, also known as therapeutic group home, may not receive individual, group or family counseling or psychological testing without prior authorization by the OHCA or its designated agent.~~

~~(e)~~ **(d) Home and Community Based Waiver Services for the Mentally Retarded.** All providers participating in the Home and Community Based Waiver Services for the mentally retarded program must have a separate contract with this Authority to provide services under this program. All services are specified in the individual's plan of care.

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

(a) **Outpatient Behavioral Health Services.** Outpatient behavioral health services are covered for children as set forth in this Section and following the requirements as defined in the OHCA BH Provider Manual, unless specified otherwise, and when provided in accordance with a documented individualized service plan and/or medical record, developed to treat the identified behavioral health and/or substance abuse disorder(s).

(1) All services are to be for the goal of improvement of functioning, independence, or well being of the member. The services and treatment plans are to be recovery focused, trauma and co-occurring specific. The member must be able to actively participate in the treatment. Active participation means that the member must have sufficient cognitive abilities, communication skills, and short-term memory to derive a reasonable benefit from the treatment.

(2) All outpatient BH services will require authorization through OHCA, or its designated agent, following established medical necessity criteria. Providers are required to follow these criteria and guidelines under the OHCA BH Provider Manual. OHCA does retain final administrative review over both prior authorization and review of services as required by 42 CFR 431.10.

(3) Unauthorized services will not be SoonerCare compensable, unless designated by OHCA.

(b) **Adults.** There is no coverage for adults for services by a LBHP.

(c) **Children.** Coverage for children includes the following services (all services, except for the Initial or Level of Care Assessments or Crisis Intervention, require authorization by OHCA or its designated agent, providers listed in 317:30-5-280(a)(1),(a)(3)and (a)(4) are exempt from authorization):

(1) **Bio-Psycho-Social and Level of Care Assessments.**

(A) The interview and assessment is defined as a face-to-face interaction with the member. Assessment includes a history, mental status, full bio-psycho-social evaluation, a disposition, communications with family or other sources, review of laboratory or other pertinent medical information, and medical/clinical consultations as necessary.

(B) Assessments for Children's Level of Care determination of medical necessity must follow a specified assessment process through OHCA or their designated agent. Only one assessment is allowable per provider per member. If there has been a break in service over a six month period, or the assessment is conducted for the purpose of determining a child's need for inpatient psychiatric admission, then an additional unit can be authorized by OHCA, or their designated agent.

(2) Individual and/or Interactive psychotherapy in an outpatient setting including an office, clinic, or other confidential setting. The services may be performed at the residence of the member if it is demonstrated that it is clinically beneficial, or if the member is unable to go to a clinic or office. Individual psychotherapy is defined as a one to one treatment using a widely accepted modality or treatment framework suited to the individual's age, developmental abilities and diagnosis. It may include specialized techniques such as biofeedback or hypnosis.

(3) Family Psychotherapy is performed in an outpatient setting limited to an office, clinic, or other confidential setting. Family therapy is a face-to-face interaction between a therapist and the patient/family to facilitate emotional, psychological or behavioral changes and promote communication and understanding. Family therapy must be provided for the benefit of the member as a specifically identified component of an individual treatment plan.

(4) Group and/or Interactive Group psychotherapy in an outpatient setting must be performed in an office, clinic, or other confidential setting. Group therapy is a face-to-face interaction between a therapist and two or more unrelated patients (though there may be siblings in the same group, just not siblings only) to facilitate emotional, psychological, or behavioral changes. All group therapy records must indicate group size. Maximum total group size is six for ages four up to 18. Groups 18-20 year olds can include eight individuals. Group therapy must be provided for the benefit of the member as a specifically identified component of an individual treatment plan. Multi-family group therapy size is limited to eight family units.

(5) Assessment/Evaluation and testing is provided by a psychologist, certified psychometrist, psychological technician of a psychologist or a LBHP utilizing tests selected from currently accepted assessment test batteries. For assessments conducted in a school setting, the Oklahoma State Department of Education requires that a licensed supervisor sign the assessment. Eight hours/units of testing per patient (over the age of two), per provider is allowed with authorization every 12 months. In circumstances where it is determined that further testing is medically necessary and/or needed for specialty testing, additional hours/units may be prior authorized by the OHCA or designated agent based upon medical necessity and consultation review. Test results must be reflected in the service plan or medical record. The service plan must clearly document the need for the testing and what the testing is expected to achieve. Any testing performed for a child under three must be prior authorized. Testing units must be billed on the date the testing, interpretation, scoring, and/or reporting was performed and supported by documentation.

(6) Crisis intervention services for the purpose of stabilization and hospitalization diversion as clinically appropriate.

(7) Payment for therapy services provided by a LBHP to any one member is limited to eight sessions/units per month. All units/sessions, except Assessment and Crisis Intervention must be authorized by the OHCA or their designated agent. A maximum of 12 sessions/units of therapy and testing services per day per provider are allowed. Case Management services are considered an integral component of the behavioral health services listed above.

(8) A child receiving Residential Behavioral Management in a foster home, also known as therapeutic foster care, or a child receiving Residential Behavioral Management in a group home, also known as therapeutic group home, may not receive individual, group or family counseling or testing without authorization by the OHCA or their designated agent.

(d) **Home and Community Based Waiver Services for the Mentally Retarded.** All providers participating in the Home and Community Based Waiver Services for the mentally retarded program must have a separate contract with this Authority to provide services under this program. All services are specified in the individual's plan of care.

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

6.a-5 **TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY**  
**CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**  
Subchapter 5. Individual Providers and Specialties  
Part 21. Outpatient Behavioral Health Services  
317:30-5-241.1  
(Reference APA WF # 10-18)

**SUMMARY:** Rules are being revised to reflect behavioral health assessments and service plan development may only be provided by licensed behavioral health professionals. Currently, bachelor level Certified Alcohol and Drug Counselors (CADCs) may perform substance abuse assessments in accordance with their Licensure Act. Due to accreditation standard requirements for Assessments, all outpatient agencies are required to conduct full bio-psycho-social assessments by a licensed Masters level professional. As a result, ODMHSAS and OHCA collaboratively agreed to restrict the realm of behavioral health assessments to licensed behavioral health professionals and disallow the use of CADC's for substance abuse assessments.

**BUDGET IMPACT:** Agency staff has determined that these revisions are budget neutral.

**MEDICAL ADVISORY COMMITTEE:** The Medical Advisory Committee considered the proposed rule revisions on March 25, 2010, and recommended Board approval.

**AUTHORITY:** The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes

**PUBLIC HEARING:** A public hearing was held on January 19, 2011. No comments were received before, during, or after the hearing.

**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY**  
**CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**  
**PART 21. OUTPATIENT BEHAVIORAL HEALTH SERVICES**

**317:30-5-241.1 Screening, assessment and service plan**

All providers must comply with the requirements as set forth in the OHCA BH Provider Billing Manual.

(1) **Screening.**

(A) **Definition.** Screening is for the purpose of determining whether the member meets basic medical necessity and need for further BH assessment and possible treatment services.

(B) **Qualified professional.** Screenings can be performed by any credentialed staff members as listed under OAC 317:30-5-240.3.

(C) **Target population.** This service is compensable only on behalf of a member who is under a PACT program.

(2) **Assessment.**

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

(B) **Qualified professional.** This service is performed by an LBHP ~~or AODTP~~ for AOD. CADCs are permitted to provide Drug and Alcohol

assessments through June 30, 2010. Effective July 1, 2010 all assessments must be provided by LBHPs.

(C) **Time requirements.** The minimum face-to-face time spent in assessment session(s) with the member and others as identified previously in paragraph (1) of this subsection for a low complexity Behavioral Health Assessment by a Non-Physician is one and one half hours. For a moderate complexity, it is two hours or more.

(D) **Target population and limitations.** This service is compensable on behalf of a member who is seeking services for the first time from the contracted agency. This service is not compensable if the member has previously received or is currently receiving services from the agency, unless there has been a gap in service of more than six months and it has been more than one year since the previous assessment.

(3) **Behavioral Health Services Plan Development.**

(A) **Definition.** The Behavioral Health Service Plan is developed based on information obtained in the assessment and includes the evaluation of all pertinent information by the practitioners and the member. It includes a discharge plan. It is a process whereby an individualized rehabilitation plan is developed that addresses the members strengths, functional assets, weaknesses or liabilities, treatment goals, objectives and methodologies that are specific and time limited, and defines the services to be performed by the practitioners and others who comprise the treatment team. BH Service Plan Development is performed with the direct active participation of the member and a member support person or advocate if requested by the member. In the case of children under the age of ~~16~~ 18, it is performed with the participation of the parent or guardian and the child as age and developmentally appropriate, and must address school and educational concerns and assisting the family in caring for the child in the least restrictive level of care. For adults, it is focused on recovery and achieving maximum community interaction and involvement including goals for employment, independent living, volunteer work, or training.

(B) **Qualified professional.** This service is performed by an LBHP ~~or AODTP for AOD~~.

(C) **Time requirements.** Service Plan updates are required every six months during active treatment. Updates can be conducted whenever needed as determined by the provider and member.

(4) **Assessment/Evaluation testing.**

(A) **Definition.** Assessment/Evaluation testing is provided by a clinician utilizing tests selected from currently accepted assessment test batteries. Test results must be reflected in the Service Plan. The medical record must clearly document the need for the testing and what the testing is expected to achieve.

(B) **Qualified professionals.** Assessment/Evaluation testing will be provided by a psychologist, certified psychometrist, psychological technician of a psychologist or a LBHP. For assessments conducted in a school setting, the Oklahoma State Department of Education requires that a licensed supervisor sign the assessment.

6.a-6 **TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY**  
**CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**  
Subchapter 5. Individual Providers and Specialties  
Part 62. Private Duty Nursing  
317:30-5-556. [AMENDED]  
317:30-5-560. [AMENDED]  
(Reference APA WF # 10-23)

**SUMMARY:** Rules are revised clarify that Private Duty Nursing (PDN) is available to eligible individuals in their primary residence and to remove the requirement that treatment plans for (PDN) be updated and signed by the member's physician annually

**BUDGET IMPACT:** Agency staff has determined that these revisions are budget neutral.

**MEDICAL ADVISORY COMMITTEE:** The Medical Advisory Committee considered the proposed rule revisions on May 20, 2010, and recommended Board approval.

**AUTHORITY:** The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes

**PUBLIC HEARING:** A public hearing was held on February 22, 2011. No comments were received before, during, or after the hearing.

**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY**  
**CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**  
**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**  
**PART 62. PRIVATE DUTY NURSING**

**317:30-5-556. Definitions**

~~The definition of private~~ Private duty nursing is medically necessary care provided on a regular basis by a Licensed Practical Nurse or Registered Nurse in the member's primary residence or to assist outside the home during transport to medical appointments and emergency room visits in lieu of transport by ambulance.

**317:30-5-560. Treatment Plan**

(a) An eligible organization must create a treatment plan for the member as part of the authorization process for private duty nursing services. The initial treatment plan must be signed by the member's attending physician. ~~It must be updated and signed annually.~~

(b) The treatment plan must include all of the following medical and social data so that ~~OHCA Care Managers~~ an OHCA Care Management Nurse can appropriately determine medical necessity by the use of the Private Duty Nursing Acuity Grid:

- (1) diagnosis;
- (2) prognosis;
- (3) anticipated length of treatment;
- (4) number of hours of private duty nursing requested per day;
- (5) assessment needs and frequency (e.g., vital signs, glucose checks, neuro checks, respiratory);
- (6) medication method of administration and frequency;
- (7) age-appropriate feeding requirements (diet, method and frequency);
- (8) respiratory needs;

- (9) mobility requirements including need for turning and positioning, and the potential for skin breakdown;
- (10) developmental deficits;
- (11) casting, orthotics, therapies;
- (12) age-appropriate elimination needs;
- (13) seizure activity and precautions;
- (14) age-appropriate sleep patterns;
- (15) disorientation and/or combative issues;
- (16) age-appropriate wound care and/or personal care;
- (17) communication issues;
- (18) social support needs;
- (19) name, skill level, and availability of all caregivers; and
- (20) other pertinent nursing needs such as dialysis, isolation.

6.a-7 **TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY**  
**CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**  
Subchapter 5. Individual Providers and Specialties  
Part 21. Outpatient Behavioral Health Services  
317:30-5-241. [AMENDED]  
(Reference APA WF # 10-29)

**SUMMARY:** Outpatient Behavioral Health Rules are revised to refer to the Behavioral health provider reference tool as the Behavioral Health Manual rather than the Behavioral Health Billing Manual as well as to clean up discrepancies between OHCA and ODMHSAS policy for consistency.

**BUDGET IMPACT:** Agency staff has determined that these revisions are budget neutral.

**MEDICAL ADVISORY COMMITTEE:** The Medical Advisory Committee considered the proposed rule revisions on May 20, 2010, and recommended Board approval.

**AUTHORITY:** The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes

**PUBLIC HEARING:** A public hearing was held on January 19, 2011. No comments were received before, during, or after the hearing.

**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY**  
**CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**  
**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**  
**PART 21. OUTPATIENT BEHAVIORAL HEALTH SERVICES**

**317:30-5-241. Covered Services**

(a) Outpatient behavioral health services are covered for adults and children as set forth in this Section and following the requirements as defined in the OHCA BH Provider ~~Billing~~ Manual, unless specified otherwise, and when provided in accordance with a documented individualized service plan, developed to treat the identified behavioral health and/or substance abuse disorder(s).

(b) All services are to be for the goal of improvement of functioning, independence, or well being of the member. The services and treatment plans are to be recovery focused, trauma and co-occurring specific. The member must be able to actively participate in the treatment. Active participation means that the member must have sufficient cognitive abilities, communication skills, and short-term memory to derive a reasonable benefit from the treatment.

(c) All outpatient BH services will require ~~prior~~ authorization through OHCA, or its designated agent, following established medical necessity criteria. Providers are required to follow these criteria and guidelines under the OHCA BH Provider ~~Billing~~ Manual. ~~The OHCA or its designated agent who performs the services identified in paragraph (1) of this subsection uses its independent medical judgment to perform both the review of services and the prior authorization of services.~~ OHCA does retain final administrative review over both prior authorization and review of services as required by 42 CFR 431.10.

(d) ~~Non-prior-authorized Unauthorized services will not be SoonerCare compensable, unless designated by OHCA with the exception of the initial 1-4~~



~~sessions (to be used prior to completion of the Service Plan), Assessment Service Plan (moderate complexity), Crisis Intervention, and Adult Facility Based Crisis Stabilization.~~

6.a-8 **TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY**  
**CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**  
Subchapter 5. Individual Providers and Specialties  
Part 21. Outpatient Behavioral Health Services  
317:30-5-241.2. [AMENDED]  
(Reference APA WF # 10-53)

**SUMMARY:** Outpatient Behavioral Health rules are revised to change the definition of Partial Hospitalization Services (PHP) to require that the services are reasonable and necessary for the diagnosis and active treatment of the member's condition, are reasonably expected to improve or maintain the member's condition and are provided in accordance with the Code of Federal Regulations. The original Emergency rule adding PHP as a covered SoonerCare service was adopted in November 2010. PHP consists of a package of therapeutically intensive clinical services offered in community and family based programs and is a component of the behavioral health residential treatment center (RTC) diversion project which focuses on alternative levels of treatment services aimed at stepping individuals down from inpatient facilities and into clinically appropriate settings offering lower levels of care.

**BUDGET IMPACT:** Agency staff has determined that the most recent revisions under review at this time are budget neutral.

**MEDICAL ADVISORY COMMITTEE:** The Medical Advisory Committee considered the proposed rule revisions on November 17, 2010, and recommended Board approval.

**AUTHORITY:** The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes

**PUBLIC HEARING:** A public hearing was held on February 22, 2011. Written comments were received before the public hearing regarding these changes and were considered during the rulemaking process.

**CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**  
**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**  
**PART 21. OUTPATIENT BEHAVIORAL HEALTH SERVICES**

**317:30-5-241.2. Psychotherapy**

(a) **Individual/Interactive Psychotherapy.**

(1) **Definition.** Individual Psychotherapy is a face-to-face treatment for mental illnesses and behavioral disturbances, in which the clinician, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior and encourage growth and development. Insight oriented, behavior modifying and/or supportive psychotherapy refers to the development of insight of affective understanding, the use of behavior modification techniques, the use of supportive interactions, the use of cognitive discussion of reality, or any combination of these items to provide therapeutic change.

(2) **Definition.** Interactive Psychotherapy is individual psychotherapy that involves the use of play therapy equipment, physical aids/devices, language interpreter, or other mechanisms of nonverbal communication to overcome barriers to the therapeutic interaction between the clinician and the member who has not yet developed or who has lost the expressive

language communication skills to explain his/her symptoms and response to treatment, requires the use of a mechanical device in order to progress in treatment, or the receptive communication skills to understand the clinician. The service may be used for adults who are hearing impaired and require the use of language interpreter.

(3) **Qualified professionals.** With the exception of a qualified interpreter if needed, only the member and the LBHP Licensed Behavioral Health Professional (LBHP) or AODTP Certified Alcohol and Drug Counselor (CADC), for substance abuse (SA) only, should be present and the setting must protect and assure confidentiality. Ongoing assessment of the member's status and response to treatment as well as psycho-educational intervention are appropriate components of individual counseling. The counseling must be goal directed, utilizing techniques appropriate to the service plan and the member's developmental and cognitive abilities. Individual/Interactive counseling must be provided by a LBHP or CADC ~~when treatment is for a mental illness~~ and by an AODTP when treatment is for an alcohol or other drug disorder only.

(4) **Limitations.** A maximum of 6 units per day per member is compensable.

(b) **Group Psychotherapy.**

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

(2) **Group sizes.** Group Psychotherapy is limited to a total of eight adult (18 and over) individuals except when the individuals are residents of an ICF/MR where the maximum group size is six. For all children under the age of 18, the total group size is limited to six.

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

(4) **Qualified professionals.** Group psychotherapy will be provided by a LBHP or CADC ~~when treatment is for a mental illness and by an AODTP when treatment is for~~ an alcohol or other drug disorder only. Group Psychotherapy must take place in a confidential setting limited to the LBHP ~~or the AODTP~~ CADC conducting the service, an assistant or co-therapist, if desired, and the group psychotherapy participants.

(5) **Limitations.** A maximum of 12 units per day per member is compensable.

(c) **Family Psychotherapy.**

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

(2) **Qualified professionals.** Family Psychotherapy must be provided by a LBHP or CADC ~~when treatment is for a mental illness and by an AODTP when treatment is for~~ an alcohol or other drug disorder only.

(3) **Limitations.** A maximum of 12 units per day per member/family unit is compensable.

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

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

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

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

(1) **Definition.** Partial hospitalization services are services that (1) Are reasonable and necessary for the diagnosis or active treatment of the member's condition; (2) Are reasonably expected to improve or maintain the member's condition and functional level and to prevent relapse or hospitalization and (3) Are provided in accordance with services outlined in 42 CFR 410.43.

(2) **Qualified professionals.** All services in the PHP are provided by a team, which must be composed of one or more of the following participants: physician, registered nurse, licensed behavioral health professional (LBHP), a case manager, or other certified Behavioral Health/Substance Abuse paraprofessional staff. Refer to OHCA BH Provider Manual for further requirements. The treatment plan is directed under the supervision of a physician.

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

(4) **Limitations.** Services are limited to children 0-20 only. Services must be offered at a minimum of 3 hours per day, 5 days per week. Therapeutic services are limited to 4 billable hours per day and must be prior authorized. PHP services are all inclusive with the exception of physician services and drugs that cannot be self-administered, those services are separately billable. Refer to OHCA BH Provider Billing Manual for further definition.

(5) **Reporting.** Reporting requirements must be followed as outlined in the OHCA BH Provider Billing Manual.

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

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

(2) **Qualified professionals.** All services in Day Treatment are provided by a team, which must be composed of one or more of the following participants: physician, registered nurse, licensed behavioral health professional (LBHP), a case manager, or other certified Behavioral Health/Substance Abuse paraprofessional staff. Refer to OHCA BH Provider Billing Manual for further requirements. Services are directed by an LBHP.

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

(4) **Limitations.** Services must be offered at a minimum of 4 days per week at least 3 hours per day. Refer to OHCA BH Provider Billing Manual for further requirements.

6.a-9 **TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY**  
**CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**  
Subchapter 3. General Provider Policies  
Part 1. General Scope and Administration  
317:30-3-5. [AMENDED]  
(Reference APA WF # 10-56)

**SUMMARY:** SoonerCare cost sharing rules are revised to comply with Federal law on Native American cost-sharing exemptions. Native Americans are now exempt from SoonerCare co-pays or premiums when they receive services provided by I/T/U providers or through referral by contract health services. Rules are also revised to correspond with CMS nominal cost share guidelines pertaining to prescription co-pays as well as clarify that a member's cost sharing liability is capped at 5% of the member's gross annual income.

**BUDGET IMPACT:** Agency staff has determined that these revisions will have a total annual budget impact of \$876,206 total; State share of \$205,402.

**MEDICAL ADVISORY COMMITTEE:** The Medical Advisory Committee considered the proposed rule revisions on January 20, 2011, and recommended Board approval.

**AUTHORITY:** The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; Section 5006(a) of the American Recovery and Reinvestment Act of 2009; 42 CFR 447.54

**PUBLIC HEARING:** A public hearing was held on February 22, 2011. One comment was received before the public hearing and was considered during the rulemaking process.

**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY**  
**CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**  
**SUBCHAPTER 3. GENERAL PROVIDER POLICIES**  
**PART 1. GENERAL SCOPE AND ADMINISTRATION**

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

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

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

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

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

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

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

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

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

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

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

(2) In the event there is a disagreement whether the services are in or out of the scope of the contracts referenced in (1) of this subsection, the Oklahoma Health Care Authority shall be the final authority for this decision. The provider seeking payment under the SoonerCare Program may appeal to OHCA under the provisions of OAC 317:2-1-2.1.

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

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

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

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

(B) Members in nursing facilities and intermediate care facilities for the mentally retarded.

(C) Pregnant women.

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

(E) Native Americans providing documentation of ethnicity in accordance with 317:35-5-25 who receive items and services furnished by the Indian Health Service, an Indian Tribe, Tribal Organization, or

Urban Indian Organization or through referral under contract health services.

- (2) Co-payment is not required for the following services:
- (A) Family planning services. Includes all contraceptives and services rendered.
  - (B) Emergency services provided in a hospital, clinic, office, or other facility.
- (3) Co-payments are required in an amount not to exceed the federal allowable for the following:
- (A) Inpatient hospital stays.
  - (B) Outpatient hospital visits.
  - (C) Ambulatory surgery visits including free-standing ambulatory surgery centers.
  - (D) Encounters with the following rendering providers:
    - (i) Physicians,
    - (ii) Advanced Practice Nurses,
    - (iii) Physician Assistants,
    - (iv) Optometrists,
    - (v) Home Health Agencies,
    - (vi) Certified Registered Nurse Anesthetists, ~~and~~
    - (vii) Anesthesiologist Assistants,
    - (viii) Durable Medical Equipment providers, and
    - (ix) Outpatient behavioral health providers.
  - (E) Prescription drugs.
    - (i) Zero for preferred generics.
    - ~~(ii) \$2.00 for prescriptions having a SoonerCare allowable of \$29.99 or less.~~
    - ~~(iii) \$3.00 for prescriptions having a SoonerCare allowable of \$30.00 or more.~~
    - (ii) \$0.65 for prescriptions having a SoonerCare allowable payment of \$0.00-\$10.00.
    - (iii) \$1.20 for prescriptions having a SoonerCare allowable payment of \$10.01-\$25.00.
    - (iv) \$2.40 for prescriptions having a SoonerCare allowable payment of \$25.01-\$50.00.
    - (v) \$3.50 for prescriptions having a SoonerCare allowable payment of \$50.01 or more.
  - (F) Crossover claims. Dually eligible Medicare/SoonerCare members must make a co-payment in an amount that does not exceed the federal allowable per visit/encounter for all Part B covered services. This does not include dually eligible HCBS waiver members.
- (4) Aggregate cost-sharing liabilities in a given calendar year may not exceed 5% of the member's gross annual income.



6.a-10 **TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY**  
**CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**  
Subchapter 5. Individual Providers-Fee For Service  
317:30-5-700. [AMENDED]  
317:30-5-700.1. [AMENDED]  
(Reference APA WF # 10-58)

**SUMMARY:** Orthodontia rules are revised to clarify eligibility requirements for SoonerCare Orthodontic services; clarify provider requirements for General or Pediatric dental practitioners who have completed at least 200 certified hours of continuing education in the field of orthodontics practice; and remove references to Relative Value Units (RVU's) as well as other minor formatting revisions.

**BUDGET IMPACT:** Agency staff has determined that these revisions are budget neutral.

**MEDICAL ADVISORY COMMITTEE:** The Medical Advisory Committee considered the proposed rule revisions on March 9, 2011, and recommended Board approval.

**AUTHORITY:** The Oklahoma Health Care Authority Board; the Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes

**PUBLIC HEARING:** A public hearing was held on February 22, 2011. Written comments were received before the hearing and were considered during the rulemaking process.

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

**317:30-5-700. Orthodontic services**

(a) In order to be eligible for SoonerCare Orthodontic services, members must be referred through a primary care dentist; a member can receive a referral from a primary care dentist to the orthodontist only after meeting the following:

- (1) the member has had a caries free initial visit; or
- (2) has all decayed areas restored and has received a six month hygiene evaluation indicating the member remains caries free; and
- (3) has demonstrated competency in maintaining an appropriate level of oral hygiene.

(b) Member with cleft palate can be referred directly by their treating physician without a dental referral and are exempt from above requirements.

(c) The Oklahoma State Medicaid SoonerCare Orthodontic Program limits orthodontic services to handicapping malocclusions determined to be severe enough to warrant medically necessary treatment. The orthodontic provider has the ability to determine if members may qualify with a visual screening. Diagnostic record accumulation and/or submission should only occur for members with high potential for acceptance. These orthodontic services include the following:

- (1) a handicapping malocclusion, as measured on the Handicapping Labio-Lingual Deviation Index (HLD) with a minimum score of 30; and
- (2) any classification secondary to cleft palate or other maxillofacial deformity- ;

(3) if a single tooth or anterior crossbite is the only medical need finding, service will be limited to interceptive treatment;

(4) fixed appliances only; and

(5) permanent dentition with the exception of cleft defects.

~~(b)~~ (d) Reimbursement for Orthodontic services is limited to:

(1) Orthodontists, or

(2) General or Pediatric dental practitioners who have completed at least 200 certified hours of continuing education in the field of orthodontics practice in an under served area, and successfully completed at least 25 comprehensive cases to include 10 or more extraction cases, and submit for review at least 25 successfully completed comprehensive cases. Of these 25 comprehensive cases, ten or more must be extraction cases. An applicant for this certification must practice in an OHCA deemed under served area. The comprehensive cases submitted should be of a complexity consistent with type of handicapping Malocclusion likely to be treated in the SoonerCare program.

(A) Cases submitted must include at least one of each of the following types:

(i) deep overbite where multiple teeth are impinging upon the soft tissue of the palate;

(ii) impacted canine or molar requiring surgical exposure;

(iii) bilateral posterior crossbite requiring fixed rapid palatal expansion; and

(iv) skeletal class II or III requiring orthognathic surgery.

~~(A)~~ (B) As with all dental or orthodontia treatment performed and reimbursed by Medicaid SoonerCare, all pre and post orthodontic records must be available for review.

~~(B)~~ (C) Verification of the continuing education hours and the number of cases completed are reviewed by the OHCA Dental Unit every two years.

~~(e)~~ (e) The following limitations apply to orthodontic services:

(1) Cosmetic orthodontic services are not a covered benefit of the Oklahoma State Medicaid SoonerCare Program and no requests should be submitted;

(2) All orthodontic procedures require prior authorization for payment;

(3) Prior authorization for orthodontic treatment is not a notification of the ~~patient's~~ member's eligibility and does not guarantee payment. Payment for authorized services depends on the ~~client's~~ member's eligibility at the beginning of each treatment year;

(4) The ~~client~~ member must be Medicaid eligible SoonerCare-eligible and under 18 years of age at the time the request for prior authorization for treatment is received by the OHCA and on the date that the last year of orthodontic service is to begin. Services cannot be added or approved after eligibility has expired:

(A) ~~Clients~~ Members receive a permanent Medical Identification Card;

(B) It is the orthodontist's responsibility to verify that the ~~patient~~ member has current Medicaid SoonerCare eligibility and the date of birth indicates the ~~client~~ member is under age 18.

~~(d)~~ (f) Orthodontic services are an elective procedure. The orthodontist must interview the prospective ~~patient~~ member as to his/her understanding of and willingness to cooperate fully in a lengthy treatment program.

~~(e)~~ (g) The interview information is unavailable to OHCA except through the provider's recommendation of treatment. The interview process for OHCA ~~clients~~ members is equivalent to that of private pay patients.

~~(f)~~ (h) Providers are not obligated to accept a ~~client~~ member when it appears that the ~~client~~ member will not cooperate in the orthodontic hygiene

treatment program, does not return to the general dentist for preventive visits or is not willing to keep eligibility for Medicaid SoonerCare current.

### 317:30-5-700.1. Orthodontic prior authorization

(a) The following records and documentation, plainly labeled with the ~~patient's~~ member's full name, recipient identification number (RID), and the orthodontist's name are required for prior authorization of orthodontic services ~~for a child~~ and must be submitted to the Dental ~~Authorization~~ Unit of the OHCA ~~for review~~ when the member has a total score of not less than 30 points or meets other eligibility criteria in paragraph (d).

(1) Completed currently approved ADA dental claim form;

(2) Complete and scored Handicapping Labio-Lingual Deviations Index with Diagnosis of Angle's classification;

(3) Detailed description of any ~~oromaxillofacial~~ oral maxillofacial anomaly;

(4) Estimated length of treatment;

(5) ~~Delineation of each stage, the service to be provided and length of treatment required for each stage if multi stage treatment is indicated~~ Intraoral photographs showing teeth in centric occlusion and/or photographs of trimmed anatomically occluded diagnostic casts. A lingual view of casts may be included to verify impinging overbites;

~~(6) Properly occluded and anatomically trimmed study models or 3 D model images;~~

~~(7)~~(6) Cephalometric x-rays with tracing, and panoramic film, ~~and facial photographs~~ with a request for prior authorization of comprehensive orthodontic treatment;

~~(8)~~(7) If diagnosed as a surgical case, submit An ~~an~~ oral surgeon's written opinion that orthognathic surgery ~~or bone grafting~~ is indicated and the surgeon is willing to provide this service; ~~and~~

~~(9)~~(8) Additional pertinent information as determined necessary by the orthodontist or as requested by the ~~OHCA's Orthodontic Consultant~~ OHCA.

(b) ~~Models~~ All images, x-rays, and ~~all~~ required documentation must be submitted in one package. OHCA is not responsible for lost or damaged materials.

(c) All records and documentation submitted in a request for prior authorization for orthodontic treatment are reviewed by the OHCA Orthodontic Consultant for compensability and length of treatment. Any documentation on which a decision is made will not be returned.

(d) Some children not receiving a minimum score of 30 on the Handicapping Labio-Lingual Deviation Index (HLD) may have other conditions to be considered. In the event an orthodontist believes there are other medical, social, or emotional conditions impacting the general health of the child, he/she refers to the conditions listed on the EPSDT exception section found on the HLD. The following guidelines and restrictions apply to other conditions:

(1) Other medical, social, or emotional conditions are limited to those conditions that affect the medical, social or emotional function of the child.

(2) Other medical, social, or emotional conditions are not scored if the sole condition sought to be improved is the cosmetic appearance of the child.

(3) Such other medical, social, or emotional conditions must be demonstrated by objective evidence such as supported documentation outside the child's immediate family (i.e., a child's teacher, primary care physician, ~~mental~~ behavioral health provider, school counselor).

(4) Objective evidence must be submitted with the HLD.

(5) When such other medical, social, or emotional conditions are reflected on the HLD, the OHCA Orthodontic Consultant must review the data and use his or her professional judgment to score the value of the conditions.

(6) The OHCA Orthodontic Consultant may consult with and utilize the opinion of the orthodontist who completes the form.

(e) If it is determined that the malocclusion is not severe enough to warrant medically necessary orthodontic services or the ~~patient's~~ member's age precludes approval, a computer generated notice is issued to the provider and ~~recipient~~ member with notice of the denial, the reason for the denial, and appeal rights (see OAC 317:2-1 for grievance procedures and process).

(f) Orthodontic treatment and payment for the services are approved within the scope of ~~Medicaid~~ SoonerCare. If orthodontic treatment is approved, a computer generated notice is issued authorizing the first year of treatment.

(1) Approval of orthodontic treatment is given in accordance with the following:

(A) Authorization for the first year includes the ~~banding and wires and the first year of adjustments~~ placement of appliances, arch wires, and a minimum of six adjustments. It is expected that orthodontic members be seen every four to eight weeks for the duration of active treatment.

(B) Subsequent adjustments will be authorized in one year intervals and the treating orthodontist must provide a comprehensive progress report at the 24 month interval.

(C) All approved treatment is included on the original prior authorization and will include the total payment for that treatment year.

(2) Claim and payment are made as follows:

(A) Payment for the first year of treatment includes the banding, wires, and adjustments as well as all ancillary services, including the removal of appliances, and the construction and placing of retainers. ~~The authorization number must be included on all claims submitted for processing.~~

~~(B) The provider files one claim at the beginning of each treatment year for the entire year.~~

~~(C) (B)~~ Payment is not made for comprehensive treatment beyond 36 months.

~~(g) Relative Value Units (RVU's) have been developed by OHCA for the first year's treatment and each subsequent year's treatment. The allowable charge is computed by multiplying the RVU by the current conversion factor.~~

~~(h)~~ (g) If the elient member moves from the geographic area or shows a need to change their provider, then the provider who received the yearly payment is financially responsible until completion of that elient's member's orthodontic treatment for the current year.

~~(i)~~ (h) If the provider who received yearly payment does not agree to be financially responsible, then the Oklahoma Health Care Authority will recoup funds paid for the elient's member's orthodontic treatment.

~~(j)~~ (i) All orthodontic services are subject to post-utilization review. This review may include a request by the OHCA to submit medical documentation necessary to complete the review. After review is completed, these materials are returned to the orthodontist.

~~(k)~~ (j) Study models must be diagnostic and meet the following requirements:

(1) Study models must be properly poured and adequately trimmed without large voids or positive bubbles present.

(2) Centric occlusion must be clearly indicated by pencil lines on the study models, making it possible to occlude the teeth on the models in centric occlusion.

(3) 3-D model images are ~~encouraged~~ preferred.

(4) Study models not in compliance with the above described diagnostic guidelines are not accepted. The provider ~~is asked to~~ may send new ~~models~~ images that meet these requirements. If the provider does not respond, the request for treatment is denied.

(5) All measurements are made or judged on the basis of greater than or more than the minimal criteria. Measurement, counting, recording, or consideration is performed only on teeth that have erupted and may be seen on the study models.

6.a-11 **TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY**  
**CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**  
Subchapter 5. Individual Providers and Specialties  
Part 5. Pharmacies  
317:30-5-78. [AMENDED]  
(Reference APA WF # 10-62)

**SUMMARY:** Rules are revised to allow for a new pricing benchmark, Wholesale Acquisition Cost (WAC), in the event that the Average Wholesale Price (AWP) is no longer published by OHCA's pharmacy pricing vendor. Rules are also revised to reflect the change in pricing methodology for injectable drugs that are submitted through the pharmacy system.

**BUDGET IMPACT:** Agency staff has determined that these revisions are budget neutral.

**MEDICAL ADVISORY COMMITTEE:** The Medical Advisory Committee considered the proposed rule revisions on March 9, and recommended Board approval.

**AUTHORITY:** The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes;

**PUBLIC HEARING:** A public hearing was held on February 22, 2011. No comments were received before, during, or after the hearing.

**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**  
**PART 5. PHARMACIES**

**317:30-5-78. Reimbursement**

(a) **Reimbursement.** Reimbursement for pharmacy claims is based on the sum of an estimate of the ingredient cost, plus a dispensing fee.

(b) **Ingredient Cost.** Ingredient cost is estimated by one of the following methods:

(1) **Maximum Allowable Cost.**

(A) The State Maximum Allowable Cost ~~(MAC)~~ (SMAC) is established for certain products which have a Food and Drug Administration (FDA) approved generic equivalent. The ~~State MAC~~ SMAC will be calculated using prices from pharmaceutical wholesalers who supply these products to pharmacy providers in Oklahoma. Pharmacies may challenge a specific ~~product's MAC~~ product's SMAC price by providing invoices that reflect a net cost higher than the calculated ~~State MAC~~ SMAC price and by certifying that there is not another product available to them which is generically equivalent to the higher priced product.

(B) The Federal Upper Limit (FUL) is established by CMS in accordance with applicable federal laws and regulations.

(C) Injectable drugs which are dispensed by a retail pharmacy through the Vendor Drug Program shall be priced based on a formula equivalent to the Medicare allowed charge whether they are furnished through the pharmacy program or through the medical program.

(2) **The Estimated Acquisition Cost.** The Estimated Acquisition Cost (EAC) means the agency's best estimate of the price generally and currently paid by providers for a drug marketed or sold by a particular manufacturer or labeler. EAC is typically based on a benchmark published price plus or minus a percentage. The current benchmark price is the Average Wholesale

Price (AWP) as provided by the OHCA's pricing resource. EAC is calculated as AWP minus 12%. The Wholesale Acquisition Cost (WAC) means the price paid by the wholesaler for drugs purchased from the wholesaler's supplier, typically the manufacturer of the drug. Should the AWP no longer be published by the agency's pricing vendor then the agency will use WAC as the benchmark price whereas the EAC will be calculated as WAC + 5.6%.

(c) **Maximum allowable dispensing fee.** The maximum allowable dispensing fee for prescribed medication is established by review of surveys. A recommendation is made by the ~~Rates and Standards Committee~~ State Plan Amendment Rate Committee and presented to the Oklahoma Health Care Authority Board for their approval. There may be more than one level or type of dispensing fee if approved by the OHCA Board and CMS. A contracted pharmacy agrees to participate in any survey conducted by the OHCA with regard to dispensing fees. The pharmacy shall furnish all necessary information to determine the cost of dispensing drug products. Failure to participate may result in administrative sanctions by the OHCA which may include but are not limited to a reduction in the dispensing fee.

(d) ~~Payment Reimbursement for prescription claims.~~ Payment for prescription claims will be: Prescription claims will be reimbursed using the lower of the following calculation methods:

(1) the lower of estimated acquisition cost, Federal Upper Limit (FUL), or State Maximum Allowable Cost (SMAC) plus a dispensing fee, or

(2) usual and customary charge to the general public, ~~whichever is lower.~~ The pharmacy is responsible to determine its usual and customary charge to the general public. The OHCA may conduct periodic reviews within its audit guidelines to verify the pharmacy's usual and customary charge to the general public and the pharmacy agrees to make available to the OHCA's reviewers prescription and pricing records deemed necessary by the reviewers. The OHCA defines general public as the patient group accounting for the largest number of non-SoonerCare prescriptions from the individual pharmacy, but does not include patients who purchase or receive their prescriptions through other third-party payers. If a pharmacy offers discount prices to a portion of its customers (i.e. -10% discount to senior citizens), these lower prices would be excluded from the usual and customary calculations unless the patients receiving the favorable prices represent more than 50% of the pharmacy's prescription volume. The usual and customary charge will be a single price which includes both the product price and the dispensing fee. For routine usual and customary reviews, the pharmacy may provide prescription records for non-SoonerCare customers in a manner which does not identify the customer by name so long as the customer's identity may be determined later if a subsequent audit is initiated. The OHCA will provide the pharmacy notice of its intent to conduct a review of usual and customary charges at least ten days in advance of its planned date of review.

(e) **Payment of Claims.** In order for an eligible provider to be paid for filling a prescription drug, the pharmacy must complete all of the following:

- (1) have an existing provider agreement with OHCA,
- (2) submit the claim in a format acceptable to OHCA,
- (3) have a prior authorization before filling the prescription, if a prior authorization is necessary,
- (4) have a proper brand name certification for the drug, if necessary, and
- (5) include the usual and customary charges to the general public as well as the estimated acquisition cost and dispensing fee.

(f) **Claims.** Prescription reimbursement may be made only for individuals who are eligible for coverage at the time a prescription is filled. Member eligibility information may be accessed by swiping a SoonerCare identification card through a commercial card swipe machine which is

connected to the eligibility database or via the Point of Sale (POS) system when a prescription claim is submitted for payment. Persons who do not contract with commercial vendors can use the Member Eligibility Verification System (EVS) at no additional cost.



6.a-12 **TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY  
CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS  
AND CHILDREN-ELIGIBILITY**

Subchapter 5. Eligibility and Countable Income  
Part 3. Non-Medical Eligibility Requirements  
317:35-5-25. [AMENDED]  
(Reference APA WF # 10-63)

**SUMMARY:** SoonerCare eligibility rules are revised Per CMS guidance and Puerto Rican law; so that only new certified birth certificates will be accepted as verification of citizenship for Puerto Ricans who are using their birth certificate as proof of citizenship and whose eligibility for benefits will be determined for the first time on or after October 1, 2010. This rule change does not prohibit Puerto Ricans from using other forms of citizenship verification; it only applies to the use of birth certificates. In the case the applicant has not yet received his or her new certified birth certificate, reasonable opportunity to obtain citizenship verification will be afforded to the applicant. Rules are also revised to comply with new Federal law that eliminates the five-year bar on SoonerCare services for Afghani and Iraqi special immigrants. These special immigrants will now be eligible for SoonerCare services past the previous eight month eligibility period and will no longer be subject to the five-year bar on services that is applied to other immigrants.

**BUDGET IMPACT:** Agency staff has determined that these revisions are budget neutral.

**MEDICAL ADVISORY COMMITTEE:** The Medical Advisory Committee considered the proposed rule revisions on January 20, 2011, and recommended Board approval.

**AUTHORITY:** The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; Centers for Medicare and Medicaid Services Bulletin, September 20, 2010

**PUBLIC HEARING:** A public hearing was held on February 22, 2011. No comments were received before, during, or after the hearing.

**SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME  
PART 3. NON-MEDICAL ELIGIBILITY REQUIREMENTS**

**317:35-5-25. Citizenship/alien status and identity verification requirements**  
(a) **Citizenship/alien status and identity verification requirements.** Verification of citizenship/alien status and identity are required for all adults and children approved for SoonerCare. An exception is individuals who are initially eligible for SoonerCare as deemed newborns; according to Section 1903(x) of the Social Security Act, they will not be required to further document citizenship or identity at any subsequent SoonerCare eligibility redetermination. They are considered to have provided satisfactory documentation of citizenship and identity by virtue of being born in the United States.

(1) The types of acceptable evidence that verify identity and citizenship include:

(A) United States (U.S.) Passport;

- (B) Certificate of Naturalization issued by U.S. Citizenship & Immigration Services (USCIS) (Form N-550 or N-570);
- (C) Certificate of Citizenship issued by USCIS (Form N-560 or N-561);
- (D) Copy of the Medicare card or printout of a BENDEX or SDX screen showing receipt of Medicare benefits, Supplemental Security Income or disability benefits from the Social Security Administration; or
- (E) Tribal membership card or Certificate of Degree of Indian Blood (CDIB) card, with a photograph of the individual.

(2) The types of acceptable evidence that verify citizenship but require additional steps to obtain satisfactory evidence of identity are listed in subparagraphs (A) and (B). Subparagraph (A) lists the most reliable forms of verification and is to be used before using items listed in (B). Subparagraph (B) lists those verifications that are less reliable forms of verification and are used only when the items in (A) are not attainable.

(A) Most reliable forms of citizenship verification are:

(i) A U.S. public Birth Certificate showing birth in one of the 50 states, the District of Columbia, Puerto Rico (on or after 1/13/1941), Guam (on or after 4/10/1899), the U.S. Virgin Islands (on or after 1/17/1917), American Samoa, Swain's Island, or the Northern Mariana Islands after 11/4/1986~~+~~. For Puerto Ricans whose eligibility is being determined for the first time on or after October 1, 2010 and using a birth certificate to verify citizenship, the birth certificate must be a certified birth certificate issued by Puerto Rico on or after July 1, 2010;

(ii) A Report of Birth Abroad of a U.S. citizen issued by the Department of Homeland Security or a Certification of birth issued by the State Department (Form FS-240, FS-545 or DS-1350);

(iii) A U.S. Citizen ID Card (Form I-179 or I-197);

(iv) A Northern Mariana Identification Card (Form I-873) (Issued by the INS to a collectively naturalized citizen of the U.S. who was born in the Northern Mariana Islands before 11/3/1986);

(v) An American Indian Card issued by the Department of Homeland Security with the classification code "KIC" (Form I-872);

(vi) A Final Adoption Decree showing the child's name and U. S. place of birth;

(vii) Evidence of U.S. Civil Service employment before 6/1/1976;

(viii) An Official U.S. Military Record of Service showing a U.S. place of birth (for example a DD-214);

(ix) Tribal membership card or Certificate of Degree of Indian Blood (CDIB) card, without a photograph of the individual, for Native Americans;

(x) Oklahoma Voter Registration Card; or

(xi) Other acceptable documentation as approved by OHCA.

(B) Other less reliable forms of citizenship verification are:

(i) An extract of a hospital record on hospital letterhead established at the time of the person's birth that was created five years before the initial application date and that indicates a U.S. place of birth. For children under 16 the evidence must have been created near the time of birth or five years before the date of application;

(ii) Life, health, or other insurance record showing a U.S. place of birth that was created at least five years before the initial application date and that indicates a U.S. place of birth;

(iii) Federal or State census record showing U.S. citizenship or a U.S. place of birth (generally for persons born 1900 through 1950). The census record must also show the applicant's/member's age; or

(iv) One of the following items that show a U.S. place of birth and was created at least five years before the application for SoonerCare. This evidence must be one of the following and show a U.S. place of birth:

- (I) Seneca Indian tribal census record;
- (II) Bureau of Indian Affairs tribal census records of the Navajo Indians;
- (III) U.S. State Vital Statistics official notification of birth registration;
- (IV) An amended U.S. public birth record that is amended more than five years after the person's birth; or
- (V) Statement signed by the physician or midwife who was in attendance at the time of birth.

(3) Acceptable evidence of identity that must accompany citizenship evidence listed in (A) and (B) of paragraph (2) of this subsection includes:

- (A) A driver's license issued by a U.S. state or territory with either a photograph of the individual or other identifying information such as name, age, sex, race, height, weight, or eye color;
- (B) A school identification card with a photograph of the individual;
- (C) An identification card issued by Federal, state, or local government with the same information included on driver's licenses;
- (D) A U.S. military card or draft record;
- (E) A U.S. military dependent's identification card;
- (F) A Native American Tribal document including Certificate of Degree of Indian Blood, or other U.S. American Indian/Alaska Native Tribal document with a photograph of the individual or other personal identifying information;
- (G) A U.S. Coast Guard Merchant Mariner card;
- (H) A state court order placing a child in custody as reported by the OKDHS;
- (I) For children under 16, school records may include nursery or daycare records;
- (J) If none of the verification items on the list are available, an affidavit may be used for children under 16. An affidavit is only acceptable if it is signed under penalty of perjury by a parent or guardian stating the date and place of the birth of the child and ~~cannot be used if an affidavit for citizenship was provided.~~ cannot be used if an affidavit for citizenship was provided.

**(b) Reasonable opportunity to obtain citizenship verification.**

(1) When the applicant/member is unable to obtain citizenship verification, a reasonable opportunity is afforded the applicant/member to obtain the evidence as well as assistance in doing so. A reasonable opportunity is afforded the applicant/member before taking action affecting the individual's eligibility for SoonerCare. The reasonable opportunity time frame usually consists of 60 days. In rare instances, the time frame may be extended to a period not to exceed an additional 60 days.

(2) The following methods of verification are the least reliable forms of verification and should only be used as a last resort:

- (A) Institutional admission papers from a nursing facility, skilled care facility or other institution. Admission papers generally show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth;
- (B) Medical (clinic, doctor, or hospital) record created at least five years before the initial application date that indicates a U.S. place

of birth. For children under 16, the document must have been created near the time of birth. Medical records generally show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth. An immunization record is not considered a medical record for purposes of establishing U.S. citizenship;

(C) Written affidavit. Affidavits are only used in rare circumstances. If the verification requirements need to be met through affidavits, the following rules apply:

(i) There must be at least two affidavits by two individuals who have personal knowledge of the event(s) establishing the applicant's/member's claim of citizenship;

(ii) At least one of the individuals making the affidavit cannot be related to the applicant/member;

(iii) In order for the affidavit to be acceptable the persons making them must be able to provide proof of their own citizenship and identity;

(iv) If the individual(s) making the affidavit has information which explains why evidence establishing the applicant's/member's claim or citizenship does not exist or cannot be readily obtained, the affidavit must contain this information as well;

(v) The State must obtain a separate affidavit from the applicant/member or other knowledgeable individual (guardian or representative) explaining why the evidence does not exist or cannot be obtained; and

(vi) The affidavits must be signed under penalty of perjury.

(c) **Alienage verification requirements.** SoonerCare services are provided as listed to the defined groups as indicated in this subsection if they meet all other factors of eligibility.

(1) **Eligible aliens (qualified aliens).** The groups listed in the following subparagraphs are eligible for the full range of SoonerCare services. A qualified alien is:

(A) an alien who was admitted to the United States and has resided in the United States for a period greater than five years from the date of entry and who was:

(i) lawfully admitted for permanent residence under the Immigration and Nationality Act;

(ii) paroled into the United States under Section 212(d)(5) of such Act for a period of at least one year;

(iii) granted conditional entry pursuant to Section 203(a)(7) of such Act as in effect prior to April 1, 1980; or

(iv) a battered spouse, battered child, or parent or child of a battered person with a petition under 204(a)(1)(A) or (B) or 244(a)(3) of the Immigration and Naturalization Act.

(B) an alien who was admitted to the United States and who was:

(i) granted asylum under Section 208 of such Act regardless of the date asylum is granted;

(ii) a refugee admitted to the United States under Section 207 of such Act regardless of the date admitted;

(iii) an alien with deportation withheld under Section 243(h) of such Act regardless of the date deportation was withheld;

(iv) a Cuban or Haitian entrant as defined in Section 501(e) of the Refugee Education Assistance Act of 1980, regardless of the date of entry;

(v) an alien who is a veteran as defined in 38 U.S.C. ' 101, with a discharge characterized as an honorable discharge and not on the grounds of alienage;

- (vi) an alien who is on active duty, other than active duty for training, in the Armed Forces of the United States;
- (vii) the spouse or unmarried dependent child of an individual described in (C) of this paragraph.
- (viii) a victim of a severe form of trafficking pursuant to Section 107(b) of the Trafficking Victims Protection Act of 2000; or
- (ix) admitted as an Amerasian immigrant.

(C) permanent residents who first entered the country under (B) of this paragraph and who later converted to lawful permanent residence status.

**(2) Other aliens lawfully admitted for permanent residence (non-qualified aliens).** Non-qualified aliens are those individuals who were admitted to the United States and who do not meet any of the definitions in paragraph (1) of this subsection. Non-qualified aliens are ineligible for SoonerCare for five years from the date of entry except that non-qualified aliens are eligible for emergency services only when the individual has a medical condition (including emergency labor and delivery) with acute symptoms which may result in placing his/her health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of body organ or part without immediate medical attention. The only exception is when a pregnant woman qualifies under the pregnancy related benefits covered under the Title XXI program because the newborn child will meet the citizenship requirement at birth.

**(3) Afghan Special Immigrants.** Afghan special immigrants, as defined in Public Law 110-161, who have special immigration status after December 26, 2007, are exempt from the five year period of ineligibility for SoonerCare services. ~~for a time limited period. The time limited exemption period for Afghan special immigrants is eight months from the date of entry into the United States as a special immigrant or the date of conversion to special immigrant status.~~ All other eligibility requirements must be met to qualify for SoonerCare services. If these individuals do not meet one of the categorical relationships, they may apply and be determined eligible for Refugee Medical Assistance. ~~Once the eight month exemption period ends, Afghan special immigrants are no longer exempt from the five year bar for SoonerCare services and are only eligible for services described in (2) of this subsection until the five year period ends.~~ Afghan special immigrants are considered lawful permanent residents.

**(4) Iraqi Special Immigrants.** Iraqi special immigrants, as defined in Public Law 110-181, who have special immigration status after January 28, 2008, are exempt from the five year period of ineligibility for SoonerCare services. ~~for a time limited period. The time limited exemption period for Iraqi special immigrants is eight months from the date of entry into the United States as a special immigrant or the date of conversion to special immigrant status.~~ All other eligibility requirements must be met to qualify for SoonerCare services. If these individuals do not meet one of the categorical relationships, they may apply and be determined eligible for Refugee Medical Assistance. ~~Once the eight month exemption period ends, Iraqi special immigrants are no longer exempt from the five year bar for SoonerCare services and are only eligible for services described in (2) of this subsection until the five year period ends.~~ Iraqi special immigrants are considered lawful permanent residents.

**(5) Undocumented aliens.** Undocumented aliens who do not meet any of the definitions in (1)-(2) of this subsection are eligible for emergency services only when the individual has a medical condition (including emergency labor and delivery) with acute symptoms which may result in placing his/her health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of body organ or part without immediate

medical attention. The only exception is when a pregnant woman qualifies under the pregnancy related benefits covered under the Title XXI program because the newborn child will meet the citizenship requirement at birth.

(6) **Ineligible aliens.**

(A) Ineligible aliens who do not fall into the categories in (1) and (2) of this subsection, yet have been lawfully admitted for temporary or specified periods of time include, but are not limited to: foreign students, visitors, foreign government representatives, crewmen, members of foreign media and temporary workers including agricultural contract workers. This group is ineligible for SoonerCare, including emergency services, because of the temporary nature of their admission status. The only exception is when a pregnant woman qualifies under the pregnancy related benefits covered under the Title XXI program because the newborn child will meet the citizenship requirement at birth.

(B) These individuals are generally issued Form I-94, Arrival Departure Record, on which an expiration date is entered. This form is not the same Form I-94 that is issued to persons who have been paroled into the United States. Parolees carry a Form I-94 that is titled "Arrival-Departure Record - Parole Edition". Two other forms that do not give the individual "Immigrant" status are Form I-186, Nonresident Alien Mexican Border Crossing Card, and Form SW-434, Mexican Border Visitors Permit.

(7) **Preauthorization.** Preauthorization is required for payment of emergency medical services rendered to non-qualified and undocumented aliens. Persons determined as having lawful alien status must have the status verified through Systematic Alien Verification for Entitlements (SAVE).

(d) **Alienage.** A decision regarding eligibility cannot be made until the eligibility condition of citizenship and alienage is determined.

(1) **Immigrants.** Aliens lawfully admitted for permanent residence in the United States are classified as immigrants by the BCIS. These are individuals who entered this country with the express intention of residing here permanently.

(2) **Parolees.** Under Section 212(d)(5) of the Immigration and Nationality Act, individuals can be paroled into the United States for an indefinite or temporary period at the discretion of the United States Attorney General. Individuals admitted as Parolees are considered to meet the "citizenship and alienage" requirement.

(3) **Refugees and Western Hemisphere aliens.** Under Section 203(a)(7) of the Immigration and Nationality Act, Refugees and Western Hemisphere aliens may be lawfully admitted to the United States if, because of persecution or fear of prosecution due to race, religion, or political opinion, they have fled from a Communist or Communist-dominated country or from the area of the Middle East; or if they are refugees from natural catastrophes. These entries meet the citizenship and alienage requirement. Western Hemisphere aliens will meet the citizenship requirement for SoonerCare if they can provide either of the documents in subparagraphs (A) and (B) of this paragraph as proof of their alien status.

(A) Form I-94 endorsed "Voluntary Departure Granted-Employment Authorized", or

(B) The following court-ordered notice sent by BCIS to each of those individuals permitted to remain in the United States: "Due to a Court Order in *Silva vs. Levi*, 76 C4268 entered by District Judge John F. Grady in the District Court for the Northern District of Illinois, we are taking no action on your case. This means that you are permitted

to remain in the United States without threat of deportation or expulsion until further notice. Your employment in the United States is authorized".

(4) **Special provisions relating to Kickapoo Indians.** Kickapoo Indians migrating between Mexico and the United States carry Form I-94, Arrival-Departure Record (Parole Edition). If Form I-94 carries the statement that the Kickapoo is "paroled pursuant to Section 212(d)(5) of the Immigration and Nationality Act" or that the "Kickapoo status is pending clarification of status by Congress" regardless of whether such statements are preprinted or handwritten and regardless of a specific mention of the "treaty", they meet the "citizenship and alienage" requirement. All Kickapoo Indians paroled in the United States must renew their paroled status each year at any local Immigration Office. There are other Kickapoos who have entered the United States from Mexico who carry Form I-151 or Form I-551, Alien Registration Receipt Cards. These individuals have the same status as other individuals who have been issued Form I-151 or Form I-551 and therefore, meet the citizenship and alienage requirements. Still other Kickapoos are classified as Mexican Nationals by the BCIS. They carry Form I-94, Arrival-Departure Record, which has been issued as a visiting visa and does not make mention of the treaty. Such form does not meet the "citizenship and alienage" requirements but provides only the ineligible alien status described in (c)(4)(b) of this Section.

(5) **American Indians born in Canada.** An American Indian born in Canada, who has maintained residence in the United States since entry, is considered to be lawfully admitted for permanent residence if he/she is of at least one-half American Indian blood. This does not include the non-citizen whose membership in an Indian tribe or family is created by adoption, unless such person is of at least 50 percent or more Indian blood. The methods of documentation are birth or baptismal certificate issued on a reservation, tribal records, letter from the Canadian Department of Indian Affairs, or school records.

(6) **Permanent non-immigrants.** Marshall Islanders and individuals from the Republic of Palau and the Federated States of Micronesia are classified as permanent non-immigrants by BCIS. They are eligible for emergency services only.

6.a-13 **TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY**  
**CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**  
Subchapter 5. Individual Providers and Specialties  
Part 75. Federally Qualified Health Centers  
317:30-5-660.5. [AMENDED]  
317:30-5-661.4. [AMENDED]  
317:30-5-664.3. [AMENDED]  
(Reference APA WF # 10-04)

**SUMMARY:** Federally Qualified Health Center (FQHC) Rules are revised to clarify reimbursement for certain Licensed Behavioral Health Professionals in FQHC's. Additionally, revisions are made to reflect contracting and reimbursement requirements for covered services in FQHC and school settings. Policy revisions are needed to make certain LBHP's who provide behavioral health services in FQHC's are reimbursed appropriately. Revisions are also needed to identify behavioral health services that are permissible in FQHC's and school settings. These revisions ensure that the reimbursement rates for services rendered in FQHC's comply with cost based reimbursement accounting principles thereby eliminating payment errors and guarding the Agency's Federal Financial Participation (FFP) from being at risk.

**BUDGET IMPACT:** Agency staff has determined that these revisions are budget neutral.

**MEDICAL ADVISORY COMMITTEE:** The Medical Advisory Committee considered the proposed rule revisions on March 9, 2011, and recommended Board approval.

**AUTHORITY:** The Oklahoma Health Care Authority Board; the Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes

**PUBLIC HEARING:** A public hearing was held on February 22, 2011. Comments were received before and during the hearing and considered during the rulemaking process.

**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY**  
**CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**  
**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**  
**PART 75. FEDERALLY QUALIFIED HEALTH CENTERS**

**317:30-5-660.5. Health Center service definitions**

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

**"Core Services"** means outpatient services that may be covered when furnished to a patient at the Center or other location, including the patient's place of residence.

**"Encounter or Visit"** means a face-to-face contact between ~~a~~ an approved health care professional as authorized in the FQHC state plan pages and an eligible SoonerCare member for the provision of defined services through a Health Center within a 24-hour period ending at midnight, as documented in the patient's medical record.

**"Licensed ~~Mental~~ Behavioral Health Professional ~~(MHP)~~ (LBHP)"** means licensed psychologists, licensed clinical social workers (LCSWs), licensed marital and family therapists (LMFTs), licensed professional counselors



(LPCs), licensed behavioral practitioners (LBPs), and licensed alcohol and drug counselors (LADCs).

"Other ambulatory services" means other health services covered under the State plan other than core services.

"Physician" means:

(A) a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which the function is performed or who is a licensed physician employed by the Public Health Service;

(B) within limitations as to the specific services furnished, a doctor of dentistry or dental or oral surgery, a doctor of optometry, or a doctor of podiatry;

(C) a resident as defined in OAC 317:25-7-5(4) who meet the requirements for payment under SoonerCare;

"Physicians' services" means professional services that are performed by a physician at the Health Center (or are performed away from the Center, excluding inpatient hospital services) whose agreement with the Center provides that he or she will be paid by the Health Center for such services.

"PPS" means prospective payment system all-inclusive per visit rate method specified in the State plan.

#### **317:30-5-661.4. Behavioral health professional services provided at Health Centers and other settings**

(a) Medically necessary behavioral health services that are primary, preventive, and therapeutic and that would be covered if provided in another setting may be provided by Health Centers. Services provided by a Health Center (refer to OAC ~~317:30-5-241~~ 317:30-5-240.3 for a description of services) must meet the same requirements as services provided by other behavioral health providers. Rendering providers must be eligible to individually enroll or meet the requirements as an agency/organization provider specified in OAC 317:30-5-240.2, 317:30-5-280 and 317:30-5-595.

(1) Behavioral Health Services services include:

~~(1) (A) Assessment/Evaluation/Testing;~~

~~(2) Alcohol and/or Substance Abuse Services Assessment and Treatment plan development;~~

~~(3) (B) Crisis Intervention Services;~~

~~(4) Medication Training and Support~~

~~(5) (C) Individual/Interactive Psychotherapy;~~

~~(6) (D) Group Psychotherapy; and~~

~~(7) (E) Family Psychotherapy; ;~~

(F) Psychological Testing; and

(G) Case Management (as an integral component of services 1-6 above).

(b) Medically necessary behavioral health professional therapy services are covered when provided in accordance with a documented individualized treatment plan, developed to treat the identified ~~mental~~ behavioral health and/or substance abuse disorder(s). A minimum of a 45 to 50 minute one-on-one standard clinical session must be completed by ~~a Health Center~~ an health care professional authorized in the approved FQHC State Plan pages in order to bill ~~an~~ the PPS encounter rate for the session. Services rendered by providers not authorized under the approved FQHC state plan pages to bill the PPS encounter rate will be reimbursed pursuant to the SoonerCare fee-for-service fee schedule and must comply with rules found at OAC 317:30-5-280 through 317:30-5-283.

~~(c) In order to support the member's access to behavioral health services, these services may take place in settings away from the Health Center. Off-site behavioral health services must take place in a confidential setting.~~

(c) Centers are reimbursed the PPS rate for services when rendered by approved health care professionals, as authorized under FQHC state plan pages, if the Health Center receives funding pursuant to Section 330 or is otherwise funded under Public Law to provide primary health care services at locations off-site (not including satellite or mobile locations) to Health Center patients on a temporary or intermittent basis, unless otherwise limited by Federal law.

(d) Health Centers that operate day treatment programs in school settings must meet the requirements found at OAC 317:30-5-240.2(7).

(e) In order to support the member's access to behavioral health services, these services may take place in settings away from the Health Center. Off-site behavioral health services must take place in a confidential setting.

### **317:30-5-664.3. Health Center encounters**

(a) Health Center encounters that are billed to the OHCA must meet the definition in this Section and are limited to services covered by OHCA. ~~These services include other health (ambulatory) services included in the State Plan.~~ Only encounters provided by the authorized health care professional on the approved FQHC state plan pages within the scope of their licensure trigger a PPS encounter rate.

(b) An encounter is defined as a face-to-face contact between a health care professional and a member for the provision of defined services through a Health Center within a 24-hour period ending at midnight, as documented in the member's medical record.

(c) For information about multiple encounters, refer to OAC 317:30-5-664.4.

(d) Services considered reimbursable encounters (including any related medical supplies provided during the course of the encounter) include:

- (1) medical;
- (2) diagnostic;
- (3) ~~addiction,~~ dental, medical and ~~mental~~ behavioral health screenings;
- (4) vision;
- (5) physical therapy;
- (6) occupational therapy;
- (7) podiatry;
- (8) ~~mental~~ behavioral health;
- ~~(9) alcohol and drug;~~

~~(10)~~ (9) speech;

~~(11)~~ (10) hearing;

~~(12)~~ (11) medically necessary Health Center encounters with a RN or LPN and related medical supplies (other than drugs and biologicals) furnished on a part-time or intermittent basis to home-bound members (refer to OAC 317:30-5-661.3);

~~(13)~~ (12) any other medically necessary health services (i.e. optometry and podiatry) covered by OHCA are also reimbursable as permitted within the Health Center's scope of services and allowed under OHCA's SoonerCare State Plan and OHCA Administrative Rules when medically reasonable and necessary for the diagnosis or treatment of illness or injury, and must meet all applicable coverage requirements.

(e) Services and supplies incident to a physician's professional service are reimbursable within the encounter if the service or supply is:

(1) Of a type commonly furnished in physicians' offices;

(2) of a type commonly rendered either without a charge or included in the health clinic's bill;

(3) furnished as an incidental, although integral, part of a physician's professional services;

(4) furnished under the direct, personal supervision of a physician; and

(5) in the case of a service, furnished by a member of the clinic's health care staff who is an employee of the clinic.

(f) Only drugs and biologicals which cannot be self-administered are included within the scope of this benefit.

**6.a-42 TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY  
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**

Subchapter 3. General Provider Policies

Part 1. General Scope and Administration

317:30-3-59. [AMENDED]

317:30-3-60. [AMENDED]

Subchapter 5. Individual Providers and Specialties

Part 1. Physicians

317:30-5-2. [AMENDED]

317:30-5-9. [AMENDED]

**(Reference APA WF # 10-11)**

**SUMMARY:** Rules are revised to ensure OHCA rules are consistent with reimbursement practices and make coverage rules more consistent throughout policy. Specifically, rules are revised to be consistent with the Centers for Medicare and Medicaid Services (CMS) requirements regarding the elimination of office and inpatient consultation codes. Additional revisions include general policy cleanup as it relates to these sections.

**BUDGET IMPACT:** Agency staff has determined that these revisions are budget neutral.

**MEDICAL ADVISORY COMMITTEE:** The Medical Advisory Committee considered the proposed rule revisions on July 15, 2010, and recommended Board approval.

**AUTHORITY:** The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes

**PUBLIC HEARING:** A public hearing was held on February 22, 2011. No comments were received before, during, or after the hearing.

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

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

The following are excluded from SoonerCare coverage for adults:

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

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

(3) Services of two physicians for the same type of service to the same member ~~at the same time on the same day~~, except when warranted by the necessity of supplemental skills are required and different specialties are involved. ~~When supplemental skills are warranted, the initial consultation is reported utilizing the appropriate CPT code for inpatient consultations. If the consultant physician initiates treatment at the initial consultation and participates thereafter in the member's care, the procedure codes for subsequent hospital care must be used.~~

(4) Refractions and visual aids.

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

- (6) Sterilization of members who are under 21 years of age, mentally incompetent, or institutionalized or reversal of sterilization procedures for the purposes of conception.
- (7) Non-therapeutic hysterectomies.
- (8) Induced abortions, except when certified in writing by a physician that the abortion was necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, or that the pregnancy is the result of an act of rape or incest. (Refer to OAC 317:30-5-6 or 317:30-5-50.)
- (9) Medical services considered experimental or investigational.
- (10) Services of a Certified Surgical Assistant.
- (11) Services of a Chiropractor. Payment is made for Chiropractor services on Crossover claims for coinsurance and/or deductible only.
- (12) Services of an independent licensed Physical and/or Occupational Therapist.
- (13) Services of a Psychologist.
- (14) Services of an independent licensed Speech and Hearing Therapist.
- (15) Payment for more than four outpatient visits per month (home or office) per member, except those visits in connection with family planning or related to emergency medical conditions.
- (16) Payment for more than two nursing facility visits per month.
- (17) More than one inpatient visit per day per physician.
- (18) Payment for removal of benign skin lesions unless medically necessary.
- (19) Physician services which are administrative in nature and not a direct service to the member including such items as quality assurance, utilization review, treatment staffing, tumor board review or multidisciplinary opinion, dictation, and similar functions.
- (20) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.
- (21) Payment for the services of social workers, licensed family counselors, registered nurses or other ancillary staff, except as specifically set out in OHCA rules.
- (22) Mileage.
- (23) A routine hospital visit on the date of discharge unless the member expired.
- (24) Direct payment to perfusionist as this is considered part of the hospital reimbursement.
- (25) Inpatient chemical dependency treatment.
- (26) Fertility treatment.
- (27) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.

### **317:30-3-60. General program exclusions - children**

- (a) The following are excluded from SoonerCare coverage for children:
  - (1) Inpatient admission for diagnostic studies that could be performed on an outpatient basis.
  - (2) Services or any expense incurred for cosmetic surgery unless the physician certifies the procedure emotionally necessary.
  - (3) Services of two physicians for the same type of service to the same member ~~at the same time~~ on the same day, except when ~~warranted by the necessity of supplemental skills are required and different specialties are involved.~~ When supplemental skills are warranted, the initial consultation is reported utilizing the appropriate CPT code for inpatient consultations. If the consultant physician initiates treatment at the

~~initial consultation and participates thereafter in the member's care, the procedure codes for subsequent hospital care must be used.~~

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

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

(6) Non-therapeutic hysterectomies.

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

(8) Medical services considered experimental or investigational.

(9) Services of a Certified Surgical Assistant.

(10) Services of a Chiropractor.

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

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

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

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

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

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

(17) Mileage.

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

(b) Notwithstanding the exclusions listed in (1)-(18) of subsection (a), the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) provides for coverage of needed medical services normally outside the scope of the medical program when performed in connection with an EPSDT screening and prior authorized.

## **SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**

### **PART 1. PHYSICIANS**

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

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

(1) Coverage includes the following medically necessary services:

(A) Inpatient hospital visits for all SoonerCare covered stays. All inpatient services are subject to post-payment review by the OHCA, or its designated agent.

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

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

- (i) Recognition as clinical faculty with participation in such activities as faculty call, faculty meetings, and having hospital privileges;
- (ii) Board certification or completion of an accredited residency program in the fellowship specialty area;
- (iii) Hold unrestricted license to practice medicine in Oklahoma;
- (iv) If Clinical Fellow, practicing during second or subsequent year of fellowship;
- (v) Seeing members without supervision;
- (vi) Services provided not for primary purpose of medical education for the clinical fellow or chief resident;
- (vii) Submit billing in own name with appropriate Oklahoma SoonerCare provider number.
- (viii) Additionally if a clinical fellow practicing during the first year of fellowship, the clinical fellow must be practicing within their area of primary training. The services must be performed within the context of their primary specialty and only to the extent as allowed by their accrediting body.

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

- (i) Attending physician performs chart review and signs off on the billed encounter;
- (ii) Attending physician is present in the clinic/or hospital setting and available for consultation;
- (iii) Documentation of written policy and applicable training of physicians in the training program regarding when to seek the consultation of the attending physician.

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

- (i) The member must be at least minimally examined by the attending physician or a licensed physician under the supervision of the attending physician;
- (ii) The contact must be documented in the medical record.

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

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

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

- (i) Transplant procedures, except kidney and cornea, must be prior authorized to be compensable.
- (ii) To be prior authorized all procedures are reviewed based on appropriate medical criteria.
- (iii) To be compensable under the SoonerCare program, all organ transplants must be performed at a facility which meets the requirements contained in Section 1138 of the Social Security Act.
- (iv) Procedures considered experimental or investigational are not covered.



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

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

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

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

(BB) Ventilator equipment.

(CC) Home dialysis equipment and supplies.

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

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

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

5As:

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

(II) Advising the member to quit;

(III) Assessing the willingness of the member to quit;

(IV) Assisting the member with referrals and plans to quit;

and

(V) Arranging for follow-up.

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

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

(iv) Chart documentation must include a separate note and signature along with the member specific information addressed in the five steps and the time spent by the practitioner performing the counseling. Anything under three minutes is considered part of a routine visit.

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

(2) General coverage exclusions include the following:

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

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

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

~~initial consultation is reported utilizing the appropriate CPT code for inpatient consultations. If the consultant physician initiates treatment at the initial consultation and participates thereafter in the member's care, the procedure codes for subsequent hospital care must be used.~~

- (D) Refractions and visual aids.
- (E) Pre-operative care within 24 hours of the day of admission for surgery and routine post-operative care as defined under the global surgery guidelines promulgated by Current Procedural Terminology (CPT) and the Centers for Medicare and Medicaid Services (CMS).
- (F) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.
- (G) Sterilization of members who are under 21 years of age, mentally incompetent, or institutionalized or reversal of sterilization procedures for the purposes of conception.
- (H) Non-therapeutic hysterectomies.
- (I) Medical services considered experimental or investigational.
- (J) Payment for more than four outpatient visits per month (home or office) per member, except those visits in connection with family planning or related to emergency medical conditions.
- (K) Payment for more than two nursing facility visits per month.
- (L) More than one inpatient visit per day per physician.
- (M) Physician services which are administrative in nature and not a direct service to the member including such items as quality assurance, utilization review, treatment staffing, tumor board review or multidisciplinary opinion, dictation, and similar functions.
- (N) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.
- (O) Payment for the services of social workers, licensed family counselors, registered nurses or other ancillary staff, except as specifically set out in OHCA rules.
- (P) Induced abortions, except when certified in writing by a physician that the abortion was necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, or that the pregnancy is the result of an act of rape or incest. (Refer to OAC 317:30-5-6 or 317:30-5-50.)
- (Q) Speech and Hearing services.
- (R) Mileage.
- (S) A routine hospital visit on the date of discharge unless the member expired.
- (T) Direct payment to perfusionist as this is considered part of the hospital reimbursement.
- (U) Inpatient chemical dependency treatment.
- (V) Fertility treatment.
- (W) Payment for removal of benign skin lesions unless medically necessary.

(b) **Children.** Payment is made to physicians for medical and surgical services for members under the age of 21 within the scope of the Authority's SoonerCare program, provided the services are medically necessary for the diagnosis and treatment of illness or injury, or to improve the functioning of a malformed body member. Medical and surgical services for children are comparable to those listed for adults. In addition to those services listed for adults, the following services are covered for children.

(1) **Pre-authorization of inpatient psychiatric services.** All inpatient psychiatric services for members under 21 years of age must be prior

authorized by an agency designated by the Oklahoma Health Care Authority. All psychiatric services are prior authorized for an approved length of stay. Non-authorized inpatient psychiatric services are not SoonerCare compensable.

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

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

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

(3) **Procedures for requesting extensions for inpatient services.** The physician and/or facility must provide necessary justification to enable OHCA, or its designated agent, to make a determination of medical necessity and appropriateness of treatment options. Extension requests for psychiatric admissions must be submitted to the OHCA or its designated agent. Extension requests must contain the appropriate documentation validating the need for continued treatment in accordance with the medical necessity criteria described in OAC 317:30-5-95.26, 317:30-5-95.28 and 317:30-5-95.30. Requests must be made prior to the expiration of the approved inpatient stay. All decisions of OHCA or its designated agent are final.

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

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

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

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

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

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

(C) Services of two physicians for the same type of service to the same member at the same time on the same day, except when warranted by the necessity of supplemental skills are required and different specialties are involved. ~~When supplemental skills are warranted, the initial consultation is reported utilizing the appropriate CPT code~~

~~for inpatient consultations. If the consultant physician initiates treatment at the initial consultation and participates thereafter in the member's care, the procedure codes for subsequent hospital care must be used.~~

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

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

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

(G) Non-therapeutic hysterectomies.

(H) Medical Services considered experimental or investigational.

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

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

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

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

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

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

(O) Mileage.

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

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

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

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

### **317:30-5-9. Medical services**

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

(b) **Covered office services.**

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

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

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

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

(A) Casting materials

(B) Dressing for burns

(C) Contraceptive devices

(D) IV Fluids

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

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

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

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

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

(10) Payment is made for both an office visit and an injection of joints performed during the visit if the joint injection code does not have a global coverage designation.

(11) Payment is made for an office visit in addition to allergy testing.

(12) Separate payment is made for antigen.

(13) Eye exams are covered for members between ages 21 and 65 for medical diagnosis only.

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

(15) Separate payment is made for the following specimen collections:

(A) Catheterization for collection of specimen; and

(B) Routine Venipuncture.

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

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

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

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

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

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

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

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

(6) Refractive services are not covered for persons between the ages of 21 and 65.

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

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

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

**(d) Covered inpatient medical services.**

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

(2) Payment is allowed for the services of two physicians when supplemental skills are required and different specialties are involved. ~~When supplemental skills are warranted, the initial consultation is reported utilizing the appropriate CPT code for inpatient consultations. If the consultant physician initiates treatment at the initial consultation and participates thereafter in the member's care, the procedure codes for subsequent hospital care must be used.~~

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

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

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

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

(2) A hospital admittance or visit and surgery on the same day would not be covered if post-operative days are included in the surgical procedure. If there are no post-operative days, a physician can be paid for visits.

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

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

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

**(f) Other medical services.**

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

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

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

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

6.a-43 **TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY**  
**CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**  
Subchapter 5. Individual Providers and Specialties  
Part 17. Medical Suppliers  
317:30-5-211.19. [AMENDED]  
(Reference APA WF # 10-34)

**SUMMARY:** Medical Suppliers' rules are revised to set guidelines for quality assurances and safeguards. Rules set guidelines related to DMEPOS quality standards, manufacturer standards, member education, maintenance and repair of products, safety and infection control, and provider contact and follow-up services.

**BUDGET IMPACT:** Agency staff has determined that these revisions are budget neutral.

**MEDICAL ADVISORY COMMITTEE:** The Medical Advisory Committee considered the proposed rule revisions on July 15, 2010, and recommended Board approval.

**AUTHORITY:** The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes

**PUBLIC HEARING:** A public hearing was held on February 22, 2011. No comments were received before, during, or after the hearing.

**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY**  
**CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**  
**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**  
**PART 17. MEDICAL SUPPLIERS**

**317:30-5-211.19. Quality assurances and safeguards**

All SoonerCare billed durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) must have the following quality assurances and safeguards:

(1) All DMEPOS items provided to SoonerCare members must meet manufacturer standards. The equipment must be provided by trained professionals in a manner that is both nationally recognized for safe and effective member care and that meets the member's needs and therapeutic goals, and that the member has received the appropriate education in order to minimize any hazard or safety risks.

(A) DMEPOS suppliers must only provide items that meet applicable state and federal regulations and medical device effectiveness and safety standards.

(B) DMEPOS suppliers must make available the manufacturer copies of the features, warranties, and instructions for each type of item.

(2) All DMEPOS supplier personnel who are educating SoonerCare members, or repairing SoonerCare DMEPOS items, must be working within the scope of their practice and meet all state and federal requirements.

(A) DMEPOS suppliers must have equipment delivery, set-up, and member education accomplished by competent technical and professional personnel who are licensed, certified, or registered, and who are functioning within their scope of practice as required by state and federal standards.

(B) DMEPOS suppliers must provide the appropriate information about equipment set-up features, routine use, troubleshooting, cleaning, and maintenance.

(C) DMEPOS suppliers must provide education and instructional material that is tailored to the member's needs, abilities, learning preferences, and language.

(D) DMEPOS suppliers must make repairs and maintenance available on all equipment and item(s) provided.

(3) DMEPOS suppliers must implement a program that promotes the safe use of equipment, and minimizes safety risks, infections, and hazards. Suppliers must investigate any incident, injury, or infection in which DMEPOS items were a contributor.

(A) DMEPOS suppliers must provide relevant information about infection control issues related to the use of the equipment and item(s) provided.

(B) DMEPOS suppliers must ensure that the member can use all equipment and item(s) provided safely and effectively in the settings of anticipated use.

(4) DMEPOS suppliers must make available their regular business hours and after-hour access telephone numbers for customer service, and for information about equipment repair, and emergency coverage.

(5) DMEPOS suppliers must provide follow-up services to members, consistent with the types of equipment and item(s) provided, and recommendations from the prescribing physician.



**6.a-44 TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY  
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**

Subchapter 3. General Provider Policies  
Part 1. General Scope and Administration  
317:30-3-29. [NEW]

**(Reference APA WF # 10-36)**

**SUMMARY:** General provider rules are revised to clarify the criteria used to review and revise provider fee schedules. Rules clarify that provider fee schedules may be revised based on efficiency, budget considerations, economy, and quality of care. Rules provide guidelines related to fee schedule updates and provider notifications of such updates. Rules also provide guidance related to public notice of significant proposed changes in methods and standards for setting provider payment rates for services.

**BUDGET IMPACT:** Agency staff has determined that these revisions are budget neutral.

**MEDICAL ADVISORY COMMITTEE:** The Medical Advisory Committee considered the proposed rule revisions on July 15, 2010, and recommended Board approval.

**AUTHORITY:** The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes

**PUBLIC HEARING:** A public hearing was held on February 22, 2011. No comments were received before, during, or after the hearing.

**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY  
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE  
SUBCHAPTER 3. GENERAL PROVIDER POLICIES  
PART 1. GENERAL SCOPE AND ADMINISTRATION**

**317:30-3-29. Revisions of provider fee schedules**

(a) The Oklahoma Health Care Authority (OHCA) reserves the right to review and/or update and adjust provider fee schedules. Provider fee schedules will be reviewed annually and adjustments to the fee schedules may be made at any time based on efficiency, budget considerations, economy, and quality of care. The OHCA assures that all payments will be sufficient to enlist enough providers so that care and services are available under the State Plan at least to the extent that such care and services are available to the general population in the geographic area. The OHCA may issue revisions to provider fee schedules during the year that they are effective. Providers will be notified of any revisions to the fee schedule and the revision effective dates. Provider fee schedules, when reviewed and changed, are posted to the OHCA's website in relation to the current State Fiscal Year. The OHCA will adjust provider fee schedules to:

(1) comply with changes in state or federal requirements;

(2) comply with changes in nationally recognized coding systems, such as Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT);

(3) establish an initial allowable amount for a new procedure based on information that was not available when the fee schedule was established for the current year; and

(4) adjust the allowable amount when the OHCA determines that the current allowable amount is:

(A) not appropriate for the service provided; or

(B) based on errors in data or calculation.

(b) The OHCA will provide public notice, unless specified below, of any significant proposed change in its methods and standards for setting provider payment rates for services. The OHCA will not provide notice if:

(1) the change is being made to conform to Medicare methods or levels of reimbursement;

(2) the change is required by a court order; or

(3) the change is based on changes in wholesalers' or manufacturers' prices of drugs or materials.

6.a-45 **TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY**  
**CHAPTER 2. GRIEVANCE PROCEDURES AND PROCESS**

317:2-1-1. [AMENDED]

**CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY**

Subchapter 21. Breast and Cervical Cancer Treatment Program

317:35-21-1. through 317:35-21-6. [AMENDED]

317:35-21-8. through 317:35-21-9. [AMENDED]

317:35-21-11. through 317:35-21-13. [AMENDED]

317:35-21-14. [NEW]

**(Reference APA WF 10-37 A & B)**

**SUMMARY:** Oklahoma Cares rules are revised to add a provision for medical eligibility review by the OHCA. The medical review will ensure that the original screening has properly indentified the woman as eligible for further testing or treatment. The rule revision further clarifies that income is a requirement for eligibility through SoonerCare, clarifies the meaning of "in need of treatment" and adds to policy that medical and financial eligibility appeals for applicants will be handled through the OHCA.

**BUDGET IMPACT:** Agency staff has determined that these revisions will result in \$543,000 total annual savings; \$135,750 state share savings.

**MEDICAL ADVISORY COMMITTEE:** The Medical Advisory Committee considered the proposed rule revisions on March 9, 2011, and recommended Board approval.

**AUTHORITY:** The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes

**PUBLIC HEARING:** A public hearing was held on February 22, 2011. No comments were received before, during, or after the hearing.

**CHAPTER 2. GRIEVANCE PROCEDURES AND PROCESS**

**317:2-1-1. Purpose**

The purpose of this Chapter is to describe the different types of grievances addressed by the Oklahoma Health Care Authority (OHCA). The rules explain the step by step processes that must be followed by a party seeking redress from the OHCA. ~~All~~ The majority of hearings on eligibility issues for members are conducted by the Oklahoma Department of Human Services, and are not contained in this Chapter. Hearings will not be granted when the sole issue to be determined is a Federal or State law requiring an automatic change adversely affecting some or all members.

**CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY**

**SUBCHAPTER 21. BREAST AND CERVICAL CANCER TREATMENT PROGRAM**

**317:35-21-1. Oklahoma Cares Breast and Cervical Cancer Treatment program**

(a) The Breast and Cervical Cancer Prevention and Treatment Act of 2000 (BCCPTA) allows states to provide Medicaid to uninsured women under age 65 who are in need of treatment for breast and/or cervical cancer. ~~Medical eligibility is determined~~ A medical eligibility evaluation is performed through the Centers for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program (NBCCEDP) as needed. If

the evaluation determines the woman is in need of treatment for breast and/or cervical cancer, including pre-cancerous conditions and early stage, recurrent or metastatic cancer the case is forwarded to OHCA for final medical eligibility determination.

(b) To receive Breast and Cervical Cancer (BCC) Treatment services, the woman must meet all of the following conditions.

(1) The woman must have been screened for BCC under the CDC Breast and Cervical Cancer Early Detection Program (see OAC 317:35-21-3) established under Title XV of the Public Health Service (PHS) Act, and upon screening examination found to be in need of treatment, including an abnormal finding on screening examination, precancerous conditions and that is potentially indicative of a cancerous or precancerous condition or found to have an early stage, recurrent or metastatic cancer of the breast or cervix. (see OAC 317:35-21-5).

(2) The woman must:

(A) not have creditable insurance coverage that covers ~~BCC—the treatment of breast or cervical cancer~~ (see OAC 317:35-21-4),

(B) not be eligible for any other categorically needy Medicaid ~~SoonerCare~~ eligibility group,

(C) be under 65 years of age,

(D) be a US citizen or qualified alien (see OAC 317:35-5-25 for citizenship/alien status and identity verification requirements),

(E) be a resident of Oklahoma,

(F) declare her Social Security number,

(G) assign her rights to Third Party Liability if she has insurance that is not creditable, and

(H) declare her household income for the purpose of determining ~~that she is not otherwise eligible for Medicaid. For the BCC treatment program, income is not a condition of eligibility and verification of income is not required~~ eligibility for services under the SoonerCare program.

### **317:35-21-2. Scope of coverage**

The ~~BCC~~ Oklahoma Cares Breast and Cervical Treatment program provides the full scope of ~~Medicaid~~ SoonerCare coverage. Coverage is not limited to treatment of breast and/or cervical cancer.

### **317:35-21-3. CDC screening**

(a) To be eligible for the Oklahoma Cares Breast and Cervical Cancer Treatment program, a woman must be screened under the CDC Breast and Cervical Cancer Early Detection Program. A woman is considered screened under the CDC program if her screening was provided all or in part by CDC Title XV funds, or the service was rendered by a provider funded at least in part by CDC Title XV funds, and/or if she is screened by another provider whose screening activities are pursuant to CDC Title XV of the Public Health Service (PHS) Act.

(b) Prior to certification of the BCC application an OHCA Care Management nurse must review the application and clinical data to verify the BCC applicant meets medical eligibility criteria for the BCC program.

~~(b) (c) Prior to certification of the BCC application, Upon verification by OHCA Care Management, the application is forwarded to the OKDHS worker must to verify that the BCC applicant was screened by a CDC provider and found to be in need of treatment~~ meets criteria for the program as outlined in 317:35-21-1.

### **317:35-21-4. Creditable coverage**

(a) Creditable coverage when used in this subchapter means any insurance that pays for medical bills incurred for the diagnosis and/or treatment of breast or cervical cancer. A woman having any one of the following types of coverage is considered to have creditable coverage and would normally be ineligible for the Breast and Cervical Cancer Treatment program:

- (1) Coverage under a group health plan;
- (2) Health insurance coverage, i.e., benefits consisting of medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer;
- (3) Medicare Part A and/or B;
- (4) ~~Medicaid~~ SoonerCare;
- (5) Armed Forces insurance; and/or
- (6) A state health risk pool.

(b) If a woman has limited coverage, such as limited drug coverage or limits on the number of outpatient visits, or high deductibles, she is still considered to have creditable coverage. However, if she has a policy with limited scope coverage such as those that only cover dental, vision, or long term care, or a policy that covers only a specific disease or illness, she is not considered to have creditable coverage, unless the policy provides coverage for breast or cervical cancer.

(c) There may be some circumstances when a woman has creditable coverage but that coverage does not actually cover treatment of breast or cervical cancer. In instances such as pre-existing condition exclusions, or when the annual or lifetime limit on benefits has been exhausted, a woman is not considered to have creditable coverage for this treatment. In these types of circumstances the woman may be eligible for Breast and Cervical Cancer services if she meets all other eligibility criteria.

(d) There is no requirement that a woman be uninsured for any specific length of time before she is found eligible for ~~Medicaid~~ SoonerCare under this program. If a woman loses creditable coverage for any reason and satisfies all other eligibility requirements for the BCC program it is possible for her to become immediately eligible for coverage in this program.

(e) The CDC screener ~~determines~~ evaluates whether or not the woman has creditable coverage. All health insurance, creditable or not, is listed on the OKDHS computer system in order for OHCA Third Party Liability Unit to verify insurance coverage. Questionable insurance coverage is noted in the application by the CDC screener. Applications with questionable insurance coverage are forwarded to OHCA Third Party Liability Unit for further verification.

### **317:35-21-5. In need of treatment**

In need of treatment, when used in this subchapter, means an abnormal screen determined as a result of a screening for BCC under the CDC BCC Early Detection Program established under Title XV of the Public Health Service Act, including indicating pre-cancerous conditions and early stage, recurrent or metastatic cancer. Services include diagnostic services for an abnormal finding that may be necessary to determine the extent and proper course of treatment, as well as definitive cancer treatment itself. Women who are determined to require only routine monitoring services for precancerous breast or cervical condition (e.g., breast examinations, mammograms, pelvic exams and pap smears) are not considered to be "in need of treatment".

### **317:35-21-6. Age requirements**

To be eligible for ~~Breast and Cervical Cancer services~~ the Oklahoma Cares Breast and Cervical Cancer Treatment program, a woman must be under 65 years of age. If a woman turns 65 during the certification period, eligibility

ends effective the last day of her birth month. The OKDHS worker assists the woman in determining if eligibility may continue in another Medicaid SoonerCare category.

### **317:35-21-8. Social security number**

Federal regulations require a woman furnish her Social Security number at the time of application for ~~Breast and Cervical Cancer services~~ the Oklahoma Cares Breast and Cervical Cancer Treatment program.

### **317:35-21-9. Income**

(a) There is no income limit imposed by state or federal law for the Breast and Cervical Cancer Treatment program. However, the CDC Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service (PHS) Act does allow CDC program grantees to set maximum income limits.

~~(b) Even though there is no income limit~~ Income limits are established for women receiving Breast and Cervical Cancer Treatment program services through SoonerCare. The woman is required to declare her household income so that the OKDHS worker may determine if she ~~is otherwise eligible for Medicaid~~ qualifies for the program or is otherwise SoonerCare eligible.

### **317:35-21-11. Certification for BCC**

(a) In order for a woman to receive BCC treatment services she must first be screened for BCC cancer under the CDC Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act and found to be in need of treatment. Once determined to be in need of treatment the CDC screener determines that the woman:

- (1) does not have creditable health insurance coverage,
- (2) is under age 65,
- (3) is a US citizen or qualified alien (see OAC 317:35-5-25),
- (4) is a self declared Oklahoma resident,
- (5) has provided her social security number,
- (6) is willing to assign medical rights to TPL, and
- (7) has declared all household income.

(b) If all of the conditions in subchapter (a) are met, the CDC screener assists the woman in completing the BCC application (OHCA BCC-1). The completed BCC-1 along with the documentation of clinical findings, (i.e., history and physical findings, pathology reports, radiology reports and other pertinent data) is forwarded to the ~~OKDHS office~~ OHCA Care Management Unit.

~~(c) The OHCA Care Management nurse verifies that the member meets the medical eligibility criteria described in 317:35-21-1 (a) and meets the "in need of treatment" criteria set forth in 317:35-21-1(b)1 and 317:35-21-5. If this criteria is not met or the appropriate clinical documentation is not included, the application will be denied and the OHCA will send a notice of ineligibility to the applicant. Abnormal findings do not include women who are at high risk or who could appropriately receive risk reduction therapy, but have no evidence of cancer or a precancerous condition. If it is determined that the woman does not have cancer or a precancerous condition, a future application for the BCC program must be based on a different finding of abnormality than the previous application data.~~

~~(c) (d) If all of the conditions in subchapter (a) are not met an application is not completed~~ all medical eligibility criteria are met the application will be forwarded to OKDHS for further determination of eligibility.

~~(d) (e) The OKDHS worker verifies that the screener is a CDC screener. The worker also establishes whether or not the woman is otherwise eligible for SoonerCare. If the woman is not otherwise eligible for SoonerCare, she is certified for the BCC program. If the woman is eligible under another~~

SoonerCare category, the application is certified in the other Medicaid category.

(e) (f) If a woman does not cooperate in determining her eligibility for other SoonerCare programs, her BCC application is denied and the appropriate notice is computer generated. For example, a woman otherwise eligible for SoonerCare, related to the low income families with children category, refuses to cooperate with child support enforcement without good cause would not be eligible for the BCC program.

(f) (g) If a woman in treatment for breast or cervical cancer contacts the OKDHS office and has not been through the CDC screening process, she is referred to the ~~BCC program~~ Oklahoma Cares toll free number (866-550-5585) for assistance.

(g) (h) An individual determined eligible for ~~BCC~~ the Oklahoma Cares Breast and Cervical Cancer Treatment program may be certified the first day of the month of application ~~or, if.~~ If the individual had a medical service within three months prior to the application date, certification will occur the first day of the first, second or third month prior to the month of application, in accordance with the date of the medical service, provided the date of certification is not prior to the CDC Screen.

### **317:35-21-12. Changes after certification/continued need for treatment**

(a) A woman found to be in need of treatment as the result of an abnormal BCC screen has 60 days from the date of the application to complete the initial appointment for a diagnostic procedure and an additional 60 days to complete any additional diagnostic testing required or to initiate compensable treatment for a cancerous or pre-cancerous condition. The exception to the time limit is evidence of a lack of appointment availability. Upon completion of the diagnostic testing, OHCA is provided a medical report of the findings.

(1) If the woman is found not to have breast or cervical cancer including pre-cancerous conditions and early stage, recurrent or metastatic cancer for which she is in need of treatment or fails to have diagnostic testing or begin treatment within the time frames described in OAC 317:35-21-12(a), the case is closed by OKDHS and appropriate notification is computer generated.

(2) If a medical report necessary to determine continued treatment is not received from a provider within ten working days after a request is made by OHCA, the report is considered negative and the case is closed by OKDHS and appropriate notification is computer generated.

(b) If the woman in need of treatment refuses SoonerCare compensable treatment or diagnostic services and does not plan to pursue the care in the time frames described in OAC 317:35-21-12(a), the case is closed by OKDHS and appropriate notification is computer generated.

(c) In the event a woman is unable to initiate or complete diagnostic services due to a catastrophic illness or injury occurring after certification, SoonerCare will remain open with the approval of a SoonerCare Medical Director or his/her designee.

(d) If it is determined at any time during the certification period by either the woman's treating physician or by a SoonerCare Medical Director or his or her designee that the woman is no longer in need of treatment for breast or cervical cancer or a precancerous condition, OHCA will notify OKDHS and the OKDHS worker closes the case and appropriate notification is computer generated.

(e) If it is determined at any time during the certification period that the woman has creditable health insurance coverage, the OKDHS worker closes the case and appropriate notification is computer generated.

(f) If the OKDHS worker later determines that the woman is otherwise eligible for SoonerCare, the worker takes necessary actions to certify her for the appropriate category of SoonerCare coverage.

### **317:35-21-13. Redetermination**

A periodic redetermination of eligibility is required every 12 months. The computer generated redetermination form is mailed to the woman during her 11th month of eligibility. The woman must provide a statement of current household income, and is responsible for having her ~~BCC~~ SoonerCare provider/case manager complete the statement certifying that she continues to be in need of treatment.

(1) If the completed forms are not returned, the case is closed and appropriate notice is computer generated.

(2) When the completed forms are returned timely and the woman remains eligible for the BCC program, the computer is updated to show her continued eligibility.

### **317:35-21-14. Appeals and reconsiderations**

(a) Applicants who wish to appeal a denial decision made by the OHCA or OKDHS may submit form LD-1 to the OHCA within 20 days of receipt of the decision notification. If the form is not received at the OHCA within the required time frame the appeal will not be heard. More information on the appeals process is provided at 317:2-1-2(a).

(b) Reconsiderations to the OHCA may be requested by a CDC screener if missing documentation, that could potentially result in a determination of eligibility, has been obtained. The missing documentation must be presented within 30 days of the date of the notice of denial.



6.a-46 **TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY**  
**CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**  
Subchapter 3. General Provider Policies  
Part 1. General Scope and Administration  
317:30-3-30. [NEW]  
(Reference APA WF # 10-39)

**SUMMARY:** General provider policies are revised to establish provider signature requirements. For medical review purposes, the OHCA will require that all services provided and/or ordered be authenticated by the author. The method used shall be a hand written signature, electronic signature, or signature attestation statement. Stamp signatures are not acceptable. Rules are revised to be consistent with the Centers for Medicare and Medicaid Services (CMS) regarding such provider signature requirements.

**BUDGET IMPACT:** Agency staff has determined that these revisions are budget neutral.

**MEDICAL ADVISORY COMMITTEE:** The Medical Advisory Committee considered the proposed rule revisions on July 15, 2010, and recommended Board approval.

**AUTHORITY:** The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes

**PUBLIC HEARING:** A public hearing was held on February 22, 2011. No comments were received before, during, or after the hearing.

**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY**  
**CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**  
**SUBCHAPTER 3. GENERAL PROVIDER POLICIES**  
**PART 1. GENERAL SCOPE AND ADMINISTRATION**

**317:30-3-30. Signature requirements**

(a) For medical review purposes, the Oklahoma Health Care Authority (OHCA) requires that all services provided and/or ordered be authenticated by the author. The method used shall be a hand written signature, electronic signature, or signature attestation statement. Stamped signatures are not acceptable. Pursuant to federal and/or state law, there are some circumstances for which an order does not need to be signed.

(1) Facsimile of original written or electronic signatures are acceptable for the certifications of terminal illness for hospice.

(2) Orders for clinical diagnostic tests are not required to be signed. If the order for the clinical diagnostic test is unsigned, there must be medical documentation by the treating physician that he/she intended the clinical diagnostic test be performed. This documentation showing the intent that the test be performed must be authenticated by the author via a hand written or electronic signature.

(3) Orders for outpatient prescription drugs are not required to be signed. If the order for a prescription drug is unsigned, there must be medical documentation by the treating physician that he/she intended that the prescription drug be ordered. This documentation showing the intent that the prescription drug be ordered must be authenticated by the author via a hand written or electronic signature.

(b) A hand written signature is a mark or sign by an individual on a document to signify knowledge, approval, acceptance, or obligation.

(1) If a signature is illegible, the OHCA will consider evidence in a signature log or attestation statement to determine the identity of the author of a medical record entry.

(2) If the signature is missing from an order, the OHCA will disregard the order during the review of the claim.

(3) If the signature is missing from any other medical documentation, the OHCA will accept a signature attestation from the author of the medical record entry.

(c) Providers may include in the documentation they submit a signature log that lists the typed or printed name of the author associated with initials or an illegible signature.

(1) The signature log may be included on the actual page where the initials or illegible signature are used or may be a separate document.

(2) The OHCA will not deny a claim for a signature log that is missing credentials.

(3) The OHCA will consider all submitted signature logs regardless of the date they were created.

(d) Providers may include in the documentation they submit a signature attestation statement. In order to be considered valid for medical review purposes, an attestation statement must be signed and dated by the author of the medical record entry and must contain sufficient information to identify the member.

(1) The OHCA will not consider signature attestation statements where there is no associated medical record entry.

(2) The OHCA will not consider signature attestation statements from someone other than the author of the medical record entry in question.

(3) The OHCA will consider all signature attestation statements that meet the above requirements regardless of the date the attestation was created, except in those cases where the regulations or rules indicate that a signature must be in place prior to a given event or a given date.

(e) Providers may use electronic signatures as an alternate signature method.

(1) Providers must use a system and software products which are protected against modification and must apply administrative procedures which are adequate and correspond to recognized standards and laws.

(2) Providers utilizing electronic signatures bear the responsibility for the authenticity of the information being attested to.

(3) Providers utilizing electronic signatures must comply with OAC 317:30-3-4.1.

(f) Nothing in this section is intended to absolve the provider of their obligations in accordance with the conditions set forth in their SoonerCare contract and the rules delineated in OAC 317:30.

**6.a-47 TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY  
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**

Subchapter 3. General Provider Policies  
Part 1. General Scope and Administration  
317:30-3-20.1. [REVOKED]  
(Reference APA WF # 10-44)

**SUMMARY:** General provider policies are revised to update pharmacy provider appeals rules in order to bring them in line with current practice. Current pharmacy provider appeals rules refer to processes that no longer take place.

**BUDGET IMPACT:** Agency staff has determined that these revisions are budget neutral.

**MEDICAL ADVISORY COMMITTEE:** The Medical Advisory Committee considered the proposed rule revisions on September 16, 2010, and recommended Board approval.

**AUTHORITY:** The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes

**PUBLIC HEARING:** A public hearing was held on February 22, 2011. No comments were received before, during, or after the hearing.

**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY  
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE  
SUBCHAPTER 3. GENERAL PROVIDER POLICIES  
PART 1. GENERAL SCOPE AND ADMINISTRATION**

**317:30-3-20.1 Pharmacy grievance procedures and processes [REVOKED]**

~~This section shall apply to Pharmacy Providers for appeals to findings of audits conducted by the OHCA Pharmacy department. Aggrieved providers may appeal to a subcommittee of the Drug Utilization Review Board.~~

~~(1) If a provider disagrees with a decision of the OHCA Pharmacy department audit team which has determined that the provider has received an overpayment, the provider may appeal, within 20 days of the date of that decision, the decision to a three member subcommittee of the Drug Utilization Review Board (DURB). The subcommittee shall consist of three of the four pharmacist members of the DURB. In the event that there are less than three pharmacist members appointed at any given time, the panel will be completed with other DURB members.~~

~~(2) The appeal from the OHCA Pharmacy department audit team decision shall be commenced by the receipt of a letter from the appellant provider. The letter must set out with specificity the overpayment decision to which the provider objects along with the grounds for appeal. The letter should explain in detail, the factual and/or legal basis for disagreement with the allegedly erroneous decision. The letter shall also include all relevant exhibits the provider believes necessary to decide the appeal.~~

~~(3) Upon the receipt of the appeal by the docket clerk, the matter shall be docketed for the next meeting of the DURB. Any appeal received less than three weeks before a scheduled DURB meeting will be set for the following DURB meeting.~~

~~(4) The appeal shall be forwarded to the OHCA Pharmacy Department Audit Team by the docket clerk for distribution to the members of the subcommittee and for preparation of the OHCA's case.~~

~~(5) At the discretion of the DURB, witnesses may be called and information may be solicited from any party by letter, telephonic communication, fax, or other means. The subcommittee may request that members of the Authority be present during their consideration of the appeal. Members of the Authority's Legal Division may be asked to answer legal questions regarding the appeal.~~

~~(6) The subcommittee shall issue a recommendation regarding the appeal, in writing, within 30 days of the hearing. An exception to the 30 day rule will apply in cases where the subcommittee sets the cases over until its next scheduled meeting in order to gather additional evidence. The written recommendation shall list the members of the subcommittee who participated in the decision. In cases where an appeal must be continued, the subcommittee shall issue a letter within 30 days of the initial hearing to inform the appellant of the continuance.~~

~~(7) The recommendation, after being formalized, shall be sent to the docket clerk for review by the State Medicaid Director. The State Medicaid Director shall issue a decision regarding the appeal within 10 days of the docket clerk's receipt of the recommendation from the DURB. The decision shall be issued to the appellant or his/her authorized agent.~~

~~(8) If the provider is dissatisfied with the Medicaid Director's decision, it may be appealed to the OHCA CEO under OAC 317:2-1-4(1).~~

**6.a-48 TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY**  
**CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**  
Subchapter 5. Individual Providers and Specialties  
Part 1. Physicians  
317:30-5-24. [AMENDED]  
(Reference APA WF # 10-50)

**SUMMARY:** Radiology rules are revised to update coverage guidelines to include positron emission tomography (PET) and computed tomography (CT/CTA)

**BUDGET IMPACT:** Agency staff has determined that these revisions are budget neutral.

**MEDICAL ADVISORY COMMITTEE:** The Medical Advisory Committee considered the proposed rule revisions on September 16, 2010, and recommended Board approval.

**AUTHORITY:** The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes

**PUBLIC HEARING:** A public hearing was held on February 22, 2011. No comments were received before, during, or after the hearing.

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

**317:30-5-24. Radiology**

**(a) Outpatient and emergency department.**

(1) The technical component of outpatient radiological services performed during an emergency department visit is covered.

(2) The professional component of x-rays performed during an emergency department visit is covered.

(3) Ultrasounds for obstetrical care are paid in accordance with provisions found at OAC 317:30-5-22(b)(2)(A-C).

(4) Payment is made for charges incurred for the administration of chemotherapy for the treatment of medically necessary and medically approved procedures. Payment for radiation therapy is limited to the treatment of proven malignancies and benign conditions appropriate for stereotactic radiosurgery (e.g., gamma knife).

(5) Medically necessary screening mammography is a covered benefit. Additional follow-up mammograms are covered when medically necessary.

**(b) Inpatient procedures.** Inpatient radiological procedures are compensable if done on a referral basis. Claims for inpatient interpretations by the attending physician are not compensable unless the attending physician reads interpretations for the hospital on all patients.

**(c) Inpatient radiology performed outside of hospital.** When a member is an inpatient but has to be taken elsewhere for an x-ray, such as to an office or another hospital because the admitting hospital did not have proper equipment, the place of service must still be inpatient hospital, since the member is considered to be in the hospital at the time of service.

**(d) Radiology therapy management.** Weekly clinical management is based on five fractions delivered comprising one week regardless of the time interval

separating the delivery of treatments. Weekly clinical management must be billed as one unit of service rather than five.

(e) **Miscellaneous.**

(1) **Arteriograms, angiograms and aortograms.** When arteriograms, angiograms or aortograms are performed by a radiologist, they are considered radiology, not surgery.

(2) **Injection procedure for arteriograms, angiograms and aortograms.** The "interpretation only" code and the "complete procedure" code are not both allowed for one of these procedures.

(3) **Evac-U-Kit or Evac-O-Kit.** Evac-U-Kit and Evac-O-Kit are included in the charge for the Barium Enema.

(4) **Examination.** Examination at bedside or in operating room allows an additional charge to be made. Examination outside regular hours is not a covered charge.

(5) **Supplies.** Separate payment is not made for supplies such as "administration set" used in provision of office chemotherapy.

(6) **Fluoroscopy or Esophagus study.** Separate charge for fluoroscopy or esophagus study in addition to a routine gastrointestinal tract examination is not covered unless a report is submitted indicating an esophagram was done as a separate procedure.

(f) **Magnetic Resonance Imaging, Positron Emission Tomography, and Computed Tomography.** MRI/MRA, PET, and CT/CTA scans are covered when medically necessary. Documentation in the progress notes must reflect the medical necessity. The diagnosis code must be shown on the claim.

(g) **Placement of radium or other radioactive material.**

(1) For Radium Application use the appropriate HCPCS code.

(2) When a physician supplies the therapeutic radionuclides (implant grains or Gold Seeds) and provides a copy of the invoice, payment is made at 100% of the invoice charges. Fee must include cost of radium, container, and shipping and handling.

6.a-49 **TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY**  
**CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**  
Subchapter 5. Individual Providers and Specialties  
Part 33. Transportation by Ambulance  
317:30-5-336.10. [AMENDED]  
(Reference APA WF # 10-52)

**SUMMARY:** Ambulance coverage guidelines are revised to clarify fixed wing air ambulance services. The action is to remove the prior authorization requirement in order to concur with OHCA current claims process that requires an authorization of medical necessity.

**BUDGET IMPACT:** Agency staff has determined that these revisions are budget neutral.

**MEDICAL ADVISORY COMMITTEE:** The Medical Advisory Committee considered the proposed rule revisions on September 16, 2010, and recommended Board approval.

**AUTHORITY:** The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes

**PUBLIC HEARING:** A public hearing was held on February 22, 2011. No comments were received before, during, or after the hearing.

**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY**  
**CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**  
**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**  
**PART 33. TRANSPORTATION BY AMBULANCE**

**317:30-5-336.10. Fixed wing air ambulance services**

(a) Fixed wing air ambulance transports must be ~~prior authorized~~ approved by OHCA. This approval is contingent upon medical necessity.

(b) Ambulance transport in a fixed wing aircraft is a covered service if the following requirements are met:

(1) The transport, including ancillary services (e.g. flight nurse), is ordered by a physician.

(2) The written physician order is maintained in the ~~members~~ member's file.

(3) Transport by ground vehicle would endanger the member's life due to time and distance from the hospital.

(4) Medically necessary care or services for the member's medical condition cannot be provided by a local facility.

6.a-50 **TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY**  
**CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**  
Subchapter 5. Individual Providers and Specialties  
317:30-5-763. [AMENDED]  
(Reference APA WF # 10-55A)

**SUMMARY:** ADvantage rules are revised to include a re-evaluation and approval of additional hospice services within the ADvantage waiver. The ADvantage waiver is a Home and Community Based Services program that allows individuals qualifying for SoonerCare long term care institutional services to live in a home or community based setting. Hospice is a service provided to SoonerCare members within the waiver, and currently has no authorization limits. Rules are revised to include a re-authorization process after the initial 6 months of hospice care. A re-evaluation of the member will be performed and additional hospice care authorized for a period not to exceed 60 days. A re-evaluation will be performed every 60 days until the member no longer requires hospice.

**BUDGET IMPACT:** Agency staff has determined that these revisions will result in \$868,000 total annual savings; \$217,000 state share savings for the Oklahoma Department of Human Services, who administers the ADvantage Waiver Program.

**MEDICAL ADVISORY COMMITTEE:** The Medical Advisory Committee considered the proposed rule revisions on November 17, 2010, and recommended Board approval.

**AUTHORITY:** The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes

**PUBLIC HEARING:** A public hearing was held on February 22, 2011. No comments were received before, during, or after the hearing.

**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY**  
**CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**  
**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**  
**PART 85. ADVANTAGE PROGRAM WAIVER SERVICES**

**317:30-5-763. Description of services**

Services included in the ADvantage Program are as follows:

(1) **Case Management.**

(A) Case Management services are services that assist a member in gaining access to medical, social, educational or other services, regardless of payment source of services, that may benefit the member in maintaining health and safety. Case managers initiate and oversee necessary assessments and reassessments to establish or reestablish waiver program eligibility. Case managers develop the member's comprehensive plan of care, listing only services which are necessary to prevent institutionalization of the member, as determined through assessments. Case managers initiate the addition of necessary services or deletion of unnecessary services, as dictated by the member's condition and available support. Case managers monitor the member's condition to ensure delivery and appropriateness of services and initiate plan of care reviews. If a member requires hospital or



nursing facility services, the case manager assists the member in accessing institutional care and, as appropriate, periodically monitors the member's progress during the institutional stay and helps the member transition from institution to home by updating the service plan and preparing services to start on the date the member is discharged from the institution. Case Managers must meet ADvantage Program minimum requirements for qualification and training prior to providing services to ADvantage members. Prior to providing services to members receiving Consumer-Directed Personal Assistance Services and Supports (CD-PASS), Case Managers are required to receive training and demonstrate knowledge regarding CD-PASS service delivery model, "Independent Living Philosophy" and demonstrate competency in Person-centered planning.

(B) Providers may only claim time for billable Case Management activities described as follows:

(i) A billable case management activity is any task or function defined under OAC 317:30-5-763(1)(A) that only an ADvantage case manager because of skill, training or authority, can perform on behalf of a member;

(ii) Ancillary activities such as clerical tasks like mailing, copying, filing, faxing, drive time or supervisory/administrative activities are not billable case management activities, although the administrative cost of these activities and other normal and customary business overhead costs have been included in the reimbursement rate for billable activities.

(C) Case Management services are prior authorized and billed per 15-minute unit of service using the rate associated with the location of residence of the member served.

(i) Standard Rate: Case Management services are billed using a Standard rate for reimbursement for billable service activities provided to a member who resides in a county with population density greater than 25 persons per square mile.

(ii) Very Rural/Difficult Service Area Rate: Case Management services are billed using a Very Rural/Difficult Service Area rate for billable service activities provided to a member who resides in a county with population density equal to or less than 25 persons per square mile. An exception would be services to members that reside in Oklahoma Department of Human Services/Aging Services Division (OKDHS/ASD) identified zip codes in Osage County adjacent to metropolitan areas of Tulsa and Washington Counties. Services to these members are prior authorized and billed using the Standard rate.

(iii) The latest United States Census, Oklahoma Counties population data is the source for determination of whether a member resides in a county with a population density equal to or less than 25 persons per square mile, or resides in a county with a population density greater than 25 persons per square mile.

**(2) Respite.**

(A) Respite services are provided to members who are unable to care for themselves. They are provided on a short-term basis because of the absence or need for relief of the primary caregiver. Payment for respite care does not include room and board costs unless more than seven hours are provided in a nursing facility. Respite care will only be utilized when other sources of care and support have been exhausted. Respite care will only be listed on the plan of care when it is necessary to prevent institutionalization of the member. Units of services are limited to the number of units approved on the plan of

care.

(B) In-Home Respite services are billed per 15-minute unit service. Within any one-day period, a minimum of eight units must be provided with a maximum of 28 units provided. The service is provided in the member's home.

(C) Facility-Based Extended Respite is filed for a per diem rate, if provided in Nursing Facility. Extended Respite must be at least eight hours in duration.

(D) In-Home Extended Respite is filed for a per diem rate. A minimum of eight hours must be provided in the member's home.

**(3) Adult Day Health Care.**

(A) Adult Day Health Care is furnished on a regularly scheduled basis for one or more days per week in an outpatient setting. It provides both health and social services which are necessary to ensure the optimal functioning of the member. Physical, occupational, respiratory and/or speech therapies may only be provided as an enhancement to the basic Adult Day Health Care service when authorized by the plan of care and billed as a separate procedure. Meals provided as part of this service do not constitute a full nutritional regimen. Transportation between the member's residence and the service setting is provided as a part of Adult Day Health Care. Personal Care service enhancement in Adult Day Health Care is assistance in bathing and/or hair washing authorized by the plan of care and billed as a separate procedure. Most assistance with activities of daily living, such as eating, mobility, toileting and nail care, are services that are integral to the Adult Day Health Care service and are covered by the Adult Day Health Care basic reimbursement rate. Assistance with bathing and/or hair care is not a usual and customary adult day health care service. Enhanced personal care in adult day health care for assistance with bathing and/or hair washing will be authorized when an ADvantage waiver member who uses adult day health care requires assistance with bathing and/or hair washing to maintain health and safety.

(B) Adult Day Health Care is a 15-minute unit. No more than 6 hours are authorized per day. The number of units of service a member may receive is limited to the number of units approved on the member's approved plan of care.

(C) Adult Day Health Care Therapy Enhancement is a maximum one session per day unit of service.

(D) Adult Day Health Personal Care Enhancement is a maximum one per day unit of bathing and/or hair washing service.

**(4) Environmental Modifications.**

(A) Environmental Modifications are physical adaptations to the home, required by the member's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home and without which, the member would require institutionalization. Adaptations or improvements to the home which are not of direct medical or remedial benefit to the waiver member are excluded.

(B) All services require prior authorization.

**(5) Specialized Medical Equipment and Supplies.**

(A) Specialized Medical Equipment and Supplies are devices, controls, or appliances specified in the plan of care, which enable members to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. Also included are items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such

items, and durable and non-durable medical equipment not available under the Medicaid state plan. This service excludes any equipment and/or supply items which are not of direct medical or remedial benefit to the waiver member. This service is necessary to prevent institutionalization.

(B) Specialized Medical Equipment and Supplies are billed using the appropriate HCPC procedure code. Reoccurring supplies which are shipped to the member are compensable only when the member remains eligible for waiver services, continues to reside in the home and is not institutionalized in a hospital, skilled nursing facility or nursing home. It is the provider's responsibility to verify the member's status prior to shipping these items. Payment for medical supplies is limited to the Medicare rate, or the SoonerCare rate, or actual acquisition cost plus 30 percent. All services must be prior authorized.

**(6) Advanced Supportive/Restorative Assistance.**

(A) Advanced Supportive/Restorative Assistance services are maintenance services to assist a member who has a chronic, yet stable, condition. These services assist with activities of daily living which require devices and procedures related to altered body functions. This service is for maintenance only and is not utilized as a treatment service.

(B) Advanced Supportive/Restorative Assistance service is billed per 15-minute unit of service. The number of units of this service a member may receive is limited to the number of units approved on the plan of care.

**(7) Nursing.**

(A) Nursing services are services listed in the plan of care which are within the scope of the Oklahoma Nursing Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State. Nursing services includes skilled nursing and/or private duty nursing. Skilled nursing is provided on an intermittent or part-time basis. Private duty nursing is individual and continuous care provided to a participant at home by licensed nurses. The provision of the nursing service will work to prevent or postpone the institutionalization of the member.

(B) Nursing services are services of a maintenance or preventive nature provided to members with stable, chronic conditions. These services are not intended to treat an acute health condition and may not include services which would be reimbursable under either Medicaid or Medicare's Home Health Program. This service primarily provides nurse supervision to the Personal Care Assistant or to the Advanced Supportive/Restorative Assistance Aide and assesses the member's health and prescribed medical services to ensure that they meet the member's needs as specified in the plan of care. A skilled nursing assessment/evaluation on-site visit is made to each member for whom Advanced Supportive/Restorative Assistance services are authorized to evaluate the condition of the member and medical appropriateness of services. An assessment/evaluation visit report will be made to the ADvantage Program case manager in accordance with review schedule determined in consultation between the Case Manager and the Skilled Nurse, to report the member's condition or other significant information concerning each advanced supportive/restorative care member.

(i) The ADvantage Program case manager may recommend authorization of Skilled Nursing services as part of the interdisciplinary team

planning for the member's service plan and/or assessment/evaluation of:

(I) the member's general health, functional ability and needs and/or

(II) the adequacy of personal care and/or advanced supportive/restorative assistance services to meet the member's needs including providing on-the-job training and competency testing for personal care or advanced supportive/restorative care aides in accordance with rules and regulations for delegation of nursing tasks as established by the Oklahoma Board of Nursing.

(ii) In addition to assessment/evaluation, the ADvantage Program case manager may recommend authorization of Skilled Nursing services for the following:

(I) preparing a one-week supply of insulin syringes for a blind diabetic who can safely self-inject the medication but cannot fill his/her own syringe. This service would include monitoring the member's continued ability to self-administer the insulin;

(II) preparing oral medications in divided daily compartments for a member who self-administers prescribed medications but needs assistance and monitoring due to a minimal level of disorientation or confusion;

(III) monitoring a member's skin condition when a member is at risk for skin breakdown due to immobility or incontinence, or the member has a chronic stage II decubitus ulcer requiring maintenance care and monitoring;

(IV) providing nail care for the diabetic member or member with circulatory or neurological compromise;

(V) providing consultation and education to the member, member's family and/or other informal caregivers identified in the service plan, regarding the nature of the member's chronic condition. Provide skills training (including return skills demonstration to establish competency) to the member, family and/or other informal caregivers as specified in the service plan for preventive and rehabilitative care procedures.

(C) Nursing service can be billed for service plan development and/or assessment/evaluation services or, for other services within the scope of the Oklahoma Nursing Practice Act including private duty nursing. Nursing services are billed per 15-minute unit of service. A specific procedure code is used to bill for assessment/evaluation/service plan development skilled nursing services and other procedure codes are used to bill for all other authorized nursing services. A maximum of eight units per day of skilled nursing for assessment/evaluation and/or service plan development are allowed. An agreement by a provider to perform a nurse evaluation is also an agreement, to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted. Reimbursement for a nurse evaluation is denied if the provider that produced the nurse evaluation fails to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted.

(8) **Home Delivered Meals.**

(A) Home Delivered Meals provide one meal per day. A home delivered meal is a meal prepared in advance and brought to the member's home. Each meal must have a nutritional content equal to at least one third of the Recommended Daily Allowance as established by the Food and

Nutrition Board of the National Academy of Sciences. Meals are only provided to members who are unable to prepare meals and lack an informal provider to do meal preparation.

(B) Home Delivered Meals are billed per meal, with one meal equaling one unit of service. The limit of the number of units a member is allowed to receive is limited on the member's plan of care. The provider must obtain a signature from the member or the member's representative at the time the meals are delivered. In the event that the member is temporarily unavailable (i.e., doctor's appointment, etc.) and the meal is left, the provider must document the reason a signature is not obtained. The signature logs must be available for review.

**(9) Occupational Therapy services.**

(A) Occupational Therapy services are those services that increase functional independence by enhancing the development of adaptive skills and performance capacities of members with physical disabilities and related psychological and cognitive impairments. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Treatment involves the therapeutic use of self-care, work and play activities and may include modification of the tasks or environment to enable the member to achieve maximum independence, prevent further disability, and maintain health. Under a physician's order, a licensed occupational therapist evaluates the member's rehabilitation potential and develops an appropriate written therapeutic regimen. The regimen utilizes paraprofessional occupational therapy assistant services, within the limits of their practice, working under the supervision of the licensed occupational therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Occupational Therapy services are billed per 15-minute unit of service. Payment is not allowed solely for written reports or record documentation.

**(10) Physical Therapy services.**

(A) Physical Therapy services are those services that prevent physical disability through the evaluation and rehabilitation of members disabled by pain, disease or injury. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Treatment involves use of physical therapeutic means such as massage, manipulation, therapeutic exercise, cold or heat therapy, hydrotherapy, electrical stimulation and light therapy. Under a physician's order, a licensed physical therapist evaluates the member's rehabilitation potential and develops an appropriate, written therapeutic regimen. The regimen utilizes paraprofessional physical therapy assistant services, within the limits of their practice, working under the supervision of the licensed physical therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of

services, based on the member's condition and ongoing rehabilitation potential.

(B) Physical Therapy services are billed per 15-minute units of service. Payment is not allowed solely for written reports or record documentation.

**(11) Speech and Language Therapy Services.**

(A) Speech/Language Therapy services are those that prevent speech and language communication disability through the evaluation and rehabilitation of members disabled by pain, disease or injury. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Services involve use of therapeutic means such as evaluation, specialized treatment, and/or development and oversight of a therapeutic maintenance program. Under a physician's order, a licensed Speech/Language Pathologist evaluates the member's rehabilitation potential and develops an appropriate, written therapeutic regimen. The regimen utilizes paraprofessional therapy assistant services within the limits of their practice, working under the supervision of the licensed Speech/Language Pathologist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The Pathologist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Speech/Language Therapy services are billed per 15-minute unit of service. Payment is not allowed solely for written reports or record documentation.

**(12) Respiratory Therapy Services.**

(A) Respiratory therapy services are provided for a member who, but for the availability of in-home respiratory services, would require respiratory care as an inpatient in a hospital or nursing facility. Services are provided in the member's home under the care of a physician who is familiar with the technical and medical components of home ventilator support and the physician must determine medically that in-home respiratory care is safe and feasible for the member. Treatment involved use of therapeutic means such as: evaluation, respiratory treatments, chest physiotherapy, and/or development and oversight of a therapeutic maintenance program. Under a physician's order, a registered respiratory therapist evaluates the member and develops an appropriate, written therapeutic regimen. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Respiratory Therapy services are billed per 15-minute unit of service. Payment is not allowed solely for written reports or record documentation.

**(13) Hospice Services.**

(A) Hospice is palliative and/or comfort care provided to the member and his/her family when a physician certifies that the member has a terminal illness and has six months or less to live and orders ~~Hospice Care~~ hospice care. ADvantage Hospice Care is authorized for a six month period and requires a physician certification of a terminal

illness and orders of hospice care. If the member requires more than six months of hospice care, a physician or nurse practitioner must have a face-to-face visit with the member thirty days prior to the initial hospice authorization end date and re-certify that the member has a terminal illness and has six months or less to live and orders additional hospice care. After the initial authorization period, additional periods of ADvantage Hospice may be authorized for a maximum of 60 day increments with physician certification that the member has a terminal illness and has six months or less to live. A member's service plan that includes hospice care must comply with waiver requirements to be within total service plan cost limits.

(B) A hospice program offers palliative and supportive care to meet the special needs arising out of the physical, emotional and spiritual stresses which are experienced during the final stages of illness and during dying and bereavement. The member signs a statement choosing hospice care instead of routine medical care that has the objective to treat and cure the member's illness. Once the member has elected hospice care, the hospice medical team assumes responsibility for the member's medical care for the terminal illness in the home environment. Hospice care services include nursing care, physician services, medical equipment and supplies, drugs for symptom control and pain relief, home health aide and personal care services, physical, occupational and/or speech therapy, medical social services, dietary counseling and grief and bereavement counseling to the member and/or family. A Hospice plan of care must be developed by the hospice team in conjunction with the member's ADvantage case manager before hospice services are provided. The hospice services must be related to the palliation or management of the member's terminal illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills. ADvantage Hospice may be provided to the member in a Nursing Facility (NF) only when the member is placed in the NF for ADvantage Facility Based Extended Respite. Hospice provided as part of Facility Based Extended Respite may not be reimbursed for more than five days during any 30 day period. A member that is eligible for Medicare Hospice provided as a Medicare Part A benefit, is not eligible to receive ADvantage Hospice services.

(B) (C) Hospice services are billed per diem of service for days covered by a Hospice plan of care and during which the Hospice provider is responsible for providing Hospice services as needed by the member or member's family.

(14) **ADvantage Personal Care.**

(A) ADvantage Personal Care is assistance to a member in carrying out activities of daily living such as bathing, grooming and toileting, or in carrying out instrumental activities of daily living, such as preparing meals and doing laundry, to assure personal health and safety of the individual or to prevent or minimize physical health regression or deterioration. Personal Care services do not include service provision of a technical nature, i.e. tracheal suctioning, bladder catheterization, colostomy irrigation, and operation/maintenance of equipment of a technical nature.

(B) ADvantage Home Care Agency Skilled Nursing staff working in coordination with an ADvantage Case Manager are responsible for development and monitoring of the member's Personal Care plan.

(C) ADvantage Personal Care services are prior authorized and billed per 15-minute unit of service with units of service limited to the number of units on the ADvantage approved plan of care.

(15) **Personal Emergency Response System.**

(A) Personal Emergency Response System (PERS) is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal, in accordance with member preference, a friend, a relative or a response center once a "help" button is activated. The response center is staffed by trained professionals. For an ADvantage Program member to be eligible to receive PERS service, the member must meet all of the following service criteria:

- (i) a recent history of falls as a result of an existing medical condition that prevents the individual from getting up from a fall unassisted;
- (ii) lives alone and has no regular caregiver, paid or unpaid, and therefore is left alone for long periods of time;
- (iii) demonstrates capability to comprehend the purpose of and activate the PERS;
- (iv) has a health and safety plan detailing the interventions beyond the PERS to assure the member's health and safety in his/her home;
- (v) has a disease management plan to implement medical and health interventions that reduce the possibility of falls by managing the member's underlying medical condition causing the falls; and,
- (vi) the service avoids premature or unnecessary institutionalization of the member.

(B) PERS services are billed using the appropriate HCPC procedure code for installation, monthly service or purchase of PERS. All services are prior authorized in accordance with the ADvantage approved plan of care.

**(16) Consumer-Directed Personal Assistance Services and Support (CD-PASS).**

(A) Consumer-Directed Personal Assistance Services and Supports are Personal Services Assistance and Advanced Personal Services Assistance that enable an individual in need of assistance to reside in their home and in the community of their choosing rather than in an institution and to carry out functions of daily living, self care, and mobility. CD-PASS services are delivered as authorized on the service plan. The member employs the Personal Services Assistant (PSA) and/or the Advanced Personal Services Assistant (APSA) and is responsible, with assistance from ADvantage Program Administrative Financial Management Services (FMS), for ensuring that the employment complies with State and Federal Labor Law requirements. The member may designate an adult family member or friend, an individual who is not a PSA or APSA to the member, as an "authorized representative" to assist in executing these employer functions. The member:

- (i) recruits, hires and, as necessary, discharges the PSA or APSA;
- (ii) provides instruction and training to the PSA or APSA on tasks to be done and works with the Consumer Directed Agent/Case Manager to obtain ADvantage skilled nursing services assistance with training when necessary. Prior to performing an Advanced Personal Services Assistance task for the first time, the APSA must demonstrate competency in the tasks in an on-the-job training session conducted by the member and the member must document the attendant's competency in performing each task in the ASPA's personnel file;
- (iii) determines where and how the PSA or APSA works, hours of work, what is to be accomplished and, within Individual Budget Allocation limits, wages to be paid for the work;



- (iv) supervises and documents employee work time; and,
- (v) provides tools and materials for work to be accomplished.

(B) The service Personal Services Assistance may include:

- (i) assistance with mobility and with transfer in and out of bed, wheelchair or motor vehicle, or both;
- (ii) assistance with routine bodily functions that may include:
  - (I) bathing and personal hygiene;
  - (II) dressing and grooming;
  - (III) eating including meal preparation and cleanup;
- (iii) assistance with homemaker type services that may include shopping, laundry, cleaning and seasonal chores;
- (iv) companion type assistance that may include letter writing, reading mail and providing escort or transportation to participate in approved activities or events. "Approved activities or events" means community civic participation guaranteed to all citizens including but not limited to, exercise of religion, voting or participation in daily life activities in which exercise of choice and decision making is important to the member that may include shopping for food, clothing or other necessities, or for participation in other activities or events that are specifically approved on the service plan.

(C) Advanced Personal Services Assistance are maintenance services provided to assist a member with a stable, chronic condition with activities of daily living when such assistance requires devices and procedures related to altered body function if such activities, in the opinion of the attending physician or licensed nurse, may be performed if the individual were physically capable, and the procedure may be safely performed in the home. Advanced Personal Services Assistance is a maintenance service and should never be used as a therapeutic treatment. Members who develop medical complications requiring skilled nursing services while receiving Advanced Personal Services Assistance should be referred to their attending physician who may, if appropriate, order home health services. The service of Advanced Personal Services Assistance includes assistance with health maintenance activities that may include:

- (i) routine personal care for persons with ostomies (including tracheotomies, gastrostomies and colostomies with well-healed stoma) and external, indwelling, and suprapubic catheters which includes changing bags and soap and water hygiene around ostomy or catheter site;
- (ii) remove external catheters, inspect skin and reapplication of same;
- (iii) administer prescribed bowel program including use of suppositories and sphincter stimulation, and enemas (Pre-packaged only) with members without contraindicating rectal or intestinal conditions;
- (iv) apply medicated (prescription) lotions or ointments, and dry, non-sterile dressings to unbroken skin;
- (v) use lift for transfers;
- (vi) manually assist with oral medications;
- (vii) provide passive range of motion (non-resistive flexion of joint) delivered in accordance with the plan of care, unless contraindicated by underlying joint pathology;
- (viii) apply non-sterile dressings to superficial skin breaks or abrasions; and
- (ix) use Universal precautions as defined by the Center for Disease Control.

(D) The service Financial Management Services are program administrative services provided to participating CD-PASS employer/members by the OKDHS/ASD. Financial Management Services are employer related assistance that provides Internal Revenue Service (IRS) fiscal reporting agent and other financial management tasks and functions including, but not limited to:

(i) employer payroll, at a minimum of semi monthly, and associated withholding for taxes, or for other payroll withholdings performed on behalf of the member as employer of the PSA or APSA;

(ii) other employer related payment disbursements as agreed to with the member and in accordance with the member's Individual Budget Allocation;

(iii) responsibility for obtaining criminal and abuse registry background checks, on behalf of the member, on prospective hires for PSAs or APSAs;

(iv) providing to the member, as needed, assistance with employer related cognitive tasks, decision-making and specialized skills that may include assistance with Individual Budget Allocation planning and support for making decisions including training and providing reference material and consultation regarding employee management tasks such as recruiting, hiring, training and supervising the member's Personal Services Assistant or Advanced Personal Services Assistant; and

(v) for making available Hepatitis B vaccine and vaccination series to PSA and APSA employees in compliance with OSHA standards.

(E) The service of Personal Services Assistance is billed per 15-minute unit of service. The number of units of PSA a member may receive is limited to the number of units approved on the Service Plan.

(F) The service of Advanced Personal Services Assistance is billed per 15-minute unit of service. The number of units of APSA a member may receive is limited to the number of units approved on the Service Plan.

**(17) Institution Transition Services.**

(A) Institution Transition Services are those services that are necessary to enable an individual to leave the institution and receive necessary support through ADvantage waiver services in their home and/or in the community.

(B) Institution Transition Case Management Services are services as described in OAC 317:30-5-763(1) required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or to enable the individual to function with greater independence in the home, and without which, the individual would continue to require institutionalization. ADvantage Transition Case Management Services assist institutionalized individuals that are eligible to receive ADvantage services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services to assist in the transition, regardless of the funding source for the services to which access is gained. Transition Case Management Services may be authorized for periodic monitoring of an ADvantage member's progress during an institutional stay, and for assisting the member transition from institution to home by updating the service plan, including necessary Institution Transition Services to prepare services and supports to be in place or to start on the date the member is discharged from the institution. Transition Case Management Services may be authorized to assist individuals that have not previously received ADvantage

services but have been referred by the OKDHS/ASD to the Case Management Provider for assistance in transitioning from the institution to the community with ADvantage services support.

(i) Institution Transition Case Management services are prior authorized and billed per 15-minute unit of service using the appropriate HCPC and modifier associated with the location of residence of the member served as described in OAC 317:30-5-763(1)(C).

(ii) A unique modifier code is used to distinguish Institution Transition Case Management services from regular Case Management services.

(C) Institutional Transition Services may be authorized and reimbursed under the following conditions:

(i) The service is necessary to enable the individual to move from the institution to their home;

(ii) The individual is eligible to receive ADvantage services outside the institutional setting;

(iii) Institutional Transition Services are provided to the individual within 180 days of discharge from the institution;

(iv) Transition Services provided while the individual is in the institution are to be claimed as delivered on the day of discharge from the institution.

(D) If the member has received Institution Transition Services but fails to enter the waiver, any Institution Transition Services authorized and provided are reimbursed as "Medicaid administrative" costs and providers follow special procedures specified by the OKDHS/ASD to bill for services provided.

**(18) Assisted Living Services.**

(A) Assisted Living Services are personal care and supportive services that are furnished to waiver members who reside in a homelike, non-institutional setting that includes 24-hour on-site response capability to meet scheduled or unpredictable resident needs and to provide supervision, safety and security. Services also include social and recreational programming and medication assistance (to the extent permitted under State law). The assisted living services provider is responsible for coordinating services provided by third parties to ADvantage members in the assisted living center. Nursing services are incidental rather than integral to the provision of assisted living services. ADvantage reimbursement for Assisted Living Services includes services of personal care, housekeeping, laundry, meal preparation, periodic nursing evaluations, nursing supervision during nursing intervention, intermittent or unscheduled nursing care, medication administration, assistance with cognitive orientation, assistance with transfer and ambulation, planned programs for socialization, activities and exercise and for arranging or coordinating transportation to and from medical appointments. Services, except for planned programs for socialization, activities and exercise, are to meet specific needs of the participant as determined through individualized assessment and documented on the participant's service plan.

(B) The ADvantage Assisted Living Services philosophy of service delivery promotes service member choice, and to the greatest extent possible, service member control. Members have control over their living space and choice of personal amenities, furnishing and activities in their residence. The Assisted Living Service provider's documented operating philosophy, including policies and procedures, must reflect and support the principles and values associated with the

ADvantage assisted living philosophy and approach to service delivery that emphasizes member dignity, privacy, individuality, and independence.

(C) ADvantage Assisted Living required policies for Admission/Termination of services and definitions.

(i) ADvantage-certified Assisted Living Centers (ALCs) are required to accept all eligible ADvantage members who choose to receive services through the ALC subject only to issues relating to:

(I) unit availability;

(II) the compatibility of the participant with other residents; and

(III) the center's ability to accommodate residents who have behavior problems, wander, or have needs that exceed the services the center provides.

(ii) The ALC may specify the number of units the provider is making available to service ADvantage participants.

(iii) Mild or moderate cognitive impairment of the applicant is not a justifiable reason to deny ALC admission. Centers are required to specify whether they are able to accommodate individuals who have behavior problems or wander. Denial of admission due to a determination of incompatibility must be approved by the case manager and the ADvantage Administration (AA). Appropriateness of placement is not a unilateral determination by the ALC. The ADvantage Case Manager, the member and/or member's designated representative and the ALC in consultation determine the appropriateness of placement.

(iv) The ALC is responsible for meeting the member's needs for privacy and dignity. Inability to meet those needs will not be recognized as a reason for determining that an ADvantage participant's placement is inappropriate. The ALC agrees to provide or arrange and coordinate all of the services listed in the description of assisted living center services in the Oklahoma State Department of Health regulations (OAC 310:663-3-3) except for specialized services.

(v) In addition, the ADvantage participating ALC agrees to provide or coordinate the following services:

(I) Provide an emergency call system for each participating ADvantage member;

(II) Provide up to three meals per day plus snacks sufficient to meet nutritional requirements, including modified special diets, appropriate to members' needs and choices; and

(III) Arrange or coordinate transportation to and from medical appointments.

(vi) The provider may offer any specialized service or unit for residents with Alzheimer's disease and related dementias, physical disabilities or other special needs that the facility intends to market.

(vii) If the provider arranges and coordinates services for members, the provider is obligated to assure the provision of those services.

(viii) Under OAC 310:663-1-2, "personal care" is defined as "assistance with meals, dressing, movement, bathing or other personal needs or maintenance, or general supervision of the physical and mental well-being of a person". For ADvantage Assisted Living Services, assistance with "other personal needs" in this definition includes assistance with toileting, grooming and transferring and the term "assistance" is clarified to mean hands-

on help in addition to supervision.

(ix) The specific Assisted Living Services assistance provided along with amount and duration of each type of assistance is based upon the individual member's assessed need for service assistance and is specified in the ALC's service plan which is incorporated as supplemental detail into the ADvantage comprehensive service plan. The ADvantage Case Manager in cooperation with the Assisted Living Center professional staff develops the service plan to meet member needs. As member needs change, the service plan is amended consistent with the assessed, documented need for change in services.

(x) Definition of Inappropriate ALC Placement. Placement or continued placement of an ADvantage member in an ALC is inappropriate if any one or more of the following conditions exist:

(I) The member's needs exceed the level of services the center provides. Documentation must support ALC efforts to provide or arrange for the required services to accommodate participant needs;

(II) The member exhibits behavior or actions that repeatedly and substantially interferes with the rights or well being of other residents and the ALC has documented efforts to resolve behavior problems including medical interventions, behavioral interventions and increased staffing interventions. Documentation must support that ALC attempted interventions to resolve behavior problems;

(III) The member has a medical condition that is complex, unstable or unpredictable and treatment cannot be appropriately developed and implemented in the assisted living environment. Documentation must support that ALC attempted to obtain appropriate care for the member; or

(IV) The member fails to pay room and board charges and/or the OKDHS determined vendor payment obligation.

(xi) Termination of residence when inappropriately placed. Once a determination is made that a member is inappropriately placed, the assisted living center must inform the member and/or the member's representative, if any, and the member's ADvantage Case Manager. The ALC must develop a discharge plan in consultation with the member, the member's support network and the ADvantage Case Manager. The ALC and Case Manager must ensure that the discharge plan includes strategies for providing increased services, when appropriate to minimize risk and meet the higher care needs of members awaiting a move out of the ALC, if reason for discharge is inability to meet member needs. If voluntary termination of residency is not arranged, the ALC must provide written notice to the member and to the member's representative, with a copy to the member's ADvantage Case Manager, giving the member 30 days notice of the ALC's intent to terminate the residency agreement and move the member to a more appropriate care provider. The 30 day requirement shall not apply when emergency termination of the residency agreement is mandated by the member's immediate health needs or when termination of the residency agreement is necessary for the physical safety of the member or other residents of the ALC. The written notice of involuntary termination of residency for reasons of inappropriate placement must include:

(I) a full explanation of the reasons for the termination of residency;

(II) the date of the notice;

(III) the date notice was given to the member and the member's representative;

(IV) the date by which the member must leave the ALC; and

(V) notification of appeal rights and process for submitting appeal of termination of Medicaid Assisted Living services to the OHCA.

(D) ADvantage Assisted Living Services provider standards in addition to licensure standards.

(i) Physical environment

(I) The ALC must provide lockable doors on the entry door of each unit and a lockable compartment within each member unit for valuables. Member residents must have exclusive rights to their units with lockable doors at the entrance of their individual and/or shared unit except in the case of documented contraindication. Units may be shared only if a request to do so is initiated by the member resident.

(II) The ALC must provide each unit with a means for each member resident to control the temperature in the individual living unit through the use of a damper, register, thermostat, or other reasonable means that is under the control of the resident and that preserves resident privacy, independence and safety, provided that the Oklahoma State Department of Health may approve an alternate means based on documentation that the design of the temperature control is appropriate to the special needs of each member who has an alternate temperature control.

(III) For ALCS built prior to January 1, 2008, each ALC individual residential unit must have a minimum total living space (including closets and storage area) of 250 square feet; for ALCs built after December 31, 2007, each ALC individual residential unit must have a minimum total living space (including closets and storage area) of 360 square feet.

(IV) The ALC shall provide a private bathroom for each living unit which must be equipped with one lavatory, one toilet, and one bathtub or shower stall.

(V) The ALC must provide at a minimum a kitchenette, defined as a space containing a refrigerator, cooking appliance (microwave is acceptable), and adequate storage space for utensils.

(VI) The member is responsible for furnishing their rental unit. If a member is unable to supply basic furnishings defined as a bed, dresser, nightstand, chairs, table, trash can and lamp, or if the member supplied furnishings pose a health or safety risk, the member's Case Manager in coordination with the ALC must assist the member in obtaining basic furnishings for the unit.

(VII) The ALC must meet the requirements of all applicable federal and state laws and regulations including, but not limited to, the state and local sanitary codes, state building and fire safety codes and laws and regulations governing use and access by persons with disabilities.

(VIII) The ALC must ensure the design of common areas accommodates the special needs of their resident population and that the residential unit accommodates the special needs of the individual in compliance with ADA Accessibility Guidelines (28 CFR Part 36 Appendix A).

(IX) The ALC must provide adequate and appropriate social and recreational space for residents and the common space must be proportionate to the number of residents and appropriate for

the resident population.

(X) The ALC must provide appropriately monitored outdoor space for resident use.

(ii) Sanitation

(I) The ALC must maintain the facility, including its individual units, that is clean, safe, sanitary, insect and rodent free, odorless, and in good repair at all times.

(II) The ALC must maintain buildings and grounds in a good state of repair and in a safe and sanitary condition, and in compliance with the requirements of applicable regulations, bylaws and codes.

(III) The ALC stores clean laundry in a manner that prevents contamination and changes linens at time intervals necessary to avoid health issues.

(IV) The ALC must provide housekeeping in member units that maintains a safe, clean and sanitary environment.

(V) The ALC must have policies and procedures for members' pets.

(iii) Health and Safety

(I) The ALC must provide building security that protects residents from intruders with security measures appropriate to building design, environment risk factors and the resident population.

(II) The ALC must respond immediately and appropriately to missing residents, accidents, medical emergencies or deaths.

(III) The ALC must have a plan in place to prevent, contain and report any diseases that are considered to be infectious and/or are listed as diseases that must be reported to the Oklahoma State Department of Health.

(IV) The ALC must adopt policies for prevention of abuse, neglect and exploitation that include screening, training, prevention, investigation, protection during investigation and reporting.

(V) The ALC must provide services and facilities that accommodate the needs of resident to safely evacuate in the event of fires or other emergencies.

(VI) The ALC must ensure that staff are trained to respond appropriately to emergencies.

(VII) The ALC staff must ensure that fire safety requirements are met.

(VIII) The ALC must offer meals that provide balanced and adequate nutrition for residents.

(IX) The ALC must adopt safe practices for the preparation and delivery of meals;

(X) The ALC must provide a 24-hour response to personal emergencies that is appropriate to the needs of the resident population.

(XI) The ALC must provide safe transportation to and from ALC sponsored social/recreational outings.

(iv) Staff to resident ratios

(I) The ALC must ensure that a sufficient number of trained staff be on duty, awake, and present at all times, 24 hours a day, seven days a week, to meet the needs of residents and to carry out all the processes listed in the ALC's written emergency and disaster preparedness plan for fires and other natural disasters.

(II) The ALC must ensure that staffing is sufficient to meet

the needs of the ADvantage Program residents in accordance with each individual's ADvantage Service Plan.

(III) The ALC must have plans in place to address situations where there is a disruption to the ALC's regular work force.

(v) Staff training and qualifications

(I) The ALC must ensure that all staff have qualifications consistent with their job responsibilities.

(II) All staff assisting in, or responsible for, food service must have attended a food service training program offered or approved by the Oklahoma Department of Health;

(III) The ALC must provide staff orientation and ongoing training to develop and maintain the knowledge and skills of staff. All direct care and activity staff receive at least eight hours of orientation and initial training within the first month of their employment and at least four hours annually thereafter. Staff providing direct care on a dementia unit must receive four additional hours of dementia specific training. Annual first aid and CPR certification do not count towards the four hours of annual training.

(vi) Staff supervision

(I) The ALC must ensure delegation of tasks to non-licensed staff must be consistent and in compliance with all applicable State regulations including, but not limited to, the Oklahoma Nurse Practice Act and the OSDH Nurse Aide Certification rules.

(II) The ALC must ensure that, where the monitoring of food intake or therapeutic diets is provided at the prescribed services level, a registered dietitian monitors the member's health and nutritional status.

(vii) Resident rights

(I) The ALC must provide to each member and member's representative, at the time of admission, a copy of the resident statutory rights listed in O.S. 63-1-1918 amended to include additional rights and clarification of rights as listed in the ADvantage Consumer Assurances. A copy of the resident rights must be posted in an easily accessible, conspicuous place in the facility. The facility must ensure that its staff is familiar with, and observes, the resident rights.

(II) The ALC must conspicuously post for display in an area accessible to residents, employees and visitors, the assisted living center's complaint procedures and the name, address and telephone number of a person authorized to receive complaints. A copy of the complaint procedure must also be given to each resident, the resident's representative, or where appropriate, the court appointed guardian. The ALC must ensure that all employees comply with the ALC's complaint procedure.

(III) The ALC must provide to each member and member's representative, at the time of admission, information about Medicaid grievance/appeal rights including a description of the process for submitting a grievance/appeal of any decision that decreases Medicaid services to the member.

(viii) Incident reporting

(I) The ALC must maintain a record of incidents that occur and report incidents to the member's ADvantage Case Manager, to the ADvantage Program AA and to other entities as required by law or regulation.

(II) Incidents requiring report by licensed Assisted Living Centers are those defined by the Oklahoma State Department of



Health (OSDH) in OAC 310:663-19-1.

(III) Reports of incidents must be made to the member's Advantage Case Manager via facsimile or by telephone within one business day of the reportable incident's discovery. A follow-up report of the incident must be submitted via facsimile or mail to the member's Advantage Case Manager within five business days after the incident. The final report must be filed with the member's Advantage Case Manager and to the Advantage Administration when the full investigation is complete not to exceed ten business days after the incident.

(IV) Each ALC having reasonable cause to believe that a member is suffering from abuse, neglect, exploitation, or misappropriation of member property must make a report to either the Oklahoma Department of Human Services, the office of the district attorney in the county in which the suspected abuse, neglect, exploitation, or property misappropriation occurred or the local municipal police department or sheriff's department as soon as the person is aware of the situation, in accordance with Section 10-104.A of Title 43A of Oklahoma Statutes. Reports should also be made to the OSDH, as appropriate, in accordance with the ALC's licensure rules.

(V) The preliminary incident report must at the minimum include who, what, when and where and the measures taken to protect the resident(s) during the investigation. The follow-up report must at the minimum include preliminary information, the extent of the injury or damage, if any, and preliminary findings of the investigation. The final report at the minimum includes preliminary and follow-up information, a summary of investigative actions representing a thorough investigation, investigative findings and conclusions based on findings; and corrective measures to prevent future occurrences. If necessary to omit items, the final report must include why items were omitted and when they will be provided.

(ix) Provision of or arrangement for necessary health services

(I) The ALC must arrange or coordinate transportation for members to and from medical appointments.

(II) The ALC must provide or coordinate with the member and the member's Advantage Case Manager for delivery of necessary health services. The Advantage Case Manager is responsible for monitoring that all health-related services required by the member as identified through assessment and documented on the service plan are provided in an appropriate and timely manner.

(E) Assisted Living Services are billed per diem of service for days covered by the Advantage member's service plan and during which the Assisted Living Services provider is responsible for providing Assisted Living serviced as needed by the member. The per diem rate for the Advantage assisted living services for a member will be one of three per diem rate levels based upon individual member's need for service - type intensity and frequency to address member ADL/IADL and health care needs. The rate level is based upon UCAT assessment by the member's Advantage Case Manager employed by a Case Management agency that is independent of the Assisted Living Services provider.

**6.a-51 TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY  
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**

Subchapter 3. General Provider Policies

317:30-3-65.8. [AMENDED]

Subchapter 5. Individual Providers-Fee For Service

317:30-5-695. [AMENDED]

317:30-5-696. [AMENDED]

317:30-5-698. [AMENDED]

317:30-5-699. [AMENDED]

**(Reference APA WF # 10-58)**

**SUMMARY:** Dental rules are revised to ensure consistency throughout policy. Additionally, rules are revised to allow reimbursement to primary care providers for application of fluoride varnish to the gums and teeth of children ages 12 months to 42 months during a well-child visit. Reimbursement is limited to two applications per year.

**BUDGET IMPACT:** Agency staff has determined that these revisions will have a total first year impact of \$201,115; State share of \$70,511; Total Impact for each following year of \$39,097; State share of \$13,707.

**MEDICAL ADVISORY COMMITTEE:** The Medical Advisory Committee considered the proposed rule revisions on March 9, 2011, and recommended Board approval.

**AUTHORITY:** The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes

**PUBLIC HEARING:** A public hearing was held on February 22, 2011. Written comments in support of the revisions were received before the hearing and considered during the rulemaking process.

**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY  
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE  
SUBCHAPTER 3. GENERAL PROVIDER POLICIES  
PART 4. EARLY AND PERIODIC SCREENING, DIAGNOSIS  
AND TREATMENT (EPSDT) PROGRAM/CHILD HEALTH SERVICES**

**317:30-3-65.8. Dental services**

(a) At a minimum, dental services include relief of pain and infection; limited restoration of teeth and maintenance of dental health; and oral prophylaxis every 184 days. Dental care includes emergency and preventive services and therapeutic services for dental disease which, if left untreated, may become acute dental problems or may cause irreversible damage to the teeth or supporting structures. Other dental services include inpatient services in an eligible participating hospital, amalgam ~~anterior and composite~~ composites and posterior amalgam restorations, pulpotomies, chrome steel crowns, anterior root canals, pulpectomies, band and loop space maintainers, cement bases, acrylic partial and lingual arch bars; other restoration, repair and/or replacement of dental defects after the treatment plan submitted by a dentist has been authorized (refer to OAC 317:30-5-696(3) for amount, duration and scope).

(b) Dental screens should begin at the first sign of tooth eruption by the primary care provider and with each subsequent visit to determine if the child needs a referral to a dental provider. Dental examinations by a

qualified dental provider should begin before ~~between~~ the ages age of two ~~and three~~ (unless otherwise indicated) and once yearly thereafter. Additionally, children should be seen for prophylaxis once every 184 days- , if indicated by risk assessment. All other dental services for relief of pain and infection, restoration of teeth and maintenance of dental health should occur as the provider deems necessary.

(c) Separate payment will be made to the member's primary care provider for the application of fluoride varnish during the course of a well child screening for members ages 12 months to 42 months. Reimbursement is limited to two applications per year by eligible providers who have attended an OHCA-approved training course related to the application of fluoride varnish.

## SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES PART 79.DENTISTS

### 317:30-5-695. Eligible dental providers and definitions

- (a) Eligible dental providers in Oklahoma's SoonerCare program are:
- (1) individuals licensed as dentists under 59 Oklahoma Statutes § § 328.21, 328.22, and 328.23 (licensed dentists, specialty dentists and out of state dentists);
  - (2) individuals issued permits as dental interns under 59 Oklahoma Statute § 328.26;
  - (3) individuals who are third and fourth year dental students at an accredited Oklahoma dental college; and
  - (4) any individual issued a license in another state as a dentist.
- (b) All eligible providers must be in good standing with regard to their license. Any revocation or suspension status of a provider referenced in subsection (a) above renders the provider ineligible for payment or subject to recoupment under SoonerCare.
- (c) Eligible providers must document and sign records of services rendered in accordance with guidelines found at OAC 317:30-3-15.
- (d) The American Dental Association's version of Current Dental Terminology (CDT) is used by the OHCA to communicate information related to codes, and procedures for administration. Definitions, nomenclature, and descriptors as listed in the CDT will apply, with the exception of more specific definitions or limitations set forth.
- (1) "Decay" means carious lesions in a tooth; decomposition and/or dissolution of the calcified and organic components of the tooth structure.
  - (2) ~~"Palliative Treatment" means action that relieves pain but is not curative. Palliative Treatment is an all inclusive service. No other codes are billable on the same date of service. "Emergency Dental Care" includes, but is not limited to, the immediate service that must be provided to relieve the member from pain due to an acute infection, swelling, trismus or trauma.~~
  - ~~(2)(3)~~ (3) "Palliative Treatment" means action that relieves pain but is not curative. Palliative Treatment is an all inclusive service. No other codes are ~~billable~~ reimbursable on the same date of service.
  - ~~(3)(4)~~ (4) "Radiographic Caries" means dissolution of the calcified and organic components of tooth tissue that has penetrated the enamel and is approaching the dentinoenamel junction.
  - ~~(4)(5)~~ (5) "Upcoding" means reporting a more complex and/or higher cost procedure than actually performed.
  - ~~(5)(6)~~ (6) "Unbinding" means billing separately for several individual procedures that are included within one Current Dental Terminology or Current Procedural Terminology (CPT) code.

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

(1) **Adults.**

(A) Dental coverage for adults is limited to:

(i) emergency extractions;

(ii) Smoking and Tobacco Use Cessation Counseling; and

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

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

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

(2) **Home and community based waiver services (HCBWS) for the mentally retarded.** All providers participating in the HCBWS must have a separate contract with the OHCA to provide services under the HCBWS. Dental services are defined in each waiver and must be prior authorized.

(3) **Children.** The OHCA Dental Program provides the basic medically necessary treatment. The services listed below are compensable for members under 21 years of age without prior authorization. ALL OTHER DENTAL SERVICES MUST BE PRIOR AUTHORIZED. Anesthesia services are covered for children in the same manner as adults. All providers performing preventive services must be available to perform needed restorative services for those members receiving any evaluation and preventive services.

(A) **Comprehensive oral evaluation.** ~~Evaluation must be performed and recorded for each new patient, or established patient not seen for more than 18 months. This procedure is allowed once each 18 month period.~~ This procedure is performed for any member not seen by any dentist for more than 12 months.

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

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

~~(D) **Oral hygiene instructions.** This service is limited to once every 12 months. The designated dental staff instructs the member or the responsible adult (if the child is under five years of age) in proper tooth brushing and flossing by actual demonstration and provides proper verbal and/or written diet information. This service also includes dispensing a new tooth brush, and may include disclosing tablets and dental floss.~~

~~(E)~~ **(D) Radiographs (x-rays).** To be SoonerCare compensable, x-rays must be of diagnostic quality and medically necessary. A clinical examination must precede any radiographs, and chart documentation must include patient member history, prior radiographs, caries risk assessment and both dental and general health needs of the patient member. The referring dentist is responsible for providing properly identified x-rays of acceptable quality with a

referral, if that provider chooses to expose and submit for reimbursement prior to referral. Panoramic films are allowable once in a three year period and must be of diagnostic quality. Panoramic films are only compensable when chart documentation clearly indicates the test is being performed to rule out or evaluate non-caries related pathology. Prior authorization and a detailed medical need narrative are required for additional panoramic films taken within three years of the original set.

~~(F)~~(E) **Dental sealants.** Tooth numbers 2, 3, 14, 15, 18, 19, 30 and 31 must be caries free on ~~all~~ the interproximal and occlusal surfaces to be eligible for this service. This service is available through ~~18-0~~ 18 years of age and is compensable only once per lifetime. Replacement of sealants is not a covered service under the SoonerCare program.

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

~~(H)~~(G) **Composite restorations.**

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

- (I) tooth numbers O and P to age ~~4-0~~ 4 years;
- (II) tooth numbers E and F to age ~~6-0~~ 6 years;
- (III) tooth numbers N and Q to ~~5-0~~ 5 years; and
- (IV) tooth numbers D and G to ~~6-0~~ 6 years.

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

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

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

(i) posterior primary teeth when:

- (I) 50 percent or more root structure is remaining;
- (II) the teeth have no mobility; or
- (III) the procedure is provided more than 12 months prior to normal exfoliation.

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

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

(i) Stainless steel crowns are allowed if:

- (I) the child is five years of age or under;
- (II) 70 percent or more of the root structure remains; or
- (III) the procedure is provided more than 12 months prior to normal exfoliation.

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

- (I) primary teeth with pulpotomies or pulpectomies, if the above conditions exist;
- (II) primary teeth where three surfaces of extensive decay exist; or
- (III) primary teeth where cuspal occlusion is lost due to decay or accident.

(iii) Stainless steel crowns are the treatment of choice on posterior permanent teeth that have completed endodontic therapy, if more than three surfaces of extensive decay exist or where cuspal occlusion are lost due to decay prior to age ~~16-0~~ 16 years.

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

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

~~(K)~~ (J) **Pulpotomies and pulpectomies.**

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

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

(II) Tooth numbers O and P before age ~~5-0~~ 5 years;

(III) Tooth numbers E and F before ~~6-0~~ 6 years;

(IV) Tooth numbers N and Q before ~~5-0~~ 5 years; and

(V) Tooth numbers D and G before ~~6-0~~ 5 years.

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

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

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

(ii) Acceptable ADA filling materials must be used.

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

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

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

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

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

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

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

~~(M)~~ (L) **Space maintainers.** Certain limitations apply with regard to this procedure. Providers are responsible for recementation of any maintainer placed by them for six months post insertion.

(i) **Band and loop type space maintenance.** This procedure must be provided in accordance with the following guidelines:

(I) This procedure is compensable for all primary molars where permanent successor is missing or where succedaneous tooth is more than 5mm below the crest of the alveolar ridge or where the successor tooth would not normally erupt in the next 12 months.

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

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

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

(V) Post operative bitewing x-rays must be available for review.

(VI) Bilateral band and loop space maintainer is allowed if member does not have eruption of the four mandibular anterior teeth in position or if sedation case that presents limitations to fabricate other space maintenance appliances.

(ii) **Lingual arch bar.** Payment is made for the services provided in accordance with the following:

(I) Lingual arch bar is used where when permanent incisors are erupted and multiple missing teeth exist in the same arch.

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

(III) Multiple missing upper anterior primary incisors may be replaced with the appliance to age 6-0 6 years to prevent abnormal swallowing habits.

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

(iii) **Interim partial dentures.** This service is for anterior permanent tooth replacement or if the member is missing three or more posterior teeth to age 16-0 16 years of age.

~~(N)(M) **Analgesia.** Use of nitrous oxide is compensable for four occurrences per year. Analgesia services are reimbursable in accordance with the following:~~

(i) **Inhalation of nitrous oxide.** Use of nitrous oxide is compensable for four occurrences per year and is not separately reimbursable, if provided on the same date by the same provider as IV sedation, non-intravenous conscious sedation or general anesthesia. The need for this service must be documented in the member's record. This procedure is not covered when it is the dentist's usual practice to offer it to all patients.

(ii) **Non-intravenous conscious sedation.** Non-intravenous conscious sedation is not separately reimbursable, if provided on the same date by the same provider as analgesia, anxiolysis, inhalation of nitrous oxide, IV sedation or general anesthesia. Non-intravenous conscious sedation is reimbursable when determined to be medically necessary for documented handicapped members, uncontrollable members or justifiable medical or dental conditions. The report must detail the member's condition.

No services are reimbursable when provided primarily for the convenience of the member and /or the dentist, it must be medically necessary.

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

~~(P)(O) Sedative treatment restorations.~~ ADA acceptable materials must be used for temporary restoration. This restoration is used for very deep cavities to allow the tooth an adequate chance to heal itself or an attempt to prevent the need for root canal therapy. This restoration, when properly used, is intended to relieve pain and may include a direct or indirect pulp cap. The combination of a pulp cap and sedative fill is the only restorative procedure allowed per tooth per day. Subsequent restoration of the tooth is allowed after a minimum of 30 days. Sedative restorations include removal of decay, if present, and direct or indirect pulp cap, if needed. These services are reimbursable for the same tooth on the same date of service. Permanent restoration of the tooth is allowed after 30 days unless the tooth becomes symptomatic and requires pain relieving treatment.

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

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

~~(S)(R) Smoking and Tobacco Use Cessation Counseling.~~ Smoking and Tobacco Use Cessation Counseling is covered when performed utilizing the five intervention steps of asking the patient member to describe his/her smoking, advising the patient member to quit, assessing the willingness of the patient member to quit, assisting with referrals and plans to quit, and arranging for follow-up. Up to eight sessions are covered per year per individual who has documented tobacco use. It is a covered service when provided by physicians, physician assistants, nurse practitioners, nurse midwives, and Oklahoma State Health Department and FQHC nursing staff in addition to other appropriate services rendered. Chart documentation must include a separate note, separate signature, and the patient member specific information addressed in the five steps and the time spent by the practitioner performing the counseling. Anything under three minutes is considered part of a routine visit.

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

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

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

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

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



- (ii) Periodic oral evaluation as defined in OAC 317:30-5-696(3)(B);
- (iii) Emergency examinations/limited oral evaluation. This procedure is not allowed within two months of an oral examination by the same provider for the same patient member, or if the patient member is under active treatment;
- ~~(iv) Oral hygiene instructions as defined in OAC 317:30-5-696(a)(3)(E);~~
- ~~(v) (iv) Radiographs as defined in OAC 317:30-5-696(a)(3)(F) OAC 317:30-5-696(3)(D);~~
- ~~(vi) (v) Dental prophylaxis as defined in OAC 317:30-5-696(a)(3)(H) OAC 317:30-5-696(3)(F);~~
- ~~(vii) (vi) Composite restorations:~~
  - (I) Any permanent tooth that has an opened lesion that is a food trap will be deemed medically necessary for this program and will be allowed for all anterior teeth.
  - (II) Class I posterior composite resin restorations are allowed in posterior teeth that qualify;
- ~~(viii) (vii) Amalgam. Any permanent tooth that has an opened lesion that is a food trap will be deemed as medically necessary and will be allowed; and~~
- ~~(ix) (viii) Analgesia. Use of nitrous oxide is compensable for four occurrences. Analgesia services are reimbursable in accordance with OAC 317:30-5-696(iii)(M)~~

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

(E) Periodontal scaling and root planing. Required that 50% or more of six point measurements be 4 5 millimeters or greater. This procedure is designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins and microorganism and requires anesthesia and some soft tissue removal.

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

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

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

**317:30-5-698. Services requiring prior authorization**

(a) Providers must have prior authorization for certain specified services before delivery of that service, unless the service is provided on an emergency basis (See OAC 317:30-5-695(d)(2). ~~Emergency dental care is immediate service that must be provided to relieve the member from pain due to an acute infection, swelling, trismus or trauma.~~ Requests for dental services requiring prior authorization must be accompanied by sufficient documentation. ~~Study models (where indicated), x-rays X-rays, six point periodontal charting, and comprehensive treatment plan plans are required.~~ Study models and narrative narratives may be requested by OHCA or representatives of OHCA. If the quality of the supporting material is such that a determination of authorization cannot be made, the material is returned to the provider. Any new documentation must be provided at the provider's expense. Submitted documentation used to base a decision will not be returned.

(b) Requests for prior authorization are filed on the currently approved ADA form. OHCA notifies the provider on the determination of prior authorization

using OHCA Prior Authorization Request Decision form. Prior authorized services must be billed exactly as they appear on the prior authorization. Payment is not made for any services provided prior to receiving authorization except for the relief of pain.

(c) Prosthodontic services provided to members who have become ineligible mid-treatment are covered if the member was eligible for SoonerCare on the date the final impressions were made.

(d) Listed below are examples of services requiring prior authorization for members under 21 and eligible ICF/MR residents. Minimum required records to be submitted with each request are right and left mounted bitewing x-rays and periapical films of tooth/teeth involved or the edentulous areas if not visible in the bitewings. X-rays must be ~~mounted so that they are viewed from the front of the member. If required x-rays sent are copies, submitted with x-ray film mounts and each film or print must be of good, readable quality. X-rays must be and identified by as to left and right sides with the date, member name, member ID, provider name, and provider ID. All x-rays, regardless of the media, must be placed together in the same envelope with a completed comprehensive treatment plan and a completed current ADA form requesting all treatments requiring prior authorization. The film, digital media or printout must be of sufficient quality to clearly show the requested service area of interest demonstrate for the reviewer, the pathology which is the basis for the authorization request. X-rays must be identified with member name, date, member ID number, provider name, and provider ID number and as right or left side. X-rays must be placed together in an envelope and stapled to the submission form~~ If radiographs are not taken, provider must include in narrative sufficient information to confirm diagnosis and treatment plan.

(1) **Endodontics.** Pulpotomy may be performed for the relief of pain while waiting for the decision from the OHCA on request for endodontics. A permanent restoration is not billable to the OHCA when performing pulpotomy or pulpal debridement on a permanent tooth.

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

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

(ii) Accepted ADA ~~filling~~ filling materials must be used.

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

(iv) Providers are responsible for any follow-up treatment required by a failed endodontically treated tooth within 24 months post completion.

(v) A tooth will not be approved if it appears there is not adequate natural tooth structure remaining to establish good tooth/restorative margins or if crown to root ratio is poor.

(vi) An endodontic procedure may not be approved if the tooth requires a post and core ~~in order to present adequate structure to~~ retain a crown.

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

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

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

(ii) Teeth that would require pre-fabricated post and cores to ~~minimally~~ retain a crown restoration due to lack of natural tooth structure should not be treatment planned for root canal therapy.

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

(iv) Providers are responsible for any follow-up treatment required by a failed endodontically treated tooth within 24 months post completion.

(v) A tooth will not be approved if it appears there is not adequate natural tooth structure remaining to establish good tooth/restorative margins or if there is a poor crown to root ratio or weakened root furcation area. Approval of second molars is contingent upon proof of medical necessity.

(vi) Only ADA accepted ~~filling~~ materials are acceptable under the OHCA policy.

(vii) Posterior endodontic procedure is limited to a maximum of five teeth. A request may not be approved if the tooth requires a post and core in order to present adequate structure to retain a crown.

(viii) Endodontics will not be considered if:

(I) there are missing teeth in the same arch requiring replacement;

(II) an opposing tooth has super erupted;

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

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

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

(ix) Endodontically treated teeth must be restored to limited occlusal function and all contours must be replaced. Core build-up code is only available for use if other restorative codes are not sufficient. These teeth will not be approved for a crown if it appears the apex is not adequately sealed.

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

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

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

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

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

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

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

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

(D) A crown will not be approved if adequate tooth structure does not remain to establish cleanable margins, poor crown to root ratio, or

the tooth appears to retain insufficient amounts of natural tooth structure. Cast dowel cores are not allowed.

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

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

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

~~(G)~~(H) Full cast metal crowns are treatment ~~of choice~~ for all posterior teeth,

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

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

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

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

(6) **Fixed cast non-precious metal or porcelain/metal bridges.** Only members 17 through 20 years of age where the bite relationship precludes the use of an acrylic or cast frame partial denture removable partial dentures are considered. ~~Study models with narrative are required to substantiate need for fixed bridge(s).~~ Members must have excellent oral hygiene documented in the requesting provider's records. Provider is responsible for any needed follow up for a period of five years post insertion.

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

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

- (A) dilantin hyperplasia;
- (B) cerebral palsy;
- (C) mental retardation;
- (D) juvenile periodontitis.

### 317:30-5-699. Restorations

(a) **Use of posterior composite resins.** Payment is not made for certain restorative services when posterior composite resins are used in restorations involving:

- (1) replacement of any occlusal cusp ~~+~~ or
- (2) sub-gingival margins; ~~and~~
- ~~(3) a restoration replacing more than 50 percent of the dentin.~~

(b) **Utilization parameters.** The Oklahoma Health Care Authority utilization parameters allow only one permanent restorative service to be provided per tooth per ~~12~~ 18 months. Additional restorations may be authorized upon approval of OHCA in cases of trauma. Teeth receiving a restoration are eligible within three months for consideration of single crown if endodontically treated. Providers must document use of rubber dam isolation in daily treatment progress notes. The provider is responsible for follow-up or any required replacement of a failed restoration, if the member is currently SoonerCare eligible. Fees paid for the original restorative services may be recouped if any additional treatments are required on the same tooth by a different provider within 12 months due to defective restoration or recurrent decay. If it is determined by the Dental Director that a member has received poorly rendered or insufficient treatment from a provider, the Dental Director may prior authorize corrective procedures by a second provider.

(c) **Coverage for dental restorations.** Restoration of incipient lesions is not considered medically necessary treatment. Any diagnosis not supported by radiographs requires documentation of the medical need on which the diagnosis was made. Services for dental restorations are covered as follows:

(1) If the mesial occlusal pit and the distal occlusal pit on an upper molar tooth are restored at the same appointment, this is a one surface restoration.

(2) If any two separate surfaces on a posterior tooth are restored at the same appointment, it is a two surface restoration.

(3) If any three separate surfaces on a posterior tooth are restored at the same appointment, it is a three surface restoration.

(4) If the mesial, distal, facial and/or lingual of an upper anterior tooth is restored at the same appointment, this is a four surface restoration.

(5) If any two separate surfaces on an anterior tooth are restored at the same appointment, it is a two surface restoration.

(6) If any three separate surfaces on an anterior tooth are restored at the same appointment, it is a three surface restoration.

(7) An incisal angle restoration is defined as one of the angles formed by the junction of the incisal and the mesial or distal surface of an anterior tooth. If any of these surfaces are restored at the same appointment, even if separate, it is considered as a single incisal angle restoration.

(8) When four or more separate surfaces on a posterior tooth are restored at the same appointment it is a four surface restoration.

(9) Wide embrasure cavity preparations do not become extra surfaces unless at least one half of cusp or surface is involved in the restoration. An MODFL restoration would have to include the mesial-occlusal-distal surfaces as well as either the buccal groove pit or buccal surface or at least one half the surface of one of the buccal cusps. The same logic applies for the lingual surface.

(d) **Sedative restorations.** Sedative restorations include removal of decay, if present, and direct or indirect pulp cap, if needed. These two codes are the only codes that may be used for the same tooth on the same date of service. Permanent restoration of the tooth is allowed after 30 days unless the tooth becomes symptomatic and requires pain relieving treatment.

(e) **Pulp caps.** Indirect and direct pulp cap must be ADA accepted materials, not a cavity liner. Indirect pulp cap code requires specific narrative support addressing materials used, intent and reasons for use. Utilization of these codes are verified on a post payment review.

6.a-52 **TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY**  
**CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**  
Subchapter 3. General Provider Policies  
Part 3. General Medical Program Information  
317:30-3-43. [AMENDED]  
Subchapter 5. Individual Providers and Specialties  
Part 9. Long Term Care Facilities  
317:30-5-122. [AMENDED]  
Part 41. Family Support Services  
317:30-5-412. [AMENDED]  
**CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY**  
Subchapter 9. ICF/MR, HCBW/MR, and Individuals  
Age 65 or Older In Mental Health Hospitals  
Part 1. Services  
317:35-9-4. [AMENDED]  
317:35-9-5. [AMENDED]  
317:35-9-5.1. [REVOKED]  
PART 5. Determination of Medical Eligibility For  
ICF/MR, HCBW/MR, and Individuals Age 65 or Older  
In Mental Health Hospitals  
317:35-9-45. [AMENDED]  
**CHAPTER 40. DEVELOPMENTAL DISABILITIES SERVICES**  
Subchapter 1. General Provisions  
317:40-1-1. [AMENDED]  
Subchapter 5. Member Services  
Part 1. Agency Companion Services  
317:40-5-8. [AMENDED]  
Part 3. Guidelines to Staff  
317:40-5-40. [AMENDED]  
Part 5. Specialized Foster Care  
317:40-5-55. [AMENDED]  
317:40-5-59. [AMENDED]  
Part 9. Service Provisions  
317:40-5-100. [AMENDED]  
317:40-5-103. [AMENDED]  
317:40-5-113. [AMENDED]  
Subchapter 7. Employment Services through Home and Community-Based  
Services Waivers  
317:40-7-5. [AMENDED]  
317:40-7-7. [AMENDED]  
317:40-7-15. [AMENDED]  
317:40-7-21. [AMENDED]  
Subchapter 9. Self-Directed Services  
317:40-9-1. [AMENDED]  
**(Reference APA WF 10-59 A, B & C)**

**SUMMARY:** Rules are revised to clarify policy for: Eligibility for services in an ICF/MR and HCBS waiver for persons with mental retardation and related conditions, screening process for in-home supports providers, back-up plan provisions for specialized foster care members and allowance for natural supports within the specialized foster care member's home. Clarification is also provided on training requirements for providers of job coaching services and the limits on goods and services provided through Self-Direction. Additionally policy is revised to clarify provider qualifications for assistive technology devices, and the procurement review/approval process for assistive technology devices. Further policy revisions include

clarification of transportation provider responsibilities, services not covered and limits on the types of adapted transportation allowable. Lastly, policy is revised to include clarification of family training provider qualifications and coverage limitations.

**BUDGET IMPACT:** Agency staff has determined that these revisions are budget neutral.

**MEDICAL ADVISORY COMMITTEE:** The Medical Advisory Committee considered the proposed rule revisions on March 9, 2011, and recommended Board approval.

**AUTHORITY:** The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes

**PUBLIC HEARING:** A public hearing was held on February 22, 2011. No comments were received before, during, or after the hearing.

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

**317:30-3-43. Services in an Intermediate Care Facility for the Mentally Retarded**

~~Services in an ICF/MR facility are provided to individuals with chronic mental retardation, a condition characterized by a significantly sub average general intellectual functioning existing concurrently with deficits in adaptive behavior and originating during the developmental period. Care also can be provided for the individual who is not mentally retarded but has developmental disabilities closely related to or requiring treatment similar to mental retardation. In addition to the developmental disability, he must have one or more handicapping conditions which prevent communication of basic needs, ability to meet basic self help needs, or requires care and treatment similar to that of a mentally retarded individual. To be eligible for ICF/MR services, mental retardation or developmental disability must have occurred prior to the individual's 22nd birthday per OAC 317:30-5-122 and OAC 317:35-9-45.~~

**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES  
PART 9. LONG TERM CARE FACILITIES**

**317:30-5-122. Levels of care**

~~The level of care provided by a long term care facility to a patient is based on the nature of the health problem requiring care and the degree of involvement in nursing services/care needed from personnel qualified to give this care.~~

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

(b) The level of care provided by a long term care facility or through a HCBS

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

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

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

(3) **Intermediate Care Facility for the Mentally Retarded.** ~~Care provided by a nursing facility to patients who require care and active treatment due to mental retardation or developmental disability combined with one or more handicaps. The mental retardation or developmental disability must have originated during the patient's developmental years (prior to 22 years of chronological age).~~ Care for persons with mental retardation or related conditions to provide health and/or habilitative services in a protected residential setting. To qualify for ICF/MR level of care, persons must have substantial functional limitations in three or more of the following areas of major life activity:

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

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

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

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

(E) Self-direction. The individual is 7 years old or older and significantly at risk in making age appropriate decisions or an adult who is unable to provide informed consent for medical care, personal safety or for legal, financial, habilitative or residential issues and/or has been declared legally incompetent. The individual is a danger to himself or others without supervision.

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

## **PART 41. FAMILY SUPPORT SERVICES**

### **317:30-5-412. Description of services**

Family support services include services identified in paragraphs (1) through (6). Providers of any family support service must have an applicable SoonerCare Provider Agreement for Home and Community Based Services (HCBS) Waiver Providers for persons with developmental disabilities.

(1) **Transportation services.** Transportation services are provided ~~in accordance with~~ per OAC 317:40-5-103.



(2) ~~Adaptive equipment~~ Assistive technology (AT) devices and services. ~~Adaptive equipment Assistive technology devices and services, also known as environmental accessibility adaptations, services are provided in accordance with OAC 317:40-5-100.~~

(3) **Architectural modification.** Architectural modification services are provided in accordance with per OAC 317:40-5-101.

(4) **Family training.**

(A) **Minimum qualifications.** ~~Training providers must hold current licensure as a clinical social worker, psychologist, professional counselor, or registered nurse. Training may also be provided by other local or state agencies whose trainers have been approved by the Oklahoma Department of Human Services Developmental Disabilities Services Division (DDSD) director of Human Resource Development.~~

(i) Individual providers must have a DDSD Family Training application and training curriculum approved by DDSD staff. Individual providers must hold current licensure, certification or a Bachelor's Degree in a human service field related to the approved training curriculum. Only individuals named on the SoonerCare Provider Agreement to provide Family Training services may provide service to members;

(ii) Agency or business providers must have a DDSD Family Training application and training curriculum approved by DDSD staff. Agency or business provider training staff must hold current licensure, certification or a Bachelors Degree in a human service field related to the approved training curriculum. The credentials of new training staff hired by an approved DDSD HCBS Family Training agency or business provider must be submitted to and approved by the DDSD program manager for Family Training prior to new staff training members or their families.

(B) **Description of services.** Family training services include instruction in skills and knowledge pertaining to the support and assistance of members. Services are:

(i) intended to allow families to become more proficient in meeting the needs of members who are eligible;

(ii) provided in any community setting;

(iii) provided in either group, consisting of two to 15 persons, or individual formats; and

~~(iv) for families of members served through DDSD Home and Community Based Services (HCBS) Waivers and their families. For the purpose of this service, family is defined as any person who lives with or provides care to a member served on the waiver Waiver.~~

(v) included in the member's Individual Plan (Plan) and arranged through the member's case manager; and

(vi) intended to yield outcomes as defined in the member's Plan.

(C) **Coverage limitations.** Coverage limitations for family training are:

~~(i) Description: Individual family training; Limitation: \$5,500 per Plan of Care year; and~~

~~(ii) Description: Group family training; Limitation: \$5,500 per Plan of Care year; ;~~

(iii) Session rates for individual and group sessions should not exceed a range comparable to rates charged by persons with similar credentials providing similar services;

(iv) Rates must be justified based on costs incurred to deliver the service and will be evaluated to determine if costs are reasonable.

(D) **Documentation requirements.** Providers must maintain documentation

fully disclosing the extent of services furnished that specifies:

- (i) service date;
- (ii) start and stop time for each session;
- (iii) signature of the trainer;
- (iv) credentials of the trainer;
- (v) specific issues addressed. ~~Issues must be identified in the member's Individual Plan (IP);~~
- (vi) methods used to address issues;
- (vii) progress made toward outcomes;
- (viii) member's response to the session or intervention; and
- (ix) any new ~~issued~~ issues identified during the session.
- (x) Progress reports for each member served must be submitted to the DDS case manager per OAC 340:100-5-52.
- (xi) An annual report of the provider's overall Family Training program including statistical information about members served, their satisfaction with services, trends observed, changes made in the program and program recommendations must be submitted to the DDS program manager for Family Training on an annual basis.

(5) **Family counseling.**

(A) **Minimum qualifications.** Counseling providers must hold current licensure as a clinical social worker, psychologist, or licensed professional counselor (LPC).

(B) **Description of services.** Family counseling, offered specifically to members and their natural, adoptive, or foster family members, helps to develop and maintain healthy, stable relationships among all family members.

(i) Emphasis is placed on the acquisition of coping skills by building upon family strengths.

(ii) Knowledge and skills gained through family counseling services increase the likelihood that the member remains in or returns to his or her own home.

(iii) All family counseling needs are documented in the member's ~~IP~~ Plan.

(iv) Services are rendered in any confidential setting where the member/family resides or the provider conducts business.

(C) **Coverage limitations.** Coverage limitations for family counseling are:

(i) ~~Description:~~ Individual family counseling; Unit: 15 minutes; Limitation: 400 units per Plan of Care year; and

(ii) ~~Description:~~ Group (six person maximum) family counseling; Unit: 30 minutes; Limitation: 225 units per Plan of Care year.

(D) **Documentation requirements.** Providers must maintain documentation fully disclosing the extent of services furnished that specifies:

- (i) service date;
- (ii) start and stop time for each session;
- (iii) signature of the therapist;
- (iv) credentials of the therapist;
- (v) specific issues addressed. ~~Issues must be identified in the member's IP;~~
- (vi) methods used to address issues;
- (vii) progress made toward resolving issues and outcomes;
- (viii) member's response to the session or intervention; and
- (ix) any new issue identified during the session.

(E) Reporting requirements. Progress reports for each member served must be submitted to the DDS case manager per OAC 340:100-5-52.

(6) Specialized medical supplies. Specialized medical supplies are provided per 317:40-5-104.

- ~~(A) **Minimum qualifications.** Providers must:~~
- ~~(i) be registered to do business in Oklahoma or in the state in which they are domiciled;~~
  - ~~(ii) have a Medicaid contract with Oklahoma Health Care Authority to provide unrestricted durable medical equipment to members receiving HCBS; and~~
  - ~~(iii) enter into this agreement:~~
    - ~~(I) giving assurance of ability to provide products and services; and~~
    - ~~(II) agree to the audit and inspection of all records concerning goods and services provided.~~
- ~~(B) **Description of services.** Specialized medical supplies include supplies specified in the member's IP that enable the member to increase his or her ability in the performance of activities of daily living. Specialized medical supplies also include the purchase of ancillary supplies not available under the Medicaid State Plan.~~
- ~~(i) Supplies furnished through an HCBS waiver are in addition to any supplies furnished under the Medicaid State Plan and exclude those items that are not of direct medical and remedial benefit to the member.~~
  - ~~(ii) All supplies must meet applicable standards of manufacture, design, and installation.~~
  - ~~(iii) Supplies include, but are not limited to:~~
    - ~~(I) adult briefs;~~
    - ~~(II) nutritional supplements;~~
    - ~~(III) supplies needed for respirator/ventilator care;~~
    - ~~(IV) supplies needed for health conditions;~~
    - ~~(V) supplies for decubitus care; and~~
    - ~~(VI) supplies for catheterization.~~
- ~~(C) **Coverage limitations.** Specialized medical supplies are billed using the appropriate procedure code. Individual limits are specified in each member's IP. All services are authorized in accordance with OAC 317:40-5-104.~~

**SUBCHAPTER 9. ICF/MR, HCBW/MR, AND INDIVIDUALS  
AGE 65 OR OLDER IN MENTAL HEALTH HOSPITALS  
PART 1. SERVICES**

**317:35-9-4. Services in Intermediate Care Facility for Mentally Retarded persons with Mental Retardation (public and private)**

- ~~(a) Services in an Intermediate Care Facility for Mentally Retarded (ICF/MR) are provided to an individual with mental retardation, which is a chronic condition characterized by a significantly sub average general intellectual functioning (IQ score of 75 or below) existing concurrently with deficits in adaptive behavior and originating during the developmental period. Care also can be provided for the individual who is not mentally retarded but has developmental disabilities closely related to or requiring similar treatment to mental retardation. In addition to the developmental disability, the individual must have one or more handicapping conditions which prevent communication of basic needs, ability to meet basic self help needs, or require care and treatment similar to that of a mentally retarded individual (see OAC 340:100). To be eligible for ICF/MR services, mental retardation or developmental disability must have occurred prior to the individual's 22nd birthday.~~
- ~~(b) ICF/MR services are provided in long term care facilities (public and private) which are licensed under state law to provide, on a regular basis, health related care and services to individuals who because of their physical~~

or mental condition require services above the level of room and board care which can be made available to them only through an ICF/MR.

(a) Services in a private Intermediate Care Facility for persons with Mental Retardation (ICF/MR) may be provided to members requiring health or habilitative services above the level of room and board. Services are provided to members who meet level of care and eligibility requirements per OAC 317:30-5-122 and 317:35-9-45.

(b) Services in a public ICF/MR may be provided to members who require health or habilitative services above the level of room and board. Services are provided to members who meet level of care requirements per OAC 317:30-5-122.

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

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

(b) ~~Individuals with mental retardation are eligible for SoonerCare as categorically needy under the HCBS Waiver program when eligibility conditions in (1) through (5) are met:~~

(1) The individual is determined financially eligible per OAC 317:35-9-68;

(2) The individual meets the Social Security Administration (SSA) definition of disabled;

(3) The individual requires a level of care provided in a public or private intermediate care facility for persons with mental retardation (ICF/MR) and has a diagnosis of mental retardation as defined in the Diagnostic Manual Intellectual Disability: A Textbook of Diagnosis of Mental Disorders in Persons with Intellectual Disability;

(4) It is appropriate to provide care outside the ICF/MR; and

(5) The average cost of providing care outside the ICF/MR does not exceed the cost of providing institutional care.

(b) Members receiving HCBS Waiver services per OAC 317:40-1-1 are subject to HCBS Waiver service conditions (1)-(11) of this subsection. The rules in this subsection shall not be construed as a limitation of the rights of class members set forth in the Second Amended Permanent Injunction in Homeward Bound vs. The Hissom Memorial Center.

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

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

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

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

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

(4) Members receiving Waiver services must have full access to State plan services for which they are eligible including Early and Periodic

Screening, Diagnosis and Treatment (EPSDT) services when children participate in a Waiver.

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

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

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

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

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

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

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

### **317:35-9-5.1. Home and Community Based Waiver Services for individuals with mental retardation and related conditions--[REVOKED]**

~~(a) Home and Community Based Waiver Services for individuals with mental retardation and related conditions are services which are outside the normal scope of Medicaid services. The Medicaid waiver allows the OHCA to offer certain home and community based services to categorically needy individuals who reside in nursing facilities and who have been determined not to require that level of care.~~

~~(b) Individuals with mental retardation and related conditions are eligible for Medicaid as categorically needy under the HCBW Program when the following medical and financial eligibility conditions are met:~~

~~(1) The individual is categorically needy as his/her income and resources are within the standards as listed on the appropriate schedule of DHS Appendix C 1, Schedule VIII. B. and D.~~

~~(2) The individual meets the SSA test for disability.~~

~~(3) For an individual subject to the provisions of Public Law 100-203, the individual does not require the level of care provided in a nursing facility but resided there for at least 30 continuous months prior to January 1, 1989.~~

~~(4) The average cost of providing care outside the NF does not exceed the cost of providing ICF/MR care.~~

~~(5) The individual, or responsible party acting on his/her behalf, chooses HCBW Services.~~

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

### **317:35-9-45. Determination of medical eligibility for care in a private ICF/MR Intermediate Care Facility for the Mentally Retarded Persons with Mental Retardation**

~~(a) Pre-approval of medical eligibility. Pre-approval of medical eligibility for private ICF/MR care is based on results of a current comprehensive psychological evaluation by a licensed psychologist or state staff psychologist, documentation of MR or related condition prior to age 22, and the need for active treatment according to federal standards level of care~~

requirements per OAC 317:30-5-122. Pre-approval is not necessary for individuals ~~who are severely or profoundly retarded~~ with a severe or profound intellectual disability (mental retardation). Pre-approval is made by Oklahoma Health Care Authority (OHCA) Level of Care Evaluation Unit ~~LOCEU~~ (LOCEU) analysts.

(b) ~~Medical eligibility Application~~ Application for ICF/MR services. Within ~~10~~ 30 calendar days after services begin, the facility must submit:

(1) the original of the ~~Nursing Facility Level of Care Assessment (Form LTC-300R)~~ ICF/MR Level of Care Assessment form (LTC-300) to LOCEU.

Required attachments include:

(A) ~~current~~ Current (within 90 days of requested approval date) medical information signed by a physician~~7~~.

(B) ~~a~~ A current (within 12 months of requested approval date) psychological evaluation~~7~~ by a licensed Psychologist or State staff supervised by a licensed Psychologist. The evaluation must include intelligence testing that yields a full-scale intelligence quotient, a full-scale functional or adaptive assessment, as well as the age of onset.

(C) ~~a~~ A copy of the pertinent section of the Individual Developmental Plan or other appropriate documentation relative to ~~discharge planning~~ the ICF/MR admission and the need for ICF/MR level of care~~7~~.

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

If pre-approval was determined by LOCEU and the above information is received, medical approval will be entered on an electronic medical case list known as MEDATS. Pre-approval is not needed for individuals ~~who are classified as being severely or profoundly mentally retarded on current psychological evaluation with a severe or profound intellectual disability (mental retardation).~~

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

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

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

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

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

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

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

(ii) it is attributable to any other condition, other than mental illness, found to be closely related to intellectual disability (mental retardation) because this condition results in impairment of general intellectual functioning or adaptive behavior similar to

that of persons with intellectual disability (mental retardation) and requires treatment or services similar to those required for these persons.

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

(iv) It is likely to continue indefinitely.

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

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

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

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

(iii) fetal alcohol syndrome;

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

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

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

(i) learning disability;

(ii) behavior or conduct disorders;

(iii) substance abuse;

(iv) hearing impairment or vision impairment;

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

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

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

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

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

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

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

## **SUBCHAPTER 1. GENERAL PROVISIONS**

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

**(a) Applicability.** The rules in this Section apply to services funded through Medicaid HCBS Waivers per OAC 317:35-9-5, and as defined in Section 1915(c) of the Social Security Act and ~~administered by the Oklahoma Department of Human Services (OKDHS), Developmental Disabilities Services Division (DDSD).~~ The specific waivers are the In-Home Supports Waiver (IHSW) for Adults, the In-Home Supports Waiver (IHSW) for Children, the Community

Waiver, and the Homeward Bound Waiver.

~~(b) **Program Administration.** Services funded through a HCBS Waiver for persons with mental retardation or for certain persons with related conditions are administered by DDS, under the oversight of the Oklahoma Health Care Authority (OHCA), the State Medicaid agency. The rules in this subsection do not limit the rights of class members set forth in the Second Amended Permanent Injunction in Homeward Bound vs. The Hisson Memorial Center.~~

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

~~(2) DDS must limit the utilization of the HCBS Waiver services based on:~~  
~~(A) the federally approved member capacity for the individual HCBS Waivers;~~  
~~(B) the cost effectiveness of the individual HCBS Waivers as determined according to federal requirements; and~~  
~~(C) State appropriations.~~

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

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

~~(1) accessing, with the assistance of OKDHS staff, all benefits available under Oklahoma's Medicaid State Plan or other payment sources prior to accessing funding for those same services under a HCBS Waiver program;~~  
~~(2) cooperating in the determination of medical and financial eligibility, including prompt reporting of changes in income or resources; and~~  
~~(3) choosing between services provided through a HCBS Waiver services and institutional care.~~

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

~~(1) Services provided through a HCBS Waiver services are available to Oklahoma residents meeting SoonerCare eligibility requirements established by law, regulatory authority, and policy within funding available through State or Federal resources. To be eligible for and receive services funded through any of the Waivers listed in subsection (a) of this Section, a person must first meet conditions per OAC 317:35-9-5. The individual must be determined financially eligible for SoonerCare through the OKDHS Family Support Services Division per OAC 317:35-9-68. The SoonerCare eligible individual may not simultaneously be enrolled in any other Medicaid Waiver program or receiving services in an institution including a hospital, rehabilitation facility, mental health facility, nursing facility, residential care facility as described in Section 1-819 of Title 63 of Oklahoma Statutes, or Intermediate Care facility for persons with mental retardation (ICF/MR). The individual may not be receiving DDS state-funded services such as the Family Support Assistance Payment, Respite Voucher Program, sheltered workshop services, community integrated employment services, or assisted living without waiver supports per OAC 340:100-5-22.2. The individual must also meet other Waiver-specific eligibility criteria.~~

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

~~(i) meet all criteria for HCBS Waiver services given in subsection ~~(d) (c)~~ of this Section; and~~  
~~(ii) be determined to have a disability and a diagnosis of intellectual disability (mental retardation) by the Social Security~~



Administration (SSA); or

~~(ii) (iii) be determined to have a disability, with and a diagnosis of intellectual disability (mental retardation) as defined in the Diagnostic Manual Intellectual Disability: A Textbook of Diagnosis of Mental Disorders in Persons with Intellectual Disability, and Statistical Manual of Mental Disorders by the OHCA Level of Care Evaluation Unit (LOCEU);~~

~~(I) the Social Security Administration; or~~

~~(II) the OHCA, Level of Care Evaluation Unit (LOCEU);~~

~~(iii) (iv) be three years of age or older;~~

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

~~(v) (vi) reside in:~~

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

~~(II) his or her own home;~~

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

~~(IV) a CFSD group home; and~~

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

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

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

~~(ii) be age three or older;~~

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

~~(iv) be determined, in accordance with either subunit I or both subunits II and III of this unit:~~

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

~~(I) (iii) to have intellectual disability (mental retardation) as defined in the Diagnostic Manual Intellectual Disability: A Textbook of Diagnosis of Mental Disorder in Persons with Intellectual Disability and Statistical Manual of Mental Disorders or a related condition per OAC 317:35-9-45 by the DDS and to be covered under the State's alternative disposition plan adopted under Section 1919(e)(7)(E) of the Social Security Act; or~~

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

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

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

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

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

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

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

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

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

~~(II)~~ (v) meet the ICF/MR Institutional Level of Care requirements have a disability and a diagnosis of intellectual disability (mental retardation) as defined in the Diagnostic and Statistical Manual of Mental Disorders by the OHCA/LOCEU; and

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

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

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

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

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

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

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

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

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

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

(3) The OHCA reviews the diagnostic reports listed in paragraph (2) of this subsection and makes a determination of eligibility for DDS services and ICF/MR level of care for the services funded through an IHSW or the Community Waiver HCBS Waivers.

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

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

opportunity to exercise informed choice in the selection of services.

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

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

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

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

(A) is found to be ineligible for services;

(B) cannot be located by OKDHS;

(C) does not provide required information to OKDHS;

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

~~(E) is offered declines an offer of Waiver services through either an IHSW or the Community Waiver and declines services.~~

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

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

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

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

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

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

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

(I) is hospitalized;

(II) has moved into a nursing facility;

(III) is permanently incapacitated; or

(IV) has died; and

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

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

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

(C) the behavior or condition of the person needing services is such that others in the home are at risk of being seriously harmed by the

person. For example, the person is routinely physically assaultive to the caretaker or others living in the home and sufficient supervision cannot be provided to ensure the safety of those in the home or community; or

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

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

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

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

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

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

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

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

(B) funding is available ~~in accordance with subsection (b) of this Section per OAC 317:35-9-5.~~

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

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

~~(i)~~ **(h) Continued eligibility for HCBS Waiver services.** Eligibility for ~~children~~ members receiving services provided through the HCBS Waiver ~~services~~ is re-determined by the OHCA/LOCEU if when a determination of disability ~~due to mental retardation~~ has not been made by the Social Security Administration. ~~when the~~ The OHCA/LOCEU determines categorical relationship to the SoonerCare program disabled category according to Social Security Administration guidelines. OHCA/LOCEU also approves level of care per ~~OAC 317:35-9-5~~ OAC 317:30-5-122 and confirms a diagnosis of intellectual disability (mental retardation) as defined in the Diagnostic and Statistical Manual of Mental Disorders. DDS may require a new diagnostic evaluation in accordance with paragraph ~~(d)~~ (c) (2) of this subsection and re-determination

of eligibility at any time when a significant change of condition, disability, or psychological status determined under paragraph ~~(d)~~ (c) (2) of this Section has been noted.

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

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

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

- (1) the situation resulting in case closure of a Hissom class member is resolved;
- (2) a member is incarcerated for 90 days or less;

(3) a member is admitted to a nursing facility, ICF/MR, residential care facility, hospital, rehabilitation facility, or mental health facility for 90 days or less; or

(4) a member's SoonerCare eligibility is re-established within 90 days of the date of SoonerCare ineligibility.

**SUBCHAPTER 5. MEMBER SERVICES**  
**PART 1. AGENCY COMPANION SERVICES**

**317:40-5-8. Agency companion services service authorization budget**

Upon approval of the home profile per OAC 317:40-5-40, the companion, provider agency, the Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDSD) case manager, agency companion services (ACS) staff, and others as appropriate meet to develop a service authorization budget. The service authorization budget form is used to develop the individual service budget for the member's program and is updated annually by the member's Personal Support Team (Team).

(1) The companion receives:

(A) a salary based on the level of support needed by the member. The level of support is determined by authorized DDSD staff per OAC 317:40-5-3. The ACS rate for the:

(i) employer model includes funding for the provider agency for the provision of benefits to the companion; and

(ii) contractor model does not include funding for the provider agency for the provision of benefits to the companion; ~~and.~~

(B) any combination of hourly or daily respite per Plan of Care year to equal 660 hours in order to provide respite to the companion as reflected on the service authorization budget form.

(C) Habilitation training specialist (HTS) services:

(i) may be approved by the DDSD director or designee when providing ACS with additional support represents the most cost-effective placement for the member and the member has an ongoing pattern of not:

(I) sleeping at night; or

(II) working or attending employment services, with documented and continuing efforts by the Team.

(ii) may be approved when a time limited situation exists in which the ACS provider is unable to provide ACS and the provision of HTS will maintain the placement or provide needed stability to the member; and must be reduced when the situation changes.

(iii) must be reviewed annually or more often if needed, which includes a change in agencies or individual companion providers.

(2) The service authorization budget form reflects the amount of room and board the member pays to the companion. If the amount exceeds \$450, the increase must be:

(A) agreed to by the member and, if applicable, legal guardian;

(B) recommended by the Team; and

(C) submitted with written justification attached to the service authorization budget form to the DDSD area manager or designee for approval.

(3) A back-up plan identifying respite staff is developed by the provider agency program coordination staff and companion, prior to the meeting to discuss the service authorization budget.

(A) The back-up plan:

(i) is submitted to the DDSD case manager ~~and attached to the completed service authorization form~~ for review and approval;

(ii) describes expected and emergency back-up support and program

monitoring for the home; and

(iii) is ~~signed by the companion, provider agency representative, and DDS case manager~~ reviewed initially and annually by the SFC specialist.

(B) The companion and provider agency program coordination staff equally share the responsibility to identify approved respite providers who are:

- (i) knowledgeable about the member;
- (ii) trained to implement the member's Individual Plan (Plan);
- (iii) trained per OAC 340:100-3-38; and
- (iv) when possible, involved in the member's daily life.

(C) The spouse or other adult residing in the home may provide ACS in the absence of the companion, when trained per OAC 340:100-3-38.

(D) The spouse or other adult residing in the home cannot serve as paid respite staff.

(4) The companion and respite staff are responsible for the cost of their meals and entertainment during recreation and leisure activities. Activities selected must be affordable to the member and respite staff. Concerns about affordability are presented to the Team for resolution.

(5) The member is allowed therapeutic leave per OAC 317:40-5-3.

### PART 3. GUIDELINES TO STAFF

#### 317:40-5-40. Home profile process

(a) **Applicability.** This Section ~~sets forth~~ establishes procedures for the home profile process ~~used for:~~ A home profile is required for:

- (1) agency companion services (ACS);
- (2) specialized foster care (SFC) services;
- (3) respite services delivered in the provider's home;
- (4) approving a habilitation training specialist (HTS) or other provider to provide services overnight in the HTS's or other provider's home services in a home shared by a non-relative provider and a member; and
- (5) any other situation that requires a home profile.

(b) **Pre-screening.** Designated Developmental Disabilities Services Division (DDSD) staff provides the applicant with program orientation and pre-screening information that includes, but is not limited to:

- (1) facts, description, and guiding principles of the Home and Community-Based Services (HCBS) program;
- (2) an explanation of:
  - (A) the home profile process;
  - (B) basic qualifications of the provider;
  - (C) health, safety, and environmental issues; and
  - (D) training required per OAC 340:100-3-38;
- (3) the Oklahoma Department of Human Services (OKDHS) Form 06AC012E, Specialized Foster Care/Agency Companion Information Sheet;
- (4) explanation of a background investigation conducted on the applicant and any adult or child living in the applicant's home.

(A) Background investigations are conducted at the time of application and include, but are not limited to:

- (i) Oklahoma State Bureau of Investigation (OSBI) name and ~~records~~ criminal records history search, including the Oklahoma Department of Public Safety (DPS), ~~and Sex Offenders~~ Offender Registry and Mary Rippy Violent Offender Registries;
- (ii) Federal Bureau of Investigation (FBI) national criminal history search, based on the fingerprints of the applicant and any adult members of the household;
- (iii) search of any involvement as a party in a court involvement

action;

(iv) search of all OKDHS records, including Child Welfare records and Community Services Worker Registry; ~~and~~

(v) a search of all applicable out-of-state child abuse and neglect registries for any applicant or adult household member who has not lived continuously in Oklahoma for the past five years. The home is not approved without the results of the out-of-state maintained child abuse and neglect registry checks, if a registry is maintained in the applicable state, for all adult household members living in the home. If no child abuse and neglect registry is maintained in the applicable state, a request for information is made to the applicable state; and

~~(v)~~ (vi) search of Juvenile Justice Information System (JOLTS) records for any child older than 13 years of age in the applicant's household.

(B) An application is denied if the applicant:

(i) or any person residing in the applicant's home has a criminal conviction of or pled guilty or no contest to:

(I) physical assault, battery, or a drug-related offense with the five year period preceding the application date;

(II) child abuse or neglect;

(III) domestic abuse;

(IV) a crime against a child, including, but not limited to, child pornography; ~~or~~

(V) a crime involving violence, including, but not limited to, rape, sexual assault, or homicide, but excluding physical assault and battery. Homicide ~~includes~~ including manslaughter; ~~and or~~

(ii) does not meet the requirements of OAC 340:100-3-39;

(5) OKDHS Form 06AC015E, Agency Companion/Specialized Foster Care Employment Record;

(6) OKDHS Form 06AC016E, DDS Reference Information Waiver;

(7) OKDHS Form 06AC029E, Employer Reference Letter; and

(8) OKDHS Form 06AC013E, Pre-Screening for Specialized Foster Care/Agency Companion Services.

(c) **Home profile process.** If the applicant meets the requirements of the prescreening, the home profile process described in (1) through (8) of this subsection is initiated.

(1) The applicant completes the required forms and returns the forms to the DDS address provided. Required forms include OKDHS Forms:

(A) 06AC008E, Specialized Foster Care/Agency Companion Services Application;

(B) 06AC009E, Financial Assessment;

(C) 06AC011E, Family Health History;

(D) 06AC018E, Self Study Questionnaire;

(E) 06AC019E, Child's Questionnaire;

(F) 06AC010E, Medical Examination Report, if Form 06AC011E indicates conditions that may interfere with the provision of services;

(G) 06AC017E, Insurance Information; and

(H) 06AC020E, Evacuation/Escape Plan.

(2) If an incomplete form or other information is returned to DDS, designated DDS staff sends a letter to the provider or provider agency identifying information needed to complete the required forms. The home profile is not completed until all required information is provided to DDS.

(3) Designated DDS staff completes the home profile when all required forms are completed and provided to DDS.



(4) For each reference provided by the applicant, designated DDS staff completes OKDHS Form 06AC058E, Reference Letter;

(5) Designated DDS staff, through interviews, visits, and phone calls, gathers information required to complete OKDHS Form 06AC047E, Home Profile.

(6) OKDHS Form 06AC069E, Review of Policies and Areas of Responsibilities, is dated and signed by the applicant and designated DDS staff.

(7) The DDS area residential services programs manager sends to the applicant:

(A) a provider approval letter confirming the applicant is approved to serve as a provider; or

(B) a denial letter stating the application is denied.

(8) DDS staff records the dates of completion of each part of the home profile process.

(d) **Home standards.** In order to qualify and remain in compliance, the provider's home must meet the provisions in (1) through (11) of this subsection.

(1) **General conditions.**

(A) The home, buildings, and furnishings must be comfortable, clean, and in good repair and grounds must be maintained. There must be no accumulation of garbage, debris, or rubbish or offensive odors.

(B) The home must:

(i) be accessible to school, employment, church, day programming, recreational activities, health facilities, and other community resources as needed;

(ii) have adequate heating, cooling and plumbing; and

(iii) provide space for the member's personal possessions and privacy and allow adequate space for the recreational and socialization needs of the occupants.

(C) Provisions for the member's safety must be present, as needed, including:

(i) guards and rails on stairways;

(ii) wheelchair ramps;

(iii) widened doorways;

(iv) grab bars;

(v) adequate lighting;

(vi) anti-scald devices; and

(vii) heat and air conditioning equipment guarded and installed in accordance with manufacturer requirements. Home modifications and equipment may be provided through HCBS Waivers operated by DDS.

(D) Providers must not permit members to access or use swimming or other pools, hot tubs, saunas, ponds, or spas on the premises without supervision. Swimming pools, hot tubs, saunas, ponds, or spas must be equipped with sufficient safety barriers or devices designed to prevent accidental injury or unsupervised access.

(E) The household must be covered by homeowner's or renter's insurance including personal liability.

(2) **Sanitation.**

(A) Sanitary facilities must be adequate and safe, including toilet and bathing facilities, water supply, and garbage and sewer disposal.

(B) If a septic tank or other non-municipal sewage disposal system is used, it must be in good working order.

(C) Garbage and refuse must be stored in readily cleanable containers, pending weekly removal.

(D) Sanitation for household pets and other domestic animals must be adequate to prevent health hazards.

(i) Proof of rabies or other vaccinations as required by a licensed

veterinarian must be maintained on the premises for household pets.

(ii) Pets not confined in enclosures must be under control and not present a danger to members or guests.

(E) There must be adequate control of insects and rodents, including screens in good repair on doors and windows used for ventilation.

(F) Universal precautions for infection control must be followed in care to the member. Hands and other skin surfaces must be washed immediately and thoroughly if contaminated with blood or other body fluids.

(G) Laundry equipment, if in the home, must be located in a safe, well-ventilated, and clean area, with the dryer vented to the outside.

(3) **Bathrooms.** A bathroom must:

(A) provide for individual privacy and have a finished interior;

(B) be clean and free of objectionable odors; and

(C) have a bathtub or shower, flush toilet, and sink in good repair, and hot and cold water in sufficient supply to meet the member's hygiene needs.

(i) A sink must be located near each toilet.

(ii) A toilet and sink must be provided on each floor where rooms of members who are non-ambulatory or with limited mobility are located.

(iii) There must be at least one toilet, one sink, and one bathtub or shower for every six household occupants, including the provider and family.

(4) **Bedrooms.** A bedroom must:

(A) have been constructed as such when the home was built or remodeled under permit;

(B) be provided for each member.

(i) Minor members must not share bedrooms with adults in the household.

(ii) No more than two members may share a bedroom.

(iii) Exceptions to allow members to share a bedroom may be made by the DDS area residential programs manager, when DDS determines sharing a bedroom is in the best interest of the members;

(C) have a minimum of 80 square feet of usable floor space for each member or 120 square feet for two members and two means of exit. The provider, family members, or other occupants of the home must not sleep in areas designated as common use living areas, nor share bedrooms with members;

(D) be finished with walls or partitions of standard construction that go from floor to ceiling;

(E) be adequately ventilated, heated, cooled, and lighted;

(F) include an individual bed for each member consisting of a frame, box ~~spring~~ spring, and mattress at least 36 inches wide, unless a specialized bed is required to meet identified needs. Cots, rollaways, couches, futons, and folding beds must not be used for members.

(i) Each bed must have clean bedding in good condition consisting of a mattress pad, bedspread, two sheets, pillow, pillowcase, and blankets adequate for the weather.

(ii) Sheets and pillowcases must be laundered at least weekly ~~and~~ or more often if necessary.

(iii) Waterproof mattress covers must be used for members who are incontinent;

(G) have sufficient space for each member's clothing and personal effects, including hygiene and grooming supplies.

(i) Members must be allowed to keep and use reasonable amounts of

personal belongings and have private, secure storage space.

(ii) The provider assists the member in furnishing and decorating the member's bedroom.

(iii) Window coverings must be in good condition and allow privacy for members;

(H) be on ground level for members with impaired mobility or who are non-ambulatory; and

(I) be in close enough proximity to the provider to alert the provider to nighttime needs or emergencies, or be equipped with a call bell or intercom.

(5) **Food.**

(A) Adequate storage must be available to maintain food at proper temperature, including a properly working refrigerator. Food storage must be such that food is protected from dirt and contamination and maintained at proper temperatures to prevent spoilage.

(B) Utensils, dishes, glassware, and food supplies must not be stored in bedrooms, bathrooms, or living areas.

(C) Utensils, dishes, and glassware must be washed and stored to prevent contamination.

(D) Food storage and preparation areas and equipment must be clean, free of offensive odors, and in good repair.

(6) **Phone.**

(A) A working phone must be provided in the home that is available and accessible for the member's use for incoming and outgoing calls.

(B) Phone numbers to the home and providers must be kept current and provided to DDS and, if applicable, the provider agency.

(7) **Safety.**

(A) Buildings must meet all applicable state building, mechanical, and housing codes.

(B) Heating, in accordance with manufacturer's specifications, and electrical equipment, including wood stoves, must be installed in accordance with all applicable fire and life safety codes. Such equipment must be used and maintained properly and in good repair.

(i) Protective glass screens or metal mesh curtains attached at top and bottom are required on fireplaces.

(ii) Unvented portable oil, gas, or kerosene heaters are prohibited.

(C) Extension cord wiring must not be used in place of permanent wiring.

(D) Hardware for all exit and interior doors must have an obvious method of operation that cannot be locked against exit.

(8) **Emergencies.**

(A) Working smoke detectors must be provided in each bedroom, adjacent hallways, and in two story homes at the top of each stairway. Alarms must be equipped with a device that warns of low battery condition, when battery operated.

(B) At least one working fire extinguisher must be in a readily accessible location.

(C) A working flashlight must be available for emergency lighting on each floor of the home.

(D) The provider:

(i) maintains a working carbon monoxide detector in the home;

(ii) maintains a written evacuation plan for the home and conducts training for evacuation with the member;

(iii) conducts fire drills quarterly and severe weather drills twice per year and maintains and makes available fire drill and severe weather drill documentation for review by DDS;

(iv) has a written back-up plan for temporary housing in the event of an emergency; and

(v) is responsible to re-establish a residence, if the home becomes uninhabitable.

(E) A first aid kit must be available in the home.

(F) The address of the home must be clearly visible from the street.

(9) **Special hazards.**

(A) Firearms and other dangerous weapons must be stored in a locked permanent enclosure. Ammunition must be stored in a separate locked location. Providers are prohibited from assisting members to obtain, possess, or use dangerous or deadly weapons per OAC 340:100-5-22.1.

(B) Flammable and combustible liquids and hazardous materials must be safely and properly stored in original, properly labeled containers.

(C) Cleaning supplies, medical sharps containers, poisons, and insecticides must be properly stored in original, properly labeled containers in a safe area away from food, food preparation areas, dining areas, and medications.

(D) Illegal substances are not permitted on the premises.

(10) **Vehicles.**

(A) All vehicles used to transport members must meet local and state requirements for licensing, inspection, insurance, and capacity.

(B) Drivers of vehicles must have valid and appropriate driver licenses.

(11) **Medication.** Medication for the member is stored ~~in accordance with~~ per OAC 340:100-5-32.

(e) **Evaluating the applicant and home.** The home profile includes, but is not limited to:

(1) evaluating the applicant's:

(A) interest and motivation;

(B) life skills;

(C) children in the home;

(D) methods of behavior support and discipline;

(E) marital status and background, household composition, and children;

(F) income and money management; and

(G) teamwork and supervision, back-up plan, and use of relief; and

(2) assessment and recommendation. DDS staff:

(A) evaluates the ability of the applicant to provide services ;

(B) approves only applicants who can fulfill the expectations of the role of service provider;

(C) if the applicant does not meet standards per OAC 317:40-5-40, ensures the final recommendation includes:

(i) basis for the denial decision; and

(ii) effective date for determining the applicant as not meeting standards. Reasons for denying a profile may include, but are not limited to:

(I) lack of stable, adequate income to meet the applicant's own or total family needs or poor management of available income;

(II) a physical facility that is inadequate to accommodate the addition of a member to the home or presents health or safety concerns;

(III) the age, health, or any other condition of the applicant that impedes the applicant's ability to provide appropriate care for a member;

(IV) relationships in the applicant's household are unstable and unsatisfactory;

(V) the mental health of the applicant or other family or

household member impedes the applicant's ability to provide appropriate care for a member;

(VI) references are guarded or have reservations in recommending the applicant;

(VII) the applicant fails to complete the application, required training, or verifications in a timely manner as requested or provides information that is incomplete, inconsistent, or untruthful; or

(VIII) the home is determined unsuitable for the member requiring placement;

(D) notifies the applicant in writing of the final recommendation; and

(E) if an application is canceled or withdrawn prior to completion of the profile, completes a final written assessment that includes:

(i) reason the application was canceled or withdrawn;

(ii) DDS staff's impression of the applicant based on information obtained; and

(iii) effective date of cancellation or withdrawal. Written notice is sent to the applicant to confirm cancellation or withdrawal of the application, a copy is included in local and State Office records.

(f) Annual Frequency of evaluation. Homes are assessed for initial approval. Agency Companion Services providers are assessed annually and as needed for compliance and continued approval. Specialized foster care and respite homes are assessed bi-annually and as needed for compliance and continued approval. Any other situations requiring a home profile are assessed annually and as needed for compliance and continued approval. The annual evaluation is a comprehensive review of the provider's continued ability to meet standards.

(1) The annual evaluation consists of information specifically related to the provider's home and is documented on OKDHS Form 06AC024E, Annual Review.

(2) OKDHS FORM 06AC010E must be completed a minimum of every three years following the initial approval, unless medical circumstances warrant more frequent completion.

(3) Input from the DDS case manager, Child Welfare worker, Adult Protective Services staff, Office of Client Advocacy staff, and provider agency program coordinator is included in the evaluation, if applicable.

(4) The background investigation per OAC 317:40-5-40(b) is repeated every year, except the FBI national criminal history search.

(5) Providers are notified in writing of the continued recommendation of the use of the home.

(6) Copies of OKDHS Forms 06AC024E and, if applicable, 06AC010E, are included in local and State Office records.

## PART 5. SPECIALIZED FOSTER CARE

### 317:40-5-55. Specialized Foster Care provider responsibilities

(a) **General responsibilities.** The responsibilities of all Specialized Foster Care (SFC) providers are listed in this ~~Subsection~~ Section.

(1) Providers of ~~Specialized Foster Care (SFC)~~ are required to meet all applicable standards ~~outlined in per~~ OAC 317:40-5-40.

(2) Providers of SFC are required to receive competency based training ~~as outlined in per~~ OAC 340:100-3-38. The provider keeps all required training up to date and submits documentation to the SFC specialist at the time training is completed.

(3) The provider ~~participates as a member~~ is an active participant of the ~~service recipient's~~ member's Team and assists in the development of the ~~service recipient's~~ member's Individual Plan, (Plan) ~~as described in per~~

OAC 340:100-5-50 through 100-5-58.

(4) The provider documents and notifies the case manager of any changes in behaviors or medical conditions of the ~~service recipient~~ member within one working day. Incident reports are completed by the SFC provider and submitted to the Developmental Disabilities Services Division DDS (DDSD) case manager ~~in accordance with~~ per OAC 340:100-3-34.

(5) The SFC provider is available to the ~~service recipient~~ member at any time.

(6) The primary ~~employment~~ responsibility of the SFC provider is to provide SFC services to the ~~service recipient~~ member. The SFC provider does not have ~~other~~ employment unless the ~~other~~ employment has been pre-approved by the ~~supervisor of the DDS foster care unit~~ residential programs supervisor for DDS.

(A) Generally, providers are not approved for ~~other~~ employment because the provider must be available before and after school or vocational programs and often during the day due to holidays or illnesses.

(B) If, after receiving approval for ~~other~~ employment, it is found that the SFC provider's employment interferes with the care, training, or supervision needed by the ~~service recipient~~ member, the provider must determine if he or she wants to terminate the ~~other~~ employment or have the ~~service recipient~~ member moved from the home.

(C) ~~The~~ DDS does not authorize Homemaker, Habilitation Training Specialist, or respite services in order for the SFC provider to perform ~~other~~ employment.

(7) The provider does not deliver services that duplicate the services mandated to be provided by the public school district pursuant to the Individuals With Disabilities Education Act (IDEA-B).

(8) The provider allows the ~~service recipient~~ member to have experiences, both in and out of the home, to enhance the ~~service recipient's~~ member's development, learning, growth, independence, community inclusion, and well-being, while assisting the ~~service recipient~~ member to achieve his or her maximum level of independence.

(9) The provider ensures confidentiality is maintained regarding the ~~service recipient~~ member ~~in accordance with the DDS confidentiality policy,~~ per OAC 340:100-3-2.

(10) The provider is sensitive to and assists the ~~service recipient~~ member in participating in the ~~service recipient's~~ member's choice of religious faith. No ~~service recipient~~ member is expected to attend any religious service against his or her wishes.

(11) The provider arranges, and ensures that the member obtains a dental examination at least annually, and is responsible for obtaining regular and emergency medical services as needed.

~~(11)~~ (12) The provider has a valid ~~driver's~~ driver license, maintains a motor vehicle in working order, and complies with requirements of OAC 317:40-5-103, Transportation.

~~(12) The provider arranges, and ensures that the service recipient obtains, a medical and a dental examination at least annually, and is responsible for obtaining regular and emergency medical services as needed.~~

(13) The provider transports or arranges transportation, using adapted transportation when appropriate, for the ~~service recipient~~ member to and from school, employment, church, recreational activities, and medical or therapy appointments.

(A) SFC providers may ~~sign~~ enter into a transportation contract.

(B) The provider must assure availability and use of an approved and appropriate child auto restraint system as required by law in transporting children and, in cases of adults receiving services, any

additional ~~restraints~~ safety devices identified as necessary in the Plan.

(14) The provider assures the ~~person receiving services~~ member is clean, appropriately dressed, and on time for activities and appointments.

(15) The provider ensures no other adult or child is ~~erved~~ cared for or resides in the home on a regular or part-time basis that was not approved through the home profile review process or without prior approval from the DDSD area manager or designee.

(16) The provider does not provide services to more than three individuals regardless of the type of service provided, including SFC, ~~DCFS~~ Children and Family Services Division foster care, respite, baby-sitting, or other such services. Any exception to this paragraph must be approved in writing by the director of DDSD or designee prior to authorization or service delivery.

(17) The provider permits visitation and monitoring of the home by authorized DDSD staff. In order to assure maintenance of standards, some visits are unannounced. The visits occur at least monthly and are not intended to be intrusive but to ensure the safety and well-being of the ~~service recipient~~ member.

(18) The provider encourages and cooperates in planning visits in the SFC home by relatives, guardians, or friends of the ~~service recipient~~ member. Visits by the ~~service recipient~~ member to the home of friends or relatives must be approved by the ~~service recipient's~~ member's legally authorized representative.

(19) The provider abides by the policies of DDSD ~~found at~~ per OAC 340:100-3-12, Prohibition of client abuse, and OAC 340:100-5-58, Prohibited procedures. The provider is prohibited from signing an authorization for school personnel to use physical discipline or corporal punishment.

(20) The provider notifies the DDSD case manager when the need arises for substitute supervision in the event of an emergency, in accordance with the Backup Plan, ~~as specified in~~ per OAC 317:40-5-59. If the provider is out of the home for a short duration, a natural support in the home can provide time-limited supervision.

(A) A natural support is defined as an adult relative or spouse of the specialized foster parent that resides in the home.

(B) The Team approves the natural support and defines when this support may be accessed.

(C) Persons who are considered a natural support must complete training per OAC 340:100-3-38.12.

(D) Persons acting as a natural support may only provide supervision for brief, intermittent time periods.

(21) The provider provides written 30-day notice to the ~~service recipient~~ member and DDSD case manager when it is necessary for a ~~service recipient~~ member to be moved from the home.

(22) The SFC provider does not serve as representative payee for the ~~service recipient~~ member.

(23) The provider ensures the ~~service recipient's~~ member's funds are properly safeguarded.

(24) The provider assists the ~~service recipient~~ member in accessing and using entitlement programs for which the ~~service recipient~~ member may be eligible.

(25) The provider must use the room and board reimbursement payment to meet the ~~service recipient's~~ member's needs, as specified in the room and board contract.

(A) The provider retains a copy of the current room and board contract in the home at all times.

(B) Items purchased with the room and board reimbursement include, but

are not limited to:

- (i) housing;
- (ii) food;
- (iii) clothing;
- (iv) care; ~~and~~
- (v) incidental expenses such as:
  - (I) birthday and Christmas gifts;
  - (II) haircuts;
  - (III) personal grooming equipment;
  - (IV) allowances;
  - (V) toys;
  - (VI) school supplies and lunches;
  - (VII) school pictures;
  - (VIII) costs of recreational activities;
  - (IX) special clothing items required for dress occasions and school classes such as gym shorts and shirts;
  - (X) extracurricular athletic and other equipment, including uniforms, needed for the ~~service recipient~~ member to pursue his or her particular interests or job;
  - (XI) prom and graduation expenses including caps, gowns, rings, pictures, and announcements;
  - (XII) routine transportation expenses involved in meeting the ~~service recipient's~~ member's medical, educational, or recreational needs, unless the provider has a transportation contract;
  - (XIII) non-prescription medication; and
  - (XIV) other maintenance supplies required by the ~~service recipient~~ member.

(C) All items purchased for the ~~service recipient~~ member with the room and board payment are the property of the ~~service recipient~~ member and are given by the provider to the ~~service recipient~~ member when a change of residence occurs.

(D) The room and board payment is made on a monthly basis and is prorated based on the actual days the ~~service recipient~~ member is in the home on the initial and final months of residence.

(26) The provider maintains a Personal Possession Inventory Form 06AC022E (DDS-22) for each ~~service recipient~~ member living in the home.

(27) The provider maintains the ~~service recipient's~~ member's home record ~~in accordance with~~ per OAC 340:100-3-40.

(28) The provider immediately reports to the DDS SFC staff all changes in the household including, but not limited to:

- (A) telephone number;
- (B) address;
- (C) marriage or divorce;
- (D) persons moving into or out of the home;
- (E) provider's health status;
- (F) provider's employment; and
- (G) provider's income.

(29) The provider maintains home owner's or renter's insurance, including applicable liability coverages, and provides a copy to the SFC Specialist.

(30) The provider serves as the Health Care Coordinator and follows the Health Care Coordinator policy ~~outlined in~~ per OAC 340:100-5-26.

(31) Each SFC provider follows all applicable rules of the Oklahoma Department of Human Services and the Oklahoma Health Care Authority, promotes the independence of the ~~service recipient~~ member, and follows recommendations of the ~~service recipient's~~ member's Team.

(b) **Responsibilities specific to SFC providers serving children.** The



provider is charged with the same general legal responsibility any parent has to exercise reasonable and prudent behavior in his or her actions and in the supervision and support of the child.

(1) The provider works with the DDS case manager and ~~Division of Children and Family Services (DCFS)~~ CFSD staff when the provider needs respite for a child in custody.

(2) The provider participates in the development of the Individual Education Plan (IEP) and may serve as surrogate parent when appropriate.

(3) The provider obtains permission and legal consent from the child's custodial parent or guardian and DDS case manager prior to traveling out of state for an overnight visit. If the child is in the custody of the OKDHS, the permission of the ~~DCFS~~ CFSD specialist is also secured.

(4) The provider obtains permission and legal consent from the child's custodial parent or guardian and DDS case manager prior to involvement of the child in any publicity. If the child is in OKDHS custody, the permission of the ~~DCFS~~ CFSD specialist is also secured.

(c) **Responsibilities specific to SFC providers serving adults.** Additional SFC provider responsibilities for serving adults are given in this Subsection.

(1) The provider obtains permission from the ~~service recipient's~~ member's legal guardian, when applicable, and notifies the DDS case manager, prior to:

(A) traveling out of state for an overnight visit.

(B) involvement of the ~~service recipient~~ member in any publicity.

(2) When the ~~service recipient~~ member is his or her own payee or has a representative payee, the provider ensures the monthly contribution for services as identified in a written agreement between the ~~service recipient~~ member and the provider, is used toward the cost of food, rent, and household expenses.

(A) The ~~service recipient's~~ member's minimum monthly contribution is \$250.00 per month.

(B) Changes in the ~~service recipient's~~ member's monthly contribution are developed on an individualized basis by the ~~service recipient's~~ member's Team.

### **317:40-5-59. Back-up Plan for persons receiving Specialized Foster Care**

Prior to a ~~service recipient~~ member moving into Specialized Foster Care (SFC), the SFC provider ~~the Developmental Disabilities Services Division (DDS) case manager, and other appropriate Team members cooperatively~~ and the SFC specialist develop a Back-up Plan. The SFC specialist communicates the Back-Up Plan in writing to the DDS case manager for incorporation into the Individual Plan.

(1) The Back-up Plan identifies the person(s) who provides emergency back-up supports.

(2) The ~~service recipient's~~ member's natural family is considered as the first resource for the Back-up Plan at no cost to OKDHS, unless the member is in the custody of the Oklahoma Department of Human Services.

(3) The Back-up Plan contains the name(s) and current telephone number(s) of the person(s) providing back-up service.

(4) The When paid providers are necessary, the Back-up Plan explains specifically where the service is to be provided.

(A) If back-up service is to be provided outside the SFC home, a Home Profile must be completed for the back-up staff per OAC 317:40-5-40.

(B) If back-up service is to be provided in the SFC home, the person providing this service must have completed all necessary requirements to become a paid provider, including:

(i) ~~criminal background check~~ an Oklahoma State Bureau of

Investigation (OSBI) name and criminal records history search , including the Department of Public Safety (DPS), Sex Offender, and Mary Rippy Violent Offender Registries;

(ii) ~~traffic record check~~ a Federal Bureau of Investigation (FBI) national criminal history search, based on the fingerprints of the applicant;

(iii) ~~valid driver license~~ a search of any involvement as a party in a court action;

(iv) ~~Division of Children and Family Services (DCFS) abuse registry check~~ a search of all Oklahoma Department of Human Services (OKDHS) records, including child welfare (CW) records;

(v) a search of all applicable out-of-state child abuse and neglect registries for any applicant who has not lived continuously in Oklahoma for the past five years. The applicant is not approved without the results of the out-of-state maintained child abuse and neglect registry checks, if a registry is maintained in the applicable state;

~~(v)~~ (vi) Community Services Worker registry check;

~~(vi) a check of the Juvenile On-Line Tracking System (JOLTS) for children residing in the home;~~

(vii) Oklahoma statutorily mandated liability insurance of ~~10/20/10~~ minimum coverage, and a valid driver license; and

(viii) completion of required DDSD training per OAC 340:100-3-38.4.

(C) The Back-up Plan details where the service recipient member and provider will stay if the provider's home is not habitable. If there is a fee to stay in the alternate location, the fee is paid by the provider and not reimbursed by DDSD.

(5) The Back-up Plan is jointly reviewed at least monthly by the DDSD case manager and the SFC specialist and the SFC provider to ensure the Back-up Plan continues to be appropriate and current.

(6) The SFC provider is responsible to report any needed changes in the Back-up Plan to the case manager and SFC specialist.

(7) The SFC specialist will report any changes in the Back-up Plan to the case manager.

## PART 9. SERVICE PROVISIONS

### 317:40-5-100. Assistive technology devices and services

(a) **Applicability.** The rules in this Section apply to assistive technology (AT) services and devices authorized by the Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDSD) through Home and Community Based Services (HCBS) Waivers.

(b) **General information.**

(1) AT devices include the purchase, rental, customization, maintenance, and repair of devices, controls, and appliances. AT devices include:

(A) visual alarms;

(B) telecommunication devices (TDDS);

(C) telephone amplifying devices;

(D) other devices for protection of health and safety of members who are deaf or hard of hearing;

(E) tape recorders;

(F) talking calculators;

(G) specialized lamps;

(H) magnifiers;

(I) braille writers;

(J) braille paper;

(K) talking computerized devices;

- (L) other devices for protection of health and safety of members who are blind or visually impaired;
- (M) augmentative and alternative communication devices including language board and electronic communication devices;
- (N) competence based cause and effect systems such as switches;
- (O) mobility and positioning devices including:
  - (i) wheelchairs;
  - (ii) travel chairs;
  - (iii) walkers;
  - (iv) positioning systems;
  - (v) ramps;
  - (vi) seating systems;
  - (vii) standers;
  - (viii) lifts;
  - (ix) bathing equipment;
  - (x) specialized beds;
  - (xi) specialized chairs; and
- (P) orthotic and prosthetic devices, including:
  - (i) braces;
  - (ii) prescribed modified shoes;
  - (iii) splints; and
- (Q) environmental controls or devices;
- (R) items necessary for life support and devices necessary for the proper functioning of such items, including durable and non-durable medical equipment not available through SoonerCare.

(2) AT services include:

- (A) sign language interpreter services for members who are deaf;
- (B) reader services;
- (C) auxiliary aids;
- (D) training the member and provider in the use and maintenance of equipment and auxiliary aids;
- (E) repair of AT devices; and
- (F) evaluation of the AT needs of a member.

(3) AT devices and services must be included in the member's Individual Plan (IP) and arrangements for this HCBS service must be made through the member's case manager.

(4) AT devices are provided by vendors with a Durable Medical Equipment (DME) contract with the Oklahoma Health Care Authority (OHCA).

(5) AT devices and services are authorized in accordance with requirements of The Oklahoma Central Purchasing Act, other applicable statutory provisions, OAC 580:15 and OKDHS approved purchasing procedures.

(6) AT services are provided by an appropriate professional services provider with a current HCBS contract with OHCA and current unrestricted licensure and certification with their professional board, if applicable.

~~(6)~~(7) AT devices or services may be authorized when the device or service:

- (A) has no utility apart from the needs of the person receiving services;
- (B) is not otherwise available through SoonerCare, AT retrieval program, Department of Rehabilitative Services, or any other third party or known community resource;
- (C) has no less expensive equivalent that meets the member's needs;
- (D) is not solely for family or staff convenience or preference;
- (E) is based on the assessment and Personal Support Team (Team) consideration of the member's unique needs;
- (F) is of direct medical or remedial benefit to the member;
- (G) enables the member to maintain, increase, or improve functional

capabilities;

(H) is supported by objective documentation included in a professional assessment except as specified per OAC 317:40-5-100;

(I) is within the scope of assistive technology per OAC 317:40-5-100; and

(J) is the most appropriate and cost effective bid if applicable.

(K) exceeds a cost of \$50. AT devices or services with a cost of \$50 or less are not authorized through DDSD HCBS Waivers.

(c) **Assessments.** Assessments for AT devices or services are performed by a licensed professional service provider(s) and reviewed by other providers whose services may be affected by the type of device selected. A licensed professional must:

(1) determine whether the person's identified outcome can be accomplished through the creative use of other resources such as:

(A) household items or toys;

(B) equipment loan programs;

(C) low-technology devices or other less intrusive options; or

(D) a similar, more cost-effective device.

(2) recommend the most appropriate AT based on the member's:

(A) present and future needs, especially for members with degenerative conditions;

(B) history of use of similar AT, and ability to use the device currently and for at least the foreseeable future (no less than 5 years); and

(C) outcomes.

(3) complete an assessment, including a decision making review and device trial that provides supporting documentation for purchase, rental, customization, or fabrication of an AT device. Supporting documentation must include:

(A) review of device considered;

(B) availability of device rental with discussion of advantages and disadvantages;

(C) how frequently and in what situations device will be used in daily activities and routines;

(D) how the member and caregiver(s) will be trained to use the AT device; and

(E) features and specifications of the device that are necessary for the member, including rationale for why other alternatives are not available to meet the member's needs.

(4) provide a current, unedited videotape or pictures of the person member using the device, including the time frames of the trials recorded, upon request by DDSD staff.

(d) **Authorization of repairs, or replacement of parts.** Repairs to AT devices, or replacement of device parts, do not require a professional assessment or recommendation. DDSD area office resource development staff with assistive technology experience may authorize repairs and replacement of parts for previously recommended assistive technology.

(e) **Retrieval of assistive technology devices.** When devices are no longer needed by a member, OKDHS/DDSD staff may retrieve the device.

(f) **Team decision-making process.** The member's Personal Support Team reviews the licensed professional's assessment and decision making review. The Team ensures the recommended AT:

(1) is needed by the member to achieve a specific, identified functional outcome;

(A) A functional outcome, in this Section, means the activity is meaningful to the member, occurs on a frequent basis, and would require assistance from others, if the member could not perform the

activity independently, such as self-care, assistance with eating, or transfers.

(B) Functional outcomes must be reasonable and necessary given a member's age the diagnosis and abilities.

(2) allows the member receiving services to:

(A) improve or maintain health and safety;

(B) participate in community life;

(C) express choices; or

(D) participate in vocational training or employment;

(3) will be used frequently or in a variety of situations;

(4) will fit easily into the member's lifestyle and work place;

(5) is specific to the member's unique needs; and

(6) is not authorized solely for family or staff convenience.

(g) **Requirements and standards for AT devices and service providers.**

(1) Providers guarantee devices, work, and materials for one year, and supply necessary follow-up evaluation to ensure optimum usability.

(2) Providers ensure a licensed occupational therapist, physical therapist, speech therapist, or rehabilitation engineer evaluate the need for AT and individually customize AT devices as needed.

(h) **Services not covered through AT devices and services.** Assistive technology devices and services do not include;

(1) trampolines;

(2) hot tubs;

(3) bean bag chairs;

(4) recliners with lift capabilities;

(5) computers except as adapted for individual needs as a primary means of oral communication and approved per OAC 317:40-5-100;

(6) massage tables; ~~and~~

(7) educational games and toys; or

(8) generators.

(i) **Approval or denial of AT.** DDS approval, conditional approval for pre-determined trial use, or denial of the purchase, rental, or lease/purchase of the AT is determined per OAC 317:40-5-100.

(1) The DDS case manager sends the AT request to designated DDS area office resource development staff with AT experience. The request must include:

(A) the licensed professional's assessment and decision making review;

(B) a copy of the Plan of Care (POC);

(C) documentation of current Team consensus, including consideration of issues per OAC 317:40-5-100; and

(D) all additional documentation to support the need for the assistive technology device or service.

(2) The designated area office resource development staff, with AT experience, approves or denies the AT request when ~~there is no fixed rate for the device and~~ the device has a cost less than \$2500, and the POC is below the State Office reviewer limit based on+

~~(A) the criteria given in subsection (d) of this Section;~~

~~(B) the scope of the program, as explained in subsection (a) (b) of this Section; and .~~

~~(C) the cost effectiveness of the AT, as explained in subsection (a) of this Section.~~

(3) The State Office programs manager for AT approves or denies the AT request when the device has a cost less than \$2500, and the POC is above the area office reviewer limit based on the scope of the program, as explained in subsection (b) of this Section.

~~(3)~~ (4) Authorization for purchase or a written denial is provided within ten working days of receipt of a complete request.

(A) If the AT is approved, a letter of authorization is issued.

(B) If additional documentation is required by the area office resource development staff with AT experience, to authorize the recommended AT, the request packet is returned to the case manager for completion.

(C) If necessary, the case manager will contact the licensed professional to request the additional documentation and the licensed professional will supply further documentation ~~upon request of the area office resource development staff with AT experience.~~

(D) The authorization of AT that ~~has no fixed rate and~~ is \$2,500 or more is performed as in paragraph (2) of this subsection, except that the area office resource development staff with AT experience:

(i) solicits three bids for the AT;

(ii) submits the AT request, bids, and other relevant information to the DDS State Office AT programs manager within five working days of receipt of the required bids; and

(iii) the State Office AT programs manager or designee issues a letter of authorization, a written denial, or a request for additional information within five working days of receipt of all required documentation for AT.

(j) **Approval of vehicle adaptations.** Vehicle adaptations are assessed and approved per OAC 317:40-5-100. In addition, the requirements in this paragraph must be met.

(1) The vehicle to be adapted must be owned or in the process of being purchased by the member receiving services or his or her family.

(2) The AT request must include a certified mechanic's statement that the vehicle and adaptations are mechanically sound.

(3) Vehicle adaptations are limited to one vehicle in a ten year period per member. Authorization for more than one vehicle adaptation in a 10-year period must be approved by the DDS division administrator or designee.

(k) **Denial.** Procedures for denial of an AT device or service are described in this paragraph.

(1) The person denying the AT request provides a written denial to the case manager citing the reason for denial per policy.

(2) The case manager sends the Notice of Action, OKDHS form 06MP004E, to the member and his or her family or guardian.

(3) Denial of assistive technology services may be appealed through the OKDHS hearing process per OAC 340:2-5.

(l) **Return of an AT device.** If, during a trial use period or rental of a device, the therapist or Team including the licensed professional if available, who recommended the AT, determines the device is not appropriate, the licensed professional sends a brief report describing the reason(s) for the change of device recommendation to the DDS case manager. The case manager forwards the report to the designated area office resource development staff, who arranges for the return of the equipment to the vendor or manufacturer.

(m) **Rental of AT devices.** AT devices are rented when the licensed professional or area office resource development staff with AT experience determines rental of the device is more cost effective than purchase of the device or the licensed professional recommends a trial period to determine if the device meets the needs of the member.

(1) The rental period begins on the date the manufacturer or vendor delivers the equipment to the member, unless otherwise stated in advance by the manufacturer or vendor.

(2) Area office resource development staff with AT experience monitor use of equipment during the rental agreement for:

(A) cost effectiveness of the rental time frames;

(B) conditions of renewal; and

(C) the Team's re-evaluation of the member's need for the device per OAC 317:40-5-100.

(3) Rental costs are applied toward the purchase price of the device whenever such option is available from the manufacturer or vendor.

(4) If a device is rented for a trial use period, the Team decides within 90 days whether:

(A) the equipment meets the member's needs; and

(B) to purchase the equipment or return it.

(n) **Assistive Technology Committee.** The committee reviews equipment requests when deemed necessary by the OKDHS/DDSD state office assistive technology programs manager.

(1) The AT committee is comprised of:

(A) DDSD professional staff members of the appropriate therapy;

(B) DDSD AT state office programs manager;

(C) the DDSD area manager or designee; and

(D) an AT expert not employed by OKDHS.

(2) The AT committee performs a paper review, providing technical guidance, oversight, and consultation.

(3) The AT committee may endorse or recommend denial of a device or service, based on criteria given in this Section. Any endorsement or denial includes a written rationale for the decision and, if necessary, an alternative solution(s), directed to the case manager within 20 working days of receipt of the request. Requests reviewed by the AT committee result in suspension of time frames specified in OAC 317:40-5-100.

### **317:40-5-103. Transportation**

(a) Applicability. The rules in this Section apply to transportation services provided through the Oklahoma Department of Human Services (OKDHS), Developmental Disabilities Services Division (DDSD) Home and Community Based Services (HCBS) Waivers.

~~(a)(b)~~ General Information. Transportation services include ~~acquisition of, and payment for the use of,~~ adapted, non-adapted, and public transportation.

(1) Transportation services ~~is~~ are provided to promote inclusion in the community, access to programs and services, and participation in activities to enhance community living skills. Members are encouraged to utilize natural supports or community agencies that can provide transportation without charge before accessing transportation services.

(2) Services include, but are not limited to, transportation to and from medical appointments, work or employment services, recreational activities, and other community activities within the number of miles authorized in the Plan of Care.

(A) Adapted or non-adapted transportation ~~is~~ may be provided for each eligible person; or

(B) Public transportation ~~is~~ may be provided up to a maximum of \$5,000 per Plan of Care year. The director of DDSD or designee may approve requests for public transportation services totaling more than \$5,000 per year ~~if~~ when public transportation is the most cost-effective alternative option. For the purposes of this Section, public transportation is defined as:

(i) ~~public transportation~~ services, such as an ambulance when medically necessary, a bus, or a taxi; or

(ii) a transportation program operated by the ~~service recipient's~~ member's employment services or day services provider.

(3) ~~Services are provided to eligible service recipients in accordance with the service recipient's Plan of Care.~~ Transportation services must

be included in the member's Individual Plan (Plan) and arrangements for this service must be made through the member's case manager.

(4) Authorization of Transportation Services is based on:

- (A) Team consideration, ~~in accordance with~~ per OAC 340:100-5-52, of the unique needs of the person and the most cost effective type of transportation services that meets the ~~service recipient's~~ member's need, in accordance with subsection (d) of this Section; and
- ~~(B) the service recipient's participation in Waiver services; and~~
- ~~(C) (B) the scope of the transportation services program as explained in this section~~ Section.

~~(b)~~ (c) Standards for transportation providers. All drivers employed by contracted transportation providers must have a valid and current Oklahoma ~~drivers~~ driver license, and the vehicle(s) must meet applicable local and state requirements for vehicle licensure, inspection, insurance, and capacity.

(1) The provider must ensure that any vehicle used to transport ~~service recipients~~ members:

- (A) meets the needs of the ~~service recipient~~ member;
- (B) is maintained in a safe condition;
- (C) has a current vehicle tag; and
- (D) is operated in accordance with local, state, and federal law, regulation, and ordinance.

(2) The provider maintains liability insurance in an amount sufficient to pay for injuries or loss to persons or property occasioned by negligence or malfeasance by the agency, its agents, or employees.

~~(3) The transportation provider must adequately maintain equipment installed to provide supports for service recipients. Regular maintenance and repairs of vehicles are the responsibility of the transportation provider. Providers of adapted transportation services are also responsible for maintenance and repairs of modifications made to vehicles. Providers of non adapted transportation with a vehicle modification funded through HCBS assistive technology services may have repairs authorized per OAC 317:40-5-100.~~

(4) Providers must maintain documentation fully disclosing the extent of services furnished that specifies:

- (A) the service date;
- (B) the location and odometer mileage reading at the starting point and destination;
- (C) the name of the ~~service recipient~~ member transported; and
- (D) the purpose of the trip; and .
- ~~(E) the starting point and destination.~~

(5) A family member, including a family member living in the same household, of an adult ~~service recipient~~ member may establish a contract to provide transportation services to:

- (A) work or employment services;
- (B) medical appointments; and
- (C) other activities identified in the Individual Plan as necessary to meet the needs of the ~~service recipient~~ member, as defined in OAC 340:100-3-33.1.

(6) Individual transportation providers must provide to the DDS Area Office verification of vehicle licensure, insurance and capacity before a contract may be established, and updated verification of each upon expiration. Failure to provide updated verification of current and valid Oklahoma driver license, vehicle licensure, and as applicable may result in cancellation of the contract.

~~(e)~~ (d) Services not covered. Services that cannot be claimed as transportation services include:



- (1) services not approved by the Team;
- (2) services not authorized by the Plan of Care;
- (3) trips that have no specified purpose or destination;
- (4) trips for family, provider, or staff convenience;
- (5) transportation provided by the ~~person receiving services~~ member;
- (6) transportation provided by the service recipient's member's spouse; ~~or~~
- (7) transportation provided by the mother or father biological, step or adoptive parents of the service recipient member or legal guardian, if when the service recipient member is a minor;
- ~~(6)~~ (8) trips when the ~~service recipient member~~ member is not in the vehicle;
- ~~(7)~~ (9) transportation claimed for more than one ~~service recipient member~~ member per vehicle at the same time or for the same miles, except public transportation;
- ~~(8)~~ (10) transportation outside the State of Oklahoma unless:
  - (A) the transportation is provided to access the nearest available medical or therapeutic service; or
  - (B) advance written approval is given by the DDSD ~~Area Manager~~ area manager or designee;
- ~~(9)~~ (11) services which are mandated to be provided by the public schools pursuant to the Individuals with Disabilities Education Act;
- ~~(10)~~ (12) transportation that occurs during the performance of the ~~service recipient's member's~~ member's paid employment, even if the employer is a contract provider; or
- (13) transportation when a closer appropriate location was not selected.

~~(d)~~ (e) **Assessment and Team process.** At least annually, the Team addresses the ~~service recipient's member's~~ member's transportation needs. The Team determines the most appropriate means of transportation based on the:

- (1) present needs of the ~~person receiving services~~ member. When addressing the possible need for adapted transportation, the Team considers the needs of the ~~service recipient member~~ member only. The needs of other individuals living in the same household are considered separately;
- (2) ~~service recipient's member's~~ member's ability to access public transportation services; and
- (3) the availability of other transportation resources including ~~family, neighbors, friends~~ natural supports, and community agencies.

~~(e)~~ (f) **Adapted Transportation.** Adapted transportation ~~provides~~ may be transportation provided in modified vehicles ~~or vehicles specifically procured to~~ with wheelchair or stretcher safe travel systems or lifts that meet medical or behavioral needs of the service recipient member which that cannot be met with the use of a standard passenger vehicle, including a van when the modification to the vehicle was not funded through HCBS assistive technology service and is owned or leased by the DDSD HCBS provider agency. Vehicle modifications that may be needed include, but are not limited to, wheelchair safe travel systems, wheelchair lifts, raised roofs and doors, and exterior mounted wheelchair or scooter carriers.

(1) Adapted transportation is not authorized when a provider agency leases an adapted vehicle from a member or a member's family.

(2) Exceptions to receive adapted transportation services for modified vehicles other than those with wheelchair/stretcher safe travel systems and lifts may be authorized by the DDSD program manager for transportation services when documentation supports the need and there is evidence the modification costs exceeded \$10,000. All other applicable requirements of OAC 317:40-5-103 must be met.

(3) Adapted transportation services do not include vehicles with modifications including, but not limited to:

- (A) restraint systems;

- (B) plexi-glass windows;
- (C) barriers between the driver and the passengers;
- (D) turney seats; and
- (E) seat belt extenders.

~~(1)~~ (4) The Team determines if the ~~service recipient~~ member needs adapted transportation according to:

- (A) the ~~service recipient's~~ member's need for physical support when sitting;
- (B) the ~~service recipient's~~ member's need for physical assistance during transfers from one surface to another;
- (C) the portability of the ~~service recipient's~~ member's wheelchair;
- (D) associated health problems the ~~service recipient~~ member may have; and
- (E) ~~behavioral issues related to vehicle travel~~ less costly alternatives to meet the need.

~~(2)~~ (5) The transportation provider and the equipment vendor ensure that requirements of the Americans with Disabilities Act are met ~~when Team recommended vehicle modifications are installed.~~

~~(3)~~ (6) The transportation provider ensures that all staff assisting with transportation have been trained according to the requirements specified by the Team and the equipment manufacturer.

~~(4) The adapted transportation rate is not paid when a vehicle has been adapted with funds from the HCBWS program.~~

~~(f)~~ (g) **Authorization of transportation services.** The authorization limitations given in this subsection include the total of all transportation units on the Plan of Care, not just the units authorized for the residential setting identified.

(1) Up to 12,000 units of transportation services may be authorized in a ~~service recipient's member's plan of care in accordance with~~ Plan of Care per OAC 340:100-3-33 and OAC 340:100-3-33.1.

(2) When there is a combination of non-adapted transportation and public transportation on a Plan of Care, the total cost for transportation cannot exceed the cost for non-adapted transportation services at the current non-adapted transportation reimbursement rate multiplied by 12,000 miles for the Plan of Care year.

~~(2)~~ (3) The ~~Area Manager~~ area manager or designee may approve:

- (A) up to 14,400 miles per Plan of Care year for people who have extensive needs for transportation services; and
- (B) a combination of non-adapted transportation and public transportation on a Plan of Care, when the total cost for transportation does not exceed the cost for non-adapted transportation services at the current non-adapted transportation reimbursement rate multiplied by 14,400 miles for the Plan of Care year.

~~(3)~~ (4) The ~~Division Director~~ division director or designee may approve:

- (A) transportation services in excess of 14,400 miles per Plan of Care year in extenuating situations when person-centered planning has identified specific needs which require additional transportation for a limited period; or
- (B) any combination of public transportation services with adapted or non-adapted; or
- (C) public transportation services in excess of \$5000 when this is the most cost effective service option for necessary transportation.

### **317:40-5-113. Adult Day Services**

(a) **Introduction.** Adult Day Services are provided by agencies approved by the Developmental Disabilities Services Division (DDSD) of the Oklahoma Department of Human Services (OKDHS) that have a valid Oklahoma Health Care

Authority contract for providing Adult Day Services. This service is available through the Community Waiver and through the In-Home Supports Waiver for Adults. Adult Day Services is a structured, comprehensive program that provides a variety of health, social, and related support services in a protective environment for some portion of a day. ~~Individuals~~ Members who participate in adult day services receive these services on a planned basis during specified hours. Adult day services are designed to work toward the goals of:

- (1) promoting the member's maximum level of independence;
- (2) maintaining the member's present level of functioning as long as possible, preventing or delaying further deterioration;
- (3) assisting the member in achieving the highest level of functioning possible;
- (4) providing support, respite, and education for families and other caregivers; and
- (5) fostering socialization and peer interaction.

(b) **Eligibility requirements.** Adult Day Services are provided to eligible members whose teams have determined the service is appropriate to meet their needs. Members must:

- (1) require ongoing support and supervision ~~in a safe environment~~ when away from their own residence;
- (2) be 18 years of age or older; and
- (3) not pose a threat to others.

(c) **Provider requirements.** Provider agencies must:

- (1) meet the licensing requirements set forth by Section 1-873 et seq of Title 63 of the Oklahoma Statutes;
- (2) comply with OAC 310:605, Adult Day Care Centers;
- (3) allow DDS staff to make announced and unannounced visits to the facility during the hours of operation;
- (4) provide the DDS case manager a copy of the individualized plan of care;
- (5) submit incident reports per OAC 340:100-3-34;
- (6) maintain a copy of the member's Individual Plan (Plan);
- (7) submit Oklahoma Department of Human Services (OKDHS) ~~Adult Day Services Progress Report Form 06WP046E~~ to the DDS case manager ~~by the tenth of each month for the previous month's services~~, Provider Progress Report for each member receiving services; and
- (8) serve as a member of the Personal Support Team and meet the Personal Support Team requirements per OAC 340:100-5-52.

(d) **Coverage.** The member's Plan contains detailed descriptions of services to be provided and ~~documentation of~~ specifies hours of services. All services must be authorized in the Plan and reflected in the approved plan of care. Arrangements for care must be made with the member's case manager.

## SUBCHAPTER 7. EMPLOYMENT SERVICES THROUGH HOME AND COMMUNITY-BASED SERVICES WAIVERS

### 317:40-7-5. Community-Based Services

Community-Based Services are provided in sites and at times typically used by others in the community and promote independence, inclusion within the community, and the creation of natural supports. Community-based services must reflect the ~~service recipient's~~ member's choice and values in situations that are typical for age and culture.

- (1) Approved Community-Based Services are individualized work-related supports targeting inclusion into integrated experiences. Community-Based Services are pre-planned, documented activities supported by a schedule relating to the ~~service recipient's~~ member's identified employment

outcomes. Approved activities include:

- (A) active participation in formalized volunteer activities;
  - (B) active participation in paid or unpaid work experience sites in community settings;
  - (C) training through generic entities such as trade schools, Vo Techs, junior colleges, or other community groups. The provider is paid for the time during which direct supports are necessary and provided;
  - (D) stamina-enhancing programs that occur in integrated settings;
  - (E) transportation to and from employment or community-based activities;
  - (F) meals and breaks which must occur during the conduct of the ~~service recipient's~~ member's employment activities;
  - (G) job tours or job shadowing scheduled with and provided by a community business entity;
  - (H) using Workforce OK services; and
  - (I) attending job fairs.
- (2) Any other work-related community-based activities must be approved through the exception process described in OAC 317:40-7-21.
- (3) Community-Based Services continue if the ~~service recipient~~ member has to go to a center-based facility for support such as repositioning or personal care, as long as the ~~service recipient~~ member returns immediately to a planned community-based activity. The amount of time for the repositioning and personal care are based upon a health care positioning plan approved by the Team.
- (4) ~~Community Based Services are provided to groups of no more than five people. Community-Based Services are available for individual and group placements.~~

(A) Individual placement means the member is provided supports that enable him or her to participate in approved community-based activities described in this Section individually and not as part of a group placement.

(B) Group Placement means two to five members are provided supports that enable him or her to participate in approved community-based activities described in this Section.

### **317:40-7-7. Job coaching services**

(a) Job coaching services:

- (1) 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 ~~certified as a job coach, who have completed DDS~~ sanctioned training per OAC 340:100-3-38.2;
  - (2) 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 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 available for individual and group placements.
- (A) Individual placement is:

(i) one member receiving job coaching services who:

- (I) works in an integrated job setting;
- (II) is paid at or more than minimum wage;
- (III) does not receive services from a job coach who is simultaneously responsible for continuous job coaching for a group;
- (IV) is employed by a community employer or provider agency;

and

(V) has a job description that is specific to the member's work; and

(ii) authorized when on-site supports by a certified job coach are provided more than 20% of the member's compensable work time. Job coaching services rate continues until a member reaches 20% or less job coach intervention for four consecutive weeks, at which time stabilization services begin.

(B) Group placement is two to eight members receiving continuous support in an integrated work site, who may earn less than minimum wage ; and

(5) 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):

(1) evaluates the need for job coaching services at least annually; and

(2) 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;

(2) work quality;

(3) independence;

(4) minimum wage opportunities; and

(5) competitive work opportunities.

### **317:40-7-15. Service requirements for employment services through Home and Community-Based Services Waivers**

(a) The Developmental Disabilities Services Division (DDSD) case manager, member, a member's family or, if applicable, legal guardian, and provider develop a preliminary plan of services including:

(1) site and amount of the services to be offered;

(2) types of services to be delivered; and

(3) expected outcomes.

(b) To promote community integration and inclusion, employment services are only delivered in non-residential sites.

(1) Employment services through Home and Community-Based Services (HCBS) Waivers cannot be reimbursed if those services occur in the residence or property of the member or provider-paid staff, including garages and sheds, whether or not the garage or shed is attached to the home.

(2) No exceptions to OAC 317:40-7-15(b) are authorized.

(c) Providers of HCBS employment services comply with OAC 340:100-17.

(d) The service provider is required to notify the DDSD case manager in writing when the member:

(1) is placed in a new job;

(2) loses his or her job. A Personal Support Team (Team) meeting must be held if the member loses the job;

(3) experiences significant changes in the community-based schedule or employment schedule; or

(4) experiences other circumstances, per OAC 340:100-3-34.

(e) The provider submits Oklahoma Department of Human Services (OKDHS) ~~Form 06WFO66E, Employment Progress Report, to the DDSD case manager by the tenth of each month for the previous month's services~~ Provider Progress Report per OAC 340:100-5-52, for each member receiving services.

(f) The cost of a member's employment services, excluding transportation and state-funded services per OAC 340:100-17-30, cannot exceed \$25,000 per Plan of Care year.

(g) Each member receiving residential supports per OAC 340:100-5-22.1 or

group home services is employed for 30 hours per week or receives a minimum of 30 hours of employment services, adult day services per OAC 317:40-5-113, or a combination of both, each week, excluding transportation to and from the member's residence.

(1) Thirty hours of employment service each week can be a combination of community-based services, center-based services, employment training specialist (ETS) intensive training services, stabilization services, and job coaching services. Center-based services cannot exceed 15 hours per week for members receiving services through the Homeward Bound ~~waiver~~ Waiver.

(2) Less than 30 hours of employment activities per week requires approval per OAC 317:40-7-21.

### **317:40-7-21. Exception process for employment services through Home and Community-Based Services Waivers**

(a) All exceptions to rules in OAC 317:40-7 are:

(1) approved ~~in accordance with~~ per OAC 317:40-7-21 prior to service implementation;

(2) intended to result in the Personal Support Team (Team) development of an employment plan tailored to meet the member's needs;

(3) identified in the Individual Plan (Plan) process per OAC 340:100-5-50 through 340:100-5-58; and

(4) documented and recorded on ~~Oklahoma Department of Human Services (OKDHS) Form 06WPD047E, Exception Request for Waiver Employment Services,~~ in the Individual Plan by the Developmental Disabilities Services Division (DDSD) case manager after Team approval.

(b) A request for an exception to the minimum of 30 hours per week of employment services, adult day services per OAC 317:40-5-113, or a combination of both, per OAC 317:40-7-15, includes documentation of the Team's:

(1) discussion of:

(A) current specific situation that requires an exception;

(B) all employment efforts, successful and unsuccessful, made by the member and Team in the past year; and

(C) progress toward previous exception strategies or plans;

(2) plan with specific steps and target dates to address the situation throughout the Plan of Care year so the exception may be lessened or no longer necessary at the end of the Plan of Care year; and

(3) specific residential schedule to provide integrated activities outside the home while the plan to increase to 30 hours is implemented.

(c) A request for an exception to the maximum limit of 15 hours per week for center-based services, per OAC 317:40-7-6, or continuous supplemental supports, per OAC 317:40-7-13, for a member receiving services through the Homeward Bound Waiver includes documentation of the Team's:

(1) discussion of:

(A) current specific situation that requires an exception;

(B) all employment efforts, successful and unsuccessful, made by the member and Team in the past year; and

(C) progress toward previous exception strategies or plans; and

(2) plan with specific steps and target dates to address the situation throughout the Plan of Care year so the exception may be lessened or no longer necessary at the end of the Plan of Care year.

(d) A request for an alternative to required community-based activities per OAC 317:40-7-5 includes documentation of the Team's:

(1) discussion of:

(A) current specific situation that requires an exception;

(B) all employment efforts, successful and unsuccessful, made by the

member and Team in the past year; and

(C) progress toward previous exception strategies or plans; and

(2) plan with specific steps and target dates to address the situation throughout the Plan of Care year so the exception may be lessened or no longer necessary at the end of the Plan of Care year.

~~(e) Within ten working days of the annual Individual Planning or interim meeting, the DDS case manager sends OKDHS Form 06WP047E to area employment services staff, who reviews the form to ensure all criteria per OAC 317:40-7-21 are met. If criteria are:~~

~~(1) not met, employment services staff returns OKDHS Form 06WP047E with recommendations to the DDS case management supervisor and case manager for resubmission; or~~

~~(2) met, employment services staff returns OKDHS Form 06WP047E to the case management supervisor to resume the approval process and input of units on the member's Plan of Care.~~

~~(f) (e) Exception requests per OAC 340:40-7-21(f) are documented by the DDS case manager after Team consensus and submitted via OKDHS Form 06WP047E to the DDS area manager or designee within ten working days after the annual IP or interim Team meeting. The area manager approves or denies the request with a copy to the DDS area office claims staff and case manager based on the thoroughness of the Team's discussion of possible alternatives and reasons for rejection of the other possible alternatives.~~

(1) State dollar reimbursement for absences of a member receiving services through the Community Waiver in excess of 10% of authorized units up to 150 units is approved for medical reasons only. The request includes:

(A) Team's discussion of current specific situation that requires an exception;

(B) specific medical issues necessitating the exception request; and

(C) a projection of units needed to complete the State fiscal year.

(2) A request for any other exception to rules in OAC 317:40-7-21 requires documentation of the Team's discussion of:

(A) current specific situation that requires an exception;

(B) all employment efforts, successful and unsuccessful, made by the member and Team in the past year; and

(C) progress toward previous exception strategies or plans.

~~(g) (f) The DDS director or designee may review exceptions granted per OAC 317:40-7-21, directing the Team to provide additional information, if necessary, to comply with OAC 340:100-3-33.1 and other applicable rules.~~

## SUBCHAPTER 9. SELF-DIRECTED SERVICES

### 317:40-9-1. Self-Directed Services (SDS)

(a) Applicability. The rules in this section apply to self-directed services provided through Home and Community Based Service (HCBS) Waivers operated by the Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDSD).

(b) Traditional service delivery methods are available for eligible members who do not elect to self-direct their services.

(c) General Information. Self-Direction is an option for members receiving Home and Community Based Services (HCBS) through the In-Home Supports Waiver for Adults (IHSW-A) or the In-Home Supports Waiver for Children (IHSW-C). Self-Direction provides the opportunity for a member to exercise choice and control in identifying, accessing, and managing specific waiver services and supports in accordance with their needs and personal preferences. Self-Directed Services (SDS) are Waiver services that the Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDSD) specifies may be directed by the member or representative using both employer

and budget authority.

(1) Services may be directed by:

- (A) an adult member, if the member has the ability to self-direct; or
- (B) a legal representative of the member, including a parent, spouse or legal guardian; or
- (C) a non-legal representative freely chosen by the member or their legal representative.

(2) The person directing services must:

- (A) be 18 years of age or older;
- (B) comply with OKDHS/DDSD and Oklahoma Health Care Authority (OHCA) rules and regulations;
- (C) complete required OKDHS/DDSD training for self-direction;
- (D) sign an agreement with OKDHS/DDSD;
- (E) be approved by the member or their legal representative to act in the capacity of a representative; and
- (F) demonstrate knowledge and understanding of the member's needs and preferences.

(d) SDS program includes:

(1) SDS Budget. A plan of care is developed to meet the member's needs without consideration of SDS. The member may elect to self-direct part or all of the amount identified for traditional Habilitation Training Specialist (HTS) services. This amount is under the control and discretion of the member in accordance with this policy and the approved IHSW, and is the allocated amount which may be used to develop the SDS budget. The SDS budget details the specific plan for spending.

(A) A SDS budget is developed annually at the time of the annual plan development and updated as necessary by the member, case manager, parent, legal guardian, and others the member invites to participate in the development of the budget.

(B) Payment may only be authorized for goods and services not covered by SoonerCare or other generic funding sources, and meets the criteria of service necessity per OAC 340:100-3-33.1.

(C) The member's SDS budget includes the actual cost of administrative activities including fees for services performed by a Financial Management Services (FMS) subagent, background checks, workers compensation insurance and the amount identified for SD-HTS and SD-GS.

(D) The SDS budget is added to the plan of care to replace any portion of traditional HTS services to be self-directed.

(2) The SD-Habilitation Training Specialist (SD-HTS) supports the member's self-care, daily living 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. SD-HTS must be included in the approved SDS budget. Payment will not be made for routine care and supervision that is normally provided by a family member or the member's spouse. SD-HTS are provided only during periods when staff is engaged in purposeful activity that directly or indirectly benefits the member. At no time are SD-HTS services authorized for periods during which the staff are allowed to sleep. Legally responsible persons may not provide services per OAC 340:100-3-33.2. Other family members providing services must be employed by provider agencies per OAC 340:100-3-33.2. For the purpose of this policy family members include parents and siblings including step and half and anyone living in the same home as the member. Payment does not include room and board, maintenance, upkeep or improvements to the member's or family's residence. A SD-HTS must:

- (A) be 18 years of age;
- (B) pass a background check per OAC 340:100-3-39;
- (C) demonstrate



- competency to perform required tasks;
- (D) complete required training per OAC 340:100-3-38.5;
- (E) sign an agreement with OKDHS/DDSD and the member;
- (F) be physically able and mentally alert to carry out the duties of the job;
- (G) not work more than 40 hours in any week in the capacity of a SD-HTS; and
- (H) not implement restrictive or intrusive procedures per OAC 340:100-5-57.

(3) Self-Directed Goods and Services (SD-GS). SD-GS are incidental, non-routine goods and services that promote the member's self-care, daily living, adaptive functioning, general household activity, meal preparation and leisure skills needed to reside successfully in the community and do not duplicate other services authorized in the member's plan of care. These goods and services must be included in the individual plan and approved SDS budget. SD-GS must meet the following requirements:

- (A) The item or service is justified by a recommendation from a licensed professional.
- (B) The item or service is not prohibited by Federal and State statutes and regulations.
- (C) One or more of the following additional criteria are met:
  - (i) the item or service would increase the member's functioning related to the disability;
  - (ii) the item or service would increase the member's safety in the home environment; or
  - (iii) the item or service would decrease dependence on other SoonerCare funded services.
- (D) SD-GS may include, but are not limited to:
  - (i) fitness items that can be purchased at most retail stores;
  - (ii) personal emergency monitoring systems;
  - (iii) food catcher;
  - (iv) specialized swing set;
  - (v) toothettes or electric toothbrush;
  - (vi) seat lift;
  - (vii) weight loss program; or
  - (viii) gym memberships when:
    - (I) there is an identified need for weight loss or increased physical activity- ;
    - (II) justified by outcomes related to weight loss, increased physical activity or stamina; and
    - (III) in subsequent plan of care year requests, documentation is provided that supports member's progress toward weight loss or increased physical activity or stamina.
- (E) SD-GS may not be used for:
  - (i) co-payments for medical services;
  - (ii) over-the-counter medications;
  - (iii) items or treatments that have not been approved by the Food and Drug Administration;
  - (iv) homeopathic services;
  - (v) services available through any other funding source such as SoonerCare, Medicare, private insurance, public school system, Rehabilitation Services or natural supports;
  - (vi) room and board, including deposits, rent and mortgage payments;
  - (vii) personal items and services not directly related to the member's disability;
  - (viii) vacation expenses;

- (ix) insurance;
- (x) vehicle maintenance or any other transportation related expense;
- (xi) costs related to internet access;
- (xii) clothing;
- (xiii) tickets and related costs to attend recreational events;
- (xiv) services, goods or supports provided to or benefiting persons other than the member; or
- (xv) experimental goods or services.
- (xvi) personal trainers;
- (xvii) spa treatments; or
- (xviii) goods or services with costs that significantly exceed community norms for the same or similar good or service.

(F) SD-GS are reviewed and approved by DDS division director or designee.

(e) Member Responsibilities. When the member chooses the SDS option, the member or member's representative is the employer of record and must:

(1) enroll and complete the OKDHS/DDSD sanctioned training course in self-direction. The training must be completed prior to the implementation of self-direction and will cover the following areas:

- (A) staff recruitment;
- (B) hiring of staff as employer of record;
- (C) orientation and instruction of staff in duties consistent with approved specifications;
- (D) supervision of staff including scheduling and service provisions;
- (E) evaluation of staff;
- (F) discharge of staff;
- (G) philosophy of self-direction;
- (H) OHCA policy on self-direction;
- (I) individual budgeting;
- (J) development of a self-directed support plan;
- (K) cultural diversity; and
- (L) rights, risks, and responsibilities.

(2) sign an agreement with OKDHS/DDSD;

(3) agree to utilize the services of a FMS subagent;

(4) agree to pay administrative costs for background checks, FMS subagent fee, and worker's compensation insurance from their SDS budget;

(5) comply with federal and state employment laws and ensure no employee works more than 40 hours per week in the capacity of SD-HTS;

(6) ensure that each employee is qualified to provide the services for which he/she is employed and that all billed services are actually provided;

(7) ensure that each employee complies with all OKDHS/DDSD training requirements for In-Home Support Waivers per OAC 340:100-3-38.5;

(8) recruit, hire, supervise, and discharge when necessary all employees providing self-directed services;

(9) verify employee qualifications;

(10) obtain a background screening on all employees providing SD-HTS per OAC 340:100-3-39;

~~(11) send monthly progress reports to the case manager by the 10th of each month for the preceding month of service via mail, e-mail or personal delivery per OAC 340:100-5-52.~~

(12) participate in the Individual Plan and SDS budget process;

(13) immediately notify the case manager of any changes in circumstances or emergencies, which may require modification of the type or amount of services provided for in the member's Individual Plan or SDS

budget;

(14) wait for approval of budget modifications before implementing changes;

(15) comply with OKDHS/DDSD and OHCA administrative rules;

(16) cooperate with OKDHS/DDSD monitoring requirements per OAC 340:100-3-27;

(17) cooperate with all requirements of the FMS subagent to ensure accurate records and prompt payroll including:

(A) reviewing and signing employee time cards;

(B) verifying the accuracy of hours worked; and

(C) ensuring the appropriate expenditure of funds.

(18) complete all required documents within established timeframes;

(19) pay for services incurred in excess of the budget amount;

(20) pay for services not identified and approved in the member's SDS budget;

(21) pay for services provided by an unqualified provider;

(22) determine staff duties, qualifications, and specify service delivery practices consistent with SD-HTS waiver service specifications;

(23) orient and instruct staff in duties;

(24) evaluate staff performance;

(25) identify and train back-up staff when required;

(26) determine amount paid for services within Plan limits;

(27) schedule staff and the provision of services;

(28) ensure SD-HTS do not implement restrictive or intrusive procedures per OAC 340:100-5-57; and

(29) sign an agreement with OKDHS/DDSD and the SD-HTS.

(f) Financial Management Services (FMS) subagent responsibilities. The FMS subagent is an entity designated as an agent by OKDHS/DDSD to act on behalf of members who have employer and budget authority for the purpose of managing payroll tasks for the member's employee(s) and for making payment of SD-GS as authorized in the member's Plan. FMS subagent duties include, but are not limited to:

(1) compliance with all OKDHS/DDSD and OHCA administrative rules and contract requirements;

(2) compliance with random and targeted audits conducted by OKDHS/DDSD or the OHCA;

(3) provision of financial management support to the member by tracking individual expenditures and monitoring SDS budgets;

(4) processing the member's employee payroll, withholding, filing and paying of applicable federal, state and local employment-related taxes and insurance;

(5) collection and process of employee's time sheets and making payment to member's employees;

(6) processing and payment of invoices for SD-GS as authorized in the member's SDS budget;

(7) providing each member with information that will assist with managing the SDS budget;

(8) providing reports to members/representatives, as well as OKDHS/DDSD monthly and to OHCA upon request;

(9) providing OKDHS/DDSD and OHCA authorities access to individual member's accounts through a web-based program;

(10) assisting members in verifying employee citizenship status;

(11) maintaining separate accounts for each member's SDS budget;

(12) tracking and reporting member funds, disbursements and the balance of member funds;

(13) receiving and disbursing funds for the payment of SDS under an agreement with the OHCA; and

(14) executing and maintaining contractual agreement between OKDHS/DDSD and the SD-HTS (employee).

(g) OKDHS/DDSD Case Management responsibilities in support of SDS.

(1) The case manager develops the member's Plan per OAC 340:100-5-50 through 58;

(2) The DDSD case manager meets with the member and/or the member's representative or legal guardian to discuss the following service delivery options in the HCBS Waiver:

(A) traditional Waiver services; and

(B) self-directed services including information regarding scope of choices, options, rights, risks, and responsibilities associated with self-direction.

(3) If the member chooses self-direction, the case manager will:

(A) discuss with member or representative the amount available in the budget;

(B) assist member or representative with the development and modification of the SDS budget;

(C) submit request for SD-GS to the DDSD division director or designee for review and approval prior to the case manager's approval of the SDS budget;

(D) approve the SDS budget and modifications;

(E) assist member or representative with developing or revising an emergency back-up plan;

(F) provide FMS subagent a copy of the member's authorized SDS budget and any modifications;

(G) monitor implementation of the Plan per OAC 340:100-3-27.

(H) ensure that services are initiated within required time frames;

(I) conduct ongoing monitoring of the implementation of the Plan and the member's health and welfare;

(J) specify additional employee qualifications in the Plan based on the member's needs and preferences so long as such qualifications are consistent with approved waiver qualifications;

(K) specify in the Plan how services are provided;

(L) refer potential SD-HTS providers to the FMS subagent for enrollment;

(M) assist in locating and securing services and other community resources that promote community integration, community membership and independence, as provided in the member's Plan; and

(N) ensure any restrictive or intrusive procedures per OAC 340:100-5-57 are not implemented by the SD-HTS. If the Team determines restrictive or intrusive procedures are necessary, SD-HTS is not appropriate to meet the needs of the member and traditional services must be used.

(h) OKDHS/DDSD serves as the Organized Health Care Delivery System (OHCD) as well as the FMS provider in a Centers for Medicare and Medicaid Services (CMS) approved Government Fiscal/Employer Agent model. OKDHS/DDSD has an interagency agreement with OHCA.

(i) Voluntary Termination of Self-Directed Services. Members may discontinue self-directing services without disruption at any time, provided traditional waiver services are in place. Members or representatives may not choose the self-directed option again until the next annual planning meeting, with services resuming no earlier than the beginning of the next plan of care. Any member desiring to file a complaint must follow the procedures set forth by OKDHS at OAC 340:2-5-61.

(j) Involuntary Termination of Self-Directed Services.

(1) Members may be terminated involuntarily from self-direction and offered traditional waiver services when it has been determined by

OKDHS/DDSD Director or designee that any of the following exist:

- (A) immediate health and safety risks associated with self-direction, such as, imminent risk of death or irreversible or serious bodily injury related to waiver services;
- (B) intentional misuse of funds following notification, assistance and support from OKDHS/DDSD;
- (C) failure to follow and implement policies of self-direction after technical assistance and guidance from OKDHS/DDSD;
- (D) fraud; or
- (E) it is determined that restrictive or intrusive procedures are essential for safety.

(2) When action is taken to terminate the member from self-directed services involuntarily, the case manager assists the member in accessing needed and appropriate services through the traditional waiver services option, ensuring that no lapse in necessary services occurs for which the member is eligible.

(3) The Fair Hearing process as described in OAC 340:100-3-13 applies.

(k) Reporting requirements. While operating as an Organized Health Care Delivery System, OKDHS/DDSD will provide to the OHCA reports detailing provider activity in the format and at such times as required by the OHCA.

6.a-53 **TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY**  
**CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**  
Subchapter 3. General Provider Policies  
Part 1. General Scope and Administration  
317:30-3-4.1. [AMENDED]  
(Reference APA WF # 10-60)

**SUMMARY:** Rules are revised to clarify requirements for documenting electronic health records.

**BUDGET IMPACT:** Agency staff has determined that these revisions are budget neutral.

**MEDICAL ADVISORY COMMITTEE:** The Medical Advisory Committee considered the proposed rule revisions on March 9, 2011, and recommended Board approval.

**AUTHORITY:** The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes

**PUBLIC HEARING:** A public hearing was held on February 22, 2011. No comments were received before, during, or after the hearing.

**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY**  
**CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**  
**SUBCHAPTER 3. GENERAL PROVIDER POLICIES**  
**PART 1. GENERAL SCOPE AND ADMINISTRATION**

**317:30-3-4.1. Uniform Electronic Transaction Act**

The Oklahoma Health Care Authority enacts the provisions of the Uniform Electronic Transaction Act as provided in this Section with the exception to the act as provided in this Section.

(1) **Scope of Act.** The Electronic Transaction Act applies to an electronic record and an electronic signature created with a record that is generated, sent, communicated, received or stored by the Oklahoma Health Care Authority.

(2) **Use of electronic records and electronic signatures.** The rules regarding electronic records and electronic signatures apply when both parties agree to conduct business electronically. Nothing in these regulations requires parties to conduct business electronically. However, should a party have the capability and desire to conduct business electronically with the Oklahoma Health Care Authority, then the following guidelines must be adhered to:

(A) Only employees designated by the provider's agency may make entries in the ~~client's~~ member's medical record. All entries in the ~~client's~~ member's medical record must be dated and authenticated with a method established to identify the author. The identification method may include computer keys, Private/Public Key Infrastructure (PKIs), voice authentication systems that utilize a personal identification number (PIN) and voice authentication, or other codes. Providers must have a process in place to deactivate an employee's access to records upon termination of employment of the designated employee.

(B) When PKIs, computer key/code(s), voice authentication systems or other codes are used, a signed statement must be completed by the agency's employee documenting that the chosen method is under the sole

control of the person using it and further demonstrate that:

- (i) A list of PKIs, computer key/code(s), voice authentication systems or other codes can be verified;
- (ii) All adequate safeguards are maintained to protect against improper or unauthorized use of PKIs, computer keys, or other codes for electronic signatures; and
- (iii) Sanctions are in place for improper or unauthorized use of computer key/code(s), PKIs, voice authentication systems or other code types of electronic signatures.

(C) There must be a specific action by the author to indicate that the entry is verified and accurate. Systems requiring an authentication process include but are not limited to:

- (i) Computerized systems that require the provider's employee to review the document on-line and indicate that it has been approved by entering a unique computer key/code capable of verification;
- (ii) A system in which the provider's employee signs off against a list of entries that must be verified in the member's records;
- (iii) A mail system that sends transcripts to the provider's employee for review;
- (iv) A postcard identifying and verifying the accuracy of the record(s) signed and returned by the provider's employee; or
- (v) A voice authentication system that clearly identifies author by a designated personal identification number or security code.

(D) Auto-authentication systems that authenticate a report prior to the transcription process do not meet the stated requirements and will not be an acceptable method for the authentication process.

(E) Records may be edited by designated administrators within the provider's facility but must be authenticated by the original author. Edits must be in the form of a correcting entry which preserves entries from the original record. Edits must be completed prior to claims submission or no later than 45 days after the date of service, whichever is later.

(F) Use of the electronic signature, for clinical documentation, shall be deemed to constitute a signature and will have the same effect as a written signature on the clinical documentation. The section of the electronic record documenting the service provided must be authenticated by the employee or individual who provided the described service.

(G) Any authentication method for electronic signatures must:

- (i) be unique to the person using it;
- (ii) identify the individual signing the document by name and title;
- (iii) be capable of verification, assuring that the documentation cannot be altered after the signature has been affixed;
- (iv) be under the sole control of the person using it;
- (v) be linked to the data in such a manner that if the data is changed, the signature is invalidated; and
- (vi) provide strong and substantial evidence that will make it difficult for the signer to claim that the electronic representation is not valid.

(H) Failure to properly maintain or authenticate medical records (i.e., signature and date entry) may result in the denial or recoupment of ~~Medicaid~~ SoonerCare payments.

(3) **Record retention for provider medical records.** Providers must retain electronic medical records and have access to the records in accordance with guidelines found at OAC 317:30-3-15.

(4) **Record retention for documents submitted to OHCA electronically.**

(A) The Oklahoma Health Care Authority's system provides that receivers of electronic information may both print and store the electronic information they receive. The Oklahoma Health Care Authority is the custodian of the original electronic record and will retain that record in accordance with a disposition schedule as referenced by the Records Destruction Act. The Oklahoma Health Care Authority will retain an authoritative copy of the transferable record as described in the Electronic Transaction Act that is unique, identifiable and unalterable.

(i) **Manner and format of electronic signature.** The manner and format required by the Oklahoma Health Care Authority will vary dependant upon whether the sender of the document is a recipient member (~~client~~) or a provider. In the limited case where a provider is a client, the manner and format is dependent upon the function served by the receipt of the record. In the case the function served is a request for services, then the format required is that required by a recipient. In the case the function served is related to payment for services, then the format required is that required by a provider.

(ii) **Recipient format requirements.** The Oklahoma Health Care Authority will allow ~~recipients~~ members to request ~~Medicaid~~ SoonerCare services electronically. An electronic signature will be authenticated after a validation of the data on the form by another database or databases.

(iii) **Provider format requirements.** The Oklahoma Health Care Authority will permit providers to contract with the Oklahoma Health Care Authority, check and amend claims filed with the Oklahoma Health Care Authority, and file prior authorization requests with the Oklahoma Health Care Authority. Providers with a social security number or federal employer's identification number will be given a personal identification number (PIN). After using the PIN to access the database, a PIN will be required to transact business electronically.

(B) Providers with the assistance of the Oklahoma Health Care Authority will be required to produce and enforce a security policy that outlines who has access to their data and what transaction employees are permitted to complete as outlined in the policy rules for electronic records and electronic signatures contained in paragraph (2) of this section.

(C) Third Party billers for providers will be permitted to perform electronic transaction as stated in paragraph (2) only after the provider authorizes access to the provider's PIN and a power of attorney by the provider is executed.

(5) **Time Time and place of sending and receipt.** The provisions of the Electronic Transaction Act apply to the time and place of receipt with the exception of a power failure, Internet interruption or Internet virus. Should any of the exceptions in this paragraph occur, confirmation is required by the receiving party.

(6) **Illegal representations of electronic transaction.** Any person who fraudulently represents facts in an electronic transaction, acts without authority, or exceeds their authority to perform an electronic transaction may be prosecuted under all applicable criminal and civil laws.



6.a-54 **TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY**  
**CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**  
Subchapter 5. Individual Providers and Specialties  
Part 17. Medical Suppliers  
317:30-5-210. [AMENDED]  
(Reference APA WF # 10-61)

**SUMMARY:** Medical Suppliers rules are revised to clarify OHCA's DMEPOS provider criteria. DMEPOS providers must meet Medicare accreditation standards unless the OHCA grants an exemption based on CMS exemptions, the provider is a government-owned entity, or at a provider's request. Revisions clarify that DMEPOS providers be located within the State of Oklahoma, unless the OHCA provides an exception to this requirement. Additionally, DMEPOS providers must comply with Medicare DMEPOS Supplier Standards as specified in 42 C.F.R. 424.57(c).

**BUDGET IMPACT:** Agency staff has determined that these revisions are budget neutral.

**MEDICAL ADVISORY COMMITTEE:** The Medical Advisory Committee considered the proposed rule revisions on January 20, 2011, and recommended Board approval.

**AUTHORITY:** The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes

**PUBLIC HEARING:** A public hearing was held on February 22, 2011. One written comment was received before the hearing and was considered during the rulemaking process.

**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY**  
**CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**  
**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**  
**PART 17. MEDICAL SUPPLIERS**

**317:30-5-210. Eligible providers**

All eligible medical suppliers must have a current contract with the Oklahoma Health Care Authority. The supplier must comply with all applicable State and Federal laws. Effective January 1, 2011, all suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) must be accredited by a Medicare deemed accreditation organization for quality standards for DMEPOS suppliers in order to bill the SoonerCare program. OHCA may make exceptions to this standard ~~if it is determined that a supplier may provide acceptable service to an under served location.~~ based on the exemptions provided by the Centers for Medicare and Medicaid Services (CMS) for Medicare accreditation, if the provider is a government-owned entity, or at a provider's request and at the discretion of OHCA based on access issues and/or agency needs for SoonerCare members. Additionally, unless an exception is granted from the OHCA, all DMEPOS providers must meet the following criteria:

(1) DMEPOS providers are required to have a physical location in the State of Oklahoma, or within a designated range of the Oklahoma State border, as determined by the OHCA. The OHCA may make exceptions to this requirement if a DMEPOS provider provides a specialty item, product, or service, which is not otherwise available to SoonerCare members within the State of Oklahoma. Provider contracts for out-of-state DMEPOS providers will be

reviewed on a case-by-case basis for specialty items only. The OHCA has discretion and the final authority to approve or deny any provider contract.

(2) DMEPOS providers are required to comply with Medicare DMEPOS Supplier Standards for DMEPOS provided to SoonerCare members, except the requirement to meet surety bond requirements, as specified in 42 C.F.R. 424.57(c).

6.a-55 **TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY**  
**CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**  
Subchapter 5. Individual Providers and Specialties  
Part 5. Pharmacies  
317:30-5-72. [AMENDED]  
317:30-5-77.3. [AMENDED]  
(Reference APA WF # 10-62)

**SUMMARY:** Pharmacy rules are revised to allow for a prior authorization for a third brand name prescription if determined to be medically necessary by OHCA and if the member has not already utilized their six covered prescriptions for the month. Additional revisions include general policy cleanup as it relates to these sections.

**BUDGET IMPACT:** Agency staff has determined that these revisions are budget neutral.

**MEDICAL ADVISORY COMMITTEE:** The Medical Advisory Committee considered the proposed rule revisions on March 9, 2011, and recommended Board approval.

**AUTHORITY:** The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes

**PUBLIC HEARING:** A public hearing was held on February 22, 2011. No comments were received before, during, or after the hearing.

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

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

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

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

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

(A) unlimited monthly medically necessary prescriptions for categorically related individuals who are residents of Nursing Facilities or Intermediate Care Facilities for the Mentally Retarded; and

(B) seven additional medically necessary prescriptions which are generic products per month to the six covered under the State Plan are allowed for adults receiving services under the ~~915(e)~~ 1915(c) Home and Community Based Services Waivers. Medically necessary prescriptions beyond the two brand name or thirteen total prescriptions will be covered with prior authorization.

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

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

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

(d) **Individuals eligible for a prescription drug benefit through a Prescription Drug Plan (PDP) or Medicare Advantage - Prescription Drug (MA-PD) plan as described in the Medicare Modernization Act (MMA) of 2003.** Individuals who qualify for enrollment in a PDP or MA-PD are specifically excluded from coverage under the SoonerCare pharmacy benefit. This exclusion applies to these individuals in any situation which results in a loss of Federal Financial Participation for the SoonerCare program. The exclusion will become effective January 1, 2006, or the date Medicare Part D is implemented for dual eligible individuals, whichever is later. This exclusion shall not apply to items covered at OAC 317:30-5-72.1(2) unless those items are required to be covered by the prescription drug provider in the MMA or subsequent federal action.

### **317:30-5-77.3. Product**

(a) The Oklahoma Health Care Authority utilizes a prior authorization system subject to their authority under ~~42 U.S.C. 396r-8~~ 42 U.S.C. 1396r-8 and 63 O.S. 5030.3(B). The prior authorization program is not a drug formulary which is separately authorized in ~~42 U.S.C. 396r-8~~ 42 U.S.C. 1396r-8. Drugs are placed into two or more tiers based on similarities in clinical efficacy, side-effect profile and cost-effectiveness after recommendation by the Drug Utilization Review Board and OHCA Board approval. Drugs placed in tier number one require no prior authorization. Drugs placed in any tier other than tier number one require prior authorization.

(1) Three exceptions exist to the requirement of prior authorization:

- (A) inadequate response to one or more tier one products,
- (B) a clinical exception for a certain product in the particular therapeutic category, or
- (C) the manufacturer or labeler of a product may opt to participate in the state supplemental drug rebate program to move a product from a higher tier to a lower tier which will remove or reduce the prior authorization requirement for that product.

(i) After a drug or drug category has been added to the Prior Authorization program, OHCA or its contractor may establish a cost-effective benchmark value for each therapeutic category or individual drug. The benchmark value may be calculated based on an average cost, an average cost per day, a weighted average cost per

day or any other generally accepted economic formula. A single formula for all drugs or drug categories is not required. Supplemental rebate offers from manufacturers which are greater than the minimum required supplemental rebate will be accepted and may establish a new benchmark rebate value for the category.

(ii) Manufacturers of products assigned to tiers number two and higher may choose to pay a supplemental rebate to the state in order to avoid a prior authorization on their product or products assigned to the higher tier.

(iii) Supplemental rebate agreements shall be in effect for one year and may be terminated at the option of either party with a 60 day notice. Supplemental rebate agreements are subject to the approval of CMS. Termination of a Supplemental Rebate agreement will result in the specific product reverting to the previously assigned higher tier in the PBPA program.

(iv) The supplemental unit rebate amount for a tier two or higher product will be calculated by subtracting the federal rebate amount per unit from the benchmark rebate amount per unit.

(v) Supplemental rebates will be invoiced concurrent with the federal rebates and are subject to the same terms with respect to payment due dates, interest, and penalties for non-payment as specified at 42 U.S.C. Section 1396r-8. All terms and conditions not specifically listed in federal or state law shall be included in the supplemental rebate agreement as approved by CMS.

(vi) Drugs or drug categories which are not part of the Product Based Prior Authorization program as outlined in 63 O.S. Section 5030.5 may be eligible for supplemental rebate participation. The OHCA Drug Utilization Review Board shall determine supplemental rebate eligibility for drugs or drug categories after considering clinical efficacy, side effect profile, cost-effectiveness and other applicable criteria.

(2) All clinical exceptions are recommended by the Drug Utilization Review Board and demonstrated by documentation sent by the prescribing physician and pharmacist.

(b) Additional therapeutic categories of drugs will be subject to subsection (a) of this Section if recommended by the Drug Utilization Review Board, considered by the Medical Advisory Committee and approved by the OHCA Board.

6.a-56 **TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY**  
**CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY**  
Subchapter 5. Eligibility and Countable Income  
Part 5. Countable Income and Resources  
317:35-5-41.6. [AMENDED]  
317:35-5-41.9. [AMENDED]  
317:35-5-42. [AMENDED]  
Subchapter 10. Other Eligibility Factors for Families with Children and Pregnant Women  
Part 5. Income  
317:35-10-26. [AMENDED]  
**(Reference APA WF # 10-65)**

**SUMMARY:** Eligibility rules are revised to clarify OHCA's treatment of Individual Indian Money (IIM) Accounts as a converted resource. Funds and property held in IIM Accounts will no longer be used in an eligibility test. References to per capita payments are removed and the period in which money disbursed from IIM accounts can be counted as a resource is revised.

**BUDGET IMPACT:** Agency staff has determined that these revisions are budget neutral.

**MEDICAL ADVISORY COMMITTEE:** The Medical Advisory Committee considered the proposed rule revisions on January 20, 2011, and recommended Board approval.

**AUTHORITY:** The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; Section 5006(b) of the American Recovery and Reinvestment Act of 2009

**PUBLIC HEARING:** A public hearing was held on February 22, 2011. Written comments were received before the hearing and were considered during the rulemaking process.

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

**317:35-5-41.6. Trust accounts**

Monies held in trust for an individual applying for or receiving SoonerCare must have the availability of the funds determined. Funds held in trust are considered available when they are under the direct control of the individual or his/her spouse, and disbursement is at their sole discretion. Funds may also be held in trust and under the control of someone other than the individual or his/her spouse, such as the courts, agencies, other individuals, etc., or the Bureau of Indian Affairs (BIA).

(1) **Availability determinations.** The worker should be able to determine the availability of a trust using the definitions and explanations listed in (2) of this subsection. However, in some cases, the worker may wish to submit a trust to the OKDHS State Office for determination of availability. In these instances, all pertinent data is submitted to Family Support Services Division, Attention: Health Related and Medical Services Section, for a decision.

(2) **Definition of terms.** The following words and terms, when used in this paragraph, have the following meaning, unless the context clearly indicates otherwise:

(A) **Beneficiary.** Beneficiary means the person(s) who is to receive distributions of either income or principal, or on behalf of whom the trustee is to make payments.

(B) **Corpus/principal.** Corpus/principal means the body of the trust or the original asset used to establish the trust, such as a sum of money or real property.

(C) **Discretionary powers.** Discretionary powers means the grantor gives the trustee the power to make an independent determination whether to distribute income and/or principal to the beneficiary(ies) or to retain the income and add it to the principal of the trust.

(D) **Distributions.** Distributions means payments or allocations made from the trust from the principal or from the income produced by the principal (e.g., interest on a bank account).

(E) **Grantor (trustor/settlor).** Grantor (trustor/settlor) means the individual who establishes the trust by transferring certain assets.

(F) **Irrevocable trust.** Irrevocable trust means a trust in which the grantor has expressly not retained the right to terminate or revoke the trust and reclaim the trust principal and income.

(G) **Pour over or open trust.** Pour over or open trust means a trust which may be expanded from time to time by the addition to the trust principal (e.g., a trust established to receive the monthly payment of an annuity, a workers' compensation settlement, a disability benefit or other periodic receivable). The principal may accumulate or grow depending upon whether the trustee distributes the receivable or permits it to accumulate. Generally, the terms of the trust will determine the availability of the income in the month of receipt and the availability of the principal in subsequent months.

(H) **Primary beneficiary.** Primary beneficiary means the first person or class of persons to receive the benefits of the trust.

(I) **Revocable trust.** Revocable trust means a trust in which the grantor has retained the right to terminate or revoke the trust and reclaim the trust principal and income. Unless a trust is specifically made irrevocable, it is revocable. Even an irrevocable trust is revocable upon the written consent of all living persons with an interest in the trust.

(J) **Secondary beneficiary.** Secondary beneficiary means the person or class of persons who will receive the benefits of the trust after the primary beneficiary has died or is otherwise no longer entitled to benefits.

(K) **Testamentary trust.** Testamentary trust means a trust created by a will and effective upon the death of the individual making the will.

(L) **Trustee.** Trustee means an individual, individuals, a corporation, court, bank or combination thereof with responsibility for carrying out the terms of the trust.

(3) **Documents needed.** To determine the availability of a trust for an individual applying for or receiving SoonerCare, copies of the following documents are obtained:

(A) Trust document;

(B) When applicable, all relevant court documents including the Order establishing the trust, Settlement Agreement, Journal Entry, etc.; and

(C) Documentation reflecting prior disbursements (date, amount, purpose).

(4) **Trust accounts established on or before August 10, 1993.** The rules found in (A) - (C) of this paragraph apply to trust accounts established

on or before August 10, 1993.

(A) **Support trust.** The purpose of a support trust is the provision of support or care of a beneficiary. A support trust will generally contain language such as "to provide for the care, support and maintenance of ...", "to provide as necessary for the support of ...", or "as my trustee may deem necessary for the support, maintenance, medical expenses, care, comfort and general welfare." Except as provided in (i)-(iii) of this subparagraph, the amount from a support trust deemed available to the beneficiary is the maximum amount of payments that may be permitted under the terms of the trust to be distributed to the beneficiary, assuming the full exercise of discretion by the trustee(s) for distribution of the maximum amount to the beneficiary. The beneficiary of a support trust, under which the distribution of payments to the beneficiary is determined by one or more trustees who are permitted to exercise discretion with respect to distributions, may show that the amounts deemed available are not actually available by:

(i) Commencing proceedings against the trustee(s) in a court of competent jurisdiction;

(ii) Diligently and in good faith asserting in the proceedings that the trustee(s) is required to provide support out of the trust; and

(iii) Showing that the court has made a determination, not reasonably subject to appeal, that the trustee must pay some amount less than the amount deemed available. If the beneficiary makes the showing, the amount deemed available from the trust is the amount determined by the court. Any action by a beneficiary or the beneficiary's representative, or by the trustee or the trustee's representative, in attempting a showing to make the Agency or the State of Oklahoma a party to the proceeding, or to show to the court that SoonerCare benefits may be available if the court limits the amounts deemed available under the trust, precludes the showing of good faith required.

(B) **Medicaid Qualifying Trust (MQT).** A Medicaid Qualifying Trust is a trust, or similar legal device, established (other than by will) by an individual or an individual's spouse, under which the individual may be the beneficiary of all or part of the distributions from the trust and such distributions are determined by one or more trustees who are permitted to exercise any discretion with respect to distributions to the individual. A trust established by an individual or an individual's spouse includes trusts created or approved by a representative of the individual (parent, guardian or person holding power of attorney) or the court where the property placed in trust is intended to satisfy or settle a claim made by or on behalf of the individual or the individual's spouse. This includes trust accounts or similar devices established for a minor child pursuant to ~~Title 12 Oklahoma Statute~~ ~~83~~ 12 O.S. 83. In addition, a trust established jointly by at least one of the individuals who can establish an MQT and another party or parties (who do not qualify as one of these individuals) is an MQT as long as it meets the other MQT criteria. The amount from an irrevocable MQT deemed available to the individual is the maximum amount of payments that may be permitted under the terms of the trust to be distributed to the individual assuming the full exercise of discretion by the trustee(s). The provisions regarding MQT apply even though an MQT is irrevocable or is established for purposes other than enabling an individual to qualify for SoonerCare, and, whether or not discretion is actually exercised.

(i) **Similar legal device.** MQT rules listed in this subsection



also apply to "similar legal devices" or arrangements having all the characteristics of an MQT except that there is no actual trust document. An example is the member petitioning the court to irrevocably assign all or part of his/her income to another party (usually the spouse). The determination whether a given document or arrangement constitutes a "similar legal device" should be made by the OKDHS Office of General Counsel, Legal Unit.

(ii) **MQT resource treatment.** For revocable MQTs, the entire principal is an available resource to the member. Resources comprising the principal are subject to the individual resource exclusions (e.g., the home property exclusion) since the member can access those resource items without the intervention of the trustee. For irrevocable MQTs, the countable amount of the principal is the maximum amount the trustee can disburse to (or for the benefit of) the member, using his/her full discretionary powers under the terms of the trust. If the trustee has unrestricted access to the principal and has discretionary power to disburse the entire principal to the member (or to use it for the member's benefit), the entire principal is an available resource to the member. Resources transferred to such a trust lose individual resource consideration (e.g., home property transferred to such a trust is no longer home property and the home property exclusions do not apply). The value of the property is included in the value of the principal. If the MQT permits a specified amount of trust income to be distributed periodically to the member (or to be used for his/her benefit), but those distributions are not made, the member's countable resources increase cumulatively by the undistributed amount.

(iii) **Income treatment.** Amounts of MQT income distributed to the member are countable income when distributed. Amounts of income distributed to third parties for the member's benefit are countable income when distributed.

(iv) **Transfer of resources.** If the MQT is irrevocable, a transfer of resources has occurred to the extent that the trustee's access to the principal (for purposes of distributing it to the member or using it for the member's benefit) is restricted (e.g., if the trust stipulates that the trustee cannot access the principal but must distribute the income produced by that principal to the member, the principal is not an available resource and has, therefore, been transferred).

(C) **Special needs trusts.** Some trusts may provide that trust benefits are intended only for a beneficiary's "special needs" and require the trustee to take into consideration the availability of public benefits and resources, including SoonerCare benefits. Some trusts may provide that the trust is not to be used to supplant or replace public benefits, including SoonerCare benefits. If a trust contains such terms and is not an MQT, the trust is not an available resource.

(5) **Trust accounts established after August 10, 1993.** The rules found in (A) - (C) of this paragraph apply to trust accounts established after August 10, 1993.

(A) For purposes of this subparagraph, the term "trust" includes any legal document or device that is similar to a trust. An individual is considered to have established a trust if assets of the individual were used to form all or part of the principal of the trust and if the trust was established other than by will and by any of the following individuals:

(i) the individual;

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

(B) Where trust principal includes assets of an individual described in this subparagraph and assets of any other person(s), the provisions of this subparagraph apply to the portion of the trust attributable to the assets of the individual. This subparagraph applies without regard to the purposes for which the trust is established, whether the trustees have or exercise any discretion under the trust, and restrictions on when or whether distributions may be made from the trust, or any restrictions on the use of the distribution from the trust.

(C) There are two types of trusts, revocable trusts and irrevocable trusts.

(i) In the case of a revocable trust, the principal is considered an available resource to the individual. Home property in a revocable trust under the direct control of the individual, spouse or legal representative retains the exemption as outlined in OAC 317:35-5-41.8(a)(2). Payments from the trust to or for the benefit of the individual are considered income of the individual. Other payments from the trust are considered assets disposed of by the individual for purposes of the transfer of assets rule and are subject to the 60 months look back period.

(ii) In the case of an irrevocable trust, if there are any circumstances under which payments from the trust could be made to or for the benefit of the individual, the portion of the principal of the trust, or the income on the principal, from which payment to the individual could be made is considered available resources. Payments from the principal or income of the trust is considered income of the individual. Payments for any other purpose are considered a transfer of assets by the individual and are subject to the 60 months look back period. Any portion of the trust from which, or any income on the principal from which no payment could under any circumstances be made to the individual is considered as of the date of establishment of the trust (or if later, the date on which payment to the individual was foreclosed) to be assets disposed by the individual for purposes of the asset transfer rules and are subject to the 60 months look back period.

(6) **Exempt trusts.** Paragraph (5) of this subsection does not apply to the following trusts:

(A) A trust containing the assets of a disabled individual under the age of 65 which was established for the benefit of such individual by the parent, grandparent, legal guardian of the individual or a court if the State receives all amounts remaining in the trust on the death of the individual up to an amount equal to the total medical assistance paid on behalf of the individual. This type of trust requires:

- (i) The trust may only contain the assets of the disabled individual.
- (ii) The trust must be irrevocable and cannot be amended or dissolved without the written agreement of the Oklahoma Department of Human Services or the Oklahoma Health Care Authority.
- (iii) Trust records must be open at all reasonable times to

inspection by an authorized representative of the OHCA or OKDHS.

(iv) The exception for the trust continues after the disabled individual reaches age 65. However, any addition or augmentation after age 65 involves assets that were not the assets of an individual under age 65; therefore, those assets are not subject to the exemption.

(v) Establishment of this type of trust does not constitute a transfer of assets for less than fair market value if the transfer is made into a trust established solely for the benefit of a disabled individual under the age of 65.

(vi) Payments from the trust are counted according to SSI rules. According to these rules, countable income is anything the individual receives in cash or in kind that can be used to meet the individual's needs for food, clothing and shelter. Accordingly, any payments made directly to the individual are counted as income to the individual because the payments could be used for food, clothing, or shelter for the individual. This rule applies whether or not the payments are actually used for these purposes, as long as there is no legal impediment which would prevent the individual from using the payments in this way. In addition, any payments made by the trustee to a third party to purchase food, clothing, or shelter for the individual can also count as income to the individual. For example, if the trustee makes a mortgage payment for the individual, that payment is a shelter expense and counts as income.

(vii) A corporate trustee may charge a reasonable fee for services in accordance with its published fee schedule.

(viii) The OKDHS Form 08MA018E, Supplemental Needs Trust, is an example of the trust. Workers may give the sample form to the member or his/her representative to use or for their attorney's use.

(ix) To terminate or dissolve a Supplemental Needs Trust, the worker sends a copy of the trust instrument and a memorandum to OKDHS Family Support Services Division, Attention: Health Related and Medical Services (HR&MS) explaining the reason for the requested termination or dissolution of the Supplemental Needs Trust, and giving the name and address of the trustee. The name and address of the financial institution and current balance are also required. Health Related and Medical Services notifies OHCA/TPL to initiate the recovery process.

(B) A trust (known as the Medicaid Income Pension Trust) established for the benefit of an individual if:

(i) The individual is in need of long-term care and has countable income above the categorically needy standard for long-term care (OKDHS Appendix C-1) but less than \$3000 per month.

(ii) The Trust is composed only of pension, social security, or other income of the individual along with accumulated income in the trust. Resources can not be included in the trust.

(iii) All income is paid into the trust and the applicant is not eligible until the trust is established and the monthly income has been paid into the trust.

(iv) The trust must retain an amount equal to the member's gross monthly income less the current categorically needy standard of OKDHS Appendix C-1. The Trustee distributes the remainder.

(v) The income disbursed from the trust is considered as the monthly income to determine the cost of their care, and can be used in the computations for spousal diversion.

(vi) The trust must be irrevocable and cannot be amended or dissolved without the written agreement of the OHCA. Trust records must be open at all reasonable times to inspection by an authorized representative of the OHCA or OKDHS.

(vii) The State will receive all amounts remaining in the trust up to an amount equal to the total SoonerCare benefits paid on behalf of the individual subsequent to the date of establishment of the trust.

(viii) Accumulated funds in the trust may only be used for medically necessary items not covered by SoonerCare, or other health programs or health insurance and a reasonable cost of administering the trust. Reimbursements cannot be made for any medical items to be furnished by the nursing facility. Use of the accumulated funds in the trust for any other reason will be considered as a transfer of assets and would be subject to a penalty period.

(ix) The trustee may claim a fee of up to 3% of the funds added to the trust that month as compensation.

(x) An example trust is included on OKDHS Form 08MA011E. Workers may give this to the member or his/her representative to use or for their attorney's use as a guide for the Medicaid Income Pension Trust.

(xi) To terminate or dissolve a Medicaid Income Pension Trust, the worker sends a memorandum with a copy of the trust to OKDHS Family Support Services Division, Attention: HR&MS, explaining the reason for the requested termination or dissolution of the Medicaid Income Pension Trust, and giving the name and address of the trustee. The name and address of the financial institution, account number, and current balance are also required. Health Related and Medical Services notifies OHCA/TPL to initiate the recovery process.

(C) A trust containing the assets of a disabled individual when all of the following are met:

(i) The trust is established and managed by a non-profit association;

(ii) The trust must be made irrevocable;

(iii) The trust must be approved by the Oklahoma Department of Human Services and may not be amended without the permission of the Oklahoma Department of Human Services;

(iv) The disabled person has no ability to control the spending in the trust;

(v) A separate account is maintained for each beneficiary of the trust but for the purposes of investment and management of funds, the trust pools these accounts;

(vi) The separate account on behalf of the disabled person may not be liquidated without payment to OHCA for the medical expenses incurred by the members;

(vii) Accounts in the trust are established by the parent, grandparent, legal guardian of the individual, the individual, or by a court;

(viii) To the extent that amounts remaining in the beneficiary's account on the death of the beneficiary are not retained by the trust, the trust pays to the State from such remaining amounts an amount equal to the total medical assistance paid on behalf of the individual. A maximum of 30% of the amount remaining in the beneficiary's account at the time of the beneficiary's death may be retained by the trust.

(7) **Funds held in trust by Bureau of Indian Affairs (BIA).** Interests of

individual Indians in trust or restricted lands are not considered a resource in determining eligibility for assistance under the Social Security Act or any other federal or federally assisted program.

(8) **Disbursement of trust.** At any point that disbursement occurs, the amount disbursed is counted as a non-recurring lump sum payment in the month received. Some trusts generate income on a regular basis and the income is sent to the beneficiary. In those instances, the income is treated as unearned income in the month received.

### 317:35-5-41.9. Resource disregards

In determining need, the following are not considered as resources:

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

(2) Any payment received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970;

(3) Education grants (excluding Work Study) scholarships, etc., that are contingent upon the student regularly attending school. The student's classification (graduate or undergraduate) is not a factor;

(4) Loans (regardless of use) if a bona fide debt or obligation to pay can be established. Criteria to establish a loan as bona fide includes:

(A) An acknowledgment of obligation to repay or evidence that the loan was from an individual or financial institution in the loan business. If the loan agreement is not written, an OKDHS Loan Verification form is completed by the borrower attesting that the loan is bona fide and signed by the lender verifying the date and amount of loan. When copies of written agreements or OKDHS Loan Verification form are not available, detailed case documentation must include information that the loan is bona fide and how the debt amount and date of receipt was verified;

(B) If the loan was from a person(s) not in the loan business, the borrower's acknowledgment of obligation to repay (with or without interest) and the lender's verification of the loan are required to indicate that the loan is bona fide;

(C) Proceeds of a loan secured by an exempt asset are not an asset;

(5) Indian payments or items purchased from Indian payments (including ~~judgement judgment~~ funds or funds held in trust) distributed ~~per capita~~ by the Secretary of the Interior (BIA) or distributed ~~per capita~~ by the tribe subject to approval by the Secretary of the Interior. Also, any interest or investment income accrued on such funds while held in trust or any purchases made with ~~judgement judgment~~ funds, trust funds, interest or investment income accrued on such funds. Any income from mineral leases, from tribal business investments, etc., ~~as long as the payments are paid per capita. For purposes of this Subchapter, per capita is defined as each tribal member receiving an equal amount.~~ However, any interest or income derived from the principal or produced by purchases made with the funds after distribution is considered as any other income. Funds and property held in Individual Indian Money (IIM) Accounts are treated as a converted resource and disregarded for purposes of eligibility. Disbursements of funds from IIM accounts are to be disregarded as a resource in the month in which the disbursement was made. However, any retained disbursed funds are counted as a resource for purposes of eligibility on the first of the month following the month of disbursement;

(6) Special allowance for school expenses made available upon petitions (in writing) from funds held in trust for the student;

(7) Benefits from State and Community Programs on Aging (Title III) are disregarded. Income from the Older American Community Service Employment Act (Title V), including AARP and Green Thumb organizations as well as employment positions allocated at the discretion of the Governor of

Oklahoma, is counted as earned income. Both Title III and Title V are under the Older Americans Act of 1965 amended by PL 100-175 to become the Older Americans Act amendments of 1987;

(8) Payments for supportive services or reimbursement of out-of-pocket expenses made to individual volunteers serving as foster grandparents, senior health aides, or senior companions, and to persons serving in the Services Corps of Retired Executives (SCORE) and Active Corps of Executives (ACE);

(9) Payment to volunteers under the Domestic Volunteer Services Act of 1973 (VISTA), unless the gross amount of VISTA payments equals or exceeds the state or federal minimum wage, whichever is greater;

(10) The value of supplemental food assistance received under the Child Nutrition Act or the special food services program for children under the National School Lunch Act;

(11) Any portion of payments made under the Alaska Native Claims Settlement Act to an Alaska Native which are exempt from taxation under the Settlement Act;

(12) Experimental Housing Allowance Program (EHAP) payments made under Annual Contributions Contracts entered into prior to January 1, 1975, under Section 23 of the U.S. Housing Act of 1937, as amended;

(13) Payments made from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In Re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.);

(14) Payments made from the Radiation Exposure Compensation Trust Fund as compensation for injuries or deaths resulting from the exposure to radiation from nuclear testing and uranium mining;

(15) Federal major disaster and emergency assistance provided under the Disaster Relief Act of 1974, and comparable disaster assistance provided by States, local governments and disaster assistance organizations;

(16) ~~Interests of individual Indians in trust or restricted lands. However, any disbursements from the trust or the restricted lands are considered as income;~~

(17) Resources set aside under an approved Plan for Achieving Self-Support for Blind or Disabled People (PASS). The Social Security Administration approves the plan, the amount of resources excluded and the period of time approved. A plan can be approved for an initial period of 18 months. The plan may be extended for an additional 18 months if needed, and an additional 12 months (total 48 months) when the objective involves a lengthy educational or training program;

(18) Payments made to individuals because of their status as victims of Nazi persecution (PL 103-286);

(19) A migratory farm worker's out-of-state homestead is disregarded if the farm worker's intent is to return to the homestead after the temporary absence;

(20) Payments received under the Civil Liberties Act of 1988. These payments are to be made to individuals of Japanese ancestry who were detained in internment camps during World War II;

(21) Dedicated bank accounts established by representative payees to receive and maintain retroactive SSI benefits for disabled/blind children up to the legal age of 18. The dedicated bank account must be in a financial institution, the sole purpose of which is to receive and maintain SSI underpayments which are required or allowed to be deposited into such an account. The account must be set up and verification provided to SSA before the underpayment can be released;

(22) Payments received as a result of participation in a class action lawsuit entitled "Factor VIII or IX Concentrate Blood Products Litigation". These payments are made to hemophilia patients who are

infected with HIV. Payments are not considered as income or resources. A penalty cannot be assessed against the individual if he/she disposes of part or all of the payment. The rules at OAC 317:35-5-41.6 regarding the availability of a trust do not apply if an individual establishes a trust using the settlement payment;

(23) Payments made to certain Vietnam veterans' children with spina bifida (PL 104-204);

(24) Payments made to certain Korea service veterans' children with spina bifida (PL 108-183);

(25) Payments made to the children of women Vietnam veterans who suffer from certain birth defects (PL 106-419);

(26) For individuals with an Oklahoma Long-Term Care Partnership Program approved policy, resources equal to the amount of benefits paid on the insured's behalf by the long-term care insurer are disregarded at the time of application for long-term care services provided by SoonerCare. The Oklahoma Insurance Department approves policies as Long-term Care Partnership Program policies;

(27) Workers' Compensation Medicare Set Aside Arrangements (WCMSAs), which allocate a portion of the workers' compensation settlement for future medical expenses; and

(28) Additional payments of regular unemployment compensation in the amount of \$25 per week ending June 30, 2010 and any amount of emergency unemployment compensation paid through May 31, 2010, as authorized under the American Recovery and Reinvestment Tax Act of 2009.

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

(a) **General.** The term income is defined as that gross gain or gross recurrent benefit which is derived from labor, business, property, retirement and other benefits, and many other forms which can be counted on as currently available for use on a regular basis. When an individual's income is reduced due to recoupment of an overpayment or garnishment, the gross amount before the recoupment or garnishment is counted as income.

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

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

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

(4) In calculating monthly income, cents are included in the computation until the monthly amount of each individual's source of income has been established. When the monthly amount of each income source has been established, cents are rounded to the nearest dollar (1 - 49 cents is rounded down, and 50 - 99 cents is rounded up). For example, an individual's weekly earnings of \$99.90 are multiplied by 4.3 and the cents rounded to the nearest dollar ( $\$99.90 \times 4.3 = \$429.57$  rounds to \$430). See rounding procedures in OAC 340:65-3-4 when using BENDEX to verify OASDI benefits.

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

as income:

- (1) The coupon allotment under the Food Stamp Act of 1977;
- (2) Any payment received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970;
- (3) Educational grants (excluding work study), scholarships, etc., that are contingent upon the student regularly attending school. The student's classification (graduate or undergraduate) is not a factor;
- (4) Loans (regardless of use) if a bona fide debt or obligation to pay can be established. Criteria to establish a loan as bona fide includes:
  - (A) An acknowledgment of obligation to repay or evidence that the loan was from an individual or financial institution in the loan business. If the loan agreement is not written, an OKDHS Form 08AD103E, Loan Verification, should be completed by the borrower attesting that the loan is bona fide and signed by the lender verifying the date and amount of loan. When copies of written agreements or OKDHS Form 08AD103E are not available, detailed case documentation must include information that the loan is bona fide and how the debt amount and date of receipt was verified.
  - (B) If the loan was from a person(s) not in the loan business, the borrower's acknowledgment of obligation to repay (with or without interest) and the lender's verification of the loan are required to indicate that the loan is bona fide.
  - (C) Proceeds of a loan secured by an exempt asset are not an asset;
- (5) One-third of child support payments received on behalf of the disabled minor child;
- (6) Indian payments (including ~~judgement~~ judgment funds or funds held in trust) distributed ~~per capita~~ by the Secretary of the Interior (BIA) or distributed ~~per capita~~ by the tribe subject to approval by the Secretary of the Interior. Also, any interest or investment income accrued on such funds while held in trust or any purchases made with ~~judgement~~ judgment funds, trust funds, interest or investment income accrued on such funds. Any income from mineral leases, from tribal business investments, etc., ~~as long as the payments are made per capita. For purposes of this Subchapter, per capita is defined as each tribal member receiving an equal amount.~~ However, any interest or income derived from the principal or produced by purchases made with funds after distribution is considered as any other income;
- (7) Special allowance for school expenses made available upon petition (in writing) for funds held in trust for the student;
- (8) Title III benefits from State and Community Programs on Aging;
- (9) Payment for supportive services or reimbursement of out-of-pocket expenses made to individual volunteers serving as foster grandparents, senior health aides, or senior companions, and to persons serving in the Service Corps of Retired Executives (SCORE) and Active Corps of Executives (ACE);
- (10) Payments to volunteers under the Domestic Volunteer Services Act of 1973 (VISTA), unless the gross amount of VISTA payments equals or exceeds the state or federal minimum wage, whichever is greater;
- (11) The value of supplemental food assistance received under the Child Nutrition Act or the special food service program for children under the national School Lunch Act;
- (12) Any portion of payments made under the Alaska Native Claims Settlement Act to an Alaska Native which are exempt from taxation under the Settlement Act;
- (13) Reimbursements from an employer for out-of-pocket expenditures and allowances for travel or training to the extent the funds are used for



expenses directly related to such travel or training and uniform allowance if the uniform is uniquely identified with company names or logo;

(14) Assistance or services from the Vocational Rehabilitation program such as transportation expenses to a rehabilitation center, extra clothing, lunches, grooming needed for a training program and any other such complementary payments;

(15) Experimental Housing Allowance Program (EHAP) payments made under Annual Contributions Contracts entered into prior to January 1, 1975, under Section 23 of the U.S. Housing Act of 1937, as amended;

(16) Payments made by a public or private non-profit child care agency for a child placed in foster care or subsidized adoption;

(17) Governmental rental or housing subsidies by governmental agencies, e.g., HUD (received in-kind or in cash) for rent, mortgage payments or utilities;

(18) LIHEAP payments for energy assistance and payments for emergency situations under Emergency Assistance to Needy Families with Children;

(19) Payments made from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In Re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.);

(20) Payments made from the Radiation Exposure Compensation Trust Fund as compensation for injuries or deaths resulting from the exposure to radiation from nuclear testing and uranium mining;

(21) Federal major disaster and emergency assistance provided under the Disaster Relief Act of 1974, and comparable disaster assistance provided by States, local governments and disaster assistance organizations;

(22) Income of a sponsor to the sponsored eligible alien;

~~(23) The BIA frequently puts an individual's trust funds in an Individual Indian Money (IIM) account. To determine the availability of funds held in trust in an IIM account, the worker must contact the BIA in writing and ascertain if the funds, in total or any portion, are available to the individual. If any portion of the funds is disbursed to the individual member, guardian or conservator, such funds are considered as available income. If the BIA determines the funds are not available, they are not considered in determining eligibility. Funds held in trust by the BIA and not disbursed are considered unavailable.~~

~~(A) In some instances, BIA may determine the account is unavailable; however, they release a certain amount of funds each month to the individual. In this instance the monthly disbursement is considered as unearned income.~~

~~(B) When the BIA has stated the account is unavailable and the account does not have a monthly disbursement plan, but a review reveals a recent history of disbursements to the individual member, guardian or conservator, these disbursements must be resolved with the BIA. These disbursements indicate all or a portion of the account may be available to the individual member, guardian or conservator. When the county office is unable to resolve the situation with the BIA, the county submits a referral to the appropriate section in OKDHS Family Support Services Division (FSSD). The referral must include specific details of the situation, including the county's efforts to resolve the situation with the BIA. If FSSD cannot make a determination, a legal decision regarding availability will be obtained by FSSD, and then forwarded to the county office by FSSD. When a referral is sent to FSSD, the funds are considered as unavailable with a legal impediment until the county is notified otherwise.~~

~~(C) At each reapplication or redetermination, the worker is to contact BIA to obtain information regarding any changes as to the availability of the funds and any information regarding modifications to the IIM~~

account. Information regarding prior disbursements is also obtained at this time. All of this information is reviewed for the previous six or twelve month period, or since the last contact if the contact was within the last certification or redetermination period.

~~(D) When disbursements have been made, the worker determines whether such disbursements were made to the member or to a third party vendor in payment for goods or services. Payments made directly from the BIA to vendors are not considered as income to the member. Workers should obtain documentation to verify services rendered and payment made by BIA.~~

~~(E) Amounts disbursed directly to the members are counted as non-recurring lump sum payments in the month received. Some trusts generate income on a regular basis and the income is sent to the beneficiary. In those instances, the income is treated as unearned income in the month received;~~

~~(24) Income up to \$2,000 per year received by individual Indians, which are derived from leases or other uses of individually owned trust or restricted lands;~~

~~(25)~~(23) Income that is set aside under an approved Plan for Achieving Self-Support for Blind or Disabled People (PASS). The Social Security Administration approves the plan, the amount of income excluded and the period of time approved. A plan can be approved for an initial period of 18 months. The plan may be extended for an additional 18 months if needed, and an additional 12 months (total 48 months) when the objective involves a lengthy educational or training program;

~~(26)~~(24) Payments made to individuals because of their status as victims of Nazi persecution (PL 103-286);

~~(27)~~(25) Payments received under the Civil Liberties Act of 1988. These payments are to be made to individuals of Japanese ancestry who were detained in internment camps during World War II;

~~(28)~~(26) Payments received as a result of participation in a class action lawsuit entitled "Factor VIII or IX Concentrate Blood Products Litigation". These payments are made to hemophilia patients who are infected with HIV. However, if the payments are placed in an interest-bearing account, or some other investment medium that produces income, the income generated by the account may be countable as income to the individual;

~~(29)~~(27) Payments made to certain Vietnam veterans' children with spina bifida (PL 104-204);

~~(30)~~(28) Payments made to certain Korea service veterans' children with spina bifida (PL 108-183);

~~(31)~~(29) Payments made to the children of women Vietnam veterans who suffer from certain birth defects (PL 106-419);

~~(32)~~(30) Additional payments of regular unemployment compensation in the amount of \$25 per week ending June 30, 2010, and any amount of emergency unemployment compensation paid through May 31, 2010, as authorized under the American Recovery and Reinvestment Tax Act of 2009; and

~~(33)~~(31) Wages paid by the Census Bureau for temporary employment related to Census activities.

(c) **Determination of income.** The member is responsible for reporting information regarding all sources of available income. This information is verified and used by the worker in determining eligibility.

(1) Gross income is listed for purposes of determining eligibility. It may be derived from many sources, and some items may be automatically disregarded by the computer when so provided by state or federal law.

(2) If a member is determined to be categorically needy and is also an SSI recipient, any change in countable income (see OAC 317:35-5-42(d)(3) to

determine countable income) will not affect receipt of SoonerCare and amount of State Supplemental Payment (SSP) as long as the amount does not cause SSI ineligibility. Income which will be considered by SSI in the retrospective cycle is documented in the case with computer update at the time that SSI makes the change (in order not to penalize the member twice). If the SSI change is not timely, the worker updates the computer using the appropriate date as if it had been timely. If the receipt of the income causes SSI ineligibility, the income is considered immediately with proper action taken to reduce or close the SoonerCare benefit and SSP case. Any SSI overpayment caused by SSA not making timely changes will result in recovery by SSI in the future. When the worker becomes aware of income changes which will affect SSI eligibility or payment amount, the information is to be shared with the SSA office.

(3) Some of the more common income sources to be considered in determining eligibility are as follows:

(A) **Retirement and disability benefits.** These include but are not limited to OASDI, VA, Railroad Retirement, SSI, and unemployment benefits. Federal and State benefits are considered for the month they are intended when determining eligibility.

(i) Verifying and documenting the receipt of the benefit and the current benefit amount are achieved by:

(I) seeing the member's award letter or warrant;

(II) obtaining a signed statement from the individual who cashed the warrant; or

(III) by using BENDEX and SDX.

(ii) Determination of OASDI benefits to be considered (disregarding COLA's) for former State Supplemental recipients who are reapplying for medical benefits under the Pickle Amendment must be computed according to OKDHS Form 08AX011E.

(iii) The Veterans Administration allows their recipients the opportunity to request a reimbursement for medical expenses not covered by SoonerCare. If a recipient is eligible for the readjustment payment, it is paid in a lump sum for the entire past year. This reimbursement is disregarded as income and a resource in the month it is received; however, any amount retained in the month following receipt is considered a resource.

(iv) Government financial assistance in the form of VA Aid and Attendance or Champus payments is considered as follows:

(I) **Nursing facility care.** VA Aid and Attendance or Champus payment whether paid directly to the member or to the facility, are considered as third party resources and do not affect the income eligibility or the vendor payment of the member.

(II) **Own home care.** The actual amount of VA Aid and Attendance payment paid for an attendant in the home is disregarded as income. In all instances, the amount of VA Aid and Attendance is shown on the computer form.

(v) Veterans or their surviving spouse who receive a VA pension may have their pension reduced to \$90 by the VA if the veteran does not have dependents, is SoonerCare eligible, and is residing in a nursing facility that is approved under SoonerCare. Section 8003 of Public Law 101-508 allows these veterans' pensions to be reduced to \$90 per month. None of the \$90 may be used in computing any vendor payment or spenddown. In these instances, the nursing home resident is entitled to the \$90 reduced VA pension as well as the regular nursing facility maintenance standard. Any vendor payment or spenddown will be computed by using other income minus the monthly nursing facility maintenance standard minus any applicable

medical deduction(s). Veterans or their surviving spouse who meet these conditions will have their VA benefits reduced the month following the month of admission to a SoonerCare approved nursing facility.

(B) **SSI benefits.** SSI benefits may be continued up to three months for a recipient who enters a public medical or psychiatric institution, a SoonerCare approved hospital, extended care facility, intermediate care facility for the mentally retarded or nursing facility. To be eligible for the continuation of benefits, the SSI recipient must have a physician's certification that the institutionalization is not expected to exceed three months and there must be a need to maintain and provide expenses for the home. These continued payments are intended for the use of the recipient and do not affect the vendor payment.

(C) **Lump sum payments.**

(i) Any income received in a lump sum (with the exception of SSI lump sum) covering a period of more than one month, whether received on a recurring or nonrecurring basis, is considered as income in the month it is received. Any amount from any lump sum source, including SSI (with the exception of dedicated bank accounts for disabled/blind children under age 18), retained on the first day of the next month is considered as a resource. Such lump sum payments may include, but are not limited to, accumulation of wages, retroactive OASDI, VA benefits, Workers' Compensation, bonus lease payments and annual rentals from land and/or minerals.

(ii) Lump sum payments used to establish dedicated bank accounts by representative payees in order to receive and maintain retroactive SSI benefits for disabled/blind children under age 18 are excluded as income. The interest income generated from dedicated bank accounts is also excluded. The dedicated bank account consisting of the retroactive SSI lump sum payment and accumulated interest is excluded as a resource in both the month received and any subsequent months.

(iii) A life insurance death benefit received by an individual while living is considered as income in the month received and as a resource in the following months to the extent it is available.

(iv) Changing a resource from one form to another, such as converting personal property to cash, is not considered a lump sum payment.

(D) **Income from capital resources and rental property.** Income from capital resources can be derived from rental of a house, rental from land (cash or crop rent), leasing of minerals, life estate, homestead rights or interest.

(i) If royalty income is received monthly but in irregular amounts, an average based on the previous six months' royalty income is computed and used to determine income eligibility. Exception: At any time that the county becomes aware of and can establish a trend showing a dramatic increase or decrease in royalty income, the previous two month's royalty income is averaged to compute countable monthly income.

(ii) Rental income may be treated as earned income when the individual participates in the management of a trade or business or invests his/her own labor in producing the income. The individual's federal income tax return will verify whether or not the income is from self-employment. Otherwise, income received from rent property is treated as unearned income.

(iii) When property rental is handled by a leasing agent who collects the rent and deducts a management fee, only the rent actually received by the member is considered as income.

(E) **Earned income/self-employment.** The term "earned income" includes income in cash earned by an individual through the receipt of wages, salary, commission or profit from activities in which he/she is engaged as a self-employed individual or as an employee. See subparagraph (G) of this paragraph for earnings received in fluctuating amounts. "Earned Income" is also defined to include in-kind benefits received by an employee from an employer in lieu of wages or in conjunction with wages. Such benefits received in-kind are considered as earned income only when the employee/employer relationship has been established. The cash value of the in-kind benefits must be verified by the employer. Income from self-employment also includes in-kind benefits for a work activity or service for which the self-employed person ordinarily receives payment in his/her business enterprise. An exchange of labor or services; e.g., barter, is considered as an in-kind benefit. Medical insurance secured through the employer, whether purchased or as a benefit, is not considered in-kind but is recorded on the case computer input document for coordination with SoonerCare benefits.

(i) Advance payments of EITC or refunds of EITC received as a result of filing a federal income tax return are considered as earned income in the month they are received.

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

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

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

(I) Generally, the federal or state income tax form for the most recent year is used for calculating the self-employment income to project income on a monthly basis for the certification period. The gross income amount as well as the allowable deductions are the same as can be claimed under the Internal Revenue code for tax purposes.

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

(III) If the household's self-employment enterprise has been in existence for less than a year, the income from that self-employment enterprise is averaged over the period of time the business has been in operation to establish the monthly income amount.

(IV) If a tax return is not available because one has not been filed due to recent establishment of the self-employment enterprise, a profit and loss statement must be seen to establish the monthly income amount.

(V) The purchase price and/or payment(s) on the principal of loans for capital assets, equipment, machinery, and other durable goods is not considered as a cost of producing self-employed income. Also not considered are net losses from previous periods, depreciation of capital assets, equipment,

machinery, and other durable goods; and federal, state and local income taxes, FICA, money set aside for retirement purposes, and other work related personal expenses, such as meals and necessary transportation (these expenses are accounted for by the work related expense deduction given in OAC 340:10-3-33(1)).

(v) Countable self-employment income is determined by deducting allowable business expenses to determine the adjusted gross income. The earned income deductions are then applied to establish countable earned income.

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

(G) **Monthly income received in fluctuating amounts.** Income which is received monthly but in irregular amounts is averaged using two month's income, if possible, to determine income eligibility. Less than two month's income may be used when circumstances (e.g., new employment, unpaid sick leave, etc.) would indicate that previous income amounts would not be appropriate to use in determining future income amounts. Income received more often than monthly is converted to monthly amounts as follows:

(i) **Daily.** Income received on a daily basis is converted to a weekly amount then multiplied by 4.3.

(ii) **Weekly.** Income received weekly is multiplied by 4.3.

(iii) **Twice a month.** Income received twice a month is multiplied by 2.

(iv) **Biweekly.** Income received every two weeks is multiplied by 2.15.

(H) **Non-negotiable notes and mortgages.** Installment payments received on a note, mortgage, etc., are considered as monthly income.

(I) **Income from the Job Training and Partnership Act (JTPA).** Unearned income received by an adult, such as a needs based payment, cash assistance, compensation in lieu of wages, allowances, etc., from a program funded by JTPA is considered as any other unearned income. JTPA earned income received as wages is considered as any other earned income.

(J) **Other income.** Any other monies or payments which are available for current living expenses must be considered.

(d) **Computation of income.**

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

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

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

(4) **Deeming computation for disabled or blind minor child(ren).** An automated calculation is available for computing the income amount to be deemed from parent(s) and the spouse of the parent to eligible disabled or blind minor child(ren) by use of transaction CID. The ineligible minor

child in the computation regarding allocation for ineligible child(ren) is defined as: a dependent child under age 18.

(A) A mentally retarded child living in the home who is ineligible for SSP due to the deeming process may be approved for SoonerCare under the Home and Community Based Services Waiver (HCBS) Program as outlined in OAC 317:35-9-5.

(B) For TEFRA, the income of child's parent(s) is not deemed to him/her.

(5) **Premature infants.** Premature infants (i.e., 37 weeks or less) whose birth weight is less than 1200 grams (approximately 2 pounds 10 ounces) will be considered disabled by SSA even if no other medical impairment(s) exist. In this event, the parents' income is not deemed to the child until the month following the month in which the child leaves the hospital and begins living with his/her parents.

(6) **Procedures for deducting ineligible minor child allocation.** When an eligible individual has an ineligible spouse and ineligible minor children (not receiving TANF), the computation is as follows:

(A) Each ineligible child's allocation (OKDHS Form 08AX001E, Schedule VII. C.) minus each child's gross countable income is deducted from the ineligible spouse's income. Deeming of income is not done from child to parent.

(B) The deduction in subparagraph (A) of this paragraph is prior to deduction of the general income exclusion and work expense.

(C) After computations in subparagraphs (A) and (B) of this paragraph, the remaining amount is the ineligible spouse's countable income considered available to the eligible spouse.

(7) **Special exclusions for blind individuals.** Any blind individual who is employed may deduct the general income exclusion and the work exclusion from the gross amount of earned income. After the application of these exclusions, one-half of the remaining income is excluded. The actual work expense is then deducted from the remaining half to arrive at the amount of countable income. If this blind individual has a spouse who is also eligible due to blindness and both are working, the amount of ordinary and necessary expenses attributable to the earning of income for each of the blind individuals may be deducted. Expenses are deductible as paid but may not exceed the amount of earned income. To be deductible, an expense need not relate directly to the blindness of the individual, it need only be an ordinary and necessary work expense of the blind individual. Such expenses fall into three broad categories:

(A) transportation to and from work;

(B) job performance; and

(C) job improvement.

**SUBCHAPTER 10. OTHER ELIGIBILITY FACTORS FOR FAMILIES WITH  
CHILDREN AND PREGNANT WOMEN  
PART 5. INCOME**

**317:35-10-26. Income**

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

(1) The income of categorically needy individuals who are related to AFDC or Pregnancy does not require verification, unless questionable. If the income information is questionable, it must be verified. If there appears to be a conflict in the information provided, the worker must investigate the situation to determine if income verification is necessary.

(2) All available income, except that required to be disregarded by law or OHCA's policy, is taken into consideration in determining need. Income is considered available both when actually available and when the applicant

or member has a legal interest in a liquidated sum and has the legal ability to make such sum available for support and maintenance. When an individual's income is reduced due to recoupment of an overpayment or garnishment, the gross amount before the recoupment or garnishment is counted as income. The member is responsible for reporting all income, the source, amount and how often received.

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

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

(C) If it appears any member of the benefit group or an individual whose income is considered when determining eligibility is eligible for any type of income or benefits, the benefit group must be notified in writing by the Oklahoma ~~Department of Human Services (OKDHS)~~ Health Care Authority (OHCA). The notice must contain the information that failure to apply for and take all appropriate steps to obtain such benefits within ~~30~~ 10 days from the date of the notice will result in a determination of ineligibility. An application for Supplemental Security Income (SSI) is not required.

(D) If the member and spouse are living together or they are living apart but there has not been a clear break in the family relationship, income received by either spouse and income received jointly is considered as family income. Income cannot be diverted to a household member who is not included in the household size for health benefits. Consideration is not given to a SSI recipient's income in computing eligibility for the AFDC or Pregnancy related unit.

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

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

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

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



(A) A nonrecurring lump sum payment considered as income includes payments based on accumulation of income and payments which may be considered windfall in nature and may include but are not limited to TANF grant diversion, VA or Social Security lump sum payments, inheritance, gifts, worker's compensation payments, cash winnings, personal injury awards, etc. Retirement benefits received in a lump-sum are considered as unearned income. A non-recurring lump sum SSI retroactive payment, made to an AFDC or pregnancy related recipient who is not currently eligible for SSI, is not counted as income.

(B) Lump sum payments (minus allowable deductions related to establishing the lump sum payment) which are received by AFDC/Pregnancy related individuals or applicants are considered as income. Allowable deductions are expenses earmarked in the settlement or award to be used for a specific purpose which may include, but are not limited to, attorney's fees and court costs that are identified in the lump sum settlement, medical or funeral expenses for the immediate family, etc. "Earmarked" means that such expense is specifically set forth in the settlement or award.

(C) When a lump sum is received by a stepparent not included in the household size, only the stepparent's contribution is considered in accordance with the stepparent's liability policy.

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

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

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

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

(6) A caretaker relative can only be included in the benefit group when the biological or adoptive parent is not in the home. A stepparent can be included when the biological or adoptive parent is either incapacitated or not in the home.

(A) Consideration is not given to the income of the caretaker relative or the income of his or her spouse in determining the eligibility of the children. However, if that person is the stepparent, the policy on stepparent liability is applicable.

(B) If a caretaker relative is married and living with the spouse who is an SSI or SSP recipient, the spouse or spouse's income is not considered in determining the eligibility of the caretaker relative. The income of the caretaker relative and the spouse who is not an SSI

or SSP recipient must be considered. Only one caretaker relative is eligible to be included in any one month.

(7) A stepparent can be included when the biological or adoptive parent is either incapacitated or not in the home. The income of the stepparent is counted if the stepparent's needs are being included.

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

(b) **Earned income.** The term "earned income" refers to monies earned by an individual through the receipt of wages, salary, commission or profit from activities in which the individual is engaged as self-employed or as an employee. Payments made for accumulated annual leave/vacation leave, sick leave or as severance pay are considered as earned income whether paid during employment or at termination of employment. Temporary disability insurance payment(s) and temporary worker's compensation payments are considered as earned income if payments are employer funded and the individual remains employed. Income received as a one-time nonrecurring payment is considered as a lump sum payment. Earned income includes in-kind benefits received by an employee from an employer in lieu of wages or in conjunction with wages. An exchange of labor or services, e.g., barter, is considered as an in-kind benefit. Such benefits received in-kind are considered as earned income only when the employee/employer relationship has been established. Income from self-employment also includes in-kind benefits for a work activity or service for which the self-employed person ordinarily receives payment in the business enterprise. Medical insurance secured through the employer, whether purchased or as a benefit, is not considered in-kind income. Gross earned income is used to determine eligibility. Gross earned income is defined as the wage prior to payroll deductions and/or withholdings.

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

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

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

(ii) If the self-employment enterprise has been in existence for less than a year, the income is averaged over the period of time the business has been in operation to establish the monthly income amount.

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

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

- (i) The purchase price and/or payments on the principal of loans for capital assets, equipment, machinery, and other durable goods;
- (ii) Net losses from previous periods;
- (iii) Depreciation of capital assets, equipment, machinery, and other durable goods; and
- (iv) Federal, state and local income taxes, FICA, money set aside for retirement purposes, and other work related personal expenses, such as meals and necessary transportation. These expenses are accounted for by the work related expense deduction.

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

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

(2) **Earned income from wages, salary or commission.** If the income is from wages, salary or commission, the "earned income" is the gross income prior to payroll deductions and/or withholdings. Income from the Older American Community Service Employment Act (Title V), including AARP and Green Thumb organizations as well as employment positions allocated at the discretion of the Governor of Oklahoma, is counted as any other earned income.

(3) **Earned income from work and training programs.** Earned income from work and training programs such as the Job Training Partnership Act (JTPA) received by an adult as wages is considered as any other earned income. Also, JTPA earned income of a dependent child is considered when received in excess of six months in any calendar year.

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

(A) **Work related expenses.** The standard deduction for work related expenses such as income tax payments, Social Security taxes, and transportation to and from work, is \$240 per each full-time or part-time employed member of the benefit group.

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

(i) Child care expense may be deducted when:

- (I) suitable care for a child included in the benefit group is not available from responsible persons living in the home or through other alternate sources; and
- (II) the employed member whose income is considered must purchase care.

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

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

(iv) Child care provided by another person in the household who is not a member of the benefit group may be considered as child care expenses as long as the home meets applicable standards of State, local or Tribal law.

(v) Documentation is made of the child care arrangement indicating the name of the child care facility or the name of the in-home provider, and the documentation used to verify the actual payment of child care per month.

(5) **Formula for determining the individual's net earned income.** Formulas used to determine net earned income to be considered are:

(A) **Net earned income from employment other than self-employment.** Gross Income minus work related expense minus child care expense equals net income.

(B) **Net earned income from self-employment.** Gross income minus allowable business expenses minus work related expense and child care expense equals net income.

(c) **Unearned income.**

(1) **Capital investments.** Proceeds, i.e., interest or dividends from capital investments, such as savings accounts, bonds (other than U.S. Savings Bonds, Series A through EE), notes, mortgages, etc., received constitute income.

(2) **Life estate and homestead rights.** Income from life estate or homestead rights, constitute income after deducting actual business expenses.

(3) **Minerals.** If the member owns mineral rights, only actual income from minerals, delayed rentals, or production is considered. Evidence is obtained from documents which the member has in hand. When the member has no documentary evidence of the amount of income, the evidence, if necessary, is secured from the firm or person who is making the payment.

(4) **Contributions.** Monetary contributions are considered as income except in instances where the contribution is not made directly to the member.

(5) **Retirement and disability benefits.** Income received monthly from retirement and disability benefits are considered as unearned income. Information as to receipt and amount of OASDI benefits is obtained, if necessary, from BENDEX, the member's award letter, or verification from SSA. Retirement benefits received as a lump sum payment at termination of employment are considered as income. Supplemental Security Income (SSI) does not fall under these types of benefits.

(6) **Unemployment benefits.** Unemployment benefits are considered as unearned income.

(7) **Military benefits.** Life insurance, pensions, compensation, servicemen dependents' allowances and the like, are all sources of income which the member and/or dependents may be eligible to receive. In each case under consideration, information is obtained as to whether the member's son, daughter, husband or parent, has been in any military service. Clearance is made with the proper veterans' agency, both state and federal, to determine whether the benefits are available.

(8) **Casual and inconsequential gifts.** Monetary gifts which do not realistically represent income to meet living expenses, e.g., Christmas, graduation and birthday gifts, not to exceed \$30 per calendar quarter for each individual, are disregarded as income. The amount of the gifts are disregarded as received during the quarter until the aggregate amount has reached \$30. At that time the portion exceeding \$30 is counted as lump

sum income. If the amount of a single gift exceeds \$30, it is not inconsequential and the total amount is therefore counted. If the member claims that the gift is intended for more than one person in the family unit, it is allowed to be divided. Gifts between members of the family unit are not counted.

(9) **Grants.** Grants which are not based on financial need are considered income.

~~(10) **Funds held in trust by Bureau of Indian Affairs (BIA).** The BIA frequently puts an individual's trust funds in an Individual Indian Money (IIM) account. To determine the availability of funds held in trust in an IIM account, the social worker must contact the BIA in writing and ascertain if the funds, in total or any portion, are available to the individual. If any portion of the funds is disbursed to the individual member, guardian or conservator, such funds are considered as available income. If the BIA determines the funds are not available, they are not considered. Funds held in trust by the BIA and not disbursed are considered unavailable.~~

~~(A) In some instances, BIA may determine the account is unavailable; however, they release a certain amount of funds each month to the individual. In this instance the monthly disbursement is considered as income.~~

~~(B) When the BIA has stated the account is unavailable and the account does not have a monthly disbursement plan, but a review reveals a recent history of disbursements to the individual member, guardian or conservator, these disbursements must be resolved with the BIA. These disbursements indicate all or a portion of the account may be available to the individual member, guardian or conservator.~~

~~(C) When disbursements have been made, the worker verifies whether such disbursements were made to the member or to a third party vendor in payment for goods or services. Payments made directly from the BIA to vendors are not considered as income to the member. Workers obtain documentation to verify services rendered and payment made by BIA.~~

~~(D) Amounts disbursed directly to the members are counted as non-recurring lump sum payments in the month received. Some trusts generate income on a regular basis and the income is sent to the beneficiary. In those instances, the income is counted in the month received.~~

(d) **Income disregards.** Income that is disregarded in determining eligibility includes:

(1) Food Stamp benefits;

(2) Any payment received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970;

(3) Education Grants (including work study), scholarships, etc., that are contingent upon the student regularly attending school. The student's classification (graduate or undergraduate) is not a factor;

(4) Loans (regardless of use) if a bona fide debt or obligation to pay can be established. Criteria to establish a loan as bona fide includes an acknowledgment of obligation to repay or evidence that the loan was from an individual or financial institution in the loan business. If the loan was from a person(s) not in the loan business, the borrower's acknowledgment of obligation to repay (with or without interest) is required to indicate that the loan is bona fide. If the loan agreement is not written, OKDHS Form 08AD103E, Loan Verification, should be completed by the borrower attesting that the loan is bona fide and signed by the lender verifying the date and amount of loan. When copies of written agreements or OKDHS Form 08AD103E are not available, detailed case documentation must include information that the loan is bona fide and how

the debt amount and date of receipt was verified;

(5) Indian payments (including ~~judgement~~ judgment funds or funds held in trust) which are distributed ~~per capita~~ by the Secretary of the Interior (BIA) or distributed by the tribe subject to approval by the Secretary of the Interior. Also, any interest or investment income accrued on such funds while held in trust or any purchases made with ~~judgement~~ judgment funds, trust funds, interest or investment income accrued on such funds. Any income from mineral leases, from tribal business investments, etc., ~~as long as the payments are paid per capita. For purposes of this paragraph, per capita is defined as each tribal member receiving an equal amount.~~ However, any interest or income derived from the principal or produced by purchases made with the funds after distribution is considered as any other income;

(6) Special allowance for school expenses made available upon petition in writing from trust funds of the student;

(7) Benefits from State and Community Programs on Aging under Title III of the Older Americans Act of 1965 amended by PL 100-175 to become the Older Americans Act amendments of 1987;

(8) Unearned income received by a child, such as a needs based payment, cash assistance, compensation in lieu of wages, allowance, etc., from a program funded by the Job Training and Partnership Act (JTPA) including Job Corps income. Also, JTPA earned income received as wages, not to exceed six months in any calendar year;

(9) Payments for supportive services or reimbursement for out-of-pocket expenses made to individual volunteers serving as foster grandparents, senior health aids, or senior companions, and to persons serving in the Service Corps of Retired Executives (SCORE) and Active Corps of Executives (ACE);

(10) Payments to volunteers under the Domestic Volunteer Service Act of 1973 (VISTA), unless the gross amount of VISTA payments equals or exceeds the state or federal minimum wage, whichever is greater;

(11) The value of supplemental food assistance received under the Child Nutrition Act or the special food service program for children under the National School Lunch Act;

(12) Any portion of payments, made under the Alaska Native Claims Settlement Act to an Alaska Native, which are exempt from taxation under the Settlement Act;

(13) If an adult or child from the family group is living in the home and is receiving SSI, his/her individual income is considered by the Social Security Administration in determining eligibility for SSI. Therefore, that income cannot be considered as available to the benefit group;

(14) Experimental Housing Allowance Program (EHAP) payments made under Annual Contributions Contracts entered into prior to January 1, 1975, under Section 23 of the U.S. Housing Act of 1937, as amended;

(15) Earnings of a child who is a full-time student are disregarded;

(16) The first \$50 of the current monthly child support paid by an absent parent. Only one disregard is allowed regardless of the number of parents paying or amounts paid. An additional disregard is allowed if payments for previous months were paid when due but not received until the current month;

(17) Government rental or housing subsidies by governmental agencies, e.g., HUD (received in-kind or in cash) for rent, mortgage payments or utilities;

(18) Reimbursements from an employer for out-of-pocket expenditures and allowances for travel or training to the extent the funds are used for expenses directly related to such travel or training, and uniform allowances if the uniform is uniquely identified with company name or

logo;

(19) Low Income Home and Energy Assistance Program (LIHEAP) and Energy Crisis Assistance Program (ECAP) payments;

(20) Advance payments of Earned Income Tax Credit (EITC) or refunds of EITC as a result of filing a federal income tax return;

(21) Payments made from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In Re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.);

(22) Payments made from the Radiation Exposure Compensation Trust Fund as compensation for injuries or deaths resulting from the exposure to radiation from nuclear testing and uranium mining;

(23) Federal major disaster and emergency assistance provided under the Disaster Relief Act of 1974, and comparable disaster assistance provided by states, local governments and disaster assistance organizations;

(24) Interests of individual Indians in trust or restricted lands;

~~(25) Income up to \$2,000 per year received by individual Indians, which is derived from leases or other uses of individually owned trust or restricted lands;~~

~~(26)~~(25) Any home produce from garden, livestock and poultry utilized by the member and his/her household for their consumption (as distinguished from such produce sold or exchanged);

~~(27)~~(26) Any payments made directly to a third party for the benefit of a member of the benefit group;

~~(28)~~(27) Financial aid provided to individuals by agencies or organizations which base their payment on financial need;

~~(29)~~(28) Assistance or services received from the Vocational Rehabilitation Program, such as transportation expenses to a rehabilitation center, extra clothing, lunches, grooming needed for a training program and ~~an~~ any other such complimentary payments;

~~(30)~~(29) Payments made by a public or private non-profit child care agency for a child placed in foster care or subsidized adoption;

~~(31)~~(30) Payments made to certain Vietnam veterans' children with spina bifida (PL 104-214);

~~(32)~~(31) Payments made to certain Korea service veterans' children with spina bifida (PL 108-183);

~~(33)~~(32) Payments made to the children of women Vietnam veterans who suffer from certain birth defects (PL 106-419);

~~(34)~~(33) Additional payments of regular unemployment compensation in the amount of \$25 per week ending June 30, 2010, and any amount of emergency unemployment compensation paid through May 31, 2010, as authorized under the American Recovery and Reinvestment Tax Act of 2009; and

~~(35)~~(34) Wages paid by the Census Bureau for temporary employment related to Census activities.

(e) In computing monthly income, cents will be carried at all steps until the monthly amount is determined and then will be rounded to the nearest dollar. These rounding procedures apply to each individual and each type of income. Income which is received monthly but in irregular amounts is averaged using two month's income, if possible, to determine income eligibility. Less than two month's income may be used when circumstances (e.g., new employment, unpaid sick leave, etc.) would indicate that previous income amounts would not be appropriate to use in determining future income amounts. Income received more often than monthly is converted to monthly amounts as follows:

(1) **Daily.** Income received on a daily basis is converted to a weekly amount then ~~multiplies~~ multiplied by 4.3.

(2) **Weekly.** Income received weekly is multiplied by 4.3.

(3) **Twice a month.** Income received twice a month is multiplied by 2.

(4) **Biweekly.** Income received every two weeks is multiplied by 2.15.

6.a-57 **TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY**  
**CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**  
Subchapter 5. Individual Providers and Specialties  
Part 108. Nutrition Services  
317:30-5-1076. [AMENDED]  
(Reference APA WF # 10-66)

**SUMMARY:** Nutrition services rules are revised to clarify coverage for nutritional counseling for children as part of the EPSDT benefit and removes references to outdated policy.

**BUDGET IMPACT:** Agency staff has determined that these revisions are budget neutral.

**MEDICAL ADVISORY COMMITTEE:** The Medical Advisory Committee considered the proposed rule revisions on January 20, 2011, and recommended Board approval.

**AUTHORITY:** The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes

**PUBLIC HEARING:** A public hearing was held on February 22, 2011. Written comments in support of the rule revision were received before the hearing and considered during the rulemaking process.

**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY**  
**CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**  
**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**  
**PART 108. NUTRITION SERVICES**

**317:30-5-1076. Coverage by category**

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

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

(2) **Children.** ~~Coverage for children is in accordance with OAC 317:30-3-47.~~ Payment is made for medically necessary nutritional counseling as described above for adults. Nutritional services for the treatment of obesity may be covered for children as part of the EPSDT benefit. Additional services which are deemed medically necessary and allowable under federal regulations may be covered by the EPSDT benefit found at 317:30-3-65 and 317:30-3-65.11.

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

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



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

6.a-58 **TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY**  
**CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**

Subchapter 3. General Provider Policies

Part 1. General Scope and Administration

317:30-3-3. [AMENDED]

Subchapter 5. Individual Providers and Specialties

Part 64. Clinic Services

317:30-5-575 [NEW]

317:30-5-576 [NEW]

317:30-5-577 [NEW]

317:30-5-578 [NEW]

**(Reference APA WF # 10-67)**

**SUMMARY:** Rules are revised to add clarification and differentiate between provider group and clinic contracts. Provider groups are business entities in which one or more individual providers practice. Provider clinics are facilities or distinct parts of facilities used for the diagnosis and treatment of outpatients. Provider clinics are limited to organizations serving specialized treatment requirements or distinct groups. Clinics must have a specialized contract with the Oklahoma Health Care Authority (OHCA). These rules allow the OHCA to effectively distinguish between provider business entities and treatment facilities during the contracting process.

**BUDGET IMPACT:** Agency staff has determined that these revisions are budget neutral.

**MEDICAL ADVISORY COMMITTEE:** The Medical Advisory Committee considered the proposed rule revisions on March 9, 2011, and recommended Board approval.

**AUTHORITY:** The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes

**PUBLIC HEARING:** A public hearing was held on February 22, 2011. Written comments were received before the hearing and were considered during the rulemaking process.

**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY**  
**CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**  
**SUBCHAPTER 3. GENERAL PROVIDER POLICIES**  
**PART 1. GENERAL SCOPE AND ADMINISTRATION**

**317:30-3-3. Group billings**

(a) A group/corporation is a business entity under which one or more individual providers practice. A group does not require multiple professional providers. A single provider group is a valid group and would be identified by the business entity name. Physicians Providers who are in group affiliations and physicians providers who are incorporated under a Federal Employer Identification Number (FEIN) may be paid as a group or corporation. Unless otherwise notified, payments will be issued to a physician provider as an independent practitioner provider, under the personal Social Security Number. To be paid as a group/corporation, or under the Federal Employer Identification Number, providers must contact OHCA to secure a contract for group/corporation billing. It will be the responsibility of the group/corporation to notify the Authority OHCA of changes when a physician provider leaves or enters the

group/corporation affiliation.

(b) A clinic is a facility or distinct part of a facility used for the diagnosis and treatment of outpatients. Clinics are limited to organizations serving specialized treatment requirements or distinct groups. Clinics are specific to specialized provider types as approved by the OHCA. Clinics must have a specialized current contract with the OHCA. Clinic services are covered under 317:30-5-575 through 317:30-5-578.

**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**  
**PART 64. CLINIC SERVICES**

**317:30-5-575. General information**

(a) **Clinic services.** Clinic services means preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. The term includes the following services furnished to outpatients:

(1) Services furnished at the clinic by or under the direction of a physician or a dentist.

(2) Services furnished outside the clinic, by clinic personnel under the direction of a physician, to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address.

(b) **Prior authorization.** OHCA requires prior authorization for certain procedures to validate the medical need for the service.

(c) **Medical necessity.** Medical necessity requirements are listed at OAC 317:30-3-1(f).

**317:30-5-576. Eligible providers**

(a) **General requirements.** To be an eligible clinic provider, a clinic must be under the direction of a physician who is on the premises and who is a SoonerCare enrolled provider. In addition, the supervising physician must meet any other applicable licensure or certification required by State law or meet Medicare certification for participation. All clinic providers must have a current contract with the Oklahoma Health Care Authority (OHCA). The OHCA will review all clinic contracts to ensure compliance with all OHCA requirements, as well as all State and Federal laws. The OHCA has discretion and the final authority to approve or deny any provider contract.

(b) **National Provider Identification (NPI).** The clinic must have an organizational NPI number and each individual licensed physician and licensed non-physician practitioner must have an individual NPI and meet the provider qualification requirements applicable to the same service when it is furnished in other settings.

(c) **Written patient care policies.** A clinic under this Part must establish, in writing:

(1) a description of health services provided by the clinic;

(2) policies concerning the medical management of health problems including health conditions which require referral to physicians and provision of emergency health services; and

(3) policies concerning the maintenance and review of health records by the physician or dentist.

**317:30-5-577. Coordination of care**

The SoonerCare member's Primary Care Provider (PCP) is responsible for coordinating or delivering preventive and primary care services which are medically necessary to all SoonerCare members enrolled with him/her. If a service is rendered in the clinic setting, the clinic must forward information for the patient file regarding the diagnosis, services rendered

and need for follow-up to the member's PCP, in order to ensure continuity of care.

**317:30-5-578. Limitation on services**

Coverage is the same for adults and children unless otherwise indicated. Services are subject to the same limitations elsewhere in OHCA rules unless otherwise specified and to professional services rendered by health professionals acting within the scope of practice under State law.

6.a-59 **TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY**  
**CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**  
Subchapter 3. General Provider Policies  
Part 1. General Scope and Administration  
317:30-3-27. [AMENDED]  
(Reference APA WF # 10-68)

**SUMMARY:** Agency Telemedicine rules are revised to clarify that all services and/or networks be allowed and approved at the OHCA's discretion to ensure medical necessity.

**BUDGET IMPACT:** Agency staff has determined that these revisions are budget neutral.

**MEDICAL ADVISORY COMMITTEE:** The Medical Advisory Committee considered the proposed rule revisions on March 9, 2011, and recommended Board approval.

**AUTHORITY:** The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes

**PUBLIC HEARING:** A public hearing was held on February 22, 2011. No comments were received before, during, or after the hearing.

**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY**  
**CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**  
**SUBCHAPTER 3. GENERAL PROVIDER POLICIES**  
**PART 1. GENERAL SCOPE AND ADMINISTRATION**

**317:30-3-27. Telemedicine**

(a) **Applicability and scope.** The purpose of this Section is to implement telemedicine policy that improves access to health care services by enabling the provision of medical specialty care in rural ~~or underserved~~ areas to meet the needs of members and providers alike, while complying with all applicable federal and state statutes and regulations. Telemedicine services are not an expansion of SoonerCare covered services but an option for the delivery of certain covered services. SoonerCare views telemedicine no differently than an office visit or outpatient consultation. However, if there are technological difficulties in performing an objective through medical assessment or problems in member's understanding of telemedicine, hands-on-assessment and/or care must be provided for the member. Quality of health care must be maintained regardless of the mode of delivery.

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

(1) **"Certified or licensed health care professional"** means an individual who has successfully completed a prescribed program of study in any variety of health fields and who has obtained an Oklahoma state license or certificate indicating his or her competence to practice in that field.

(2) **"Distant site"** means the site where the specialty physician/practitioner providing the professional service is located at the time the service is provided via audio/video telecommunications.

(3) **"Interactive telecommunications"** means multimedia communications equipment that includes, at a minimum, audio/video equipment permitting two-way, real-time or near real-time service or consultation between the member and the practitioner.

(4) **"Originating site"** means the location of the SoonerCare member at the time the service is being performed by a contracted provider via audio/video telecommunications.

(5) **"Rural area"** means a county with a population of less than 50,000 people.

(6) **"Store and forward"** means the asynchronous transmission of medical information to be reviewed at a later time. A camera or similar device records (stores) an image(s) that is then sent (forwarded) via telecommunications media to another location for later viewing. The sending of x-rays, computed tomography scans, or magnetic resonance images are common store and forward applications. The original image may be recorded and/or forwarded in digital or analog format and may include video "clips" such as ultrasound examinations, where the series of images that are sent may show full motion when reviewed at the receiving location.

(7) **"Telehealth"** means the use of telecommunication technologies for clinical care (telemedicine), patient teaching and home health, health professional education (distance learning), administrative and program planning, and other diverse aspects of a health care delivery system.

(8) **"Telemedicine"** means the practice of health care delivery, diagnosis, consultation and treatment and the transfer of medical data through interactive audio, video or data communications that occur in the real-time or near real-time and in the physical presence of the member.

(9) **"Telemedicine network"** means a network infrastructure, consisting of computer systems, software and communications equipment to support telemedicine services.

~~(10) **"Underserved area"** means an area that meets the definition of a medically underserved area (MUA) or medically underserved population (MUP) by the U.S. Department of Health and Human Services (HHS).~~

(c) **Coverage.** SoonerCare coverage for telemedicine technology is limited to consultations, office visits, individual psychotherapy, psychiatric diagnostic interview examinations and testing, mental health assessments and pharmacologic management.

(1) An interactive telecommunications system is required as a condition of coverage.

(2) Coverage for telemedicine services is limited to members in rural areas, ~~underserved areas~~, or geographic areas where there is a lack of medical/psychiatric/mental health expertise locally. The coverage of all telemedicine services is at the discretion of OHCA.

(3) Office and outpatient visits that are conducted via telemedicine are counted toward the applicable benefit limits for these services.

(4) Authorized originating sites are:

(A) The office of a physician or practitioner;

(B) A hospital;

(C) A school;

(D) An outpatient behavioral health clinic;

(E) A critical access hospital;

(F) A rural health clinic (RHC);

(G) A federally qualified health center (FQHC); or

(H) An Indian Health Service facility, a Tribal health facility or an Urban Indian clinic (I/T/U).

(5) Authorized distant site specialty providers are contracted:

(A) Physicians;

(B) Advanced Registered Nurse Practitioners;

(C) Physicians Assistants;

(D) Genetic Counselors;

(E) Licensed Behavioral Health Professionals;

(F) Dietitians; and

(G) I/T/U=s with specialty service providers as listed in (A) through (F) above.

(d) **Non-covered services.** Non-covered services include:

- (1) Telephone conversation;
- (2) Electronic mail message; and
- (3) Facsimile.

(e) **Store and forward technology.** SoonerCare covers store and forward technology for applications in which, under conventional health care delivery, the medical service does not require face-to-face contact between the member and the provider. Examples include teleradiology, telepathology, fetal monitor strips, as well as physician interpretation of electrocardiogram and electroencephalogram readings that are transmitted electronically. SoonerCare does not consider these services telemedicine as defined by OHCA and will not reimburse an originating site fee for these services.

(f) **Conditions.** The following conditions apply to all services rendered via telemedicine.

(1) Interactive audio and video telecommunications must be used, permitting real-time communication between the distant site physician or practitioner and the SoonerCare member. As a condition of payment the member must be present and participating in the telemedicine visit.

(2) Only telemedicine services provided utilizing an OHCA approved network are eligible for reimbursement.

(3) For SoonerCare reimbursement, telemedicine connections to rural areas must be located within Oklahoma and the health providers must be licensed in Oklahoma or practice at an I/T/U.

(4) The telemedicine equipment and transmission speed must be technically sufficient to support the service billed. If a peripheral diagnostic scope is required to assess the member, it must provide adequate resolution or audio quality for decision making. Staff involved in the telemedicine visit need to be trained in the use of the telemedicine equipment and competent in its operation.

(5) An appropriate certified or licensed health care professional at the originating site is required to present the member to the physician or practitioner at the distant site and remain available as clinically appropriate.

(6) The health care practitioner must obtain written consent from the SoonerCare member that states they agree to participate in the telemedicine-based office visit. The consent form must include a description of the risks, benefits and consequences of telemedicine and be included in the member's medical record.

(7) If the member is a minor child, a parent/guardian must present the minor child for telemedicine services unless otherwise exempted by State or Federal law. The parent/guardian need not attend the telemedicine session unless attendance is therapeutically appropriate.

(8) The member retains the right to withdraw at any time.

(9) All existing confidentiality protections apply.

(10) The member has access to all transmitted medical information, with the exception of live interactive video as there is often no stored data in such encounters.

(11) There will be no dissemination of any member images or information to other entities without written consent from the member.

(g) **Reimbursement.**

(1) A facility fee will be paid to the originating site when the appropriate telemedicine facility fee code is used.

(A) Hospital outpatient: When the originating site is a hospital

outpatient department, payment for the originating site facility fee will be paid according to the SoonerCare fee schedule.

(B) Hospital inpatient: For hospital inpatients, payment for the originating site facility fee will be paid outside the Diagnostic Related Group (DRG) payment.

(C) FQHCs and RHCs: The originating site facility fee for telemedicine services is not an FQHC or RHC service. When an FQHC or RHC serves as the originating site, the originating site facility fee is paid separately from the center or clinic all-inclusive rate.

(D) Facilities of the Indian Health Service, tribal facilities or Urban Indian Clinics: When an I/T/U serves as the originating site, the originating site facility fee is reimbursed outside the OMB rate.

(E) Physicians'/practitioners' offices: When the originating site is a physician's office, the originating site facility fee will be paid according to the SoonerCare fee schedule. If a provider from the originating site performs a separately identifiable service for the member on the same day as telemedicine, documentation for both services must be clearly and separately identified in the member's medical record.

(2) Services provided by telemedicine must be billed with the appropriate modifier. Only the portion of the telemedicine service rendered from the distant site is billed with the modifier.

(3) If the technical component of an X-ray, ultrasound or electrocardiogram is performed at the originating site during a telemedicine transmission, the technical component and a telemedicine facility fee are billed by the originating site. The professional component of the procedure and the appropriate visit code are billed by the distant site.

(4) Post payment review may result in adjustments to payment when a telemedicine modifier is billed inappropriately or not billed when appropriate.

(5) The cost of telemedicine equipment and transmission is not reimbursable by SoonerCare.

(h) **Documentation.**

(1) Documentation must be maintained at the originating and the distant locations to substantiate the services provided.

(2) Documentation must indicate the services were rendered via telemedicine, the location of the originating and distant sites, and which OHCA approved network was used.

(3) All other SoonerCare documentation guidelines apply to the services rendered via telemedicine. Examples include but are not limited to:

(A) Chart notes;

(B) Start and stop times;

(C) Service provider's credentials; and

(D) Provider's signature.

(i) **Telemedicine network standards.** In order to be an approved telemedicine network, an applicant must be contracted with the OHCA and meet certain technical and privacy standards stated within the contract in order to ensure the highest quality of care. The OHCA has discretion and the final authority to approve or deny any telemedicine network based on agency and/or SoonerCare members' needs.



6.a-60 **TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY**  
**CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY**  
Subchapter 17. ADvantage Waiver Services  
317:35-17-3. through 317:35-17-4. [AMENDED]  
317:35-17-16. [AMENDED]  
(Reference APA WF 10-69)

**SUMMARY:** ADvantage Program rules are revised to remove language approving ADvantage services when services exceed the established cost cap. Additionally, waitlist procedures are revised to prohibit entry into the waiver at 90% of capacity, rather than the current 102% of capacity and all exceptions to the waitlist procedure are eliminated. Lastly, language is revised to state that OKDHS performs all eligibility determinations rather than the ADvantage Administration (AA).

**BUDGET IMPACT:** Agency staff has determined that these revisions will have a total budget impact of \$409,777; OKDHS state share - \$143,668.

**MEDICAL ADVISORY COMMITTEE:** The Medical Advisory Committee considered the proposed rule revisions on March 9, 2011, and recommended Board approval.

**AUTHORITY:** The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes

**PUBLIC HEARING:** A public hearing was held on February 22, 2011. No comments were received before, during, or after the hearing.

**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY**  
**CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY**  
**SUBCHAPTER 17. ADVANTAGE WAIVER SERVICES**

**317:35-17-3. ADvantage program services**

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

(1) To receive ADvantage services, individuals must meet one of the following categories:

(A) be age 65 years or older, or

(B) be age 21 or older if physically disabled and not developmentally disabled or if the person has a clinically documented, progressive degenerative disease process that responds to treatment and previously has required hospital or nursing facility (NF) level of care services for treatment related to the condition and requires ADvantage services to maintain the treatment regimen to prevent health deterioration, or

(C) if developmentally disabled and between the ages of 21 and 65, not

have mental retardation or a cognitive impairment related to the developmental disability.

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

- (A) require nursing facility level of care [see OAC 317:35-17-2];
- (B) meet service eligibility criteria [see OAC 317:35-17-3(d)]; and
- (C) meet program eligibility criteria [see OAC 317:35-17-3(e)].

(b) Home and Community Based Waiver Services are outside the scope of Medicaid State Plan services. The Medicaid waiver allows the OHCA to offer certain Home and Community Based services to an annually capped number of persons who are categorically needy (refer to OKDHS form 08AX001E (Appendix C-1), Schedule VIII. B. 1.) and without such services would be institutionalized. The estimated cost of providing an individual's care outside the nursing facility cannot exceed the annual cost of caring for that individual in a nursing facility. When determining the ADvantage service plan cost cap for an individual, the comparable SoonerCare cost to serve that individual in a nursing facility is estimated. If the individual has Acquired Immune Deficiency Syndrome (AIDS) or if the individual requires ventilator care, the appropriate SoonerCare enhanced nursing facility rate to serve the individual is used to estimate the ADvantage cost cap. ~~To meet program cost effectiveness eligibility criteria, the annualized cost of an individual's ADvantage services cannot exceed the ADvantage program services expenditure cap unless approved by the Oklahoma DHS Aging Services Division (OKDHS/ASD) in accordance with the exceptions listed in (1) (5) of this subsection. The cost of the service plan furnished to an individual may exceed the expenditure cap only when all of the increased expenditures above the cap are due solely to:~~

- ~~(1) a one time purchase of home modifications and/or specialized medical equipment; and/or~~
- ~~(2) documented need for a temporary (not to exceed a 60 day limit) increase in frequency of service or number of services to prevent institutionalization; or~~
- ~~(3) expenditures are for ADvantage Hospice services;~~
- ~~(4) expenditures in excess of the cap are for prescribed drugs, which would be paid by SoonerCare if the individual were receiving services in a nursing home; and/or~~
- ~~(5) expenditures are for Institution Transition Services, and the annualized expenditures for ADvantage services to an individual under any combination of circumstances described under exceptions (1) through (5) can reasonably be expected to be no more than 200% of the individual cap.~~

(c) Services provided through the ADvantage waiver are:

- (1) case management;
- (2) respite;
- (3) adult day health care;
- (4) environmental modifications;
- (5) specialized medical equipment and supplies;
- (6) physical therapy/occupational therapy/respiratory therapy/speech therapy or consultation;
- (7) advanced supportive/restorative assistance;
- (8) skilled nursing;
- (9) home delivered meals;
- (10) hospice care;
- (11) medically necessary prescription drugs within the limits of the waiver;
- (12) personal care (state plan) or ADvantage personal care;
- (13) Personal Emergency Response System (PERS);
- (14) Consumer-Directed Personal Assistance Services and Supports (CD-PASS);

(15) Institution Transition Services;

(16) assisted living; and

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

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

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

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

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

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

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

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

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

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

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

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

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

program eligibility, the OKDHS/ASD will provide technical assistance to the Provider for transitioning the individual to other services.

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

### **317:35-17-4. Application for ADvantage services**

(a) **Application procedures for ADvantage services.** If waiver slots are available, the application process is initiated by the receipt of a UCAT, Part I or by an oral request for services. A written financial application is not required for an individual who has an active Medicaid case. A financial application for ADvantage services consists of the Medical Assistance Application form. The form is signed by the applicant, parent, spouse, guardian or someone else acting on the applicant's behalf.

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

(2) An individual residing in an NF or requesting waiver services, or the individual's community spouse may request an assessment of resources available to each spouse by using OKDHS form MA-11, Assessment of Assets, when Medicaid application is not being made. The individual and/or spouse must provide documentation of resources. The assessment reflects all countable resources of the couple (owned individually or as a couple) and establishes the spousal share to be protected when subsequent determination of Medicaid long-term care eligibility is made.

(3) When Medicaid application is being made, an assessment of resources must be completed if it was not completed when the individual entered the NF or began receiving waiver services. For applicants of the ADvantage waiver, those resources owned by the couple the month the application was made determines the spousal share of resources. If the individual applies for Medicaid at the time of entry into the ADvantage waiver, Form MA-11 is not appropriate. However, the spousal share must be determined using the resource information provided on the Medicaid application form and computed using OKDHS form MA-12, Title XIX Worksheet.

### **(b) Date of application.**

(1) The date of application is:

(A) the date the applicant or someone acting in his/her behalf signs the application in the county office; or

(B) the date the application is stamped into the county office when the application is initiated outside the county office; or

(C) the date when the request for Medicaid is made orally and the financial application form is signed later. The date of the oral request is entered in "red" above the date the form is signed.

(2) An exception is when OKDHS has contracts with certain providers to take applications and obtain documentation. After the documentation is obtained, the contracted provider forwards the application and documentation to the OKDHS county office of the client's county of residence for Medicaid eligibility determination. The application date is the date the client signed the application form for the provider.

(c) **ADvantage waiting list procedures.** ADvantage Program "available capacity ~~in the month~~" is the number of ~~additional~~ clients that may be enrolled in the Program ~~in a given month~~ without exceeding, on an annualized basis, the maximum number authorized by the waiver to be served in the waiver year. ~~The available capacity in the month for any particular month is calculated as~~

~~follows: Available capacity in the month equals [(Waiver year C value) minus (unduplicated number during the current waiver fiscal year served as of the last day of the previous month)] divided by (the number of months remaining in the waiver year). Upon notification from the AA that 102% of the available capacity in the previous month was exceeded, OKDHS Aging Services Division (OKDHS/ASD) notifies OKDHS county offices and contract agencies approved to complete the UCAT, Parts I and II that, until further notice, requests for ADvantage services are not to be processed as applications, but referred to AA to be placed on a waiting list of requests for ADvantage services. Up to a maximum of five requests for ADvantage Program services from individuals who have resided in a nursing facility for a minimum of two months and who are transitioning from nursing facility to home based care under Oklahoma's Real Choice Systems Change Nursing Facility Transition Services Pilot are exempt from waiting list procedures. Upon implementation and for the duration of waiting list procedures, the SPEED policy described under OAC 317:35-17-17 is suspended except for persons identified through the Nursing Facility Transition Services Pilot as being exempt from waiting list procedures.~~

~~(1) Each month as additional waiver slots are available, the AA forwards requests from the waiting list to the appropriate OKDHS county office for processing the application.~~

~~(2) The criterion for suspending waiting list procedures is the occurrence of two consecutive months in which no person is retained on the waiting list the entire month and less than 95% of the available capacity in the month is attained. Upon notification from the AA that waiting list procedures are no longer necessary, OKDHS/ASD notifies OKDHS county offices and contract agencies approved to complete the UCAT, Parts I and II to process requests for ADvantage services as applications. Upon notification from the AA that 90% of the available capacity has been exceeded, OKDHS Aging Services Division (OKDHS/ASD) notifies OKDHS county offices and contract agencies approved to complete the UCAT, Parts I and II that, until further notice, requests for ADvantage services are not to be processed as applications, but referred to AA to be placed on a waiting list of requests for ADvantage services. As available capacity permits, but remaining in compliance with waiver limits of maximum capacity, and until an increase in ADvantage available capacity occurs, the AA selects in chronological order (first on, first off) requests for ADvantage from the waiting list to forward to the appropriate OKDHS county office for processing the application. When the waiver capacity exceeds the number on the waiting list and after all persons on the waiting list have been processed, waiting list procedures are suspended.~~

### **317:35-17-16. Member annual level of care re-evaluation and annual re-authorization of service plan**

(a) ~~Annually, the case manager reassesses the member's needs using the UCAT Part I, III and the then evaluates the current service plan, especially with respect to progress of the member toward service plan goals and objectives. Based on the reassessment, the case manager develops a new service plan with the member and service providers, as appropriate, and submits the new service plan to the AA for certification authorization. Along with the service plan submitted for annual recertification, the case manager forwards to AA the supporting documentation and the assessment of the existing service plan. The case manager initiates the fourth quarter monitoring to allow sufficient time for certification of a new service plan prior to the expiration date on the existing service plan.~~

~~(b) At a maximum of every 11 months, the ADvantage case manager makes a home visit to evaluate the ADvantage member using the UCAT, Parts I and III and~~

other information as necessary as part of the annual service plan development process. The OKDHS nurse evaluation substitutes for the case manager's fourth quarter assessment in the client's third year.

(1) The case manager's assessment of a member done within a 60 day period prior to the existing service plan end date is the basis for medical eligibility redetermination.

(2) As part of the service plan recertification process, the AA evaluates whether the member continues to meet policy defined criteria for Nursing Facility level of care.

(3) Except for enrollment years in which the OKDHS nurse is scheduled to do an independent assessment for medical eligibility, the AA notifies OKDHS/ASD electronically of member medical assessment by providing the member's identifying information and the member's UCAT Part III including level of care criteria domain scores to justify member medical eligibility recertification for an additional 12 month period.

(4) OKDHS/ASD determines whether a member requires further assessment for annual medical eligibility determination. For a member requiring further assessment, and at least every third year, the OKDHS nurse schedules a home visit with the member to do a UCAT reassessment which will be used for redetermination of medical eligibility.

(5) The OKDHS nurse submits the UCAT evaluation to the area nurse, or nurse designee, for a determination of continued medical eligibility. The area nurse, or designee, makes the medical eligibility decision and recertifies medical eligibility prior to expiration date of current medical eligibility certification. If medical eligibility recertification is not made prior to current medical eligibility expiration, the existing medical eligibility certification is automatically extended until recertification is determined or for 60 days, whichever is less. If the member no longer meets medical eligibility, upon making the level of care determination, the area nurse, or nurse designee, updates the system's "medical eligibility end date" and notifies the AA electronically. The AA communicates to the member's case manager that the member has been determined to no longer meet medical eligibility for ADvantage as of the effective date of the eligibility determination. The case manager communicates with the member and if requested, helps the member to arrange alternate services in place of ADvantage.

The case manager initiates the UCAT reassessment and development of the new service plan at least 40 days, but not more than 55 days, prior to the current service plan authorization end date. The case manager provides the AA the new reassessment service plan packet no less than 30 days prior to the end date of the existing plan. The new reassessment service plan packet includes the reassessed service plan, UCAT Parts I and III, Nurse Evaluation and any supporting documentation.

(b) OKDHS reviews the ADvantage case manager UCAT for a level of care redetermination. If policy defined criteria for Nursing Facility level of care cannot be determined or cannot be justified from documentation available or via direct contact with the case manager, a UCAT is completed in the home by the local OKDHS nurse. The local OKDHS nurse submits the UCAT evaluation to the area nurse, or nurse designee, to make the medical eligibility level of care determination.

(c) If medical eligibility redetermination is not made prior to current medical eligibility expiration, the existing medical eligibility certification is automatically extended until level of care redetermination is established. If the member no longer meets medical eligibility the area nurse, or nurse designee, updates the system's "medical eligibility end date" and simultaneously notifies AA electronically.

(d) If OKDHS determines a member no longer meets medical eligibility, the AA communicates to the member's case manager that the member has been determined to no longer meet medical eligibility for ADvantage as of the effective date of the eligibility determination. The case manager communicates with the member and if requested, assists the member to access other services.

6.a-61 **TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY**  
**CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**  
Subchapter 3. General Provider Policies  
Part 3. General Medical Program Information  
317:30-3-39. [NEW]  
317:30-3-40. through 317:30-3-41. [AMENDED]  
(Reference APA WF # 10-71)

**SUMMARY:** Rules are revised to include general information about three new Waivers operated by the OHCA, the Medically Fragile Waiver, the My Life My Choice Waiver and the Sooner Seniors Waiver.

**BUDGET IMPACT:** Agency staff has determined that these revisions are budget neutral.

**MEDICAL ADVISORY COMMITTEE:** The Medical Advisory Committee considered the proposed rule revisions on March 9, 2011, and recommended Board approval.

**AUTHORITY:** The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes

**PUBLIC HEARING:** A public hearing was held on February 22, 2011. No comments were received before, during, or after the hearing.

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

**317:30-3-39. Home and Community Based Services Waivers**

The Oklahoma Health Care Authority operates or oversees the operation of several Home and Community Based Services waivers. The waivers allow individuals with physical or intellectual disabilities, requiring institutional level of care, the opportunity to reside at home or in a community based setting, while receiving institutional level of care services. Brief summaries of the Waivers are set forth in OAC 317:30-3-40 and OAC 317:30-3-41. Detailed information about each Waiver is available per the following citations:

(1) Home and Community Based Services Waivers for People with Intellectual Disabilities (Mental Retardation) and Related Conditions can be found at OAC 317:40-1-1 et seq.

(2) Home and Community Based Services Waivers for People with Physical Disabilities:

(A) ADvantage Waiver information is available per OAC 317:30-5-760 et seq.

(B) Medically Fragile Waiver information is available per OAC 317:50-1-1 et seq.

(C) My Life, My Choice Waiver information is available per OAC 317:50-3-1 et seq.

(D) Sooner Seniors Waiver information is available per OAC 317:50-5-1 et seq.



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

**(a) Introduction to HCBS Waivers for Persons with intellectual disabilities.**

The Medicaid Home and Community-Based Services (HCBS) Waiver programs are authorized in accordance with Section 1915(c) of the Social Security Act.

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

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

(3) Waiver services:

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

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

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

(4) Any waiver service must be:

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

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

(i) The IP:

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

(II) contains detailed descriptions of services provided, documentation of amount and frequency of services, and types of providers to provide services.

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

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

**(b) Eligible providers.** All providers must have a current provider agreement with OHCA to provide HCBS for persons with mental retardation or related conditions.

(1) All providers, except pharmacy, specialized medical supplies and durable medical equipment providers must be reviewed by OKDHS DDSD. The review process verifies:

(A) the provider meets the licensure, certification or other standards as specified in the approved HCBS Waiver documents; and

(B) organizations that do not require licensure wishing to provide HCBS services meet program standards, are financially stable and use sound business management practices.

(2) Providers who do not meet the standards in the review process will not be approved for a provider agreement.

(3) Provider agreements with providers that fail to meet programmatic or financial requirements may not be renewed.

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

317:30-3-41. ~~Advantage program waiver services~~ Home and Community Based Services Waivers for persons with physical disabilities

(a) Advantage Waiver. The Advantage Advantage Waiver Program is a Medicaid Home and Community Based Services (HCBS) Waiver used to finance noninstitutional long-term care services through Oklahoma's Medicaid SoonerCare program for elderly and disabled individuals in specific waiver areas. To receive Advantage Advantage Program services, individuals must meet the nursing facility level of care criteria, be age 65 years or older, or age 21 or older if disabled. Advantage Advantage Program recipients members must be Medicaid SoonerCare eligible and reside in the designated service area. The number of recipients of Advantage services members in the ADVantage Waiver is limited.

~~(b) Home and Community Based services provided through the Advantage Waiver are:~~

- ~~(1) Case Management;~~
- ~~(2) Homemaker/Chore;~~
- ~~(3) Respite;~~
- ~~(4) Adult Day Health Care;~~
- ~~(5) Environmental Modifications;~~
- ~~(6) Specialized Medical Equipment and Supplies;~~
- ~~(7) Supportive/Restorative Assistance;~~
- ~~(8) Advanced Supportive/Restorative Assistance;~~
- ~~(9) Skilled Nursing; and~~
- ~~(10) Home Delivered Meals.~~

(b) Medically Fragile Waiver. The Medically Fragile Waiver Program is a Medicaid Home and Community Based Services (HCBS) Waiver used to finance non-institutional long-term care services through Oklahoma's SoonerCare program for medically fragile individuals. To receive Medically Fragile Program services, individuals must be at least 19 years of age, be SoonerCare eligible, and meet the OHCA skilled nursing facility (SNF) or hospital level of care (LOC) criteria. Eligibility does not guarantee placement in the program as Waiver membership is limited.

(c) My Life My Choice Waiver. The My Life, My Choice Waiver Program is a Medicaid Home and Community Based Services (HCBS) Waiver used to finance non-institutional long-term care services through Oklahoma's SoonerCare program for a targeted group of physically disabled individuals. The Waiver allows the OHCA to offer certain Home and Community Based services to an annually capped number of persons who without such services would be institutionalized. To be considered for My Life, My Choice Waiver Program services, individuals must be 20 to 64 years of age, be physically disabled and have transitioned to a home and community based setting through the Living Choice Program.

(d) Sooner Seniors Waiver. The Sooner Seniors Waiver Program is a Medicaid Home and Community Based Services (HCBS) Waiver used to finance non-institutional long-term care services through Oklahoma's SoonerCare program for a targeted group of elderly individuals. The Waiver allows the OHCA to offer certain Home and Community Based services to an annually capped number of persons who without such services would be institutionalized. To be considered for Sooner Seniors Waiver Program services, individuals must be 65 years of age or older, have a clinically documented, progressive degenerative disease process that responds to treatment and requires Sooner Seniors Waiver services to maintain the treatment regimen. Individuals who qualify for the Sooner Seniors Waiver must have transitioned to a home and community based setting through the Living Choice Program.

**6.a-62 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  
317:35-5-6. [AMENDED]  
317:35-5-6.1. [AMENDED]  
(Reference APA WF # 10-77)

**SUMMARY:** Eligibility rules are revised to clarify that pregnant women have thirty (30) days within application submission to provide medical proof of pregnancy in order to continue receiving SoonerCare benefits. Previous policy allowed a period of ten (10) days for submission of pregnancy verification.

**BUDGET IMPACT:** Agency staff has determined that these revisions are budget neutral.

**MEDICAL ADVISORY COMMITTEE:** The Medical Advisory Committee considered the proposed rule revisions on March 9, 2011, and recommended Board approval.

**AUTHORITY:** The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes

**PUBLIC HEARING:** A public hearing was held on February 22, 2011. No comments were received before, during, or after the hearing.

**SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME  
PART 1. DETERMINATION OF QUALIFYING CATEGORICAL RELATIONSHIPS**

**317:35-5-6. Determining categorical relationship to pregnancy-related services**

Categorical relationship to pregnancy-related services can be established by determining through medical evidence that the individual is currently or has been pregnant. Pregnancy must be verified by providing medical proof of pregnancy within ~~10~~ 30 days of application submission. OKDHS form 08MA005E, Notification of Needed Medical Services, is not required but will be accepted as medical verification. If proof of pregnancy is not provided within ~~10~~ 30 days of application submission, SoonerCare benefits will be closed for the pregnant woman at the end of the ~~ten~~ thirty day period. The expected date of delivery must be established either by information from the applicant's physician or certified nurse midwife or the member's statement.

**317:35-5-6.1. Determining categorical relationship for pregnancy related services covered under Title XXI**

Categorical relationship for pregnancy related benefits covered under Title XXI are determined in accordance with OAC 317:35-22-1 and through medical evidence that the individual is currently or has recently been pregnant and may qualify for pregnancy related services. Pregnancy must be verified by providing medical proof of pregnancy within ~~10~~ 30 days of application submission. OKDHS form 08MA005E, Notification of Needed Medical Services, is not required but will be accepted as medical verification. If proof of pregnancy is not provided within ~~10~~ 30 days of application submission, SoonerCare benefits will be closed for the pregnant woman at the end of the

~~ten~~ thirty day period. The applicant must be residing in the State of Oklahoma with the intent to remain at the time the medical service is received. The expected date of delivery must be established either by information from the applicant's physician or other qualified practitioner.

**Submitted to the CEO and Board on March 10, 2011**  
**AUTHORITY FOR EXPENDITURE OF ADDITIONAL FUNDS**  
**HEWLETT-PACKARD – FISCAL AGENT CONTRACT**

**BACKGROUND**

Hewlett-Packard (HP) is contracted to develop, operate, and maintain OHCA's MMIS (Medicaid Management Information System) through December 31, 2011. OHCA has elected to release the hard freeze on the current MMIS system and will continue to implement the new initiatives through the end of December 31, 2011.

**SCOPE OF WORK – NEW ITEMS**

- OHCA is requesting a revision to the base modification support pool and requests that an additional 14,400 hours be added to the current contract. The expansion hours will be used for either on-site or off-site staff at the discretion of OHCA. The estimated expenditure from the expansion pool is \$1.4 million, all of which is expected to be expended by December 31, 2011.
- Contractor shall acquire software and licenses at the request of OHCA. The estimated expenditure for licenses and maintenance shall not exceed \$100,000 dollars through December 31, 2011.
- Additional Optional Development Projects as approved by OHCA are as follows:
  1. Electronic Prescribing,
  2. Health Benefit Exchange Project,
  3. Meaningful Use Data Collection and Storage.
- OHCA intends to assign 2.4 million in grant funds to the Contract in order to accomplish the initiatives developed under the approved HIT Advance Planning Document. OHCA will not expend grant funds without prior approval from the grant-awarding agency.

**CONTRACT PERIOD**

Through December 31, 2011

**CONTRACT AMOUNT AND PROCUREMENT METHOD**

- The not to exceed amount for this contract for the current year is estimated to increase from \$38.9 million to an estimated \$41 million. OHCA will request CMS approval and enhanced match for services.

**RECOMMENDATION**

- Board approval to increase the contract as shown above
- Board approval is contingent on CMS and DCS approval.

**Submitted to the C.E.O. and Board on March 10, 2011**  
**AUTHORITY FOR EXPENDITURE OF ADDITIONAL FUNDS**  
**FOX SYSTEMS - MMIS CONSULTANT SERVICES**

**BACKGROUND**

OHCA awarded a contract by competitive bid to Fox Systems in 2009 for consultant services for the MMIS procurement, modification and recertification. The contract had both a firm, fixed price component, as well as hourly rates for additional work requested by OHCA. OHCA would like to amend the contract to add more hours related to system improvements and new federal initiatives.

**SCOPE OF WORK – NEW ITEMS**

Additional hours are required for:

- New federal Health Information Technology (HIT) requirements and provider incentives;
- Assistance with Advance Planning Updates (APDU) to CMS in order to obtain the correct federal match percentage for HIT technologies required under American Recovery and Reinvestment Act (ARRA); and obtain HIT technology identified in the gap analysis;
- Implementation of new federal requirements related to the ICD-10 diagnosis codes;
- System improvements needed by OHCA for new programs and more efficient operations to assist with evaluation and analysis related to the following initiatives:
  1. Health Information Exchange Initiatives required by ARRA;
  2. State Health Information Exchange Cooperative (SHIECAP);
  3. Cost Benefit Analyses.

**CONTRACT PERIOD**

Through June 30, 2013.

**CONTRACT AMOUNT AND PROCUREMENT METHOD**

The not to exceed amount for this contract for all years is estimated to increase from \$7.5 million to \$10.5 million. OHCA will request CMS approval of 90% federal funding for these services.

**RECOMMENDATION**

- Board approval for OHCA to increase the contract as discussed above
- Board approval is contingent on CMS and DCS approval.

## **AUTHORITY FOR EXPENDITURE OF FUNDS**

### **Legal Representation Covington & Burling, LLP**

#### **BACKGROUND**

Covington & Burling, LLP provides legal representation in the event the Federal government pursues a disallowance case; informs the OHCA of policy interpretations of the Federal government and changes in Federal law that may have Oklahoma implications; and represents the OHCA along with other States in the Joint State Medicaid Recovery Coalition.

#### **SCOPE OF WORK**

- Provide legal representation for defending OHCA's position in cases of the disallowance of federal funds by the Centers for Medicare and Medicaid (CMS);
- Issue relevant memorandums to answer legal questions posed or to inform OHCA of relevant federal law changes;
- Provide assistance and representation on an as needed basis should any OHCA cases require preparation for, or appearance in, Federal District Court or the United States Supreme Court;
- Represent Oklahoma in the Joint State Medicaid Recovery Coalition to recover Medicaid-paid amounts that should have been paid by Medicare

#### **CONTRACT PERIOD**

- OHCA entered into this contract for the period July 1, 2010 through June 30, 2020 with a not-to-exceed amount of \$75,000 per year.
- Because this contract will exceed the board approval threshold this year, we are now asking the board to approve this contract. The SFY11 increase is necessary because the Contractor's work on a brief related to the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) cost allocation to Medicaid required more hours than anticipated.
- ODMHSAS will provide the state share funds for this increase.

#### **CONTRACT AMOUNT AND PROCUREMENT METHOD**

- Board approval is requested to increase the not-to-exceed amount to \$150,000
- Federal matching funds for this contract are 50%
- Contract was procured under the professional services exemption to the competitive bidding requirements
- OHCA has received the required Oklahoma Attorney General approval for this contract

#### **RECOMMENDATION**

- Board approval to expend funds as detailed above

**AUTHORITY FOR EXPENDITURE OF FUNDS  
Behavioral Health Utilization Management Services**

**BACKGROUND**

The Oklahoma Health Care Authority issued an Invitation to Bid (ITB) for behavioral health utilization management services including facility inspections, prior authorization of inpatient and outpatient services, care coordination, provider education and an optional medical risk management program. This contract will replace the existing services being provided by APS under a contract that will expire June 30, 2011.

**SCOPE OF WORK**

- Inspections of Care for all facilities providing inpatient acute care, residential, psychiatric treatment, facility-based crisis stabilization, partial hospitalization, therapeutic foster care and residential behavioral management services to children
- Prior authorization and care coordination/management of the following:
  - Outpatient behavioral health services, case management, and Licensed Behavioral Health Professional services;
  - Inpatient behavioral health services, including children's acute and psychiatric residential treatment facility services, children's therapeutic foster care, facility-based crisis stabilization, and partial hospitalization program;
  - Atypical antipsychotic medications for SoonerCare members under age 5
- Behavioral health provider education
- Assistance in the review, development, and implementation of rules and procedures for the administration of any activities in this contract
- Provide telephone consultation services by psychiatrists to primary care providers, agency personnel and judges involved in decisions about children enrolled in SoonerCare;
- Optional Medical Risk Management Program to coordination for children enrolled in SoonerCare who have both physical and mental health conditions and receive care from multiple physicians

**CONTRACT PERIOD**

July 1, 2011 through June 30, 2016

**CONTRACT AMOUNT AND PROCUREMENT METHOD**

- Not-to-exceed \$40 million in total; not-to-exceed \$7 million for SFY12
- The contract will be procured by OHCA through competitive bidding
- Federal matching percentage is 75%

**RECOMMENDATION**

- Board approval to expend funds for behavioral health utilization management