OKLAHOMA HEALTH CARE AUTHORITY
REGULARLY SCHEDULED BOARD MEETING
March 30, 2015 at 1:00 P.M.
Oklahoma Health Care Authority
Charles Ed McFall Boardroom
4345 N. Lincoln Blvd.
Oklahoma City, OK

A G E N D A

Items to be presented by Tony Armstrong, Vice-Chairman

1. Call to Order / Determination of Quorum

2. Action Item – Approval of the February 12, 2015 OHCA Board Meeting Minutes

Item to be presented by Nico Gomez, Chief Executive Officer

3. Discussion Item – Chief Executive Officer's Report

   a) All Star Introduction
      - January 2015 All Star – Sirian DeLeon, Member Services Coordinator (Kevin Rupe)

   b) Financial Update – Carrie Evans, Chief Financial Officer

   c) Medicaid Director's Update – Garth Splinter, State Medicaid Director

   d) Legislative Update – Carter Kimble, Director of Governmental Relations

   e) Recognition of Cindy Roberts

Item to be presented by Nicole Nantois, Chief of Legal Services

4. Announcements of Conflicts of Interest Panel Recommendations for All Action Items Regarding This Board Meeting.

Item to be presented by Vickie Kersey, Director, Fiscal Planning and Procurement

5. a) Action Item – Consideration and Vote for the OHCA/ODMHSAS Health Home Disease Registry Request for Proposal (RFP)

   b) Action Item – Consideration and Vote for the Insure Oklahoma Multimedia Marketing RFP

Item to be presented by Tywanda Cox, Chief of Federal and State Policy

6. Action Item – Consideration and Vote of Agency Recommended Rulemaking Pursuant to Article I of the Administrative Procedures Act. The Agency Requests the Adoption of the Following Permanent Rules:

   The following permanent rules HAVE previously been approved by the Board and the Governor under Emergency rulemaking.

A. AMENDING Agency rules at OAC 317:30-5-355.1, 317:30-5-356, 317:30-5-357, 317:30-5-361, 317:30-5-664.3, and 317:30-5-664.12 and REVOKING Agency rules at OAC 317:30-5-664.4 to limit encounters within Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) to one encounter per member per day as well as limit encounters to a total of four visits per member per month for adults.
Budget Impact: Savings approved during promulgation of the emergency rule, the rule change will not result in any additional costs and/or savings to the agency.

(Reference APA WF # 14-02)

B. AMENDING Agency rules at OAC 317:30-5-56 to reduce/deny payment for preventable readmissions that occur within 30 days from discharge. The current policy reviews readmissions occurring within 15 days of prior acute care admissions or a related condition to determine medical necessity and appropriateness of care. If it is determined either or both admissions may be inappropriate, payment for either or both admissions may be denied.
Budget Impact: Savings approved during promulgation of the emergency rule, the rule change will not result in any additional costs and/or savings to the agency.

(Reference APA WF # 14-04)

C. AMENDING Agency cost-sharing rules at OAC 317:30-3-5 to permit an increase of copays to the federal maximum. Additionally, policy is amended to add diabetic supplies and smoking cessation counseling and products to the service copayment exemption list in order to ensure member have access to necessary services that improve member health outcomes.
Budget Impact: Savings approved during promulgation of the emergency rule, the rule change will not result in any additional costs and/or savings to the agency.

(Reference APA WF # 14-05)

D. AMENDING Agency oxygen and oxygen equipment rules at OAC 317:30-5-211.11 and 317:30-5-211.12 to require a prior authorization after the initial three months. In addition, rules are revised to clarify arterial blood gas analysis (ABG) and pulse oximetry testing and Certificate of Medical Necessity requirements. Rules for rental oxygen are amended to clarify that reimbursement for rented oxygen concentrators includes both stationary and portable oxygen systems.
Budget Impact: Savings approved during promulgation of the emergency rule, the rule change will not result in any additional costs and/or savings to the agency.

(Reference APA WF # 14-07)

E. AMENDING Agency rules at OAC 317:50-1-14 and 317:35-17-14 to ensure all 1915(c) waiver programs comply with federal regulation regarding conflict of interest provisions for case management services. The regulation states providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual, must not provide case management or develop the person centered service plan.
Budget Impact: Savings approved during promulgation of the emergency rule, the proposed rule change is budget neutral.

(Reference APA WF # 14-14.a & b)

F. ADDING Agency rules at OAC 317:30-5-250, 317:30-5-251, 317:30-5-252, 317:30-5-253, and 317:30-5-254 to create coverage guidelines for Health Homes. Health Homes are created to promote enhanced integration and coordination of primary, acute, behavioral health, and long-term services and supports for persons across the lifespan with chronic illness. The purpose of the Health Home is to improve the health status of SoonerCare members with Serious Mental Illness or Serious Emotional

Disturbance by promoting wellness and prevention and to improve access and continuity in healthcare for these members by supporting coordination and integration of primary care services in specialty behavioral healthcare settings. Additionally, rules are added to create a distinction between LBHPs and Licensure Candidates.
Budget Impact: Savings approved during promulgation of the emergency rule, the rule change will not result in any additional costs and/or savings to the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS).

(Reference APA WF # 14-16)

G. AMENDING Agency eligibility determinations for Aged, Blind, and Disabled (ABD) individuals applying for Medicaid services rules at OAC 317:35-5-41.2, 317:35-5-41.3, and 317:35-5-42 in order to come into compliance with federal regulations. Policy changes include adding new language regarding the Asset Verification System to check the income or resources of ABD applicants held at financial institutions, updating how resources are counted towards the maximum resource limit, exempting the value of one automobile regardless of its value from the maximum resource limit, expanding the income disregards list, and disregarding $20 of unearned income. Rules regarding income received from capital resources and rental property are amended to deduct the severance tax from the gross income for ABD applicants. Rules regarding infrequent or irregular income are amended to better match the Social Security Administration rules for determining Supplemental Security Income.
Budget Impact: Budget impact approved during promulgation of the emergency rule, the rule change will not result in any additional costs and/or savings to the agency.

(Reference APA WF # 14-17)

H. AMENDING Agency Developmental Disabilities Services (DDS) rules at OAC 317:40-1-1 to implement policy changes recommended during the Oklahoma Department of Human Services (DHS) Developmental Disabilities Services (DDS) annual policy review process. The recommended policy revisions will position DDS to utilize best practice in the administration of the statewide Request for Waiver Services list.
Budget Impact: Budget neutrality determined and approved during promulgation of the emergency rule, the rule change will not result in any additional costs and/or savings to the agency.

(Reference APA WF # 14-34)

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

I. AMENDING Agency rules at OAC 317:30-5-241.2 and 317:30-5-241.3 to add eligibility criteria required in order to receive psychosocial rehabilitation (PSR) services. Adult PSR services will be limited to members with a history of psychiatric hospitalization or admissions to crisis centers; have been determined disabled by the Social Security Administration for mental health reasons; or who are residing in residential care facilities. Children's PSR services will be limited to members with a history of psychiatric hospitalization or admissions to crisis centers; have been determined disabled by the Social Security Administration for mental health reasons; or have a current Individual Education Plan (IEP) for emotional disturbance. The aforementioned changes were approved during promulgation of the emergency rule. The following are proposed changes not previously reviewed: revisions to outpatient behavioral health rules are also made to clarify that daily or weekly summary notes and related requirements are for rehab day programs only and that all other rehab should follow general progress note requirements, to create a distinction in terminology between Licensed Behavioral Health Professionals (LBHPs) who are fully licensed by their respective licensing board and those individuals who are under supervision for licensure from an approved licensing board (Licensure Candidates). Additionally, rules are amended to clarify that group psychotherapy is not reimbursable for children

younger than three years of age. The aforementioned clarification was an oversight in last year's rule promulgation cycle. Revisions also include minor clean-up.
Budget Impact: Budget neutral

(Reference APA WF # 14-13)

J. AMENDING Agency rules at OAC 317:30-5-241, 317:30-5-276, and 317:30-5-281 to limit the number of hours that outpatient behavioral health rendering providers can be reimbursed to 35 hours per week. The aforementioned change was approved during promulgation of the emergency rule. The following are proposed changes not previously reviewed: rules are revised to correct scrivener's errors made during the 2014 permanent rulemaking session. The 2014 permanent rules clarified that individual and group psychotherapy services as well as testing cannot be provided to children ages 0-3.
Budget Impact: Budget neutral

(Reference APA WF # 14-15)

K. AMENDING Agency rules at OAC 317:40-5-3, 317:40-5-5, 317:40-5-6 317:40-5-11, 317:40-5-13, and 317:40-5-40 and REVOKING Agency rules at OAC 317:40-5-4, 317:40-5-9, and 317:40-5-10 to implement policy changes recommended during the annual Developmental Disabilities Services (DDS) policy review process. The policy changes recommended will assist DDS in becoming compliant with the new regulations of the Fair Labor Standards Act (FLSA) for "domestic service" employees, who provide "companionship services" to members. The Department of Labor has issued a new final ruling that precludes third party employers from claiming the companion exemption.
Budget Impact: Budget neutral

(Reference APA WF # 14-23)

The following permanent rules HAVE NOT previously been approved by the Board.

L. AMENDING Agency State Plan Personal Care rules at OAC 317:35-15-1, 317:35-15-2, 317:35-15-3, 317:35-15-4, 317:35-15-7, 317:35-15-8, 317:35-15-8.1, 317:35-15-9, 317:35-15-10, 317:35-15-13.1, 317:35-15-13.2, 317:35-15-14, and 317:35-15-15 to align with current procedures that are in place at OKDHS. Changes include policy clean up to remove unnecessary language regarding personal care service settings and criteria for persons eligible to serve as Personal Care Assistants. Rules also clarify the service eligibility criteria to match the terms and standards of the Uniform Comprehensive Assessment Tool (UCAT), and minor changes to language regarding the administration of State Plan Personal Care services are made to match current processes and protocol currently in place at OKDHS.
Budget Impact: Budget neutral

(Reference APA WF # 14-18)

M. AMENDING Agency rules at OAC 317:30-3-39 and 317:30-3-41 and REVOKING Agency rules at OAC 317:50-3-1 through 317:50-3-16 and 317:50-5-1 through 317:50-5-16 to transition the operational functions of two of OHCA's internal 1915c Waiver services and responsibilities as the waiver are set to expire. The two (2) internal waivers include: (a) My Life My Choice and (b) Sooner Seniors. Members will be served in the ADvantage waiver in the future.
Budget Impact: Budget neutral

(Reference APA WF # 14-19.a & b)

N. ADDING Agency rules at OAC 317:35-6-38 to implement Hospital Presumptive Eligibility (HPE) per federal regulation. HPE allows participating hospitals to make presumptive eligibility (PE) determinations, on behalf of the agency, for applicants who are deemed eligible for Medicaid services

based on preliminary information provided by the applicant. Hospitals may then provide services under HPE and bill OHCA. Hospitals are guaranteed payment for HPE services, regardless of whether or not the applicant is later found eligible for SoonerCare. The rules will delineate the parameters of the HPE program, eligibility guidelines, and hospital participation rules.
Budget Impact: Federal Mandate: The proposed rule change to implement the Hospital Presumptive Eligibility program has an estimated budget impact of $5,607,000; this cost has a federal share of $3,493,161 and a state share of $2,113,839.

(Reference APA WF # 14-20)

O. AMENDING Agency rules at OAC 317:30-5-211.1, 317:30-5-211.3, 317:30-5-211.4, 317:30-5-211.5, 317:30-5-211.9, 317:30-5-211.10, 317:30-5-211.17, 317:30-5-217, and 317:30-5-218 to clarify rules for durable medical equipment (DME) services. Changes include: updating billing and PA requirements for DME items, updating the list of DME items that require a certificate of medical necessity, clarifying that repairs for rental DME items are not covered, and revising the definition of invoice.
Budget Impact: Nominal impact, potentially budget neutral

(Reference APA WF # 14-22)

P. AMENDING Agency dental rules at OAC 317:30-5-696, 317:30-5-698, 317:30-5-699, 317:30-5-700, and 317:30-5-700.1 to align practice with the Code on Dental Procedures and Nomenclature (CDT) and to ensure the delivery of dental services meets the standard of care. Proposed revisions include guidelines for x-rays, comprehensive and periodic oral evaluations, and dental sealants.

Revisions also include clean-up to remove language regarding composite and amalgam restorations as it is referenced in a different section. Proposed revisions outline guidelines for stainless steel crowns to clarify that placement is allowed once for a minimum period of 24 months as well as other clean-up for clarity.

In addition, policy is revised to ensure root canal therapy is performed only when medically necessary. Proposed revisions clarify utilization parameters for restorations, observation time prior to making a referral for an orthodontic consultation, and the start of the treatment year for orthodontic services.

Policy is revised to clarify the treatment year for orthodontic services begin on the date of the placement of the bands. Orthodontic policy is also revised to increase observation time prior to allowing a child to be referred for a consultation.
Budget Impact: Savings were approved during promulgation of the emergency rule, the additional proposed changes will result in an additional nominal savings to the agency.

(Reference APA WF # 14-25)

Q. AMENDING Agency rules at OAC 317:30-5-14 and ADDING Agency rules at OAC 317:30-5-14.1 to establish policy for the appropriate administration of allergy testing and immunotherapy services. Criteria include: definition of allergy testing and immunotherapy, coverage requirements, non-covered services, reimbursement conditions, appropriate delivery sites, provider qualifications, and documentation requirements for home administration of immunotherapy. Additionally, revisions include clean-up to remove allergy reimbursement language from injection policy as it is referenced in the new section.
Budget Impact: Budget savings of $5,180,000; total state savings are projected as $3,200,000.

(Reference APA WF # 14-28)

R. AMENDING Agency rules at OAC 317:35-1-2, 317:35-5-4, and 317:35-5-4.1, 317:35-7-61.1 and 317:35-9-48.1 and ADDING Agency rules at OAC 317:35-5-4.2 and 317:35-5-4.3 to change the

TEFRA program eligibility rules to match federal guidelines for level of care (LOC). Changes include replacing all TEFRA language regarding mental retardation or ICF/MR to individuals with intellectual disabilities or ICF/IID. Rules regarding ICF/IID LOC eligibility will change to match current DSM-5 and SSA guidelines regarding intellectual disabilities. Specific LOC criteria for determining both hospital and nursing facility will be added to coincide with the ICF/IID criteria. TEFRA rules will also allow one additional psychological evaluation after the age of six, as medically needed. Finally, the "Definitions" section is updated to include the term "Ineligible Spouse".
Budget Impact: Nominal impact, potentially budget neutral

(Reference APA WF # 14-33)

S. AMENDING Agency long-term care eligibility rules at OAC 317:35-5-41.8 to align with federal policy. Proposed revisions include increasing home equity maximum amount to $500,000 plus the increase by the annual percentage increase in the urban component of the consumer price index and allowing the individual to decrease this equity interest through the use of a reverse mortgage or home equity loan. The term "relative" is removed from the home exemption rules for members who fail to return back home from a long-term care institution. The term "annuity" is changed to also include annuities purchased by, or on behalf of, an annuitant seeking long-term care services.
Budget Impact: Budget neutral

(Reference APA WF # 14-36)

T. AMENDING Agency inpatient psychiatric hospital rules at OAC 317:30-5-95.4, 317:30-5-95.14, and 317:30-5-95.33 to clarify that the member's signature on the Individual Plan of Care is required at the time of completion. However, if the member was too physically ill or their acuity level precluded them from signing the plan of care and/or the plan of care review at the time of completion, the member must sign the plan when their condition improves but before discharge. Rules are also revised to indicate that the individual plan of care must adhere to the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).
Budget Impact: Budget neutral

(Reference APA WF # 14-38)

U. AMENDING Agency rules at OAC 317:30-5-742.2 to indicate a 1.5 hours daily limit on services billed by the Treatment Parent Specialist (TPS) within the Therapeutic Foster Care (TFC) setting. This change in policy aligns with limitations delineated within the State Plan for this particular provider and setting. Additionally, rules are revised to make a distinction between LBHPs and Licensure Candidates.
Budget Impact: Budget neutral

(Reference APA WF # 14-39)

V. AMENDING Agency rules at OAC 317:30-5-95.6, 317:30-5-95.16, 317:30-5-95.37, and 317:30-5-95.42 to reflect that the History and Physical (H&P) should be completed within 24 hours after admission into an inpatient psychiatric hospital. Rules are also amended to clarify that the psychiatric evaluation is performed by a psychiatrist. Further, rules are amended to clarify that the psychiatric evaluation is completed within 60 hours of admission. Rules are amended to clarify recoupment methodology when documentation is not in the member’s file. Additionally, rules are amended to reflect a distinction between LBHPs and Licensure Candidates.
Budget Impact: Budget neutral

(Reference APA WF # 14-42)

W. ADDING Agency rules at OAC 317:35-6-62.1 to allow electronic notices to be sent to SoonerCare

members' designated email addresses. Members may actively select that they wish to receive electronic communications from the agency through the SoonerCare application. The agency will confirm that the member is informed of their right to change this election at any time, ensure that members receive mailed notice of this election, and that all notices are posted on the SoonerCare application for member viewing within one business day. In instances of failed electronic communications, the agency will notify the member, through the mail, of this failed correspondence and that action is necessary.
Budget Impact: Budget neutral

(Reference APA WF # 14-44)

X. AMENDING Agency inpatient psychiatric hospital rules at OAC 317:30-5-95.24 to indicate that non-specialty Psychiatric Residential Treatment Facilities (PRTF) should have a staff to member ratio of 1:6 during routine awake hours and 1:8 during sleeping hours. Additionally, changes are made to clarify that staffing ratios should always be present for each individual unit not by facility or program. Other minor grammatical changes were made to the rule.
Budget Impact: Budget neutral

(Reference APA WF # 14-45)

Y. AMENDING Agency rules at OAC 317:30-5-412, 317:30-5-422, 317:30-5-482, 317:40-5-100, 317:40-5-103, 317:40-5-152 and 317:40-7-15 and ADDING Agency rules at OAC 317:40-1-3 to implement policy changes recommended during the Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services (DDS) annual policy review process.
Budget Impact: OKDHS Budget: The rule change has total projected budget cost of $111,430. The federal share is $71,315.20 and the state share is $40,114.80.

(Reference APA WF # 14-46.a & b)

Z. AMENDING Agency rules at OAC 317:30-5-95.34 to indicate that when the History and Physical (H&P) or a combined H&P and psychiatric evaluation are completed by an allopathic or osteopathic physician with a current license and a board certification/eligible in psychiatry, the assessment(s) may count as the first visit by the physician in active treatment. Additionally, rules are revised to include a distinction between LBHPs and Licensure Candidates.
Budget Impact: Budget neutral

(Reference APA WF # 14-47)

AA. AMENDING Agency behavioral health case management rules at OAC 317:30-5-595 and 317:30-5-596 to add the State Plan authorized billing limits of 25 units per month for regular TCM and 54 units for intensive TCM. Rules are also amended to create a distinction between LBHPs and licensure candidates. Additionally, rules are revised to include CM II certification requirements; this change in rules is to correct scrivener's errors made during the 2014 permanent rulemaking session.
Budget Impact: Budget neutral

(Reference APA WF # 14-48)

BB. AMENDING Agency rules at OAC 317:35-5-25, 317:45-1-3, 317:45-9-1, 317:45-11-20, and 317:45-11-21 to change the methodology for determining Insure Oklahoma (IO) eligibility, for both IP and ESI, to the Modified Gross Adjustment Income (MAGI) methodology. The MAGI methodology will supersede previous IO eligibility criteria. The new rules will reference the MAGI methodology rules already established at OAC 317:35-6-39 through 317:35-6-54. Additional changes include amending the requirement that members notify the agency of changes in household circumstances from within 30 calendar days to 10 days. Rules will be added to indicate changes in the member's household

circumstances may require an eligibility redetermination for IO. References to IO's various FPLs will be removed; IO's income standards will now be published online using standard IO Income forms. Additionally, the reasonable opportunity for SoonerCare members to obtain citizenship or alienage documentation is changed from 60 days to 90 days.
Budget Impact: Budget neutral for program costs. $10,000,000 for system changes; the federal share is $9,000,000; state share is $1,000,000 and is provided by non-appropriated tobacco tax dollars.

(Reference APA WF # 14-49.a & b)

CC. AMENDING Agency telemedicine rules at OAC 317:30-3-27 to clarify the definition for telemedicine, and to remove the definitions sections for consistency. Proposed changes also remove coverage guidelines to expand the scope of the telemedicine delivery method. Revisions remove requirements for a presenter at the originating site to align with the Oklahoma Medical Licensure rules, and guidelines regarding the required use of OHCA-approved telemedicine networks. Proposed revisions also eliminate the originating site fee payment. Additional clean-up ensures no restrictions on services rendered using the telemedicine delivery model.
Budget Impact: The anticipated savings tied to the removal of the originating site fee payment will result in approximately $650,000 total dollars; $245,050 state dollars. Nominal impact, potentially budget neutral due to anticipated savings.

(Reference APA WF # 14-50)

DD. AMENDING Agency SoonerRide rules at OAC 317:30-3-64, 317:30-5-327, 317:30-5-327.1, 317:30-5-327.3, and 317:35-3-2 to remove coverage for transport to state Veterans Affair hospitals as these facilities are not contracted with the Oklahoma Health Care Authority. Rules also clarify coverage guidelines for escorts, and rules remove mention of the My Life, My Choice and Sooner Senior groups as the waivers are set to expire. Additional cleanup is made to the rule to align policy with current practice.
Budget Impact: Budget neutral.

(Reference APA WF # 14-52.a & b)

EE. AMENDING Agency outpatient behavioral health rules at OAC 317:30-5-241.1 to add service coverage for mental health/substance use disorder screening for SoonerCare adult and child members within an outpatient behavioral health agency setting. Additionally, rules are revised to create a distinction between LBHPs and Licensure Candidates.
Budget Impact: ODMHSAS Budget: 120,000 clients were provided mental health services through SoonerCare in SFY2015. Assuming 10% uptake in utilization of the new screening code in SFY2016, estimated budget impact would be $303,840 total dollars; $114,547 state share, $189,290 federal share.

(Reference APA WF # 14-53)

FF. AMENDING Agency outpatient behavioral health rules at OAC 317:30-5-95.9, 317:30-5-95.19, 317:30-5-95.36, 317:30-5-95.39, 317:30-5-95.41, 317:30-5-240.2, 317:30-5-240.3, 317:30-5-241.4, 317:30-5-241.5, 317:30-5-740.1, and 317:30-5-741 to create distinction between licensed behavioral health professionals and licensure candidates. Additionally, other minor grammatical errors were corrected and outdated references were removed.
Budget Impact: Budget neutral

(Reference APA WF # 14-55)

GG. AMENDING Agency high risk obstetrical (HROB) services rules at OAC 317:30-5-22 and 317:30-5-22.1 to increase access in rural areas. Currently high risk obstetrical services are allowed only after

an evaluation with Maternal Fetal Medicine (MFM) doctor and the member is deemed high risk; enhanced services are allowed only after a prior authorization request and treatment plan are initiated and submitted by the MFM. The initial intent of the HROB program was to promote the establishment of a relationship between the MFMs in urban areas with mothers located in rural communities. However, it appears that pregnant women in rural communities rarely travel to the urban areas to receive services. Allowing the general OB to request the HROB services/package for pregnant women will ensure pregnant women with high risk conditions receive HROB services.
Budget Impact: This change has an impact of $258,000 total dollars, state dollars $99,801.

(Reference APA WF # 14-58)

HH. AMENDING Agency rules at OAC 317:30-5-660.1 to allow Federally Qualified Health Centers (FQHC) to be reimbursed at the PPS rate immediately upon receiving their Health Resources and Services Administration (HRSA) grant award letter. Currently, OHCA requires the facility to submit the award letter and their Medicare certification number. In the interim, facilities contract as a clinic and are paid the fee for service (FFS) rate.
Budget Impact: Budget neutral

(Reference APA WF # 14-60)

Item to be presented by Nancy Nesser, Pharmacy Director

7. Action Item - Consideration and Vote Regarding Recommendations Made by the Drug Utilization Review Board Under 63 Oklahoma Statutes 5030.3.

   a) Consideration and vote to add **Viekira Pak™ (Ombitasvir/Paritaprevir/ Ritonavir/Dasabuvir), Northera™ (Droxidopa), Akynzeo® (Netupitant/ Palonosetron), Lemtrada™ (Alemtuzumab), Plegridy™ (Peginterferon β-1a), Brisdelle® (Paroxetine Mesylate), Orenitram™ (Treprostinil) Revatio® (Sildenafil Oral Suspension), and Myalept™ (Metreleptin)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

Item to be presented by Tony Armstrong, Vice-Chairman

8. Discussion Item – Proposed Executive Session as Recommended by the Chief of Legal Services and Authorized by the Open Meetings Act, 25 Oklahoma Statutes § 307(B) (1), (4), (7) and (9).

   a) Discussion of Pending Litigation, Investigations and Claims
      Daniels v. OHCA
      Choices v. OHCA

9. New Business

10. ADJOURNMENT

NEXT BOARD MEETING
May 14, 2015
Oklahoma Health Care Authority
Charles Ed McFall Boardroom
4345 N. Lincoln Blvd.
Oklahoma City, OK

MINUTES OF A REGULARLY SCHEDULED BOARD MEETING
OF THE HEALTH CARE AUTHORITY BOARD
February 12, 2015
Held at the Oklahoma Health Care Authority
Oklahoma City, Oklahoma

Manner and Time of Notice of Meeting: A statutorily required public meeting notice was placed on the front door of the Oklahoma Health Care Authority on February 11, 2015 at 10:30 a.m. Advance public meeting notice was provided to the Oklahoma Secretary of State. In addition to the posting of the statutory public notice, the agency placed its agenda on its website on February 9, 2015 at 7:30 a.m.

Pursuant to a roll call of the members, a quorum was declared to be present, and Chairman McFall called the meeting to order at 1:02 p.m.

BOARD MEMBERS PRESENT: Chairman McFall, Vice-Chairman Armstrong, Member Bryant, Member Robison, Member McVay, Member Case, Member Nuttle

OTHERS PRESENT:
Matt Lucas
Becky Moore, OAHCP
Jennifer Laizure, OHCA
Melissa Gower, Chickasaw Nation
David Dude, American Cancer Society
Patricia Linzy, OHCA
LeKenya Antwine, OHCA
Rick Snyder, OHA
Irene Perez, OHCA
Daryn Kirkpatrick, OHCA
Melanie Lawrence, OHCA

OTHERS PRESENT:
Becky Lucas
Patrick Harvey, Walgreens
Tina Largent, OHCA
Robert Dorrell, BCBSOK
Jim Fowler
Princiss Rockmore, OHCA
Terry Cothran, COP
Mary Brinkley, LeadingAge OK
Dana Miller, OHCA
LouAnn McFall
Lisa Moses, OHCA

DISCUSSION AND POSSIBLE VOTE ON APPROVAL OF BOARD MINUTES OF THE REGULARY SCHEDULED BOARD MEETING HELD JANUARY 8, 2015.

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 McVay moved for approval of the January 8, 2015 board meeting minutes as published. The motion was seconded by Member Robison.

FOR THE MOTION: Chairman McFall, Vice-Chairman Armstrong, Member Bryant, Member Case

ABSTAINED: Member Nuttle

ITEM 3a / ALL STARS INTRODUCTION
Nico Gomez, Chief Executive Officer

The OHCA All-Stars for December 2014 was recognized.

- Tina Largent, Sr. Exceptional Needs Coordinator, Population Care Management (Garth Splinter)

ITEM 3b / FINANCIAL UPDATE
Carrie Evans, Chief Financial Officer

Ms. Evans reported on the financial transactions through the month of December and noted that we are under budget with a $14.9 million positive state variance and the agency is under budget in program spending and in administration spending. She stated that the agency is running over budget in the revenue categories except for drug rebate which is $0.3 million under budget through December. Ms. Evans noted that we ended the month with $19.6 million state dollars under budget but we have reserved $14 million to fund fiscal year 2016. The current available state share variance is

DRAFT

$5.6 million. Looking ahead for January, Ms. Evans predicts the agency will continue to run slightly under budget. For more detailed information, see Item 3b in the board packet.

ITEM 3b.1 / REVISED FISCAL YEAR 2016 BUDGET REQUEST
Carrie Evans, Chief Financial Officer

Ms. Evans gave a report on the revised items that were presented to the senate and house budget hearings that OHCA participated in. For more detailed information, see Item 3b.1 in the board packet.

Mr. Gomez commented on the Governor's budget and stated that he was very pleased that the program and the people that we serve were seen as a priority. He stated that it is a great start to having the budget conversations and that we will continue having productive discussions to move forward.

Member Nuttle reported on the agency running under budget because of excellent operation and also the money is well managed and puts OHCA in a good position to make an argument for the funding.

ITEM 3c / MEDICAID DIRECTOR'S UPDATE
Garth Splinter, State Medicaid Director

Dr. Splinter provided an update for December that included a report on the number of enrollees in the Medicaid program. He also reported on dual enrollees, long term care members and SoonerCare contracted provider information. For more detailed information, see Item 3c in the board packet.

ITEM 3d / LEGISLATIVE UPDATE
Carter Kimble, Director of Governmental Relations

Mr. Kimble reported that the Governor's State of the State address and the 2015 legislative session began Monday, February 2nd. As of February 3, 2015, the Oklahoma Legislature filed a total of 2,129 legislative bills. OHCA is currently tracking 130 bills, of which two are OHCA request bills, 47 are direct impact bills, and the remaining bills are agency interest and employee interest, which we are still reviewing. Mr. Kimble noted that there are two OHCA request bills which are house bill 2164 and senate bill 704. For more detailed information, see Item 3d in the board packet.

ITEM 3e / RECOGNITION OF MATT LUCAS
Garth Splinter, Nico Gomez and Chairman McFall

Dr. Splinter presented Matt Lucas, retired Insure Oklahoma Director of OHCA. He gave a brief background history for Mr. Lucas and listed his accomplishments. Mr. Gomez and Chairman McFall presented Mr. Lucas with an Oklahoma flag that was previously flown at the Capitol along with a framed description of the flag as well as a citation from State Senator Brian Bingman.

ITEM 4 / ANNOUNCEMENTS OF CONFLICTS OF INTEREST PANEL RECOMMENDATIONS FOR ALL ACTIONITEMS
Nicole Nantois, Chief of Legal Services

There were no recommendations regarding conflicts.

ITEM 5a / CONSIDERATION AND VOTE ON THE REQUEST FOR PROPOSAL (RFP) FOR THE SERVICES OF A VENDOR TO PROVIDE SICKLE CELL DISEASE SERVICE
Vickie Kersey, Director of Fiscal Planning and Procurement

MOTION: Vice-Chairman Armstrong moved for Item 5a as published. The motion was seconded by Member Nuttle.

FOR THE MOTION: Chairman McFall, Member Bryant, Member McVay, Member Robison, Member Case

ITEM 5b / CONSIDERATION AND VOTE OF AUTHORITY FOR EXPENDITURE OF FUNDS FOR THE MYHEALTH CONTRACT EXTENSION
Vickie Kersey, Director of Fiscal Planning and Procurement

MOTION: Member Case moved for Item 5b as published. The motion was seconded by Member Robison.

FOR THE MOTION: Chairman McFall, Vice-Chairman Armstrong, Member Bryant, Member McVay, Member Nuttle

ITEM 6 / CONSIDERATION AND VOTE OF AGENCY RECOMMENDED RULEMAKING PURSUANT TO ARTICLE I OF THE ADMINISTRATIVE PROCEDURES ACT. THE AGENCY REQUESTS THE ADOPTION OF THE FOLLOWING PERMANENT RULES
Tywanda Cox, Chief of Federal and State Policy

A. AMENDING Agency rules at OAC 317:30-3-57, 317:30-3-65.7, and 317:30-5-432.1 to limit the number of payment for glasses to two per year. Any additional glasses beyond this limit must be prior authorized and determined to be medically necessary.
Budget Impact: The rule change has total projected budget savings of $347,055; total state savings are projected as $129,347.

(Reference APA WF # 14-08)

B. AMENDING Agency rules at OAC 317:30-5-126 to eliminate payment for hospital leave to nursing facilities and ICF/IIDs to reserve beds for members who are absent from the facility. Hospital leave is planned or unplanned leave when the patient is admitted to a licensed hospital.
Budget Impact: The rule change has a total projected budget savings of $1,615,367.27; total state savings are projected as $608,993.46.

(Reference APA WF # 14-12)

MOTION: Member Bryant moved for the approval of Item 6A-B as published. The motion was seconded by Member McVay.

FOR THE MOTION: Chairman McFall, Vice-Chairman Armstrong, Member Case, Member Robison, Member Nuttle

C. AMENDING Agency SoonerCare Choice enrollment ineligibility rules at OAC 317:25-7-13 and 317:25-7-28 to include making individuals with other forms of creditable health insurance coverage ineligible for SoonerCare Choice; individuals in the former foster care eligibility group are also ineligible for SoonerCare Choice. Additionally, members who are currently enrolled in SoonerCare Choice who have or gain other forms of creditable insurance will be disenrolled from the program. Children who are known to be in OKDHS custody are now eligible to participate in SoonerCare Choice.
Budget Impact: This rule change has total projected budget savings of $3,887,634; total state savings are projected as $1,448,921.

(Reference APA WF # 14-09)

MOTION: Member Case moved for approval of Item 6C as published. The motion was seconded by Member McVay.

FOR THE MOTION: Chairman McFall, Vice-Chairman Armstrong, Member Bryant, Member Robison, Member Nuttle

D. ADDING Agency rules at OAC 317:30-5-579 to comply with a federal mandate. The purpose of this rule is to outline special provisions for providers participating in the 340B Drug Discount program.
Budget Impact: Budget neutral

(Reference APA WF # 14-24)

E. AMENDING Agency nurse aide training program rules at OAC 317:30-5-134 to specify that payment for training will be directly reimbursed to qualified nurse aides on a quarterly basis for every quarter the individual is employed in a nursing facility. Rules are also revised to establish a maximum rate for reimbursement for nurse aides who have paid for training and competency examination fees.

DRAFT

Budget Impact: This rule change has total projected budget savings of $1,509,000; total state savings are projected as $529,500.

(Reference APA WF # 14-26)

F. AMENDING Agency Private Duty Nursing (PDN) rules at OAC 317:30-5-559, 317:30-5-560, and 317:30-5-560.1 to reflect an OHCA physician will be responsible for utilizing the acuity grid to help make a determination for medical necessity. The Care Management nurses' responsibility will be to gather, summarize, and present the individual cases to the physician.
Budget Impact: Budget Neutral

(Reference APA WF # 14-27)

G. AMENDING Agency rules at OAC 317:30-3-14 and 317:35-3-1 to lock members in to a single pharmacy and prescriber rather than a single physician and pharmacy. As a result the member is not restricted to one physician; however, the member will be locked in to one pharmacy and must receive prescriptions from an identified and approved lock-in prescriber.
Budget Impact: Budget neutral

(Reference APA WF # 14-29 a & b)

H. AMENDING Agency rules regarding SoonerCare member's freedom of choice to select their provider of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) at OAC 317:30-5-211.7 to state that providers must inform members of this right when filling or ordering DMEPOS.
Budget Impact: Budget neutral

(Reference APA WF # 14-35)

I. AMENDING Agency rules at OAC 317:25-7-7 to convey that electronic referrals will eliminate the need of paper referral documentation within members' medical records.
Budget Impact: Budget neutral

(Reference APA WF # 14-41)

MOTION: Member Nuttle moved for approval of Item 6D-I as published. The motion was seconded by Vice-Chairman Armstrong.

FOR THE MOTION: Chairman McFall, Member Bryant, Member Robison, Member McVay, Member Case

ITEM 7 / CONSIDERATION AND VOTE REGARDING RECOMMENDATIONS MADE BY THE DRUG UTILIZATION REVIEW BOARD UNDER 63 OKLAHOMA STATUTES 5030.3.
Nancy Nesser, Pharmacy Director

a) Consideration and vote to add Duavee® (Conjugated Estrogens/ Bazedoxifene), Ofev® (Nintedanib), Esbriet® (Pirfenidone) and Anoro™ Ellipta® (Umeclidinium/Vilanterol), to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

MOTION: Member Case moved for approval of Item 7a as published. The motion was seconded by Member McVay.

FOR THE MOTION: Chairman McFall, Vice-Chairman Armstrong, Member Robison, Member Bryant, Member Nuttle

ITEM 8 / PROPOSED EXECUTIVE SESSION AS RECOMMENDED BY THE CHIEF OF LEGAL SERVICES AND AUTHORIZED BY THE OPEN MEETINGS ACT, 25 OKLAHOMA STATUTES §307(B) (1), (4), (7) AND (9).
Nicole Nantois, Chief of Legal Services

Chairman McFall entertained a motion to go into Executive Session at this time.

DRAFT

MOTION: Member McVay moved for approval to go into Executive Session. The motion was seconded by Vice-Chairman Armstrong.

FOR THE MOTION: Chairman McFall, Member Robison, Member Bryant, Member Case, Member Nuttle

8. Discussion Item – Proposed Executive Session as Recommended by the Chief of Legal Services and Authorized by the Open Meetings Act, 25 Oklahoma Statutes § 307(B) (1), (4), (7) and (9).

   a) Discussion of Pending Litigation, Investigations and Claims

      - Choices v. OHCA
      - Oklahoma Counseling v. OHCA
      - Pending Long Term Care Eligibility Lawsuits

ITEM 9 / NEW BUSINESS

Mr. Gomez thanked the board for their dedication and giving their time to the OHCA board.

ITEM 10 / ADJOURNMENT

MOTION: Vice-Chairman Armstrong moved for approval for adjournment. The motion was seconded by Member Bryant.

FOR THE MOTION: Chairman McFall, Member Robison, Member McVay, Member Case, Member Nuttle

Meeting adjourned at 2:32 p.m., 2/12/2015

NEXT BOARD MEETING
March 26, 2015
Oklahoma Health Care Authority
Charles Ed McFall Boardroom
4345 N. Lincoln Blvd.
OKC, OK

Lindsey Bateman
Board Secretary

Minutes Approved: _______________

*Initials:*______________

DRAFT

FINANCIAL REPORT

For the Seven Months Ended January 31, 2015
Submitted to the CEO & Board

- Revenues for OHCA through January, accounting for receivables, were **$2,398,001,870** or **2.3% under** budget.
- Expenditures for OHCA, accounting for encumbrances, were **$2,339,685,546 or 2.8% under** budget.
- The state dollar budget variance through January is a **positive $11,587,392.**
- The budget variance is primarily attributable to the following (in millions):

Expenditures:	
Medicaid Program Variance	20.5
Administration	3.1
Revenues:	
Drug Rebate	(.8)
Taxes and Fees	2.6
Overpayments/Settlements	.2
FY15 Carryover Committed to FY16	(14.0)
Total FY 15 Variance	**$ 11.6**

ATTACHMENTS

Summary of Revenue and Expenditures: OHCA 1
Medicaid Program Expenditures by Source of Funds 2
Other State Agencies Medicaid Payments 3
Fund 205: Supplemental Hospital Offset Payment Program Fund 4
Fund 230: Quality of Care Fund Summary 5
Fund 245: Health Employee and Economy Act Revolving Fund 6
Fund 250: Belle Maxine Hilliard Breast and Cervical Cancer Treatment Revolving Fund 7

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures: OHCA
Fiscal Year 2015, For the Seven Months Ended January 31, 2015

REVENUES	FY15 Budget YTD	FY15 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 589,539,309	$ 589,539,309	$ -	0.0%
Federal Funds	1,411,673,600	1,368,855,392	(42,818,209)	(3.0)%
Tobacco Tax Collections	26,186,778	28,791,122	2,604,344	9.9%
Quality of Care Collections	45,005,772	44,675,700	(330,072)	(0.7)%
SFY 15 Carryover Committed to SFY16	14,000,000	-	(14,000,000)	100.0%
Prior Year Carryover	61,029,661	61,029,661	-	0.0%
Federal Deferral - Interest	141,941	141,941	-	0.0%
Drug Rebates	125,329,694	123,111,911	(2,217,783)	(1.8)%
Medical Refunds	26,381,890	27,127,175	745,285	2.8%
Supplemental Hospital Offset Payment Program	146,001,156	146,001,156	-	0.0%
Other Revenues	8,657,210	8,728,504	71,295	0.8%
TOTAL REVENUES	**$ 2,453,947,010**	**$ 2,398,001,870**	**$ (55,945,140)**	**(2.3)%**

EXPENDITURES	FY15 Budget YTD	FY15 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 33,479,031**	**$ 29,805,688**	**$ 3,673,343**	**11.0%**
ADMINISTRATION - CONTRACTS	**$ 73,314,674**	**$ 69,033,084**	**$ 4,281,590**	**5.8%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	23,257,265	21,123,597	2,133,668	9.2%
Acute Fee for Service Payments:				
Hospital Services	535,263,373	521,251,485	14,011,888	2.6%
Behavioral Health	11,929,689	11,296,773	632,916	5.3%
Physicians	293,218,395	277,545,735	15,672,660	5.3%
Dentists	81,300,427	76,048,521	5,251,906	6.5%
Other Practitioners	24,630,501	22,916,355	1,714,146	7.0%
Home Health Care	12,303,069	11,866,160	436,909	3.6%
Lab & Radiology	46,295,947	45,110,778	1,185,169	2.6%
Medical Supplies	23,582,452	23,009,925	572,527	2.4%
Ambulatory/Clinics	74,146,910	71,461,525	2,685,384	3.6%
Prescription Drugs	278,985,259	274,103,545	4,881,714	1.7%
OHCA Therapeutic Foster Care	1,199,623	1,069,140	130,483	10.9%
Other Payments:				
Nursing Facilities	342,401,433	336,601,741	5,799,692	1.7%
Intermediate Care Facilities for Individuals with Intellectual Disabilities Private	36,037,236	35,000,081	1,037,155	2.9%
Medicare Buy-In	79,280,479	77,621,011	1,659,468	2.1%
Transportation	41,708,864	40,705,396	1,003,468	2.4%
Money Follows the Person-OHCA	609,684	352,635	257,048	0.0%
Electonic Health Records-Incentive Payments	12,030,393	12,030,393	-	0.0%
Part D Phase-In Contribution	44,729,360	44,307,345	422,015	0.9%
Supplemental Hospital Offset Payment Program	337,424,633	337,424,633	-	0.0%
Total OHCA Medical Programs	**2,300,334,991**	**2,240,846,774**	**59,488,217**	**2.6%**
OHCA Non-Title XIX Medical Payments	89,382	-	89,382	0.0%
TOTAL OHCA	**$ 2,407,218,078**	**$ 2,339,685,546**	**$ 67,532,532**	**2.8%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ 46,728,932**	**$ 58,316,324**	**$ 11,587,392**	

OKLAHOMA HEALTH CARE AUTHORITY
Total Medicaid Program Expenditures
by Source of State Funds
Fiscal Year 2015, For the Seven Months Ended January 31, 2015

Category of Service	Total	Health Care Authority	Quality of Care Fund	HEEIA	SHOPP Fund	BCC Revolving Fund	Other State Agencies
SoonerCare Choice	$ 21,210,159	$ 21,114,799	$ -	$ 86,562	$ -	$ 8,798	$ -
Inpatient Acute Care	711,088,214	360,137,476	283,901	2,097,855	264,142,499	881,336	83,545,148
Outpatient Acute Care	214,440,199	157,307,033	24,269	2,290,882	52,200,545	2,617,471	
Behavioral Health - Inpatient	34,393,921	6,851,642	-	160,802	20,150,127		7,231,350
Behavioral Health - Psychiatrist	5,376,593	4,445,131	-	-	931,462	-	-
Behavioral Health - Outpatient	16,196,824	-	-	-	-	-	16,196,824
Behavioral Health Facility- Rehab	139,527,360	-	-	-	-	53,079	139,527,360
Behavioral Health - Case Management	12,343,300	-	-	-	-	-	12,343,300
Behavioral Health - PRTF	52,264,503	-	-	-	-	-	52,264,503
Residential Behavioral Management	13,353,365	-	-	-	-	-	13,353,365
Targeted Case Management	38,273,831	-	-	-	-	-	38,273,831
Therapeutic Foster Care	1,069,140	1,069,140	-	-	-	-	-
Physicians	312,532,251	273,975,295	33,892	3,249,604	-	3,536,548	31,736,912
Dentists	76,058,240	76,040,158	-	9,719	-	8,364	-
Mid Level Practitioners	1,879,929	1,867,140	-	11,683	-	1,106	-
Other Practitioners	21,103,932	20,784,743	260,379	55,822	-	2,988	-
Home Health Care	11,870,624	11,854,245	-	4,465	-	11,914	-
Lab & Radiology	46,115,549	44,808,365	-	1,004,770	-	302,413	-
Medical Supplies	23,171,734	21,371,813	1,581,729	161,810	-	56,382	-
Clinic Services	71,174,542	66,389,984	-	395,775	-	124,513	4,264,270
Ambulatory Surgery Centers	5,071,199	4,931,863	-	124,171	-	15,165	-
Personal Care Services	7,706,202	-	-	-	-	-	7,706,202
Nursing Facilities	336,601,741	211,941,883	124,657,876	-	-	1,982	-
Transportation	40,484,166	38,905,791	1,533,960	-	-	44,415	-
GME/IME/DME	64,140,513	-	-	-	-	-	64,140,513
ICF/IID Private	35,000,081	28,663,435	6,336,646	-	-	-	-
ICF/IID Public	32,480,505	-	-	-	-	-	32,480,505
CMS Payments	121,928,356	121,519,866	408,489	-	-	-	
Prescription Drugs	279,461,281	272,979,206	-	5,357,736	-	1,124,339	-
Miscellaneous Medical Payments	221,230	208,814	-	-	-	12,415	-
Home and Community Based Waiver	109,052,900	-	-	-	-	-	109,052,900
Homeward Bound Waiver	52,395,318	-	-	-	-	-	52,395,318
Money Follows the Person	8,219,872	352,635	-	-	-	-	7,867,236
In-Home Support Waiver	14,805,077	-	-	-	-	-	14,805,077
ADvantage Waiver	99,514,800	-	-	-	-	-	99,514,800
Family Planning/Family Planning Waiver	4,768,553	-	-	-	-	-	4,768,553
Premium Assistance*	23,429,435	-	-	23,429,435	-	-	-
Electronic Health Records Incentive Payments	12,030,393	12,030,393	-	-	-	-	-
Total Medicaid Expenditures	**$ 3,070,755,831**	**$ 1,759,550,852**	**$ 135,121,141**	**$ 38,441,091**	**$ 337,424,633**	**$ 8,803,227**	**$ 791,467,967**

* Includes $23,249,941.57 paid out of Fund 245

OKLAHOMA HEALTH CARE AUTHORITY

Summary of Revenues & Expenditures:
Other State Agencies
Fiscal Year 2015, For the Seven Months Ended January 31, 2015

REVENUE		FY15 Actual YTD
Revenues from Other State Agencies	$	335,615,042
Federal Funds		501,052,985
TOTAL REVENUES	**$**	**836,668,027**

EXPENDITURES		Actual YTD
Department of Human Services		
Home and Community Based Waiver	$	109,052,900
Money Follows the Person		7,867,236
Homeward Bound Waiver		52,395,318
In-Home Support Waivers		14,805,077
ADvantage Waiver		99,514,800
Intermediate Care Facilities for Individuals with Intellectual Disabilities Public		32,480,505
Personal Care		7,706,202
Residential Behavioral Management		10,310,575
Targeted Case Management		31,070,743
Total Department of Human Services		**365,203,356**
State Employees Physician Payment		
Physician Payments		31,736,912
Total State Employees Physician Payment		**31,736,912**
Education Payments		
Graduate Medical Education		23,985,914
Graduate Medical Education - Physicians Manpower Training Commission		2,172,666
Indirect Medical Education		31,865,924
Direct Medical Education		6,116,009
Total Education Payments		**64,140,513**
Office of Juvenile Affairs		
Targeted Case Management		1,819,397
Residential Behavioral Management		3,042,790
Total Office of Juvenile Affairs		**4,862,187**
Department of Mental Health		
Case Management		12,343,300
Inpatient Psychiatric Free-standing		7,231,350
Outpatient		16,196,824
Psychiatric Residential Treatment Facility		52,264,503
Rehabilitation Centers		139,527,360
Total Department of Mental Health		**227,563,337**
State Department of Health		
Children's First		840,690
Sooner Start		1,497,801
Early Intervention		1,738,836
Early and Periodic Screening, Diagnosis, and Treatment Clinic		1,219,929
Family Planning		(37,159)
Family Planning Waiver		4,788,824
Maternity Clinic		19,154
Total Department of Health		**10,068,075**
County Health Departments		
EPSDT Clinic		467,019
Family Planning Waiver		16,888
Total County Health Departments		**483,907**
State Department of Education		**93,317**
Public Schools		**2,710,848**
Medicare DRG Limit		**77,041,622**
Native American Tribal Agreements		**1,060,367**
Department of Corrections		**1,112,602**
JD McCarty		**5,390,923**
Total OSA Medicaid Programs	**$**	**791,467,967**
OSA Non-Medicaid Programs	**$**	**43,978,698**
Accounts Receivable from OSA	**$**	**(1,221,362)**

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 205: Supplemental Hospital Offset Payment Program Fund
Fiscal Year 2015, For the Seven Months Ended January 31, 2015

REVENUES		FY 15 Revenue
SHOPP Assessment Fee	$	145,829,024
Federal Draws		212,195,574
Interest		74,135
Penalties		97,997
State Appropriations		(15,200,000)
TOTAL REVENUES	$	**342,996,729**

EXPENDITURES	Quarter	Quarter	*Thru Fund 340* Quarter		FY 15 Expenditures
Program Costs:	7/1/14 - 9/30/14	10/1/14 - 12/31/14	1/1/15 - 3/31/15		
Hospital - Inpatient Care	92,872,986	92,764,153	78,505,360	$	264,142,499
Hospital -Outpatient Care	15,052,817	15,729,600	21,418,128	$	52,200,545
Psychiatric Facilities-Inpatient	6,919,304	7,316,146	5,914,677	$	20,150,127
Rehabilitation Facilities-Inpatient	272,784	288,429	370,249	$	931,462
Total OHCA Program Costs	115,117,891	116,098,329	106,208,413	$	337,424,633
Total Expenditures				$	**337,424,633**

CASH BALANCE	$	5,572,097

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 230: Nursing Facility Quality of Care Fund
Fiscal Year 2015, For the Seven Months Ended January 31, 2015

REVENUES	Total Revenue	State Share
Quality of Care Assessment	$ 44,651,715	$ 44,651,715
Interest Earned	23,985	23,985
TOTAL REVENUES	**$ 44,675,700**	**$ 44,675,700**

EXPENDITURES	FY 15 Total $ YTD	FY 15 State $ YTD	Total State $ Cost
Program Costs			
Nursing Facility Rate Adjustment	$ 122,529,752	$ 46,193,717	
Eyeglasses and Dentures	161,503	60,887	
Personal Allowance Increase	1,966,620	741,416	
Coverage for Durable Medical Equipment and Supplies	1,581,729	596,312	
Coverage of Qualified Medicare Beneficiary	602,441	227,120	
Part D Phase-In	408,489	408,489	
ICF/IID Rate Adjustment	3,108,875	1,172,046	
Acute Services ICF/IID	3,227,771	1,216,870	
Non-emergency Transportation - Soonerride	1,533,960	578,303	
Total Program Costs	**$ 135,121,141**	**$ 51,195,159**	**$ 51,195,159**
Administration			
OHCA Administration Costs	$ 297,605	$ 148,803	
DHS-Ombudsmen	85,376	85,376	
OSDH-Nursing Facility Inspectors	400,000	400,000	
Mike Fine, CPA	-	-	
Total Administration Costs	**$ 782,981**	**$ 634,179**	**$ 634,179**
Total Quality of Care Fee Costs	**$ 135,904,122**	**$ 51,829,337**	
TOTAL STATE SHARE OF COSTS			**$ 51,829,337**

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

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 245: Health Employee and Economy Improvement Act Revolving Fund
Fiscal Year 2015, For the Seven Months Ended January 31, 2015

REVENUES	FY 14 Carryover	FY 15 Revenue	Total Revenue
Prior Year Balance	$ 13,950,701	$ -	$ 7,178,979
State Appropriations	-	-	-
Tobacco Tax Collections	-	23,680,522	23,680,522
Interest Income	-	188,698	188,698
Federal Draws	160,262	15,508,819	15,508,819
All Kids Act	(6,679,359)	65,712	65,712
TOTAL REVENUES	**$ 7,431,604**	**$ 39,443,751**	**$ 46,557,018**

EXPENDITURES	FY 14 Expenditures	FY 15 Expenditures	Total $ YTD
Program Costs:			
Employer Sponsored Insurance		$ 23,067,494	$ 23,067,494
College Students		179,493	64,582
All Kids Act		182,448	182,448
Individual Plan			
SoonerCare Choice		$ 83,430	$ 30,018
Inpatient Hospital		2,075,248	746,674
Outpatient Hospital		2,260,868	813,460
BH - Inpatient Services-DRG		158,035	56,861
BH -Psychiatrist		-	-
Physicians		3,251,443	1,169,869
Dentists		9,099	3,274
Mid Level Practitioner		11,046	3,974
Other Practitioners		54,834	19,729
Home Health		4,465	1,606
Lab and Radiology		994,719	357,900
Medical Supplies		152,269	54,787
Clinic Services		391,723	140,942
Ambulatory Surgery Center		118,441	42,615
Prescription Drugs		5,268,598	1,895,642
Miscellaneous Medical		-	-
Premiums Collected		-	(288,008)
Total Individual Plan		**$ 14,834,218**	**$ 5,049,343**
College Students-Service Costs		**$ 177,253**	**$ 63,775**
All Kids Act- Service Costs		**$ 186**	**$ 67**
Total OHCA Program Costs		**$ 38,441,091**	**$ 28,427,709**
Administrative Costs			
Salaries	$ 30,565	$ 785,803	$ 816,368
Operating Costs	125,839	345,144	470,983
Health Dept-Postponing	-	-	-
Contract - HP	96,221	420,704	516,925
Total Administrative Costs	**$ 252,625**	**$ 1,551,651**	**$ 1,804,276**
Total Expenditures			**$ 30,231,985**
NET CASH BALANCE	**$ 7,178,979**		**$ 16,325,033**

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 250: Belle Maxine Hilliard Breast and Cervical Cancer Treatment Revolving Fund
Fiscal Year 2015, For the Seven Months Ended January 31, 2015

REVENUES	FY 15 Revenue	State Share
Tobacco Tax Collections	$ 472,460	$ 472,460
TOTAL REVENUES	**$ 472,460**	**$ 472,460**

EXPENDITURES	FY 15 Total $ YTD	FY 15 State $ YTD	Total State $ Cost
Program Costs			
SoonerCare Choice	$ 8,798	$ 2,322	
Inpatient Hospital	881,336	232,584	
Outpatient Hospital	2,617,471	690,750	
Inpatient Services-DRG	-	-	
Psychiatrist	-	-	
TFC-OHCA	-	-	
Nursing Facility	1,982	523	
Physicians	3,536,548	933,295	
Dentists	8,364	2,207	
Mid-level Practitioner	1,106	292	
Other Practitioners	2,988	789	
Home Health	11,914	3,144	
Lab & Radiology	302,413	79,807	
Medical Supplies	56,382	14,879	
Clinic Services	124,513	32,859	
Ambulatory Surgery Center	15,165	4,002	
Prescription Drugs	1,124,339	296,713	
Transportation	44,415	11,721	
Miscellaneous Medical	12,415	3,276	
Total OHCA Program Costs	$ 8,750,148	$ 2,309,164	
OSA DMHSAS Rehab	$ 53,079	$ 14,007	
Total Medicaid Program Costs	$ 8,803,227	$ 2,323,172	
TOTAL STATE SHARE OF COSTS			**$ 2,323,172**

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

SoonerCare Programs

January 2015 Data for March 2015 Board Meeting

SOONERCARE ENROLLMENT/EXPENDITURES

Delivery System		Monthly Enrollment Average SFY2014	Enrollment January 2015	Total Expenditures January 2015	Average Dollars Per Member Per Month January 2015
SoonerCare Choice Patient-Centered Medical Home		559,363	**541,627**	**$134,424,773**	
	Lower Cost *(Children/Parents; Other)*		494,650	$95,798,038	$194
	Higher Cost *(Aged, Blind or Disabled; TEFRA; BCC)*		46,977	$38,626,736	$822
SoonerCare Traditional		196,936	**232,275**	**$159,289,828**	
	Lower Cost *(Children/Parents; Other)*		121,841	$37,110,019	$305
	Higher Cost *(Aged, Blind or Disabled; TEFRA; BCC & HCBS Waiver)*		110,434	$122,179,808	$1,106
SoonerPlan*		48,266	**40,233**	**$282,668**	$7
Insure Oklahoma		23,567	**17,727**	**$4,999,092**	
	Employer-Sponsored Insurance	14,795	13,272	$3,243,906	$244
	*Individual Plan**	8,772	4,455	$1,755,187	$394
TOTAL		**828,131**	**831,862**	**$298,996,361**	

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 $128,711,581 are excluded.

Effective July 2014, members with other forms of credible health insurance coverage were no longer eligible for Choice PCMH.

*In January 2014, SoonerPlan's qualifying income guidelines decreased from 185% to 133% of FPL and Insure Oklahoma IP's qualifying income guidelines decreased from 200% to 100% of FPL.

Net Enrollee Count Change from Previous Month Total	410

New Enrollees	17,239

Members that have not been enrolled in the past 6 months.

Dual Enrollees & Long-Term Care Members (subset of data above)

Medicare and SoonerCare		Monthly Average SFY2014	Enrolled January 2015
Dual Enrollees		**109,653**	**110,619**
	Child	*192*	188
	Adult	*109,461*	110,431

		Monthly Average SFY2014	Enrolled January 2015	FACILITY PER MEMBER PER MONTH
Long-Term Care Members		**15,358**	**14,932**	**$3,378**
	Child	63	53	
	Adult	15,295	14,879	

Child is defined as an individual under the age of 21.

SOONERCARE CONTRACTED PROVIDER INFORMATION

Provider Counts		Monthly Average SFY2014	Enrolled January 2015
Total Providers		**38,330**	**40,702**
	In-State	29,277	30,968
	Out-of-State	9,053	9,734

Provider Network includes providers who are contracted to provide health care services by locations, programs, types, and specialties. Providers are being counted multiple times if they have multiple locations, programs, types, and specialties.

Program	% of Capacity Used
SoonerCare Choice	44%
SoonerCare Choice I/T/U	19%
Insure Oklahoma IP	1%

Select Provider Type Counts	*In-State*		*Totals*	
	Monthly Average SFY2014	*Enrolled January 2015**	Monthly Average SFY2014	Enrolled January 2015
Physician	*8,452*	*9,120*	*13,597*	15,528
Pharmacy	*936*	*910*	*1,266*	1,203
Mental Health Provider	*4,864*	*4,626*	*4,902*	4,681
Dentist	*1,069*	*1,110*	*1,206*	1,280
Hospital	*183*	*191*	*685*	933
Optometrist	*565*	*613*	*594*	648
Extended Care Facility	*356*	*346*	356	346

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

Total Primary Care Providers**	*5,410*	*6,013*	7,011	8,043
Patient-Centered Medical Home	*2,099*	*2,352*	2,188	2,461

**Including Physicians, Physician Assistants and Advance Nurse Practitioners.

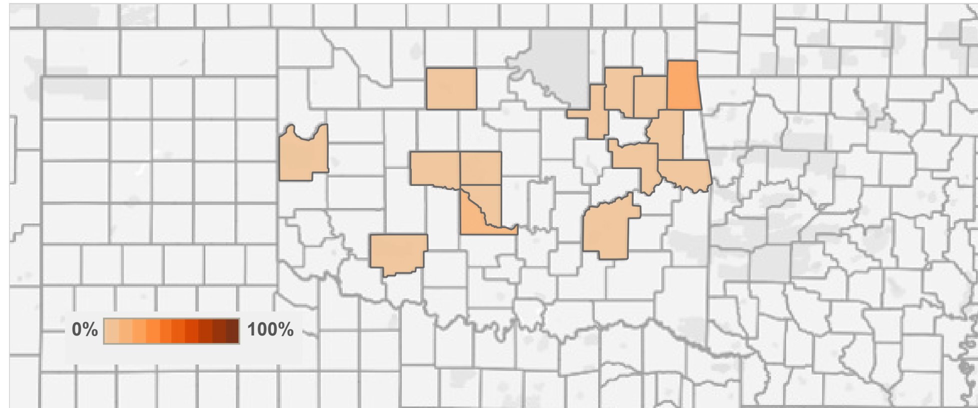
*Items shaded above represent a 10% or more increase (green) or decrease (red) from the previous fiscal year's average.

OK EPCS Provider and Pharmacy Status through February 2015

PROVIDER STATUS

State	Total Providers (1)	Ambulatory Providers (2)	Active Providers EPCS Enabled (3)	% Active Providers EPCS Enabled, Total	% Active Providers EPCS Enabled, Ambulatory	Total New eRx (4)	EPCS Transactions (4)
OK	16,715	7,993	87	0.5%	1.1%	1,191,607	2,571
National	1,708,921	724,206	22,907	1.3%	3.2%	95,995,235	413,388

% Active Providers EPCS Enabled, Ambulatory - By County



OK Provider EPCS Enablement through February 2015

- **3.6%** month over month growth of Active Providers EPCS Enabled
- **87** providers actively e-prescribing who are now EPCS enabled
- **15** counties out of **77** have at least 1 enabled provider

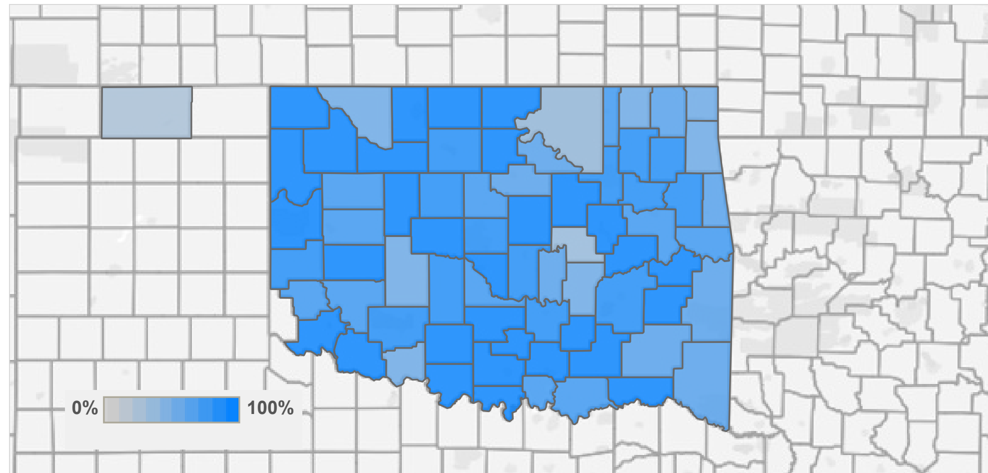
Definitions:

1. **Total Providers:** total providers in both acute and ambulatory settings based on Enclarity data
2. **Ambulatory Providers:** providers in the ambulatory setting based on the Definitive Healthcare data.
3. **Active Providers EPCS Enabled**: providers who use an EHR software that is EPCS certified and audit approved. These providers may not yet be sending EPCS transactions, but have sent an e-prescription in the past 30 days
4. **Total New eRx and EPCS Transactions**: Surescripts network transactions in the current month from all provider settings.

PHARMACY STATUS

State	Total Pharmacies (1)	Active eRx Pharmacies (2)	EPCS Enabled Pharmacies (3)	% Active eRx Pharmacies	% Pharmacies EPCS enabled	Total New eRx (4)	EPCS Transactions (4)
OK	841	775	708	92.2%	84.2%	1,191,607	2,571
National	63,180	59,501	45,677	94.2%	72.3%	95,995,235	413,388

% Pharmacy EPCS Enablement - By County



OK Pharmacy EPCS Enablement through February 2015

- **84%** of pharmacies are EPCS enabled
- **708** of **841** community pharmacies are enabled
- **74** counties out of **77** have at least 1 enabled pharmacy

Definitions:

1. **Total Pharmacies:** total number of pharmacies in the country based on NCPDP data.
2. **Active eRx Pharmacies**: ready and processing e-prescriptions from providers applications.
3. **EPCS Enabled Pharmacies**: certified and audit approved software at pharmacy, ready to receive EPCS transactions from providers; training may be needed.
4. **Total New eRx and EPCS Transactions**: Surescripts network transactions in the current month from all provider settings.

MARCH 30TH, 2015 OHCA BOARD MEETING

After the February and March deadlines and as of March 23, 2015, the Oklahoma Legislature is tracking a total of 717 legislative bills. OHCA is now tracking 53 bills, of which we have one OHCA request bill remaining, 20 direct impact bills, 6 agency interest, 7 miscellaneous and 19 employee interest bills.

OHCA REQUEST BILLS:

- SB704 – Sen. AJ Griffin, Rep. Dr. Doug Cox - Allows OHCA to recover funds put in a trust for, but not spent on, burial/funeral expenses. Recovery amount not to exceed cost of services provided. Passed unanimously out of the full Senate and received Do Pass 8-0 in (H) A&B, Health subcommittee on 3-23-15.

The following are the remaining Senate and House deadlines for 2015:

SENATE AND HOUSE DEADLINES

April 9, 2015	Senate Deadline for Reporting Single and Double assigned House bills and Joint Resolutions from Committee
April 10, 2015	Deadline for Reporting Senate bills and Joint Resolutions from House Committees
April 23, 2015	Deadline for Third Reading of Bills and Joint Resolutions from Opposite Chamber
May 29, 2015	Sine Die Adjournment, No later than 5:00 p.m.

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

Submitted to the C.E.O. and Board on March 30, 2015

AUTHORITY FOR EXPENDITURE OF FUNDS

Disease Registry

BACKGROUND

OMES (*on behalf of OHCA and ODMHSAS*) is issuing this Request for Proposal (RFP) for the services of a vendor to administer a Behavioral Health Home Management Software System for the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS). The Behavioral Health Home Management Software System shall enable electronic communication between the Oklahoma Health Homes, the Oklahoma Health Care Authority, the Oklahoma Department of Mental Health and Substance Abuse Services and the Centers for Medicare and Medicaid Services (CMS).

SCOPE OF WORK

The software system will contain:

1. Enrollment and discharge tracking;
2. Compliance;
3. Quality Assurance; and
4. Outcome monitoring the SED and SMI populations.

CONTRACT PERIOD

Date of Award-June 30, 2015 with the option of 2 renewals

CONTRACT AMOUNT AND PROCUREMENT METHOD

- Awarded through competitive bidding conducted by OMES
- Anticipated federal match is 50%
- State share will be paid by ODMHSAS
- Not to exceed $650,000 per SFY

RECOMMENDATION

- Board approval to expend funds for the services discussed above

Submitted to the C.E.O. and Board on March 30, 2015
AUTHORITY FOR EXPENDITURE OF FUNDS

Insure Oklahoma Multimedia Marketing

BACKGROUND

We are issuing this Request for Proposal (RFP) for the services of a vendor to develop and implement a multimedia marketing campaign to promote Insure Oklahoma throughout the entire State of Oklahoma.

SCOPE OF WORK

- Redesign Insure Oklahoma's website on Ektron platform, version 8.0.2.035, Section 508 Compliance (excluding coverage application and pages behind portal log-in);
- Create, write, design and produce all types of communication tools that are effective in generating increased target audience knowledge and awareness; and
- Negotiate and purchase media buys within allotted budget after developing campaign strategy.

CONTRACT PERIOD

April 1, 2015 through December 31, 2015

CONTRACT AMOUNT AND PROCUREMENT METHOD

- Awarded through competitive bidding conducted by OHCA
- Anticipated federal match is 50%
- Not to exceed $450,000 for calendar year 2015

RECOMMENDATION

- Board approval to expend funds for the services discussed above

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 35. RURAL HEALTH CLINICS

317:30-5-355.1. Definition of services

The RHC benefit package, as described in Title 42 of the Code of Federal Regulations (CFR), part 440.20, consists of two components: RHC Services and Other Ambulatory Services.

(1) **RHC services.** RHC services are covered when furnished to a member at the clinic or other location, including the member's place of residence. These services are described in this Section.

(A) **Core services.** As set out in Federal Regulations at 42 CFR 440.20(b), RHC "core" services include, but are not limited to:

(i) Physician's services;

(ii) Services and supplies incident to a physician's services;

(iii) Services of advanced practice nurses (APNs), physician assistants (PAs), nurse midwives (NMs) or specialized advanced practice nurse practitioners;

(iv) Services and supplies incident to the services of APNs and PAs (including services furnished by nurse midwives);

(v) Visiting nurse services to the homebound;

(vi) Clinical psychologist (CP) and clinical social worker (CSW) services;

(vii) Services and supplies incident to the services of CPs and CSWs.

(B) **Physicians' services.** In addition to the professional services of a physician, and services provided by an APN, PA and NMW which would be covered as RHC services under Medicare, certain primary preventive services are covered under the SoonerCare RHC benefit. The services must be furnished by or under the direct supervision of a RHC practitioner who is a clinic employee:

(i) prenatal and postpartum care;

(ii) screening examination under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program for members under 21;

(iii) family planning services;

(iv) medically necessary screening mammography and follow-up mammograms when medically necessary.

(C) **Services and supplies "incident to".** Services and supplies incident to the service of a physician, physician assistant, advanced practice nurse, clinical psychologist, or clinical social worker are covered if the service or supply is:

(i) a type commonly furnished in physicians' offices;
(ii) a type commonly rendered either without charge or included in the rural health clinic's bill;
(iii) furnished as an incidental, although integral, part of a physician's professional services;
(iv) Drugs and biologicals which cannot be self-administered or are specifically covered by Medicare law, are included within the scope of RHC services. Drugs and biologicals commonly used in life saving procedures, such as analgesics, anesthetics (local), antibiotics, anticonvulsants, antidotes and emetics, serums and toxoids are not billed separately.

(D) **Visiting nurse services.** Visiting nurse services are covered if:
(i) the RHC is located in an area in which the Centers for Medicare and Medicaid Services (CMS) has determined there is a shortage of home health agencies;
(ii) the services are rendered to members who are homebound;
(iii) the member is furnished nursing care on a part time or intermittent basis by a registered nurse, licensed practical nurse or licensed vocational nurse who is employed by or receives compensation for the services from the RHC; and
(iv) the services are furnished under a written plan of treatment.

(E) **RHC encounter.** RHC "core" services (including preventive services, i.e., prenatal, EPSDT or family planning) are part of an all-inclusive visit. A "visit" means a face-to-face encounter between a clinic patient and a RHC health professional (i.e., physicians, physician assistants, advanced practice nurses, nurse midwives, clinical psychologists and clinical social workers). Encounters with more than one health professional and multiple encounters with the same health professional that takes place on the same day and a single location, constitute a single visit except when the member, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment. Payment is made for one encounter per member per day. Medical review will be required for additional visits for children. Payment is also limited to four visits per member per month for adults.

(F) **Off-site services.** RHC services provided off-site of the clinic are covered as long as the RHC has a compensation arrangement with the RHC practitioner that SoonerCare reimbursement is made to the RHC and the RHC practitioner receives his or her compensation from the RHC. The rural health clinic must have a written contract with the physician and other RHC "core" practitioners that specifically identify how the rural health clinic services provided off-site are to

be billed to SoonerCare. It is expected that services provided in off-site settings are, in most cases, temporary and intermittent, i.e., when the member cannot come to the clinic due to health reasons.

(2) **Other ambulatory services.** A Rural Health Clinic must provide other items and services which are not "RHC services" as described in (a)(1) of this Section, and are separately billable to the SoonerCare program. Coverage of services are based upon the scope of coverage under the SoonerCare program.

(A) Other ambulatory services include, but are not limited to:

(i) dental services for members under age 21;
(ii) optometric services;
(iii) clinical lab tests performed in the RHC lab, including the lab tests required for RHC certification;
(iv) technical component of diagnostic tests such as x-rays and EKGs (interpretation of the test provided by the RHC physician is included in the encounter rate);
(v) durable medical equipment;
(vi) emergency ambulance transportation;
(vii) prescribed drugs;
(viii) prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags) and supplies directly related to colostomy care and the replacement of such devices;
(ix) specialized laboratory services furnished away from the clinic;
(x) inpatient services;
(xi) outpatient hospital services.

(B) Payment is made directly to the RHC on an encounter basis for on-site dental services by a licensed dentist or optometric services by a licensed optometrist for members under age 21. Encounters are billed as one of the following:

(i) **EPSDT dental screening.** An EPSDT dental screening includes oral examination, prophylaxis and fluoride treatment, charting of needed treatment, and, if necessary, x-rays (including two bite wing films). This service must be filed on claim form ADM-36-D for EPSDT reporting purposes.

(ii) **Dental encounter.** A dental encounter consists of all dental treatment other than a dental screening. This service must be billed on the ADM-36-D.

(iii) **Visual analysis.** Visual analysis (initial or yearly) for a child with glasses, or a child who needs glasses, or a medical eye exam. This includes the refraction and medical eye health evaluation. Glasses must be billed separately. Payment is limited to two glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.

(C) Services listed in (a)(2)(A), (v)-(viii), of this

Section, furnished on-site, require separate provider agreements with the OHCA. Service item (a)(2)(A)(iii) does not require a separate contract when furnished on-site, however, certain conditions of participation apply. (Refer to OAC 317:30-5-361 for conditions.)

(D) Other ambulatory services provided off-site by independent practitioners (through subcontracting agreements or arrangements for services not available at the clinic) must be billed to the SoonerCare program by the provider rendering the service. Independent practitioners must meet provider eligibility criteria and must have a current contract with the OHCA.

317:30-5-356. Coverage for adults

Payment is made to rural health clinics for adult services as set forth in this Section.

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

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

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

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

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

(B) **Family planning services.** Family planning services are

available only to members with reproductive capability. Family planning visits do not count as one of the four RHC visits per month.

(2) **Other ambulatory services.** Services defined as "other ambulatory" services are not considered a part of a RHC visit and are therefore billable to the SoonerCare program by the RHC or provider of service on the appropriate claim forms. Other ambulatory services are subject to the same scope of coverage as other SoonerCare services billed to the program, i.e., limited adult services and some services for under 21 subject to same prior authorization process. Refer to OAC 317:30-1, General Provisions, and OAC 317:30-3-57, 317:30-5-59, and 317:30-3-60 for general coverage and exclusions under the SoonerCare program. Some specific limitations are applicable to other ambulatory services as set forth in specific provider rules and excerpted as follows: Coverage under optometrists for adults is limited to treatment of eye disease not related to refractive errors. There is no coverage for eye exams for the purpose of prescribing eyeglasses, contact lenses or other visual aids. (See OAC 317:30-5-431.)

317:30-5-357. Coverage for children

Coverage for rural health clinic services and other ambulatory services for children include the same services as for adults in addition to the following:

(1) The receipt of an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) examination by a Medicaid eligible individual under age 21 renders that individual child eligible for all necessary follow-up care, whether or not the medically necessary services are covered under the Medicaid program. An EPSDT exam performed by a RHC must be billed on the appropriate claim form with the appropriate Preventative Medicine procedure code from the Current Procedural Terminology Manual (CPT). If an EPSDT screening is billed, a RHC encounter should not be billed on the same day. Refer to OAC 317:30-3-47 through 317:30-3-54 for coverages under EPSDT).

(2) Under EPSDT, coverage is allowed for visual screenings and eyeglasses to correct visual defects. Payment is limited to two glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.

(3) An EPSDT screening is considered a comprehensive examination. A provider billing the Medicaid program for an EPSDT screen may not bill any other visits for that patient on that same day. It is expected that the screening provider will perform necessary treatment as part of the screening charge. Additional services such as tests, immunizations, etc., required at the time of screening may be billed independently from the screening.

(4) The administration fee for immunizations should be billed if provided at the same time as a scheduled EPSDT examination.

(5) Payment may be made directly to the RHC for the professional services of physician assistants performing EPSDT screenings within the certified RHC. The claim form must include the signature of the supervising physician.

317:30-5-361. Billing

(a) **Encounters.** Payment is made for one ~~type of~~ encounter per member per day. Medical review will be required for additional visits for children. Payment is also limited to four visits per member per month for adults. Rural health clinics must bill the combined fees of all "core" services provided during an encounter on the appropriate claim form. Claims must include reasonable and customary charges.

(1) **RHC.** The appropriate revenue code is required. No HCPC or CPT code is required.

(2) **Mental health.** Mental health services must include a revenue code and a HCPCS code.

(3) **Obstetrical care.** The appropriate revenue code and HCPCS code are required. The date the member is first seen is required. The primary pregnancy diagnosis code is also required. Secondary diagnosis codes are used to describe complications of pregnancy. Delivery must be billed by the independent practitioner who has a contract with the OHCA.

(4) **Family planning.** Family planning encounters require a revenue code, HCPCS code, and a family planning diagnosis.

(5) **EPSDT screening.** EPSDT screenings must be billed by the attending provider using the appropriate Preventative Medicine procedure code from the Current Procedural Terminology Manual (CPT).

(6) **Dental.** Dental services for children must be billed on the appropriate dental claim form.

(7) **Visual analysis.** Optometric services for children are billed using the appropriate revenue code and a HCPCS code.

(b) **Services billed separately from encounters.** Other ambulatory services and preventive services itemized separately from encounters must be billed using the appropriate revenue, HCPC and/or CPT codes. Claims must include reasonable and customary charges.

(1) **Laboratory.** The rural health clinic must be CLIA certified for specialized laboratory services performed. Laboratory services must be itemized separately using the appropriate CPT or HCPCS code.

(2) **Radiology.** Radiology must be identified using the appropriate CPT or HCPC code with the technical component modifier. Radiology services are paid at the technical component rate. The professional component is included in the encounter rate.

(3) **Immunizations.** The administration fee for immunizations provided on the same day as the EPSDT exam is billed separately.

(4) **Contraceptives.** Contraceptives are billed independently from the family planning encounter. A revenue code and the appropriate CPT or HCPC codes are required. The following are examples:

(A) DepoProvera 150 mg. (Medroxyprogesterone Acetate).
(B) Insertion and implantation of a subdermal contraceptive device.
(C) Removal, implantable contraceptive devices.
(D) Removal, with reinsertion, implantable contraceptive device.
(E) Insertion of intrauterine device (IUD).
(F) Removal of intrauterine device.
(G) ParaGard IUD.
(H) Progestasert IUD.

(5) **Glasses.** Glasses prescribed by a licensed optometrist are billed using the appropriate revenue code and HCPCS code. Payment is limited to two glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.

(6) **Telemedicine.** The originating site facility fee for telemedicine services is not a rural health clinic service. When a rural health clinic serves as the originating site, the originating site facility fee is paid separately from the clinic's all-inclusive rate.

PART 75. FEDERALLY QUALIFIED HEALTH CENTERS

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. 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.~~A Health Center may bill for one medically necessary encounter per 24 hour period. Medical review will be required for additional visits for children. Payment is limited to four visits per member per month for adults.

(d) Services considered reimbursable encounters (including any related medical supplies provided during the course of the encounter) include:

(1) medical;
(2) diagnostic;
(3) dental, medical and behavioral health screenings;
(4) vision;
(5) physical therapy;

(6) occupational therapy;
(7) podiatry;
(8) behavioral health;
(9) speech;
(10) hearing;
(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);
(12) any other medically necessary health services (i.e. optometry and podiatry) are also reimbursable as permitted within the Health Center's scope of services 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.

317:30-5-664.4. Multiple encounters at Health Centers [REVOKED]
~~(a) A Health Center may bill for more than one medically necessary encounter per 24 hour period under certain conditions.~~
~~(b) It is intended that multiple medically necessary encounters will occur on an infrequent basis.~~
~~(c) A Center may not develop Center procedures that routinely involve multiple encounters for a single date of service, unless medical necessity warrant multiple encounters.~~
~~(d) Each service must have distinctly different diagnoses in order to meet the criteria for multiple encounters. For example, a medical visit and a dental visit on the same day are considered different services with distinctly different diagnoses.~~
~~(e)Similar services, even when provided by two different health care practitioners, are not considered multiple encounters.~~

317:30-5-664.12. Determination of Health Center PPS rate
(a) **Methodology.** The methodology for establishing each facility's PPS rate is found in Attachment 4.19 B of the OHCA's State Plan, as amended effective January 1, 2001, and incorporated herein by reference.

(b) **Scope of service adjustment.** If a Center significantly changes its scope of services, the Center may request in writing that new baseline encounter rates be determined. Adjustments to encounter rates are made ~~only if the change in the scope of services results in the inclusion of behavioral health services or dental services or a difference of at least five percent from the Center's current costs (other than overhead).~~if it is determined that a significant change in the scope-of-service has occurred which impacts the base rate, as indicated within the State Plan. If there is a change in scope-of-service, it is the responsibility of the FQHC to request OHCA to review services that have had a change to the scope-of-service. The OHCA may initiate a rate adjustment in accordance with procedures in the State Plan, based on audited financial statements or cost reports, if the scope of services has been modified ~~to include behavioral health services or dental services~~ or would otherwise result in a change~~ of at least five percent from~~ to the Center's current rate. If a new rate is set, the rate ~~change takes effect on the latter of the change of services date or the date of application to the OHCA for rate change.~~will be effective on the date the change in scope-of-service was implemented.

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

317:30-5-56. Utilization review

All inpatient services are subject to post-payment utilization review by the Oklahoma Health Care Authority, or its designated agent. These reviews will be based on OHCA's, or its designated agent's, admission criteria on severity of illness and intensity of treatment. In addition to the random sample of all admissions, retrospective review policy includes the following:

(1) Hospital stays less than three days in length will be reviewed for medical necessity and appropriateness of care. (Discharges involving healthy mother and healthy newborns may be excluded from this review requirement.) If it is determined that the inpatient stay was unnecessary or inappropriate, the prospective payment for the inpatient stay will be denied.

(2) Cases which indicate transfer from one acute care hospital to another will be monitored to help ensure that payment is not made for inappropriate transfers.

(3) Readmissions occurring within ~~15~~30 days of prior acute care admission for a related condition will be reviewed to determine medical necessity and appropriateness of care or whether the readmission was potentially preventable. If it is determined that either or both admissions were unnecessary or inappropriate or potentially preventable, payment for either or both admissions may be denied. Such review may be focused to exempt certain cases at the sole discretion of the OHCA.

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

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

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

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

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

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

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

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

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

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

(c) **Assignment in SoonerCare.** Any provider who holds a fee for

service contract and also executes a contract with a provider in the SoonerCare Choice program must adhere to the rules of this subsection regarding assignment.

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

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

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

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

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

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

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

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

(D) Native Americans providing documentation of ethnicity in accordance with 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.

(E) Individuals who are categorically eligible for SoonerCare through the Breast and Cervical Cancer Treatment program.

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

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

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

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

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

(D) Smoking and Tobacco Cessation counseling and products.

(E) Diabetic supplies.

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

(A) Inpatient hospital stays.

(B) Outpatient hospital visits.

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

(D) Encounters with the following rendering providers:

(i) Physicians,

(ii) Advanced Practice Nurses,

(iii) Physician Assistants,

(iv) Optometrists,

(v) Home Health Agencies,

(vi) Certified Registered Nurse Anesthetists,

(vii) Anesthesiologist Assistants,

(viii) Durable Medical Equipment providers, and

(ix) Outpatient behavioral health providers.

(E) Prescription drugs.

~~(i) Zero for preferred generics.~~

~~(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.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 17. MEDICAL SUPPLIERS

317:30-5-211.11. Oxygen and oxygen equipment

(a) **Medical necessity.** Oxygen and oxygen supplies are covered when medically necessary. Medical necessity is determined from results of arterial blood gas analysis (ABG) or pulse oximetry (SaO2) tests ~~(pO2)~~. ABG data are not required for children, but may be used if otherwise available. The test results to document Medical Necessity must be within 30 days of the date of the ~~physician's prescription. A copy of a report from an inpatient or outpatient hospital or emergency room setting will meet the requirement.~~qualified medical practitioner's Certificate of Medical Necessity. Prior authorization is required after the initial three months of billing whether qualifying tests were done at rest, during sleep, or during exercise. Appropriate documentation of ABG or SaO2 data from the member's chart should be attached to the prior authorization request(PAR).

(1) ~~For initial certification for oxygen, the ABG study or oximetry analysis used to determine medical necessity may not be performed by the DMEPOS or a related corporation. In addition, neither the study nor the analysis may be performed by a physician with a significant ownership interest in the DMEPOS performing such tests. These prohibitions include relationships through blood or marriage. A referring physician may perform the test in his/her office as part of routine member care.~~ The ABG or oximetry test used to determine medical necessity must be performed by a medical professional qualified to conduct such testing. The test may not be performed or paid for by a DMEPOS supplier, or a related corporation. A referring qualified medical practitioner may perform the test in his/her office as part of routine member care.

(2) ~~Initial certification is for no more than three months. Except in the case of sleep-induced hypoxemia, ABG or oximetry is required within the third month of the initial certification period if the member has a continued need for supplemental oxygen. Re-certification will be required every 12 months.~~

~~(A) **Adults.** Initial requests for oxygen must include ABG or resting oximetry results. The arterial blood saturation can not exceed 89% at rest on room air; the pO2 level can not exceed 59mm Hg.~~

~~(B) **Children**. Requests for oxygen for children that do not meet the following requirements should include documentation~~

~~of the medical necessity based on the child's clinical condition and are considered on a case-by-case basis. Members 20 years of age or less must meet the following requirements:~~

~~(i) birth through three years, SaO2 level equal to or less than 94%; and~~

~~(ii) ages four and above, SaO2 level equal to or less than 90%.~~In addition to ABG data, the following three tests are acceptable for determining medical necessity for oxygen prescription:

(A) At rest and awake "spot oximetry."

(B) During sleep:

(i) Overnight Sleep Oximetry done inpatient or at home.

(ii) Polysomnogram, which may be used only if medically necessary for concurrent evaluation of another condition while in a chronic stable state.

(C) During exercise with all three of the following performed in the same testing session.

(i) At rest, off oxygen showing a non-qualifying result.

(ii) During exercise, off oxygen showing a qualifying event.

(iii) During exercise, on oxygen showing improvement over test (C) ii above.

(3) Certification criteria:

(A) All qualifying testing must meet the following criteria:

(B) Adults. Initial requests for oxygen must include ABG or resting oximetry results. At rest and on room air, the arterial blood saturation (SaO2) cannot exceed 89% or the pO2 cannot exceed 59mm Hg.

(C) Children. Members 20 years of age or less must meet the following requirements:

(i) birth through three years, SaO2 equal to or less than 94%;or

(ii) ages four and above, SaO2 level equal to or less than 90%.

(iii)Requests from the qualified medical practitioner for oxygen for children who do not meet these requirements should include documentation of the medical necessity based on the child's clinical condition. These requests are considered on a case-by-case basis.

(b) **Certificate of medical necessity.**

(1) The ~~medical~~DMEPOS supplier must have a fully completed current CMN(CMS-484 or HCA-32 must be used for members 20 years of age and younger) on file to support the claims for oxygen or oxygen supplies, and to establish whether coverage criteria are met and to ensure that the oxygen services provided are consistent with the physician's prescription (refer to

instructions from Palmetto Government Benefits Administration, the Oklahoma Medicare Carrier, for further requirements for completion of the CMN).

(2) ~~The CMN must be signed by the physician prior to submitting the initial claim. When a physician prescription for oxygen is renewed, a CMN, including the required retesting, must be completed by the physician prior to the submission of claims. The medical and prescription information on the CMN may be completed by a non physician clinician, or an employee of the physician for the physician's review and signature. In situations where the physician has prescribed oxygen over the phone, it is acceptable to have a cover letter containing the same information as the CMN, stating the physician's orders, as long as the CMN has been signed by the physician or as set out above.~~ The CMN must be signed by the qualified medical practitioner prior to submitting the initial claim. If a verbal order containing qualifying data is received by the DME provider, oxygen and supplies may be dispensed using the verbal order date as the billing date. The CMN initial date, the verbal order date, and the date of delivery should be the same date. It is acceptable to have a cover letter containing the same information as the CMN, stating the qualified medical practitioner's orders. The CMN signed by the qualified medical practitioner must be attached to the PAR.

(3) ~~Prescription for oxygen services must be updated at least annually and at any time a change in prescription occurs during the year. All DMEPOS suppliers are responsible for maintaining the prescription(s) for oxygen services and CMN in each member's file. If any change in prescription occurs, the physician must complete a new CMN that must be maintained in the member's file by the DME supplier. The OHCA or its designated agent will conduct ongoing monitoring of prescriptions for oxygen services to ensure guidelines are followed. Payment adjustments will be made on claims not meeting these requirements.~~ The medical and prescription information on the CMN may be completed by a non-physician clinician, or an employee, for the qualified medical practitioner's review and signature.

(4) When a Certificate of Medical Necessity for oxygen is recertified, a prior authorization request will be required.

(5) Re-certification and related retesting will be required every 12 months.

(6) CMN for oxygen services must be updated at least annually and at any time a change in prescription occurs during the year. All DMEPOS suppliers are responsible for maintaining the prescription(s) for oxygen services and CMN in each member's file.

(7) The OHCA or its designated agent will conduct ongoing monitoring of prescriptions for oxygen services to ensure guidelines are followed. Payment adjustments will be made on claims not meeting these requirements.

317:30-5-211.12. Oxygen rental

A monthly rental payment is made for rental of liquid oxygen systems, gaseous oxygen systems and oxygen concentrators. The rental payment for a stationary system includes all contents and supplies, such as, regulators, tubing, masks, ~~etc~~etc., that are medically necessary. An additional monthly payment may be made for a portable liquid or gaseous oxygen system based on medical necessity.

(1) ~~Oxygen concentrators~~Stationary oxygen systems and portable oxygen systems are covered items for members residing in their home or in a nursing facility.

(2) For members who meet medical necessity criteria, SoonerCare covers portable liquid or gaseous oxygen systems. Portable oxygen contents are not covered for adults. The need for a portable oxygen system must be stated on the CMN. A portable system that is used as a backup system only is not a covered item.

(3) When ~~six~~four or more liters of oxygen are medically necessary, an additional payment will be paid up to 150% of the allowable for a stationary system when billed with the appropriate modifier.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 50. HOME AND COMMUNITY BASED SERVICES WAIVERS
SUBCHAPTER 1. MEDICALLY FRAGILE WAIVER SERVICES

317:50-1-14. Description of services

Services included in the Medically Fragile Waiver Program are as follows:

(1) **Case Management.**

(A) Case Management services are services that assist a member in gaining access to medical, social, educational or other services, regardless of payment source of services, that may benefit the member in maintaining health and safety. Case managers initiate and oversee necessary assessments and reassessments to establish or reestablish Waiver program eligibility. Case managers develop the member's comprehensive plan of care, 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 skilled nursing facility services, the case manager assists the member in accessing institutional care and, as appropriate, periodically monitors the member's progress during the institutional stay and helps the member transition from institution to home by updating the service plan and preparing services to start on the date the member is discharged from the institution. Case Managers must meet Medically Fragile Waiver Program minimum requirements for qualification and training prior to providing services to members. Prior to providing services to members choosing to Self-Direct their services, Case Managers are required to receive training and demonstrate knowledge regarding the Self-Directed Service delivery model.

(B) Providers may only claim time for billable Case Management activities described as follows:

(i) A billable case management activity is any task or function defined under OAC 317:50-1-15(1)(A)that only a Medically Fragile case manager because of skill, training or authority, can perform on behalf of a member;

(ii) Ancillary activities such as clerical tasks like mailing, copying, filing, faxing, drive time or

supervisory/administrative activities are not billable case management activities, although the administrative cost of these activities and other normal and customary business overhead costs have been included in the reimbursement rate for billable activities.

(C) Case Management services are prior authorized and billed per 15-minute unit of service using the rate associated with the location of residence of the member served.

(i) Standard Rate: Case Management services are billed using a Standard rate for reimbursement for billable service activities provided to a member who resides in a county with population density greater than 25 persons per square mile.

(ii) Very Rural/Difficult Service Area Rate: Case Management services are billed using a Very Rural/Difficult Service Area rate for billable service activities provided to a member who resides in a county with population density equal to or less than 25 persons per square mile. An exception would be services to members that reside in OHCA identified zip codes in Osage County adjacent to metropolitan areas of Tulsa and Washington Counties. Services to these members are prior authorized and billed using the Standard rate.

(iii) The latest United States Census, Oklahoma Counties population data is the source for determination of whether a member resides in a county with a population density equal to or less than 25 persons per square mile, or resides in a county with a population density greater than 25 persons per square mile.

(D) Providers of Home and Community Based Services (HCBS) for the member, or those who have an interest in or are employed by a provider of HCBS for the member, must not provide case management or develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS.

(2) **Institutional Transition Services.**

(A) Institutional Transition Case Management Services are Services required by the member's plan of care, which are necessary to ensure the health, welfare and safety of the member, or to enable the member to function with greater independence in the home, and without which, the member would continue to require institutionalization.

(B) ~~Waiver~~Institutional Transition Case Management services assist institutionalized members that are eligible to receive waiver services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services to assist the transition, regardless of the funding source for the services which access is gained.

(C) Institutional Transition Case Management services may be authorized for periodic monitoring of a waiver member's progress during an institutional stay, and for assisting the member transition from institution to home by updating the services plan, including preparing for necessary services and supports to be in place or to start on the date the member is discharged from the institution.

(3) **Respite.**

(A) Respite services are provided to members who are unable to care for themselves. They are provided on a short-term basis because of the absence or need for relief of the primary caregiver. Payment for respite care does not include room and board costs unless more than seven hours are provided in a nursing facility. Respite care will only be utilized when other sources of care and support have been exhausted. Respite care will only be listed on the plan of care 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.

(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~~is determined through manual pricing. If manual pricing is used, the provider is reimbursed at the provider's documented Manufacturer's Suggested Retail Price (MSRP) minus 30% or invoice cost plus 30%, whichever is the lesser of the two. OHCA may establish a fair market price through claims review and analysis.

(6) **Advanced Supportive/Restorative Assistance.**

(A) Advanced Supportive/Restorative Assistance services are maintenance services to assist a member who has a chronic, yet stable, condition. These services assist with activities of daily living which require devices and procedures related to altered body functions. This service is for maintenance only and is not utilized as a treatment service.

(B) Advanced Supportive/Restorative Assistance service is billed per 15-minute unit of service. The number of units of this service a member may receive is limited to the number of units approved on the plan of care.

(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 Medically Fragile Waiver case manager in accordance with review schedule determined in consultation between the Case Manager and the Skilled Nurse, to report the member's condition or other significant information concerning each advanced supportive/restorative care member.

(i) The case manager may recommend authorization of Skilled Nursing services as part of the interdisciplinary team planning for the member's service plan and/or assessment/evaluation of:

(I) the member's general health, functional ability and needs and/or

(II) the adequacy of personal care and/or advanced supportive/restorative assistance services to meet the member's needs including providing on-the-job training and competency testing for personal care or advanced supportive/restorative care aides in accordance with rules and regulations for delegation of nursing tasks as established by the Oklahoma Board of Nursing.

(ii) In addition to assessment/evaluation, the case manager may recommend authorization of Skilled Nursing services for the following:

(I) preparing a one-week supply of insulin syringes for a blind diabetic, who can safely self-inject the medication but cannot fill his/her own syringe. This service would include monitoring the member's continued ability to self-administer the insulin;

(II) preparing oral medications in divided daily compartments for a member who self-administers prescribed medications but needs assistance and monitoring due to a minimal level of disorientation or confusion;

(III) monitoring a member's skin condition when a member is at risk for skin breakdown due to immobility or incontinence, or the member has a chronic stage II decubitus ulcer requiring maintenance care and monitoring;

(IV) providing nail care for the diabetic member or member with circulatory or neurological compromise;

(V) providing consultation and education to the member, member's family and/or other informal caregivers identified in the service plan, regarding the nature of the member's chronic condition. Provide skills training (including return skills demonstration to establish competency) to the member, family and/or other informal caregivers as specified in the service plan for preventive and rehabilitative care procedures.

(C) Nursing service can be billed for service plan development and/or assessment/evaluation services or, for other services within the scope of the Oklahoma Nursing Practice Act including private duty nursing. Nursing services are billed per 15-minute unit of service. A specific procedure code is used to bill for assessment/evaluation/service plan development skilled nursing services and other procedure codes are used to bill for all other authorized nursing services. A maximum of eight units per day of skilled nursing for assessment/evaluation and/or service plan development are allowed. An agreement by a provider to perform a nurse evaluation is also an agreement, to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted. Reimbursement for a nurse evaluation is denied if the provider that produced the nurse evaluation fails to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted.

(8) **Home Delivered Meals.**

(A) Home Delivered Meals provide one meal per day. A home delivered meal is a meal prepared in advance and brought to the member's home. Each meal must have a nutritional content equal to at least one third of the Recommended Daily Allowance as established by the Food and Nutrition Board of the National Academy of Sciences. Meals are only provided to members who are unable to prepare meals and lack an informal provider to do meal preparation.

(B) Home Delivered Meals are billed per meal, with one meal equaling one unit of service. The limit of the number of units a member is allowed to receive is limited on the member's plan of care. The provider must obtain a signature from the member or the member's representative at the time the meals are delivered. In the event that the member is temporarily unavailable (i.e., doctor's appointment, etc.) and the meal is left, the provider must document the reason a signature is not obtained. The signature logs must be available for review.

(9) **Occupational Therapy services.**

(A) Occupational Therapy services are those services that increase functional independence by enhancing the development of adaptive skills and performance capacities of members with physical disabilities and related psychological and cognitive impairments. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Treatment involves the therapeutic use of self-care, work and play activities and may include modification of the tasks or environment to enable the member to achieve maximum independence, prevent further disability, and maintain health. Under a physician's order, a licensed occupational therapist evaluates the member's rehabilitation potential and develops an appropriate written therapeutic regimen. The regimen utilizes paraprofessional occupational therapy assistant services, within the limits of their practice, working under the supervision of the licensed occupational therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Occupational Therapy services are billed per 15-minute

unit of service. Payment is not allowed solely for written reports or record documentation.

(10) **Physical Therapy services.**

(A) Physical Therapy services are those services that prevent physical disability through the evaluation and rehabilitation of members disabled by pain, disease or injury. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Treatment involves use of physical therapeutic means such as massage, manipulation, therapeutic exercise, cold or heat therapy, hydrotherapy, electrical stimulation and light therapy. Under a physician's order, a licensed physical therapist evaluates the member's rehabilitation potential and develops an appropriate, written therapeutic regimen. The regimen utilizes paraprofessional physical therapy assistant services, within the limits of their practice, working under the supervision of the licensed physical therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Physical Therapy services are billed per 15-minute units of service. Payment is not allowed solely for written reports or record documentation.

(11) **Speech and Language Therapy services.**

(A) Speech/Language Therapy services are those that prevent speech and language communication disability through the evaluation and rehabilitation of members disabled by pain, disease or injury. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Services involve use of therapeutic means such as evaluation, specialized treatment, and/or development and oversight of a therapeutic maintenance program. Under a physician's order, a licensed Speech/Language Pathologist evaluates the member's rehabilitation potential and develops an appropriate, written therapeutic regimen. The regimen utilizes paraprofessional therapy assistant services within the limits of their practice, working under the supervision of the licensed Speech/Language Pathologist. The regimen includes education and training for informal

caregivers to assist with and/or maintain services, where appropriate. The Pathologist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Speech/Language Therapy services are billed per 15-minute unit of service. Payment is not allowed solely for written reports or record documentation.

(12) **Respiratory Therapy Services.**

(A) Respiratory therapy services are provided for a member who, but for the availability of in-home respiratory services, would require respiratory care as an inpatient in a hospital or nursing facility. Services are provided in the member's home under the care of a physician who is familiar with the technical and medical components of home ventilator support and the physician must determine medically that in-home respiratory care is safe and feasible for the member. Treatment involves use of therapeutic means such as: evaluation, respiratory treatments, chest physiotherapy, and/or development and oversight of a therapeutic maintenance program. Under a physician's order, a registered respiratory therapist evaluates the member and develops an appropriate, written therapeutic regimen. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Respiratory Therapy services are billed per 15-minute unit of service. Payment is not allowed solely for written reports or record documentation.

(13) **Hospice Services**.

(A) Hospice is palliative and/or comfort care provided to the member and his/her family when a physician certifies that the member has a terminal illness and has six months or less to live and orders hospice Care. Medically Fragile Waiver Hospice Care is authorized for a six month period and requires a physician certification of a terminal illness and orders of hospice care. If the member requires more than six months of hospice care, a physician or nurse practitioner must have a face-to-face visit with the member thirty days prior to the initial hospice

authorization end date and re-certify that the member has a terminal illness and has six months or less to live and orders additional hospice care. After the initial authorization period, additional periods of hospice may be authorized for a maximum of 60 day increments with physician certification that the member has a terminal illness and has six months or less to live. A member's service plan that includes hospice care must comply with waiver requirements to be within total service plan cost limits.

(B) A hospice program offers palliative and supportive care to meet the special needs arising out of the physical, emotional and spiritual stresses which are experienced during the final stages of illness and during dying and bereavement. The member signs a statement choosing hospice care instead of routine medical care that has the objective to treat and cure the member's illness. Once the member has elected hospice care, the hospice medical team assumes responsibility for the member's medical care for the terminal illness in the home environment. Hospice care services include nursing care, physician services, medical equipment and supplies, drugs for symptom control and pain relief, home health aide and personal care services, physical, occupational and/or speech therapy, medical social services, dietary counseling and grief and bereavement counseling to the member and/or family. A Hospice plan of care must be developed by the hospice team in conjunction with the member's case manager before hospice services are provided. The hospice services must be related to the palliation or management of the member's terminal illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills. Hospice may be provided to the member in a Nursing Facility (NF) only when the member is placed in the NF for Medically Fragile Facility Based Extended Respite. Hospice provided as part of Facility Based Extended Respite may not be reimbursed for more than five days during any 30 day period. A member that is eligible for Medicare Hospice provided as a Medicare Part A benefit, is not eligible to receive Medically Fragile Hospice services.

(C) Hospice services are billed per diem of service for days covered by a Hospice plan of care and during which the hospice provider is responsible for providing hospice services as needed by the member or member's family.

(14) **Medically Fragile Waiver Personal Care.**

(A) Medically Fragile Personal Care is assistance to a member in carrying out activities of daily living such as bathing, grooming and toileting, or in carrying out instrumental activities of daily living, such as preparing meals and doing laundry, to assure personal health and safety of the individual or to prevent or minimize physical health regression or deterioration. Personal Care services do not include service provision of a technical nature, i.e. tracheal suctioning, bladder catheterization, colostomy irrigation, and operation/maintenance of equipment of a technical nature.

(B) Medically Fragile Home Care Agency Skilled Nursing staff working in coordination with a Case Manager are responsible for development and monitoring of the member's Personal Care plan.

(C) Medically Fragile Personal Care services are prior authorized and billed per 15-minute unit of service with units of service limited to the number of units on the approved plan of care.

(15) **Personal Emergency Response System.**

(A) Personal Emergency Response System (PERS) is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal, in accordance with member preference, a friend, a relative or a response center once a "help" button is activated. The response center is staffed by trained professionals. For an Medically Fragile Program member to be eligible to receive PERS service, the member must meet all of the following service criteria:

(i) a recent history of falls as a result of an existing medical condition that prevents the individual from getting up from a fall unassisted;

(ii) lives alone and has no regular caregiver, paid or unpaid, and therefore is left alone for long periods of time;

(iii) demonstrates capability to comprehend the purpose of and activate the PERS;

(iv) has a health and safety plan detailing the interventions beyond the PERS to assure the member's health and safety in his/her home;

(v) has a disease management plan to implement medical and health interventions that reduce the possibility of falls by managing the member's underlying medical condition causing the falls; and,

(vi) the service avoids premature or unnecessary institutionalization of the member.

(B) PERS services are billed using the appropriate HCPC procedure code for installation, monthly service or purchase of PERS. All services are prior authorized in accordance with the Medically Fragile approved plan of care.

(16) **Prescription drugs.** Members are eligible for a maximum of six prescriptions per month with a limit of three brand name prescriptions. Seven additional generic prescriptions per month are allowed if medically necessary. Medically necessary prescriptions beyond the three brand name or thirteen total prescriptions will be covered with prior authorization. More information on prescription drugs is provided at 317:30-5-72.

(17) **Self-Direction.**

(A) Self-Direction is a method of service delivery that allows waiver members to determine supports and services they need to live successfully in a home or community based setting. A member choosing Self-Direction is the employer of record for his/her Personal Care and Advanced Supportive/Restorative Care service providers and must have an approved plan of care prior to initiation of any Self-Directed activities.

(B) The OHCA uses the following criteria to determine a member's service eligibility to participate in the Self-Directed Services program:

(i) residence in the Self-Directed services approved area;

(ii) member's health and safety with Self-Directed services can reasonably be assured based on a review of service history records and a review of member capacity and readiness to assume employer responsibilities under Self-Direction with any one of the following findings as basis to deny a request for Self-Direction due to inability to assure member health and safety;

(I) the member does not have the ability to make decisions about his/her care or service planning and the member's "authorized representative" is not willing to assume Self-Directed services responsibilities, or

(II) the member is not willing to assume responsibility, or to enlist an "authorized representative" to assume responsibility, in one or more areas of Self-Direction such as in service planning, or in assuming the role of employer of the Personal Services Assistant (PSA) or Advanced

Personal Services Assistant (APSA) service provider, or in monitoring and managing health or in preparation for emergency backup, or

(III) the member has a recent history of self-neglect or self-abuse as evidenced by Adult Protective Services intervention within the past 12 months and does not have an "authorized representative" with capacity to assist with Self-Direction responsibilities;

(C) The member voluntarily makes an informed choice to Self-Direct services. As part of the informed choice, decision making process for Self-Direction, the OHCA staff or the Case Manager provides consultation and assistance as the member completes a self-assessment of preparedness to assume the role of employer for their Personal Services Assistant. The orientation and enrollment process will provide the member with a basic understanding of what will be expected of them under Self-Direction, the supports available to assist them to successfully perform employer responsibilities and an overview of the potential risks involved.

(D) The OHCA uses the following criteria to determine that based upon documentation, a person is no longer allowed to participate in the Self-Directed Services option:

(i) the member does not have the ability to make decisions about his/her care or service planning and the member's "authorized representative" is not willing to assume Self-Direction responsibilities; or

(ii) the member is not willing to assume responsibility, or to enlist an "authorized representative" to assume responsibility, in one or more areas of Self-Direction such as in service planning, or in assuming the role of employer of the PSA or APSA service providers, or in monitoring and managing health or in preparation for emergency backup; or

(iii) the member has a recent history of self-neglect or self-abuse as evidenced by Adult Protective Services intervention and does not have an "authorized representative" with capacity to assist with Self-Direction responsibilities; or

(iv) the member abuses or exploits their employee; or

(v) the member falsifies time-sheets or other work records; or

(vi) the member, even with Case Manager and Financial Management Services assistance, is unable to operate successfully within their Individual Budget Allocation;

or
(vii) inferior quality of services provided by member/employer's employee, or the inability of the member/employer's employee to provide the number of service units the member requires, jeopardizes the member's health and/or safety.

(E) The member may designate a family member or friend as an "authorized representative" to assist in the service planning process and in executing member employer responsibilities. If the member chooses to designate an "authorized representative", the designation and agreement identifying the "willing adult" to assume this role and responsibility is documented with dated signatures of the member, the designee and the member's Case Manager or the OHCA staff.

(i) A person having guardianship or power of attorney or other court sanctioned authorization to make decisions on behalf of the member has legal standing to be the member's designated "authorized representative".

(ii) An individual hired to provide Personal Services Assistance to a member may not be designated the "authorized representative" for the member.

(F) Self-Directed Services are delivered as authorized on the service plan and are limited to Personal Care, Respite and Advanced Supportive/Restorative Care. The member employs the Respite or Personal Services Assistant (PSA) and/or the Advanced Personal Services Assistant (APSA) and is responsible, with assistance from the Administrative Financial Management Services (FMS), for ensuring that the employment complies with State and Federal Labor Law requirements. The member:

(i) recruits, hires and, as necessary, discharges the PSA and APSA;

(ii) provides instruction and training to the PSA or APSA on tasks to be done and works with the Case Manager to obtain skilled nursing services assistance with training when necessary. Prior to performing an Advanced Personal Services Assistance 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 APSA's personnel file;

(iii) determines where and how the PSA or APSA works, hours of work, what is to be accomplished and, within Individual Budget Allocation limits, wages to be paid for the work;

(iv) supervises and documents employee work time; and,
(v) provides tools and materials for work to be accomplished.

(G) Financial Management Services are program administrative services provided to participating Self-Directed Service employer/members by agencies contracted with the OHCA. Financial Management Services are employer related assistance that provides Internal Revenue Service (IRS) fiscal reporting agent and other financial management tasks and functions including, but not limited to:

(i) employer payroll, at a minimum of semi monthly, and associated withholding for taxes, or for other payroll withholdings performed on behalf of the member as employer of the PSA or APSA;
(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 Respite or Personal Services Assistant or Advanced Personal Services Assistant; and

(H) The service of Respite or 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.

(I) 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.

(J) Self-Directed Services rates are determined using the Individual Budget Allocation (IBA) Expenditure Accounts Determination process for each member. The IBA Expenditure Accounts Determination process includes consideration and decisions about the following:

(i) The Individual Budget Allocation (IBA) Expenditure Accounts Determination constrains total SoonerCare reimbursement for Self-Directed services to be less

than expenditures for equivalent services using agency providers.

(ii) The PSA and APSA service unit rates are calculated by the OHCA during the Self-Directed service eligibility determination process. The OHCA sets the PSA and APSA unit rates at a level that is not less than 80 percent and not more than 95 percent of the comparable Agency Personal Care (for PSA) or Advanced Supportive/Restorative (for APSA) service rate. The allocation of portions of the PSA and/or APSA rate to cover salary, mandatory taxes, and optional benefits (including Worker's Compensation insurance, if available) is determined individually for each member using the Self-Directed Services Individualized Budget Allocation Expenditure Accounts Determination Process.

(iii) The IBA Expenditure Accounts Determination process defines the level of program financial resources required to meet the member's need for Self-Directed services. If the member's need for services changes due to a change in health/disability status and/or a change in the level of support available from other sources, the Case Manager, based upon an updated assessment, amends the service plan to increase Self-Directed service units appropriate to meet additional member need. The OHCA, upon favorable review, authorizes the amended plan and updates the member's IBA. Service amendments based on changes in member need for services do not change an existing PSA or APSA rate. The member, with assistance from the FMS, reviews and revises the IBA Expenditure Accounts calculation annually or more often to the extent appropriate and necessary.

(18) **Self-Directed Goods and Services (SD-GS).**

(A) Self-Directed Goods and Services (SD-GS) are incidental, non-routine goods and services that promote the member's self-care, daily living, adaptive functioning, general household activity, meal preparation and leisure skills needed to reside successfully in the community and do not duplicate other services authorized in the member's plan of care.

(B) These goods and services are purchased from the self-directed budget.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
SUBCHAPTER 17. ADVANTAGE WAIVER SERVICES

317:35-17-14. Case Management services

(a) Case management services involve ongoing assessment, service planning and implementation, service monitoring and evaluation, member advocacy, and discharge planning.

(1) Within one working day of receipt of an ADvantage referral from the ADvantage Administration (AA), the case management supervisor assigns a case manager to the member. The case manager makes a home visit to review the ADvantage program (its purpose, philosophy, and the roles and responsibilities of the member, service provider, case manager, and OKDHS in the program), review, update and complete the UCAT assessment, discuss service needs and ADvantage service providers. The Case Manager notifies in writing the member's UCAT identified primary physician that the member has been determined eligible to receive ADvantage services. The notification is via a preprint form that contains the member's signed permission to release this health information and requests physician's office verification of primary and secondary diagnoses and diagnoses code obtained from the UCAT.

(2) Within 14 calendar days of the receipt of an ADvantage referral, the case manager completes and submits to the AA an individualized care plan and service plan for the member, signed by the member and the case management supervisor. The case manager completes and submits to the AA the annual reassessment service plan documents no sooner than 60 days before the existing service plan end date but sufficiently in advance of the end date to be received by the AA at least 30 calendar days before the end date of the existing service plan. Within 14 calendar days of receipt of a Service Plan Review Request (SPR) from the AA, the Case Manager provides corrected care plan and service plan documentation. Within five calendar days of assessed need, the case manager completes and submits a service plan addendum to the AA to amend current services on the care plan and service plan. The care plan and service plan are based on the member's service needs identified by the UCAT, Part III, and includes only those ADvantage services required to sustain and/or promote the health and safety of the member. The case manager uses an interdisciplinary team (IDT) planning approach for care plan and service plan development. Except for extraordinary circumstances, the IDT meetings are to be

held in the member's home. Variances from this policy must be presented to, and approved by, the AA in advance of the meeting. If in-home care is the primary service, the IDT includes, at a minimum, the member, a nurse from the ADvantage in-home care provider chosen by the member, and the case manager. Otherwise, the member and case manager constitute a minimum IDT.

(3) The case manager identifies long-term goals, challenges to meeting goals, and service goals including plan objectives, actions steps and expected outcomes. The ADvantage case manager documents on the care plan the presence of two or more ADvantage members residing in the same household and/or when the member and personal care provider reside together. The case manager documents on the IVRA system in the member record any instance in which a member's health or safety would be "at risk" if even one personal care visit is missed. The case manager identifies services, service provider, funding source, units and frequency of service and service cost, cost by funding source and total cost for ADvantage services. The member signs and indicates review/agreement with the care plan and service plan by indicating acceptance or non-acceptance of the plans. The member, the member's legal guardian or legally authorized representative shall sign the service plan in the presence of the case manager. The signatures of two witnesses are required when the member signs with a mark. If the member refuses to cooperate in development of the service plan, or, if the member refuses to sign the service plan, the case management agency refers the case to the AA for resolution. In addition, based on the UCAT and/or case progress notes that document chronic uncooperative or disruptive behaviors, the OKDHS nurse or AA may identify members that require AA intervention through referral to the AA's Escalated Issues unit.

(A) For members that are uncooperative or disruptive, the case manager develops an individualized plan to overcome challenges to receiving services focusing on behaviors, both favorable and those that jeopardize the member's well-being and includes a design approach of incremental plans and addenda that allow the member to achieve stepwise successes in the modification of their behavior.

(B) The AA may implement a service plan without the member's signature when, for these members, the presence of a document that "requires" their signature may itself trigger a "conflict". In these circumstances, mental health/behavioral issues may prevent the member from controlling their behavior to act in their own interest.

Since the person by virtue of level of care and the IDT assessment, needs ADvantage services to assure their health and safety, the AA may authorize the service plan if the case manager demonstrates effort to work with and obtain the member's agreement. Should negotiations not result in agreement with the care plan and service plan, the member may withdraw their request for services or request a fair hearing.

(4) CD-PASS Planning and Supports Coordination.

(A) The ADvantage Case Management provider assigns to the CD-PASS member a Case Manager that has successfully completed training on CD-PASS, Independent Living Philosophy, Person-Centered Planning and the individual budgeting process and process guidelines. Case Managers that have completed this specialized CD-PASS training are referred to as Consumer-Directed Agent/Case Managers (CDA/CM) with respect to their CD-PASS service planning and support role in working with CD-PASS members. The CDA/CM educates the member about their rights and responsibilities as well as about community resources, service choices and options available to the member to meet CD-PASS service goals and objectives.

(B) The member may designate a family member or friend as an "authorized representative" to assist in the service planning process and in executing member employer responsibilities. If the member chooses to designate an "authorized representative", the designation and agreement identifying the "willing adult" to assume this role and responsibility is documented with dated signatures of the member, the designee and the member's Case Manager or the AA staff.

(i) A person having guardianship or power of attorney or other court sanctioned authorization to make decisions on behalf of the member has legal standing to be the member's designated "authorized representative".

(ii) An individual hired to provide Consumer-Directed Personal Assistance Services and Supports (CD-PASS) services to a member may not be designated the "authorized representative" for the member.

(iii) The case manager reviews the designation of Authorized Representative, Power of Attorney and Legal Guardian status on an annual basis and this is included in the reassessment packet to AA.

(C) The CDA/CM provides support to the member in the Person-Centered CD-PASS Planning process. Principles of Person-Centered Planning are as follows:

(i) The person is the center of all planning

activities.

(ii) The member and their representative, or support team, are given the requisite information to assume a controlling role in the development, implementation and management of the member's services.

(iii) The individual and those who know and care about him or her are the fundamental sources of information and decision-making.

(iv) The individual directs and manages a planning process that identifies his or her strengths, capacities, preferences, desires, goals and support needs.

(v) Person-Centered Planning results in personally-defined outcomes.

(D) The CDA/CM encourages and supports the member, or as applicable their designated "authorized representative", to lead, to the extent feasible, the CD-PASS service planning process for Personal Services Assistance. The CDA/CM helps the member define support needs, service goals and service preferences including access to and use of generic community resources. Consistent with member-direction and preferences, the CDA/CM provides information and helps the member locate and access community resources. Operating within the constraints of the Individual Budget Allocation (IBA) units, the CDA/CM assists the member in translating the assessment of member needs and preferences into an individually tailored, personalized service plan.

(E) To the extent the member prefers, the CDA/CM develops assistance to meet member needs using a combination of traditional Personal Care and CD-PASS PSA services. However, the CD-PASS IBA and the PSA unit authorization will be reduced proportional to agency Personal Care service utilization.

(F) The member determines with the PSA to be hired, a start date for PSA services. The member coordinates with the CDA/CM to finalize the service plan. The start date must be after authorization of services, after completion and approval of the background checks and after completion of the member employee packets.

(G) Based on outcomes of the planning process, the CDA/CM prepares an ADvantage service plan or plan amendment to authorize CD-PASS Personal Service Assistance units consistent with this individual plan and notifies existing duplicative Personal Care service providers of the end date for those services.

(H) If the plan requires an APSA to provide assistance with Health Maintenance activities, the CDA/CM works with the member and, as appropriate, arranges for training by a skilled nurse for the member or member's family and the APSA to ensure that the APSA performs the specific Health Maintenance tasks safely and competently;

(i) If the member's APSA has been providing Advanced Supportive Restorative Assistance to the member for the same tasks in the period immediately prior to being hired as the PSA, additional documentation of competence is not required;

(ii) If the member and APSA attest that the APSA has been performing the specific Health Maintenance tasks to the member's satisfaction on an informal basis as a friend or family member for a minimum of two months in the period immediately prior to being hired as the PSA, and no evidence contra-indicates the attestation of safe and competent performance by the APSA, additional documentation is not required.

(I) The CDA/CM monitors the member's well being and the quality of supports and services and assists the member in revising the PSA services plan as needed. If the member's need for services changes due to a change in health/disability status and/or a change in the level of support available from other sources to meet needs, the CDA/CM, based upon an updated assessment, amends the service plan to modify CD-PASS service units appropriate to meet additional member's need and forwards the plan amendment to the AA for authorization and update of the member's IBA.

(J) In the event of a disagreement between the member and CD-PASS provider the following process is followed:

(i) either party may contact via a toll free number the Member/Provider Relations Resource Center to obtain assistance with issue resolution;

(ii) if the issue cannot be resolved with assistance from the Member/Provider Relations Resource Center or from CD-PASS Program Management, the CD-PASS Program Management will submit the dispute to the ADvantage Escalated Issues Unit for resolution. The Escalated Issues Unit will work with the member and provider to reach a mutually agreed upon resolution;

(iii) if the dispute cannot be resolved by the ADvantage Escalated Issues Unit it will be heard by the Ethics of Care Committee. The Ethics of Care Committee will make a final determination with regard to settlement of the dispute;

(iv) at any step of this dispute resolution process the member may request a fair hearing, to appeal the dispute resolution decision.

(K) The CDA/CM and the member prepare an emergency backup/emergency response capability for CD-PASS PSA services in the event a PSA provider of services essential to the individual's health and welfare fails to deliver services. As part of the planning process, the CDA/CM and member define what failure of service or neglect of service tasks would constitute a risk to health and welfare to trigger implementation of the emergency backup. Any of the following may be used in planning for the backup:

(i) Identification of a qualified substitute provider of PSA services and preparation for their quick response to provide backup services when called upon in emergency circumstances (including execution of all qualifying background checks, training and employment processes); and/or,

(ii) Identification of one or more qualified substitute ADvantage agency service providers (Adult Day Care, Personal Care or Nursing Facility Respite provider) and preparation for their quick response to provide backup services when called upon in emergency circumstances.

(L) If the emergency backup fails, the CDA/CM is to request the AA to authorize and facilitate member access to Adult Day Care, Agency Personal Care or Nursing Facility Respite services.

(5) The case manager submits the care plan and service plan to the case management supervisor for review. The case management supervisor documents the review/approval of the plans within two working days of receipt from the case manager or returns the plans to the case manager with notations of errors, problems, and concerns to be addressed. The case manager re-submits the corrected care plan and service plan to the case management supervisor within two working days. The case management supervisor returns the approved care plan and service plan to the case manager. Within one working day of receiving supervisory approval, the case manager forwards, via postal mail, a legible copy of the care plan and service plan to the AA. Case managers are responsible for retaining all original documents for the member's file at the agency. Only priority service needs and supporting documentation may be faxed to the AA with the word, "PRIORITY" being clearly indicated and the justification attached. "Priority" service needs are defined as services needing immediate authorization to protect the

health and welfare of the member and/or avoid premature admission to the nursing facility. Corrections to service conditions set by the AA are not considered to be a priority unless the health and welfare of the member would otherwise be immediately jeopardized and/or the member would otherwise require premature admission to a nursing facility.

(6) Within one working day of notification of care plan and service plan authorization, the case manager communicates with the service plan providers and with the member to facilitate service plan implementation. Within five working days of notification of an initial service plan or a new reassessment service plan authorization, the case manager visits the member, gives the member a copy of the service plan or computer-generated copy of the service plan and evaluates the progress of the service plan implementation. The case manager evaluates service plan implementation on the following minimum schedule:

(A) within 30 calendar days of the authorized effective date of the service plan or service plan addendum amendment; and

(B) monthly after the initial 30 day follow-up evaluation date.

(b) **Authorization of service plans and amendments to service plans.** The ADvantage Administration (AA) authorizes the individual service plan and all service plan amendments for each ADvantage member. When the AA verifies member ADvantage eligibility, plan cost effectiveness, that service providers are ADvantage authorized and SoonerCare contracted, and that the delivery of ADvantage services are consistent with the member's level of care need, the service plan is authorized.

(1)Except as provided by the process described in OAC 317:30-5-761(6), family members may not receive payment for providing ADvantage waiver services. A family member is defined as an individual who is legally responsible for the member (spouse or parent of a minor child).

(2) The OKDHS/ASD may under criteria described in OAC 317:35-15-13 authorize personal care service provision by an Individual PCA (an individual contracted directly with OHCA). Legally responsible family members are not eligible to serve as Individual PCA's.

(3) If the service plan authorization or amendment request packet received from case management is complete and the service plan is within cost effectiveness guidelines, the AA authorizes or denies authorization within five working days of receipt of the request. If the service plan is not within cost-effectiveness guidelines, the plan is referred for administrative review to develop an alternative cost-

effective plan or assist the member to access services in an alternate setting or program. If the request packet is not complete, the AA notifies the case manager immediately and puts a "hold" on authorization until the required additional documents are received from case management.

(4) The AA authorizes the service plan by entering the authorization date and assigning a control number that internally identifies the OKDHS staff completing the authorization. Notice of authorization and a computer-generated copy of the authorized plan or a computer-generated copy of the authorized plan are provided to case management. AA authorization determinations are provided to case management within one working day of the authorization date. A service plan may be authorized and implemented with specific services temporarily denied. The AA communicates to case management the conditions for approval of temporarily denied services. The case manager submits revisions for denied services to AA for approval within 5 working days.

(5) For audit purposes (including Program Integrity reviews), the computer-generated copy of the authorized service plan is documentation of service authorization for ADvantage waiver and State Plan Personal Care services. State or Federal quality review and audit officials may obtain a copy of specific service plans with original signatures by submitting a request to the member's case manager.

(c) **Change in service plan**. The process for initiating a change in the service plan is described in this subsection.

(1) The service provider initiates the process for an increase or decrease in service to the member's service plan. The requested changes and justification for them are documented by the service provider and, if initiated by a direct care provider, submitted to the member's case manager. If in agreement, the case manager requests the service changes on a care plan and service plan amendment submitted to the AA within five calendar days of assessed need. The AA authorizes or denies the care plan and service plan changes per 317:35-17-14.

(2) The member initiates the process for replacing Personal Care services with Consumer-Directed Personal Services and Supports (CD-PASS) in geographic areas in which CD-PASS services are available. The member may contact the AA or by calling the toll-free number established to process requests for CD-PASS services.

(3) A significant change in the member's physical condition or caregiver support, one that requires additional goals, deletion of goals or goal changes, or requires a four-hour or more adjustment in services per week, requires an updated

UCAT reassessment by the case manager. The case manager develops an amended or new service plan and care plan, as appropriate, and submits the new amended plans for authorization.

(4) One or more of the following changes or service requests require an Interdisciplinary Team review and service plan goals amendment:

(A) the presence of two or more ADvantage members residing in the same household, or

(B) the member and personal care provider residing together, or

(C) a request for a family member to be a paid ADvantage service provider, or

(D) a request for an Individual PCA service provider.

(5) Based on the reassessment and consultation with the AA as needed, the member may, as appropriate, be authorized for a new service plan or be eligible for a different service program. If the member is significantly improved from the previous assessment and does not require ADvantage services, the case manager obtains the member's dated signature indicating voluntary withdrawal for ADvantage program services. If unable to obtain the member's consent for voluntary closure, the case manager requests assistance from the AA. The AA requests that the OKDHS area nurse initiate a reconsideration of level of care.

(6) Providers of Home and Community Based Services (HCBS) for the member, or those who have an interest in or are employed by a provider of HCBS for the member, must not provide case management or develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 22. HEALTH HOMES

317:30-5-250. Purpose

Health Homes for Individuals with Chronic Conditions are created to promote enhanced integration and coordination of primary, acute, behavioral health, and long-term services and supports for persons across the lifespan with chronic illness. The purpose of the Health Home is to improve the health status of SoonerCare members with Serious Mental Illness or Serious Emotional Disturbance by promoting wellness and prevention and to improve access and continuity in health care for these members by supporting coordination and integration of primary care services in specialty behavioral health settings.

317:30-5-251. Eligible providers

(a) **Agency requirements.** Providers of Health Home (HH) services are responsible for providing HH services to qualifying individuals within the provider's specified service area. Qualifying providers must be:

(1) Certified by the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) as a Community Mental Health Center under OAC 450:17; or

(2) Accredited as a provider of outpatient behavioral health services from one of the national accrediting bodies; or

(3) Certified by ODMHSAS as a Mental Illness Service Program pursuant to OAC 450:27; or

(4) Certified by ODMHSAS as a Program of Assertive Community Treatment (PACT) pursuant to OAC 450:55.

(5) In addition to the accreditation/certification requirements in (1) - (4), providers must also have provider specific credentials from ODMHSAS for Health Home Services (OAC 450:17; OAC 450:27; OAC 450:55).

(b) **Health Home team.** Health Homes will utilize an interdisciplinary team of professionals and paraprofessionals to identify an individual's strengths and needs, create a unified plan to empower persons toward self-management and coordinate the individual's varied healthcare needs. HH teams will vary in size depending on the size of the member panel and acuity of members. HH team composition will vary slightly between providers working with adults and children.

(1) Health Homes working with adults with Serious Mental Illness (SMI) will utilize a multidisciplinary team consisting of the following:

(A) Health Home Director;

(B) Nurse Care Manager (RN or LPN);

(C) Consulting Primary Care Practitioner (PCP);

(D) Psychiatric Consultant (317:30-5-11);
(E) Certified Behavioral Health Case Manager (CM)(OAC 450:50; 317:30-5-595);
(F) Wellness Coach/Peer Support Specialist (OAC 450:53; 317:30-5-240.3); and
(G) Administrative support.

(2) In addition to the individuals listed in (1)(A) through (G) above, teams working with adults with SMI (PACT teams only) will also have at least one of the following team members:
(A) Licensed Behavioral Health Professional or Licensure Candidate (317:30-5-240.3);
(B) Substance abuse treatment specialist (Licensed Alcohol and Drug Counselor (LADC) or Certified Alcohol and Drug Counselor (CADC); or
(C) Employment specialist.

(3) Health Homes working with children with Serious Emotional Disturbance (SED) will utilize a multidisciplinary team consisting of the following:
(A) Project Director;
(B) Nurse Care Manager (RN or LPN);
(C) Consulting Primary Care Practitioner (PCP);
(D) Psychiatric Consultant (317:30-5-11);
(E) Care Coordinator (CM II Wraparound Facilitator as defined in 317:30-5-595(2)(C);
(F)Family Support Provider (317:30-5-240.3);
(G) Youth/Peer Support Specialist (OAC 450:53; 317:30-5-240.3);
(H) Children's Health Home Specialist; and
(I) Administrative Support.

317:30-5-252. Covered Services

Health Home services are covered for adults with Serious Mental Illness (SMI) and children with Serious Emotional Disturbance (SED) as set forth in this Section unless specified otherwise, and when provided in accordance with a documented care plan. The care plan must be client directed, integrated, and reflect the input of the team (including the involvement of the consulting primary care physician or APRN in managing the medical component of the plan), as well as others the client chooses to involve. Coverage includes the following services:

(1) **Comprehensive Care Management.**
(A) **Definition.** Comprehensive care management services consist of developing a Comprehensive Care Plan to address needs of the whole person and involves the active participation of the Nurse Care Manager, certified Behavioral Health Case Manager, Primary Care Practitioner, the Health Home clinical support staff with participation of other team members, family and caregivers.
(B) **Service requirements.** Comprehensive care management services include the following, but are not limited to:

(i) Identifying high-risk members and utilizing member information to determine level of participation in care management services;
(ii) Assessing preliminary service needs; participating in comprehensive person-centered service plan development; responsible for member physical health goals, preferences and optimal clinical outcomes;
(iii) Developing treatment guidelines that establish clinical pathways for health teams to follow across risk levels or health conditions;
(iv) Monitoring individual and population health status and service use to determine adherence to or variance from best practice guidelines; and
(v) Developing and disseminating reports that indicate progress toward meeting outcomes for member satisfaction, health status, service delivery and cost.

(C) **Qualified professionals.** Comprehensive care management services are provided by a health care team with participation from the client, family and caregivers, consisting of the following required professionals and paraprofessionals:
(i) Nurse Care Manager (RN or LPN within scope of practice);
(ii) Certified Behavioral Health Case Manager; and
(iii) Primary Care Practitioner.

(2) **Care coordination.**

(A) **Definition.** Care coordination is the implementation of the Comprehensive Care Plan with active member involvement through appropriate linkages, referrals, coordination, and follow-up to needed services and supports.

(B) **Service requirements.** Care coordination services include the following, but are not limited to:
(i) Care coordination for primary health care, specialty health care, and transitional care from emergency departments, hospitals and Psychiatric Residential Treatment Facilities (PRTFs);
(ii) Ensuring integration and compatibility of mental health and physical health activities;
(iii) Providing on-going service coordination and link members to resources;
(iv) Tracking completion of mental and physical health goals in member's Comprehensive Care Plan;
(v) Coordinating with all team members to ensure all objectives of the Comprehensive Care Plan are progressing;
(vi) Appointment scheduling;
(vii) Conducting referrals and follow-up monitoring;
(viii) Participating in hospital discharge processes; and
(ix) Communicating with other providers and members/family.

(C) **Qualified professionals.** Team members are responsible to ensure implementation of the Comprehensive Care Plan, which includes mental health goals, physical health goals, and other life domain goals for achievement of clinical outcomes. Care coordination services are provided by a primary care practitioner-led team which includes the following professionals:

(i) Nurse Care Manager (RN or LPN); and

(ii) Certified Behavioral Health Case Managers.

(3) **Health promotion.**

(A) **Definition.** Health promotion consists of providing health education specific to the member's chronic condition.

(B) **Service requirements.** Health promotion will minimally consist of the following, but is not limited to:

(i) Providing health education specific to member's condition;

(ii) Developing self-management plans with the member;

(iii) Providing support for improving social networks and providing health promoting lifestyle interventions including:

(I) Substance use prevention;

(II) Smoking prevention and cessation;

(III) Obesity reduction and prevention;

(IV) Nutritional counseling; and

(V) Increasing physical activity.

(C) **Qualified professionals.** Health promotion services must be provided by the Primary Care Practitioner, Registered Nurse Care Manager (or LPN within full scope of practice) and the Wellness Coach or Health Home Specialist at the direction of the Health Home Director.

(4) **Comprehensive transitional care.**

(A) **Definition.** Care coordination services for comprehensive transitional care are designed to streamline plans of care, reduce hospital admissions and interrupt patterns of frequent hospital emergency department use.

(B) **Service requirements.** In conducting comprehensive transitional care, the Nurse Care Manager and the case manager will work as co-leads. The duties of the Nurse Care Manager or the case manager include, but are not limited to the following:

(i) Developing contracts or Memorandums of Understanding (MOUs) with regional hospitals or system(s) to ensure a formalized structure for transitional care planning, to include communication of inpatient admissions and discharges of Health Home members;

(ii) Maintaining a mutual awareness and collaboration to identify individuals seeking emergency department services that may benefit from connection with a Health Home site; and

(iii) Motivate hospital staff to notify the Health Home staff of such opportunities.

(5) **Individual and family support services**

(A) **Definition.** Individual and family support services assist individuals in accessing services that will reduce barriers and improve health outcomes, with a primary focus on increasing health literacy, the ability of the member to self- manage their care, and facilitate participation in the ongoing revision of their Comprehensive Care Plan.

(B) **Service requirements.** Individual and family support services include, but are not limited to:

(i) Teaching individuals and families self-advocacy skills;

(ii) Providing peer support groups;

(iii) Modeling and teaching how to access community resources;

(iv) Assisting with obtaining and adhering to medications and other prescribed treatments; and

(v) Identifying resources to support the member in attaining their highest level of health and functioning in their families and in the community, including transportation to medically necessary services.

(C) **Qualified individuals.** Individual and family support service activities must be provided by one of the following:

(i) Wellness Coaches/Recovery support specialist/Children's Health Home specialist; or

(ii) Care coordinators; or

(iii) Family Support Providers.

(6) **Referral to community and social support services**

(A) **Definition.** Provide members with referrals to community and social support services in the community.

(B) **Service requirements**. Providing assistance for members to obtain and maintain eligibility for the following services as applicable, including but not limited to:

(i) Healthcare;

(ii) Disability benefits;

(iii) Housing;

(iv) Transportation;

(v) Personal needs; and

(vi) Legal services.

(C) **Limitations.** For members with Developmental Disabilities, the Health Home will refer to and coordinate with the approved Developmental Disabilities case management entity for these services.

317:30-5-253. Reimbursement

(a) In order to be eligible for payment, HHs must have an approved Provider Agreement on file with OHCA. Through this agreement, the HH assures that OHCA's requirements are met and assures compliance

with all applicable Federal and State regulations. These agreements are renewed annually with each provider.

(b) A Health Home may bill up to three months for outreach and engagement to a member attributed to but not yet enrolled in a Health Home. The reimbursement for outreach and engagement is limited to once per month and is not reimbursable in the same month that the HH receives reimbursement for qualified HH services.

(c) The HH will be reimbursed a monthly care coordination payment upon successful submission of a claim for one or more of the covered services listed in 317:30-5-251.

317:30-5-254. Limitations

(a) Children/families for whom case management services are available through OKDHS/OJA staff are not eligible for concurrent Health Home services.

(b) The following services will not be reimbursed separately for individuals enrolled in a Health Home:

(1) Targeted case management;
(2) Service Plan Development, low complexity;
(3) Medication training and support;
(4) Peer to Peer support (family support);
(5) Medication management and support and coordination linkage when provided within a Program of Assertive Community Treatment (PACT);
(6) Medication reminder;
(7) Medication administration;
(8) Outreach and engagement.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELGIBILITY
SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME
PART 5. COUNTABLE INCOME AND RESOURCES

317:35-5-41.2. Miscellaneous Personal property

(a) **Property used to produce goods and services**. Personal property necessary to perform daily activities or to produce goods for home consumption is excluded if the equity value does not exceed ~~$6000~~$6,000. An equity value in excess of ~~$6000~~$6,000 is a countable resource. The property does not have to produce a 6% annual return. The ~~$6000~~$6,000 equity maximum includes all such resources in total and does not pertain to each item separately. Examples of property used to produce goods and services are tractors, wildcatting tools, mechanized equipment for gardening, livestock grown for home consumption, etc.

(b) **Cash savings and bank accounts.** Money on hand or in a savings account is considered as a countable resource. ~~The member's statement that he/she does not have any money on hand or on deposit is sufficient unless there are indications to the contrary. When there is information to the contrary or when the member does not have records to verify the amount on deposit, verification is obtained from bank records.~~Verification of the member's countable income or resources held in bank accounts or at other financial institutions can be established through an Asset Verification System (AVS). Title 56, O.S., Section 1671 provides that financial records obtained for the purpose of establishing eligibility for assistance or services must be furnished without cost to the member or the Agency.

(1) Checking accounts may or may not represent savings. Current bank statements are evaluated with the member to establish what, if any, portion of the account represents savings. Any income which has been deposited during the current month is not considered unless it exceeds what is considered as ordinary maintenance expense for the month.

(2) Accounts which are owned jointly by the member and a person not receiving SoonerCare are considered available to the member in their entirety unless it can be established what part of the account actually belongs to each of the owners and the money is actually separated and the joint account dissolved. When the member is in a nursing facility and the spouse is in the home or if both are institutionalized, a joint bank account may be maintained with one-half of the account considered available to each.

(c) **Life insurance policies.** If the total face value of all life insurance policies owned by an individual is ~~$1500~~$1,500 or less, the policies (both face value and cash surrender value) are excluded as resources. Verification of the member's countable

income or resources held in bank accounts or at other financial institutions can be established through an AVS.

(1) If the total face value of all policies owned by an individual exceeds ~~$1500~~$1,500, the net cash surrender value of such policies must be counted as resources. Life insurance policies which do not provide a cash surrender value (e.g., term insurance) are not used in determining whether the total face value of all policies is over $1,500.

(2) The face value of a life insurance policy which has been assigned to fund a prepaid burial contract must be evaluated and counted according to the policy on burial funds or, if applicable, the policy on the irrevocable burial contract.

(3) The net cash surrender value of insurance (i.e., cash surrender value less any loans or unpaid interest thereon) usually can be verified by inspection of the insurance policies and documents in the member's possession or by use of the OKDHS Form 08MP061E, Request to Insurance Company.

(4) Dividends which accrue and which remain with the insurance company increase the amount of resource. Dividends which are paid to the member are considered as income if the life insurance policy is not an excluded resource.

(5) If an individual has a life insurance policy which allows death benefits to be received while living, and the individual meets the insurance company's requirements for receiving such proceeds, the individual is not required to file for such proceeds. However, if the individual does file for and receive the benefits, the payment will be considered as income in the month it is received and countable as a resource in the following months to the extent it is available. The payment of such benefits is not considered a conversion of a resource because the cash surrender value of the insurance policy is still available to the individual. The individual is in effect, receiving the death benefits and not the cash surrender value.

(d) **Burial spaces.** The value of burial spaces for an individual, the individual's spouse or any member of the individual's immediate family will be excluded from resources. "Burial spaces" means conventional grave sites, crypts, mausoleums, urns, and other repositories which are customarily and traditionally used for the remains of deceased persons. "Immediate family" means the individual's minor and adult children, including adopted children and step-children; and the individual's brothers, sisters, parents, adoptive parents, and the spouse of these individuals. Neither dependency nor living in the same household will be a factor in determining whether a person is an immediate family member. Verification of the member's countable income or resources held in bank accounts or at other financial institutions can be established through an AVS.

(e) **Burial funds.** Revocable burial funds not in excess of ~~$1500~~$1,500 are excluded as a resource if the funds are specifically set aside for the burial arrangements of the

individual or the individual's spouse. Any amount in excess of ~~$1500~~$1,500 is considered as a resource. Burial policies which require premium payments and do not accumulate cash value are not considered to be prepaid burial policies. Verification of the member's countable income or resources held in bank accounts or at other financial institutions can be established through the AVS.

(1) "Burial funds" means a prepaid funeral contract or burial trust with a funeral home or burial association which is for the individual's or spouse's burial expenses.

(2) The face value of a life insurance policy, when properly assigned by the owner to a funeral home or burial association, may be used for purchasing "burial funds" as described in (1) of this subsection. The $1,500 burial fund exclusion must also be reduced by the face value of a life insurance policy for which a funeral provider has been made the irrevocable beneficiary, if the life insurance policy owner has irrevocably waived his or her right to, and cannot obtain, any cash surrender value the life insurance policy may generate.

(3) The burial fund exclusion must be reduced by the face value of life insurance policies owned by the individual or spouse; and amounts in an irrevocable trust or other irrevocable arrangement.

(4) Interest earned or appreciation on the value of any excluded burial funds is excluded if left to accumulate and become a part of the burial fund.

(5) If the member did not purchase his/her own prepaid burial, even if his/her money was used for the purchase, the member is not the "owner" and the prepaid burial funds cannot be considered a resource to him/her. However, if the member's money was used by another to purchase the prepaid burial, the rules on transfer of property must be applied since the purchaser (owner) could withdraw the funds any time.

(f) **Irrevocable burial contract.** Oklahoma law provides that a purchaser (buyer) of a prepaid funeral contract may elect to make the contract irrevocable. The irrevocability cannot become effective until 30 days after purchase. For an irrevocable contract to be valid, the election to make it irrevocable must be made by the purchaser (owner) or the purchaser's guardian or an individual with power of attorney for the purchaser (owner). In instances where the OKDHS Form 08MA084E, Management of Recipient's Funds, is on file in the nursing facility, the form serves as a power of attorney for the administrator to purchase and/or elect to make irrevocable the burial funds for the member. Verification of the member's countable income or resources held in bank accounts or at other financial institutions can be established through an AVS.

(1) ~~If the irrevocable election was made prior to July 1, 1986, and the member received assistance on July 1, 1986, the full amount of the~~The irrevocable contract ~~is not~~shall not be considered a countable resource. ~~This exclusion applies only if the member does not add to the amount of the contract. Interest~~

~~accrued on the contract is not considered as added by the member. Any break in assistance will require that the contract be evaluated at the time of reapplication according to rules in (2) of this subsection.~~

(2) ~~If the effective date for the irrevocable election or application for assistance is July 1, 1986, or later:~~ Effective October 1, 2015, the cash value of any life insurance policies and/or designated accounts shall be excluded as a resource up to a maximum of $1,500. This exclusion shall be reduced dollar for dollar by the face value amount of any irrevocable prepaid burial contract.

~~(A) the face value amount of an irrevocable burial contract cannot exceed $6,000 plus accrued interest through August 4, 1998.~~

~~(B) the face value amount of an irrevocable burial contract cannot exceed $7,500 plus accrued interest for the period August 5, 1998, through October 31, 2009.~~

~~(C) after November 1, 2009, state statute excludes the face value of an irrevocable burial contract, up to $10,000. This exclusion includes any combination of irrevocable contract, revocable prepaid account, designated account or cash value in life insurance policies not used to fund the burial policy, regardless of the face value, provided the cash value in policies and designated accounts does not exceed $1500. When the amount exceeds $10,000, the member is ineligible for assistance.Accrued interest is not counted as a part of the $10,000 limit regardless of when it is accrued.~~

~~(D) the face value of life insurance policies used to fund burial contracts is counted towards the $10,000 limit.~~

(g) **Medical insurance.** If a member is covered by insurance other than SoonerCare, then SoonerCare is the payer of last resort and should not be ~~bill~~billed until all other payers have paid. If payment is made directly to the member, the member must reimburse OHCA up to the amount paid by SoonerCare. Any amount remaining after payment to OHCA is considered as an available resource.

317:35-5-41.3. Automobiles, pickups, and trucks

Automobiles, pickups, and trucks are considered in the eligibility determination for SoonerCare benefits. Verification of the member's countable resources held in bank accounts or at other financial institutions can be established through an AVS.

(1) **Exempt automobiles.** One automobile is excluded from counting as a resource~~ to the extent its current market value (CMV) does not exceed $4,500. The CMV in excess of $4,500 is counted against the resource limit; or exempt one automobile, pickup or truck per family regardless of the value if it is verified that the car is used:~~

~~(A) for medical services 4 times a year to obtain either medical treatment or prescription drugs; or~~

~~(B) for employment purposes; or~~

~~(C) especially equipped for operation by or transportation of a handicapped person~~.

(2) **Other automobiles.** The equity in other automobiles, pickups, and trucks is considered as a countable resource. The current market value, less encumbrances on the vehicle, is the equity. Only encumbrances that can be verified are considered in computing equity.

(A) The market value of each year's make and model is established on the basis of the "Avg. Trade In" value as shown in the current publication of the National Automobile Dealers Association (NADA) on "Cars, Trucks, and Imports".

(B) If a vehicle's listing has been discontinued in the NADA book, the household's estimate of the value of the vehicle is accepted unless the worker has reason to believe the estimate is incorrect.

(C) The market value of a vehicle no longer operable is the verified salvage value.

(D) In the event the member and worker cannot agree on the value of the vehicle, the member secures written appraisal by two persons who are familiar with current values. If there is substantial unexplained divergence between these appraisals or between the book value and one or more of these appraisals, the worker and the member jointly arrange for the market value to be established by an appraisal made by a third person who is familiar with current values and who is acceptable to both the member and the worker.

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. Verification of the member's countable income or resources held in bank accounts or at other financial institutions can be established through an AVS.

(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 x 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~~The value of Supplemental Nutrition Assistance Program (food stamps) received;

(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 judgment funds or funds held in trust) distributed by the Secretary of the Interior (BIA) or distributed by the tribe subject to approval by the Secretary of the Interior. Also, any interest or investment income accrued on such funds while held in trust or any purchases made with judgment funds, trust funds, interest or investment income accrued on such funds. Any income from mineral leases, from tribal

business investments, etc. However, any interest or income derived from the principal or produced by purchases made with 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) 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;
(24) Payments made to individuals because of their status as victims of Nazi persecution (PL 103-286);
(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;
(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;
(27) Payments made to certain Vietnam veterans' children with spina bifida (PL 104-204);
(28) Payments made to certain Korea service veterans' children with spina bifida (PL 108-183);
(29) Payments made to the children of women Vietnam veterans who suffer from certain birth defects (PL 106-419);
(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~~
(31) Wages paid by the Census Bureau for temporary employment related to Census activities~~.~~;
(32) Income tax refunds;
(33) Home energy assistance;
(34) Food or shelter based on need provided by nonprofit agencies;
(35) Money someone else spends to pay your expenses for items other than food or shelter (e.g., someone pays for your telephone or medical bills);
(36) Earnings up to $1,750 per month to a maximum of $7,060 per year (effective January 2014) for a student under age 22;
(37) The cost of impairment-related work expenses for items or services that a disabled person needs in order to work; and
(38) The first $2,000 of compensation received per calendar year for participating in certain clinical trials;

(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. When the difference between the gross and net income represents a production or severance tax (e.g., most oil royalties are reduced by this tax), the OHCA only uses the net figure when determining income eligibility. The production or severance tax is the cost of producing the income, and, therefore, is deducted from the gross income. 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~~months' 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~~rental property is treated as unearned income.

(iii) When ~~property rental~~rental property 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) Work study received by an individual who is attending school is considered as earned income with appropriate earned income disregards applied.

(ii) Money from the sale of whole blood or blood plasma is considered as self-employment income subject to necessary business ~~expense~~expenses and appropriate earned income disregards.

(iii) 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)).

(iv) 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**~~**Infrequent 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.~~

(i) Income is considered to be infrequent if the individual receives it only once during a calendar quarter from a single source and the individual did not receive that type of income in the month preceding or following the month the income was received.

(ii) Income is considered to be irregular if the individual cannot reasonably expect to receive it.

(iii) OHCA excludes the following amount of infrequent or irregular income:

(I) the first $30 per calendar quarter of earned income; and

(II) the first $60 per calendar quarter of unearned income.

(iv) Infrequent or irregular income, whether earned or unearned, that exceeds these amounts is considered countable income in the month it is received.

(G) **Monthly income received in fluctuating amounts.** Income which is received monthly but in irregular amounts is averaged using two ~~month's~~months' income, if possible, to determine income eligibility. Less than two ~~month's~~months' 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 or unearned income.** The general income exclusion of $20 per month is allowed for earned or unearned income, unless the unearned income is SSP, on the combined ~~earned~~ income of the eligible individual and eligible or ineligible spouse. See paragraph ~~(6)~~(5) of this subsection if there are ineligible minor children. After the $20 exclusion, deduct $65 and one-half of the remaining combined earned income. The total gross amount of unearned income of the eligible individual and eligible or ineligible spouse is considered.

~~(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)~~(2) **Countable income.** The countable income is the sum of the earned income ~~after exclusions~~ and the total gross unearned income after exclusions.

~~(4)~~(3) **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~~An intellectually disabled 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)~~(4) **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)~~(5) **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)~~(6) **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.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 40. DEVELOPMENTAL DISABILITIES SERVICES
SUBCHAPTER 1. GENERAL PROVISIONS

317:40-1-1. Home and Community-Based Services (HCBS) Waivers for persons with intellectual disabilities or certain persons with related conditions

(a) **Applicability.** The rules in this Section apply to services funded through Medicaid HCBS Waivers per ~~OAC~~Oklahoma Administrative Code (OAC) 317:35-9-5 and ~~as defined in~~per Section 1915(c) of the Social Security Act. 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 provisions.** Each individual requesting services provided through ~~a~~an HCBS Waiver 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 and institutional care~~.~~; and

(4) reporting to DHS within 30 calendar days of moving any changes in address or other contact information.

(c) **Waiver Eligibility.** 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~~ an HCBS Waiver are available to Oklahoma residents meeting SoonerCare eligibility requirements established by law, regulatory authority, and policy within funding available through State or Federal resources. To be eligible for and receive services funded through any of the Waivers listed in ~~subsection~~ (a) of this Section, a person must meet conditions per OAC 317:35-9-5. The individual must be determined financially eligible for SoonerCare per OAC 317:35-9-68. The SoonerCare eligible individual may not simultaneously be enrolled in any other Medicaid Waiver program or receiving services in an institution including a hospital, rehabilitation facility, mental health facility, nursing facility, residential care facility ~~as described in~~ per Section 1-819 of Title 63 of Oklahoma Statutes, or Intermediate Care facility for ~~persons~~

~~with mental retardation (ICF/MR)~~individuals with intellectual disabilities (ICF/IID). The individual may not be receiving ~~DDSD~~Developmental Disabilities Services (DDS) state-funded services, such as the Family Support Assistance Payment, Respite Voucher Program, sheltered workshop services, community integrated employment services, or assisted living without waiver 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 ~~given~~listed in ~~subsection~~ (c) of this Section; and

(ii) be determined to have a disability and a diagnosis of intellectual disability by the Social Security Administration (SSA); or

(iii) be determined to have a disability, and a diagnosis of intellectual disability as defined in the Diagnostic and Statistical Manual of Mental Disorders by the OHCA Level of Care Evaluation Unit (LOCEU);

(iv) be three years of age or older;

(v) be determined by the OHCA/LOCEU to meet the ~~ICF/MR~~ ICF/IID Institutional Level of Care requirements per OAC 317:30-5-122;

(vi) reside in:

(I) the home of a family member or friend;

(II) his or her own home;

(III) ~~an OKDHS Children and Family Services Division (CFSD)~~a DHS Child Welfare Service (CWS) foster home; or

(IV) a ~~CFSD~~CWS group home; and

(vii) have critical support needs that can be met through a combination of non-paid, non-Waiver, and SoonerCare resources available to the individual, and with HCBS Waiver resources ~~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~~listed in ~~subsection~~ (c) of this Section;

(ii) be determined to have a disability and a diagnosis of intellectual disability by the SSA; or

(iii) have an intellectual disability as defined in the Diagnostic and Statistical Manual of Mental Disorders

or a related condition by ~~the DDSD~~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

(iv) be determined to have a disability and a diagnosis of intellectual disability as defined in the Diagnostic and Statistical Manual of Mental Disorders or the OHCA/LOCEU; and

(v) be three years of age or older; and

(vi) be determined by the OHCA/LOCEU, to meet the ~~ICF/MR~~ICF/IID Institutional Level of Care requirements per OAC 317:30-5-122; and

(vii) have critical support needs that can be met by the Community Waiver and cannot be met by IHSW services or other service alternatives, as determined by the ~~DDSD Division Director~~DDS director or designee.

(C) **Homeward Bound Waiver.** To be eligible for services funded through the Homeward Bound Waiver, the person must:

(i) be certified by the United States District Court for the Northern District of Oklahoma as a member of the plaintiff class in *Homeward Bound et al. v. The Hissom Memorial Center*, Case No. 85-C-437-E;

(ii) meet all criteria for HCBS Waiver services ~~given~~ listed in ~~subsection~~ (c) of this Section; and

(iii) be determined to have a disability and a diagnosis of intellectual disability by SSA; or

(iv) have an intellectual disability as defined in the Diagnostic and Statistical Manual of Mental Disorders or a related condition per OAC 317:35-9-45 by ~~DDSD~~ DDS and to be covered under the State's alternative disposition plan adopted under Section 1919(e)(7)(E) of the Social Security Act; or

(v) have a disability as defined in the Diagnostic and Statistical Manual of Mental Disorders by the OHCA/LOCEU; and

(vi) meet ~~the ICF/MR~~ICF/IID Institutional Level of Care requirements per OAC 317:30-5-122 by the OHCA/LOCEU.

(2) The person desiring services through any of the Waivers listed in ~~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 12 months of requested approval date,~~ psychologist 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.

(I)Intelligence testing results obtained at 16 years of age or older are considered valid of the current status, provided they are compatible with current behavior. Intelligence testing results obtained between 7 to 16 years of age are considered current for four years when the full scale intelligence quotient is less than 40, and for two years when the intelligence quotient is 40 or above.

(II) DDS may require a current psychological evaluation when a significant change of condition, disability, or psychological status is noted;

(B) a social service summary, current within 12 months of requested approval date, that includes a developmental history; and

(C) a medical evaluation current within 90 calendar days of requested approval date; and

(D) a completed ~~ICF/MR~~ICF/IID Level of Care Assessment form (LTC-300); and

(E) proof of disability according to SSA guidelines. If a disability determination ~~had~~has not been made by SSA, ~~the~~ OHCA/LOCEU may make a disability determination using the same guidelines as SSA.

(3) ~~The~~ OHCA reviews the diagnostic reports listed in ~~paragraph~~ (2) of this subsection and makes a determination of eligibility for ~~DDSD~~DDS HCBS Waivers.

(4) For individuals who are determined to have an intellectual disability or a related condition by ~~DDSD~~ DDS in accordance with the State's alternative disposition plan adopted under Section 1919(e)(7)(E) of the Social Security Act, ~~DDSD~~DDS reviews the diagnostic reports listed in ~~paragraph~~ (2) of this subsection and, on behalf of the OHCA, makes a determination of eligibility for ~~DDSD~~ DDS HCBS Waiver services and ~~ICF/MR~~ICF/IID level of care.

(5) A determination of need for ~~ICF/MR~~ICF/IID Institutional Level of Care does not limit the opportunities of the person receiving services to participate in community services. Individuals are assured of the opportunity to exercise informed choice in the selection of services.

(d) **Request list.** When ~~State DDSD~~state DDS resources are unavailable for new persons to be added to services funded through ~~a~~an HCBS Waiver, persons are placed on a statewide Request for Waiver Services List.

(1) The Request for Waiver Services List is maintained in chronological order, based on the date of receipt of a

written request for services on Form 06MP001E, Request for Developmental Disabilities Services. The applicant must submit the required documentation per Form 06MP001E, Request for Developmental Disabilities Services for initial consideration of potential eligibility.

(2) The Request for Waiver Services List for persons requesting services provided through ~~a~~an HCBS Waiver is administered by ~~DDSD~~DDS uniformly throughout the state.

(3) An individual is removed from the Request for Waiver Services List ~~if~~when the individual:

(A) is found to be ineligible for services;

(B) cannot be located by ~~OKDHS~~DHS;

(C) fails to respond or does not provide ~~required~~ requested information to ~~OKDHS~~DHS;

(D) is not a resident of the state of Oklahoma at the time of requested Waiver approval date; or

(E) declines an offer of Waiver services

(4) An individual removed from the Request for Waiver Services List due to the inability to locate the individual by DHS, may later submit to DDS a written request to be returned to the Request for Waiver Services List. The individual will be returned at the same chronological place on the Request for Waiver Services List that the individual had prior to removal, provided that the individual was on the list prior to January 1, 2015.

(e) **Applications.** When resources are sufficient for initiation of HCBS Waiver services, ~~DDSD~~DDS ensures action regarding a request for services occurs within 45 calendar days. ~~If~~When action is not taken within the required 45 calendar days, the applicant may seek resolution ~~as described in~~ per OAC 340:2-5.

(1) Applicants are allowed 60 calendar days to provide information requested by ~~DDSD~~ DDS to determine eligibility for services.

(2) ~~If~~When requested information is not provided within 60 calendar days, the applicant is notified that the request ~~has been~~was denied, and the individual is removed from the Request for Waiver Services List.

(f) **Admission protocol.** Initiation of services funded through ~~a~~ an HCBS Waiver occurs in chronological order from the Request for Waiver Services List in accordance with ~~subsection~~ (d) of this Section based on the date of ~~DDSD~~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~~ the individual acting on the member's behalf, and upon determination of eligibility, in accordance with ~~subsection~~ (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~~DHS 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~~an HCBS Waiver;

(3) Waiver services are required for people who transition to the community from a public or ~~ICF/MR~~ICF/IID who are children in the State's custody receiving services from ~~OKDHS~~ DHS. Under some circumstances Waiver services related to accessibility may be authorized in advance of transition, but may not be billed until the day the member leaves the ~~ICF/MR~~ ICF/IID and enters the Waiver;

(4) individuals subject to the provisions of Public Law 100-203 residing in nursing facilities for at least 30 continuous 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 an intellectual disability or a related condition, who are covered under the State's alternative disposition plan adopted under Section 1919(e)(7)(E) of the Social Security Act, choose to receive services funded through the Community or Homeward Bound Waiver.

(g) **Movement between ~~DDSD~~ DDS HCBS Waiver programs.** A person's movement from services funded through one DDS-administered HCBS Waiver, to services funded through another ~~DDSD-administered~~ DDS-administered HCBS Waiver is explained in this subsection.

(1) When a member receiving services funded through the IHSW for children becomes 18 years of age, services through the IHSW for adults become effective.

(2) Change to services funded through the Community Waiver from services funded through the IHSW occurs only when:

(A) a member has critical health and safety support needs that cannot be met by IHSW services, non-Waiver services, or other resources as determined by the ~~DDSD Director~~ DDS director or designee; and

(B) funding is available per OAC 317:35-9-5.~~.~~

(3) Change to services funded through the IHSW from services funded through the Community Waiver may only occur when a member's history of annual service utilization has been 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.

(h) **Continued eligibility for HCBS Waiver services.** Eligibility for members receiving services provided through the HCBS Waiver is re-determined by the OHCA/LOCEU when a determination of disability has not been made by the Social Security Administration. The OHCA/LOCEU determines categorical relationship to the SoonerCare disabled category according to Social Security Administration guidelines. OHCA/LOCEU also approves level of care per OAC 317:30-5-122 and confirms a diagnosis of intellectual disability as defined in the Diagnostic and Statistical Manual of Mental Disorders. ~~DDSD~~ DDS may require a new ~~diagnostic~~psychological evaluation ~~in accordance with paragraph (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 (c)(2) of this Section~~ has been noted.

(i) **HCBS Waiver services case closure.** Services provided through ~~a~~ an HCBS Waiver are terminated, when:

(1) ~~when~~ a member or ~~the member's legal guardian~~ the

individual acting on the member's behalf 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~~ ICF/IID, residential care facility, hospital, rehabilitation facility, or mental health facility for more than 30 consecutive calendar 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~~per 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~~DHS policy or service delivery in a manner that places the health or welfare of the member at risk, after efforts to remedy the situation through Adult Protective Services or Child Protective Services have 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~~the individual acting on the member's behalf has engaged in fraud or misrepresentation, failed to use resources as agreed on in the Individual Plan, or knowingly misused public funds associated with these services;

(12) ~~when~~ the member or ~~his/her legal representative~~the individual acting on the member's behalf 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~~the individual acting on the member's behalf:

(A) does not respond to the notice of intent to terminate; or

(B) the response prohibits ~~case management (the case manager)~~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~~the individual acting on the member's behalf fails to cooperate with the case manager to implement a Fair Hearing decision;
(14) ~~when~~ it is determined that services provided through ~~a~~an HCBS Waiver 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~~the individual acting on the member's behalf fails to cooperate with service delivery;
(16) ~~when~~ a family member, ~~authorized representative~~the individual acting on the member's behalf, other individual in the member's household, or persons who routinely visit, pose a threat of harm or injury to provider staff or official DHS representatives ~~of OKDHS~~; or
(17) ~~when~~ a member no longer receives a minimum of one Waiver service per month and ~~DDSD~~DDS is unable to monitor member on a monthly basis.

(j) **Reinstatement of services.** Waiver services are reinstated when:
(1) the situation resulting in case closure of a Hissom class member is resolved;
(2) a member is incarcerated for 90 calendar days or less;
(3) a member is admitted to a nursing facility, ~~ICF/MR~~ ICF/IID, residential care facility, hospital, rehabilitation facility, or mental health facility for 90 calendar days or less; or
(4) a member's SoonerCare eligibility is re-established within 90 calendar days of the date of SoonerCare ineligibility.

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

317:30-5-241.2. Psychotherapy

(a) **Psychotherapy.**

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

(2) **Interactive Complexity.** Psychotherapy is considered to involve "interactive complexity" when there are communication factors during a visit that complicate delivery of the psychotherapy by the ~~LBHP~~qualified practitioner. Sessions typically involve members who have other individuals legally responsible for their care (i.e. minors or adults with guardians); members who request others to be involved in their care during the session (i.e. adults accompanied by one or more participating family members or interpreter or language translator); or members that require involvement of other third parties (i.e. child welfare, juvenile justice, parole/probation officers, schools, etc.). Psychotherapy should only be reported as involving interactive complexity when at least one of the following communication factors is present:

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

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

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

sentinel event and/or report with patient and other visit participants.

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

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

(4) **Limitations.** A maximum of 6 units per day per member is compensable. Except for psychotherapy involving interactive complexity as described in this Section, only the member and the ~~Licensed Behavioral Health Professional (LBHP)~~qualified practitioner should be present during the session. Psychotherapy for a child younger than three must be medically necessary and meet established Child (0-36 months of Age) criteria as set forth in the Prior Authorization Manual.

(b) **Group Psychotherapy.**

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

(2) **Group sizes.** Group Psychotherapy is limited to a total of eight adult (18 and over) individuals except when the individuals are residents of an ICF/IID 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~~practitioners.** Group psychotherapy will be provided by an LBHP or Licensure Candidate. Group Psychotherapy must take place in a confidential setting limited to the ~~LBHP~~qualified practitioner, 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. Group Psychotherapy is not reimbursable for a child younger than three.~~ must be medically necessary and meet established Child (0-36 months of Age) criteria as set forth in the Prior Authorization Manual.~~

(c) **Family Psychotherapy.**

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

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

(3) **Limitations.** A maximum of 12 units per day per member/family unit is compensable. The ~~provider~~practitioner may not bill any time associated with note taking and/or medical record upkeep. The ~~provider~~practitioner may only bill the time spent in direct face-to-face contact. ~~Provider~~Practitioner must comply with documentation requirements listed in OAC 317:30-5-248.

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

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

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

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

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

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

(1) **Definition.** Partial hospitalization services are services that (1) Are reasonable and necessary for the diagnosis or

active treatment of the member's condition; (2) Are reasonably expected to improve the member's condition and functional level and to prevent relapse or hospitalization and (3) Include the following:

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

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

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

(D) Drugs and biologicals furnished for therapeutic purposes.

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

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

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

(2) **Qualified ~~professionals~~practitioners**.

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

(i) A licensed physician;

(ii) Registered nurse; and

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

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

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

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

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

(5) **Service requirements.**

(A) Therapeutic Services are to include the following:

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

(ii) Crisis management services available 24 hours a day, 7 days a week;

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

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

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

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

(C) Interchangeable services which include the following:

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

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

(iii) Medication Training and Support; and

(iv) Expressive therapy.

(6) **Documentation requirements.** Documentation needs to specify active involvement of the member's family, caretakers, or significant others involved in the individual's treatment. A nursing health assessment must be completed within 24 hours of admission. A physical examination and medical history must be coordinated with the Primary Care Physician. Service plan updates are required every three (3) months or more frequently based on clinical need. Records must be documented according to Section OAC 317:30-5-248.

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

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

(B) Medical director must be a licensed psychiatrist.

(C) A psychiatrist/physician must be available 24 hours a day, 7 days a week.

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

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

(2) **Qualified ~~professionals~~practitioners.** 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) or Licensure Candidate, a case manager, or other certified Behavioral Health/Substance Abuse paraprofessional staff. Services are directed by an LBHP or Licensure Candidate.

(3) **Qualified providers.** Provider agencies for Day Treatment must be accredited to provide Day Treatment services by one of the national accrediting bodies; The Joint Commission (TJC), Commission on Accreditation of Rehabilitation Facilities (CARF) 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. Behavioral Health Rehabilitation Group size is limited to a maximum of 8 individuals as clinically appropriate given diagnostic and developmental functioning. Children under age 6 are not eligible for behavioral health rehabilitation services, unless a prior authorization for children ages 4 and 5 has been granted by OHCA or its designated agent based on a finding of medical necessity.

(5) **Service requirements.** On-call crisis intervention services must be available 24 hours a day, 7 days a week

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

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

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

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

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

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

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

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

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

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

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

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

317:30-5-241.3. Behavioral Health Rehabilitation (BHR) services

(a) **Definition**. Behavioral Health Rehabilitation (BHR) services are goal oriented outpatient interventions that target the maximum reduction of mental and/or behavioral health impairments and strive to restore the members to their best possible mental and/or behavioral health functioning. BHR services must be coordinated in a manner that is in the best interest of the member and may be provided in a variety of community and/or professional settings that protect and assure confidentiality. For purposes of this Section, BHR includes Psychosocial Rehabilitation, Outpatient Substance Abuse Rehabilitation, and Medication Training and Support.

(b) **Psychosocial Rehabilitation (PSR).**

(1) **Definition.** PSR services are face-to-face Behavioral

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

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

(3) **Qualified ~~providers~~practitioners**. A Certified Behavioral Health Case Manager II (CM II), CADC, ~~and~~ LBHP, or Licensure Candidate may perform PSR, following development of a service plan and treatment curriculum approved by an LBHP or Licensure Candidate. The CM II and CADC must have immediate access to a ~~fully licensed~~ LBHP who can provide clinical oversight and collaborate with the qualified PSR provider in the provision of services. A minimum of one monthly face-to-face consultation with a ~~fully licensed~~ LBHP is required for PSR providers ~~regularly rendering services in an agency setting~~. ~~A~~In addition, a minimum of one face-to-face consultation per week with a ~~fully licensed~~LBHP or Licensure Candidate is required for PSR providers regularly rendering services away from the outpatient behavioral health agency site.

(4) **Group sizes**. The maximum staffing ratio is fourteen members for each qualified provider for adults and eight to one for children under the age of eighteen.

(5) **Limitations.**

(A) **Transportation**. Travel time to and from PSR treatment is not compensable. Group PSR services do not qualify for the OHCA transportation program, but OHCA will arrange for transportation for those who require specialized transportation equipment.

(B) **Time**. Breaks, lunchtime and times when the member is unable or unwilling to participate are not compensable and must be deducted from the overall billed time.

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

(D) **Eligibility for PSR services.** ~~PSR services are intended for adults with Serious Mental Illness (SMI), children with Serious Emotional Disturbance (SED), and children with other emotional or behavioral disorders. The following members are not eligible for PSR services:~~All PSR services require prior authorization and must meet established medical necessity criteria.

(i)**Adults.** PSR services for adults are limited to members who have a history of psychiatric hospitalization or admissions to crisis centers, have been determined disabled by the SSA for mental health reasons, are residing in residential care facilities or are receiving services through a specialty court program.

(ii) **Children.** PSR services for children are limited to members who have a history of psychiatric hospitalization or admissions to crisis centers; have been determined disabled by the SSA for mental health reasons; have a current Individual Education Plan (IEP) or 504 Plan for emotional disturbance; or have been evaluated by a school psychologist, licensed psychologist or psychiatrist and determined to be "at risk" as outlined in the Prior Authorization Manual.

(iii) The following members are not eligible for PSR services:

~~(i)~~(I) Residents of ICF/IID facilities, unless authorized by OHCA or its designated agent;

~~(ii)~~(II) children under age 6, unless a prior authorization for children ages 4 and 5 has been granted by OHCA or its designated agent based on the criteria in (5)(D)(ii) above as well as a finding of medical necessity;

~~(iii)~~(III) children receiving RBMS in a group home or therapeutic foster home, unless authorized by OHCA or its designated agent;

~~(iv)~~(IV) inmates of public institutions;

~~(v)~~(V) members residing in inpatient hospitals or IMDs; and

~~(vi)~~(VI) members residing in nursing facilities.

(E) **Billing limits.** PSR services are time-limited services designed to be provided over the briefest and most effective period possible and as adjunct (enhancing) interventions to compliment more intensive behavioral health therapies. Service limits are based on the member's needs according to the CAR or other approved tool, the requested placement based on the level of functioning rating, medical necessity, and best practice. Service limitations are designed to help prevent rehabilitation diminishing return by remaining within reasonable age and developmentally appropriate daily limits. PSR services authorized under this Section are separate and distinct from, but should not duplicate the structured services required for children residing in group home or therapeutic foster care settings, or receiving services in Day Treatment or Partial Hospitalization Programs. Children under an ODMHSAS Systems of Care program and adults residing in residential care facilities may be prior authorized additional units as part of an intensive transition period. PSR is billed in unit increments of 15 minutes with the following limits:

(i) **Group PSR.** The maximum is 24 units per day for adults and 16 units per day for children.

(ii) **Individual PSR.** The maximum is six units per day.

(iii) **Per-Member service levels and limits.** Unless otherwise specified, group and/or individual PSR services provided in combination may not exceed the monthly limits established in the individual's prior authorization. Limits on PSR services are established based on the level for which the member has been approved.

(iv) **EPSDT.** Pursuant to OAC 317:30-3-65 et seq., billing limits may be exceeded or may not apply if documentation demonstrates that the requested services are medically necessary and are needed to correct or ameliorate defects, physical or behavioral illnesses or conditions discovered through a screening tool approved by OHCA or its designated agent. The OHCA has produced forms for documenting an EPSDT child health checkup screening which the provider can access on the OHCA website.

(F) **Progress Notes.** In accordance with OAC 317:30-5-241.1, the behavioral health service plan developed by the LBHP or Licensure Candidate must include the member's strengths, functional assets, weaknesses or liabilities, treatment goals, objectives and methodologies that are specific and time-limited, and defines the services to be

performed by the practitioners and others who comprise the treatment team. When PSR services are prescribed, the plan must address objectives that are specific, attainable, realistic, and time-limited. The plan must include the appropriate treatment coordination to achieve the maximum reduction of the mental and/or behavioral health disability and to restore the member to their best possible functional level. Progress notes for PSR day programs ~~may be in the form of daily summary or weekly summary notes.~~must be documented in accordance with the requirements found in 317:30-5-248(5). Progress notes for all other Behavioral Health Rehabilitation services must ~~include the following:~~be documented in accordance with the requirements found in 317:30-5-248(3).

~~(i) Curriculum sessions attended each day and/or dates attending during the week;~~
~~(ii) Start and stop times for each day attended and the physical location in which the service was rendered;~~
~~(iii) Specific goal(s) and objectives addressed during the week;~~
~~(iv) Type of Skills Training provided each day and/or during the week including the specific curriculum used with member;~~
~~(v) Member satisfaction with staff intervention(s);~~
~~(vi) Progress, or barrier to, made towards goals, objectives;~~
~~(vii) New goal(s) or objective(s) identified;~~
~~(viii) Signature of the lead qualified provider; and~~
~~(ix) Credentials of the lead qualified provider;~~

(G) **Additional documentation requirements.**

(i) a list/log/sign in sheet of participants for each Group rehabilitative session and facilitating qualified provider must be maintained; and
(ii) Documentation of ongoing consultation and/or collaboration with an LBHP or Licensure Candidate related to the provision of PSR services.

(H) **Non-Covered Services.** The following services are not considered BHR and are not reimbursable:

(i) Room and board;
(ii) educational costs;
(iii) supported employment; and
(iv) respite.

(c) **Outpatient Substance Abuse Rehabilitation Services.**

(1) **Definition.** Covered outpatient substance abuse rehabilitation services are provided in non-residential settings in regularly scheduled sessions intended for

individuals not requiring a more intensive level of care or those who require continuing services following more intensive treatment regimes. The purpose of substance abuse rehabilitation services is to begin, maintain, and/or enhance recovery from alcoholism, problem drinking, drug abuse, drug dependency addiction or nicotine use and addiction. Rehabilitation services may be provided individually or in group sessions, and they take the format of curriculum based education and skills training.

(2) **Limitations.** Group sessions may not be provided in the home.

(3) **Eligibility.** Members eligible for substance abuse rehabilitation services must meet the criteria for ASAM PCC Treatment Level 1, Outpatient Treatment.

(4) **Qualified ~~providers~~practitioners.** CM II, CADC~~ or~~, LBHP or Licensure Candidate.

(5) **Billing limits.** Group rehabilitation is limited to two (2) hours per session. Group and/or individual outpatient substance abuse rehabilitation services provided in combination may not exceed the monthly limits established in the individual's prior authorization. Limits on services are established based on the level for which the member has been approved. There are no limits on substance abuse rehabilitation services for individuals determined to be Level 4.

(6) **Documentation requirements.** Documentation requirements are the same as for PSR services as set forth in 30-5-241.3(b)(5)(F).

(d) **Medication training and support.**

(1) **Definition.** Medication Training and Support is a documented review and educational session by a registered nurse, advanced practice nurse, or physician assistant focusing on a member's response to medication and compliance with the medication regimen. The review must include an assessment of medication compliance and medication side effects. Vital signs must be taken including pulse, blood pressure and respiration and documented within the medical or clinical record. A physician is not required to be present, but must be available for consult. Medication Training and Support is designed to maintain the member on the appropriate level of the least intrusive medications, encourage normalization and prevent hospitalization.

(2) **Limitations.**

(A) Medication Training and Support may not be billed for SoonerCare members who reside in ICF/IID facilities.

(B) Two units are allowed per month per patient.

(C) Medication Training & Support is not allowed to be

billed on the same day as an evaluation and management (E/M) service provided by a psychiatrist.

(3) **Qualified professionals**. Must be provided by a licensed registered nurse, an advanced practice nurse, or a physician assistant as a direct service under the supervision of a physician.

(4) **Documentation requirements. –** Medication Training and Support documented review must focus on:

(A) a member's response to medication;

(B) compliance with the medication regimen;

(C) medication benefits and side effects;

(D) vital signs, which include pulse, blood pressure and respiration; and

(E) documented within the progress notes/medication record.

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

317:30-5-241. Covered Services

(a) Outpatient behavioral health services are covered for adults and children as set forth in this Section when provided in accordance with a documented individualized service plan, developed to treat the identified behavioral health and/or substance use disorder(s), unless specified otherwise.
(b) All services are to be for the goal of improvement of functioning, independence, or well-being of the member. The services and service 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) In order to be reimbursed for services, providers must submit a completed Customer Data Core (CDC) to OHCA or its designated agent. The CDC must be reviewed, updated and resubmitted by the provider every six months. Reimbursement is made only for services provided while a current CDC is on file with OHCA or its designated agent. For further information and instructions regarding the CDC, refer to the Behavioral Health Provider Manual.
(d) All outpatient BH services must be provided following established medical necessity criteria. Some outpatient behavioral health services may require authorization. For information regarding services requiring authorization and the process for obtaining them, refer to the Behavioral Health Provider Manual. Authorization of services is not a guarantee of payment. The provider is responsible for ensuring that the eligibility, medical necessity, procedural, coding, claims submission, and all other state and federal requirements are met. OHCA does retain the final administrative review over both authorization and review of services as required by 42 CFR 431.10.
(e) Services to nursing facility residents. Reimbursement is not allowed for outpatient behavioral health services provided to members residing in a nursing facility. Provision of these services is the responsibility of the nursing facility and reimbursement is included within the rate paid to the nursing facility for the member's care.
(f) In addition to individual service limitations, reimbursement for outpatient behavioral health services is limited to 35 hours per rendering provider per week. Service hours will be calculated using a rolling four week average. Services not included in this limitation are:
   (1) Assessments;
   (2) Testing;

(3) Service plan development; and
(4) Crisis intervention services.

PART 25. PSYCHOLOGISTS

317:30-5-276. Coverage by category

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

(1) All services are to be for the goal of improvement of functioning, independence, or wellbeing 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) In order to be reimbursed for services, providers must submit a completed Customer Data Core (CDC) to OHCA or its designated agent. The CDC must be reviewed, updated and resubmitted by the provider every six months. Reimbursement is made only for services provided while a current CDC is on file with OHCA or its designated agent. For further information and instructions regarding the CDC, refer to the Prior Authorization Manual.

(3) Some outpatient behavioral health services may require authorization. For information regarding services requiring authorization and the process for obtaining them, refer to the Prior Authorization Manual. Authorization of services is not a guarantee of payment. The provider is responsible for ensuring that the eligibility, medical necessity, procedural, coding, claims submission, and all other state and federal requirements are met. OHCA does retain the final administrative review over both authorization and review of services as required by 42 CFR 431.10.

(b) **Adults.** Coverage for adults by a psychologist is limited to Bio-Psycho-Social Assessments when required by OHCA as part of a preoperative prior authorization protocol for organ transplant or bariatric surgical procedures.

(1) 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. The pre-op evaluation should aim to assess the member's psychological well-

being, ability to make informed decisions, and willingness to participate actively in postoperative treatment.

(2) For bariatric preoperative assessments, issues to address include, but are not limited to: Depression, self-esteem, stress management, coping skills, binge eating, change in eating habits, other eating disorders, change in social roles, changes associated with return to work/school, body image, sexual function, lifestyle issues, personality factors that may affect treatment and recovery, alcohol or substance use disorders, ability to make lasting behavior changes, and need for further support and counseling.

(c) **Children.** Coverage for children includes the following services:

(1) 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) 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. 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. Psychotherapy is considered to involve "interactive complexity" when there are communication factors during a visit that complicate delivery of the psychotherapy by the psychologist. Sessions typically involve members who have other individuals legally responsible for their care (i.e. minors or adults with guardians); members who request others to be involved in their care during the session (i.e. adults accompanied by one or more participating family members or interpreter or language translator); or members that require involvement of other third parties (i.e. child welfare, juvenile justice, parole/probation officers, schools, etc.). Psychotherapy should only be reported as involving interactive complexity when at least one of the following communication factors is present:

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

(B) Caregiver emotions/behavior that interfere with implementation of the treatment plan.
(C) Evidence/disclosure of a sentinel event and mandated report to a third party (i.e. abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with patient and other visit participants.
(D) Use of play equipment, physical devices, interpreter or translator to overcome barriers to therapeutic interaction with a patient who is not fluent in the same language or who has not developed or lost expressive or receptive language skills to use or understand typical language.

(3) 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 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 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) 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. Eight hours/units of testing per patient (over the age of ~~two~~three), per provider is allowed every 12 months. There may be instances when further testing is appropriate based on established medical necessity criteria found in the Prior Authorization Manual. 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. Testing for a child younger than three must be medically necessary and meet established criteria as set forth in the Prior Authorization Manual. Justification for additional testing beyond allowed amount as specified in

this section must be clearly explained and documented in the medical record. Testing units must be billed on the date the testing, interpretation, scoring, and/or reporting was performed and supported by documentation.

(6) Health and Behavior codes - behavioral health services are available only to chronically and severely medically ill children.

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

(8) Payment for therapy services provided by a psychologist to any one member is limited to eight sessions/units per month. A maximum of 12 sessions/units of therapy and testing services per day per provider are allowed. A maximum of 35 hours of therapy per week per provider are allowed. The weekly service hour limitation will be calculated using a rolling four week average. 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 unless allowed by the OHCA or its designated agent.

(d) **Home and Community Based Waiver Services for the Intellectually Disabled.** All providers participating in the Home and Community Based Waiver Services for the intellectually disabled 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.

(f) **Nursing Facilities.** Services provided to members residing in nursing facilities may not be billed to SoonerCare.

PART 26. LICENSED BEHAVIORAL HEALTH PROVIDERS

317:30-5-281. Coverage by Category

(a) **Outpatient Behavioral Health Services.** Outpatient behavioral health services are covered as set forth in this Section, 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 use disorder(s), unless specified otherwise.

(1) All services are to be for the goal of improvement of functioning, independence, or wellbeing 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) In order to be reimbursed for services, providers must submit a completed Customer Data Core (CDC) to OHCA or its designated agent. The CDC must be reviewed, updated and resubmitted by the provider every six months. Reimbursement is made only for services provided while a current CDC is on file with OHCA or its designated agent. For further information and instructions regarding the CDC, refer to the Prior Authorization Manual.

(3) Some outpatient behavioral health services may require authorization. For information regarding services requiring authorization and the process for obtaining them, refer to the Prior Authorization Manual. Authorization of services is not a guarantee of payment. The provider is responsible for ensuring that the eligibility, medical necessity, procedural, coding, claims submission, and all other state and federal requirements are met. OHCA does retain the final administrative review over both authorization and review of services as required by 42 CFR 431.10.

(b) **Adults.** Coverage for adults by a LBHP is limited to Bio-Psycho-Social Assessments when required by OHCA as part of a preoperative prior authorization protocol for organ transplant or bariatric surgical procedures.

(1) 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. The pre-op evaluation should aim to assess the member's psychological well-being, ability to make informed decisions, and willingness to participate actively in postoperative treatment.

(2) For bariatric preoperative assessments, issues to address include, but are not limited to: depression, self-esteem, stress management, coping skills, binge eating, change in eating habits, other eating disorders, change in social roles, changes associated with return to work/school, body image, sexual function, lifestyle issues, personality factors that may affect treatment and recovery, alcohol or substance use disorders, ability to make lasting behavior changes, and need for further support and counseling.

(c) **Children.** Coverage for children includes the following services:

(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) 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. Psychotherapy is considered to involve "interactive complexity" when there are communication factors during a visit that complicate delivery of the psychotherapy by the LBHP. Sessions typically involve members who have other individuals legally responsible for their care (i.e. minors or adults with guardians); members who request others to be involved in their care during the session (i.e. adults accompanied by one or more participating family members or interpreter or language translator); or members that require involvement of other third parties (i.e. child welfare, juvenile justice, parole/probation officers, schools, etc.). Psychotherapy should only be reported as involving interactive complexity when at least one of the following communication factors is present:

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

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

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

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

(3) 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~~three), per provider is allowed every 12 months. There may be instances when further testing is appropriate based on established medical necessity criteria found in the Prior Authorization Manual. Justification for additional testing beyond allowed amount as specified in this section must be clearly explained and documented in the medical record. 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. ~~Testing for a child younger than three must be medically necessary and meet established Child (0-36 months of Age) criteria as set forth in the Prior Authorization Manual.~~ 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. A maximum of 12 sessions/units of therapy and testing services per day per provider are allowed. A maximum of 35 hours of therapy per week per provider are allowed. The weekly service hour limitation

will be calculated using a rolling four week average. 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 unless allowed by the OHCA or their designated agent.

(d) **Home and Community Based Waiver Services for the Intellectually Disabled.** All providers participating in the Home and Community Based Waiver Services for the intellectually disabled 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.

(f) **Nursing Facilities.** Services provided to members residing in nursing facilities may not be billed to SoonerCare.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 40. DEVELOPMENTAL DISABILITIES SERVICES
SUBCHAPTER 5. MEMBER SERVICES
PART 1. AGENCY COMPANION SERVICES

317:40-5-3. Agency companion services

(a) Agency companion services (ACS) are:

(1) ~~are~~ provided by agencies that have a provider agreement with the Oklahoma Health Care Authority (OHCA);

(2) ~~provide~~ provided by independent contractors of the provider agency and provide a shared ~~a~~ living arrangement developed to meet the specific needs of the member that includes ~~a live-in companion providing~~ supervision, supportive assistance, and training in daily living skills, and integrates the member into the shared experiences of a family ~~provided~~ in a ~~shared~~ home owned or rented by the ~~member,~~ companion~~, or in a mutually rented or owned home~~;

(3) ~~are~~ available to members 18 years of age or older who are eligible for services through Community or Homeward Bound Waivers. Persons under ~~the age of~~ 18 years of age may be served with approval from the ~~DDSD~~ Oklahoma Department of Human Services Developmental Disabilities Services (DDS) director or designee;

(4) ~~are~~ based on the member's need for residential services per ~~OAC~~ Oklahoma Administrative Code(OAC) 340:100-5-22 and support as described in the member's Individual Plan (Plan), per OAC 340:100-5-50 through 340:100-5-58.

(b) An agency companion:

(1) must ~~be employed by or~~ have an approved home profile per OAC 317:40-5-3 and contract with a provider contract with a provider agency approved by ~~the Oklahoma Department of Human Services Developmental Disabilities Services Division (DDSD)~~DDS;

(2) may provide companion services for one member. Exceptions to serve as companion for two members may be approved by the ~~DDSD~~ DDS director or designee. Exceptions may be approved when members have an existing relationship and to separate them would be detrimental to their well being and the companion demonstrates the skill and ability required to serve as companion for two members;

(3) household is limited to one individual companion provider. Exceptions for two individual companion providers in a household who each provide companion services to different members may be approved by the ~~DDSD~~ DDS director or designee;

(4) may not provide companion services to more than two

members at any time;

(5) household may not serve more than three members through any combination of companion or respite services;

(6) may not have employment, volunteer activities, or personal commitments that prevent the companion from fulfilling his or her responsibilities to the member per OAC 317:40-5.

~~(A) Employment as an agency companion is the companion's primary employment.~~

~~(B) The companion may not have other employment when approved to serve two members regardless of the levels of support required by the members.~~

~~(C)~~ (A) The companion may have ~~other~~ employment when the:

(i) ~~the Team~~ personal support team (Team) documents and addresses all related concerns in the member's Plan;

(ii) ~~the other~~ employment is approved in advance by the ~~DDSD~~ DDS area manager or designee; and

(iii) ~~the~~ companion's employment does not require on-call duties and occurs during time the member is engaged in outside activities such as school, employment or other routine scheduled meaningful activities; and

(iv) ~~the~~ companion provides assurance the employment is such that the member's needs will be met by the companion should the member's outside activities be disrupted.

~~(D)~~(B) If, after receiving approval for ~~other~~ employment, authorized ~~DDSD~~ DDS staff determines the ~~other~~ employment interferes with the care, training, or supervision needed by the member, the companion must terminate, within 30 calendar days:

(i) ~~the other~~ his or her employment; or

(ii) his or her ~~employment~~ contract as an agency companion.

~~(E)~~(C) Homemaker, habilitation training specialist, and respite services are not provided for the companion to maintain other employment.

(c) Each member may receive up to 60 days per year of therapeutic leave without reduction in the agency companion's ~~salary~~ payment.

(1) Therapeutic leave:

(A) is a SoonerCare payment made to the contract provider to enable the member to retain services; and

(B) is claimed when the:

(i) ~~the~~ member does not receive ACS for 24 consecutive hours due to:

(I) a visit with family or friends without the companion;

(II) vacation without the companion; or

(III) hospitalization, regardless of whether the companion is present; or

(ii) ~~the~~ companion uses authorized respite time;

(C) is limited to no more than 14 consecutive, calendar days per event, not to exceed 60 days per Plan of Care (POC) year; and

(D) cannot be ~~accrued~~ carried over from one ~~Plan of Care (POC)~~ POC year to the next.

(2) The therapeutic leave daily rate is the same amount as the ACS per diem rate except for the pervasive rate ~~which~~ that is paid at the enhanced agency companion per diem rate.

(3) The provider agency pays the agency companion the ~~salary that~~ payment he or she would earn if the member were not on therapeutic leave.

(d) The companion may receive a combination of hourly or daily respite per POC year equal to 660 hours ~~for respite for the companion~~.

(e) Habilitation Training Specialist (HTS) services:

(1) may be approved by the ~~DDSD~~ DDS director or designee when providing ACS with additional support represents the most cost-effective placement for the member when there is an ongoing pattern of not:

(A) sleeping at night; or

(B) working or attending employment, educational, or day services ~~with documented and continuing efforts by the Team~~;

(2) may be approved when a time-limited situation exists in which the ~~ACS~~ companion provider is unable to provide ACS, and the provision of HTS will maintain the placement or provide needed stability for the member, and must be reduced when the situation changes;

(3) must be reviewed annually or more frequently as needed, which includes a change in agencies or individual companion providers~~.~~; and

(4) must be documented by the Team and the Team must continue efforts to resolve the need for HTS.

(f)~~ The agency receives a provider rate based on the agency's service model. The AC rate for the:~~

~~(1) employer model includes funding for the provider agency for the provision of benefits to the companion; or~~

~~(2) contractor model does not include funding for the provider agency for the provision of benefits to the companion. ~~The contractor model does not include funding for the provider agency for the provision of benefits to the

companion.

(g) The agency receives a ~~provider~~ daily rate based on the member's level of support. Levels of support for the member and corresponding payment are:

(1) determined by authorized ~~DDSD~~ DDS staff ~~in accordance with~~ per levels described in (A) through(D); and

(2) re-evaluated when the member has a change in agency companion providers ~~which~~ that includes a change in agencies or individual companion providers.

(A) **Intermittent level of support.** Intermittent level of support is authorized when the member:

(i) requires minimal physical assistance with basic daily living skills, such as bathing, dressing, and eating;

(ii) may be able to spend short periods of time unsupervised inside and outside the home; and

(iii) requires assistance with medication administration, money management, shopping, housekeeping, meal preparation, scheduling appointments, arranging transportation or other activities.

(B) **Close level of support.** Close level of support is authorized when the member requires:

(i) ~~requires~~ regular, frequent and sometimes constant physical assistance and support to complete daily living skills, such as bathing, dressing, eating, and toileting;

(ii) ~~requires~~ extensive assistance with medication administration, money management, shopping, housekeeping, meal preparation, scheduling appointments, arranging transportation or other activities; and

(iii) ~~requires~~ assistance with health, medication, or behavior interventions that may include the need for specialized training, equipment, and diet.

(C) **Enhanced level of support.** Enhanced level of support is authorized when the member:

(i) is totally dependent on others for:

(I) completion of daily living skills, such as bathing, dressing, eating, and toileting; and

(II) medication administration, money management, shopping, housekeeping, meal preparation, scheduling appointments, and arranging transportation or other activities;

(ii) demonstrates ongoing complex medical issues requiring specialized training courses per OAC 340:100-5-26; or

(iii) has behavioral issues that requires a protective intervention plan (PIP) with a restrictive or intrusive procedure ~~as defined in~~ per OAC 340:100-1-2. The PIP must:

(I) be approved by the Statewide Behavior Review Committee (SBRC), per OAC 340:100-3-14;

(II) be reviewed by the Human Rights Committee (HRC), per OAC 340:100-3-6, or

(III) have received expedited approval per OAC 340:100-5-57.

(D) **Pervasive level of support.** Pervasive level of support is authorized when the member:

(i) requires additional professional level support to remain in an agency companion setting due to pervasive behavioral or emotional challenges. The support must be provided:

(I) by a licensed professional counselor (LPC) or professional with a minimum of Masters of Social Work (MSW) degree; and

(II) as ongoing support and training to the companion, offering best practice approaches in dealing with specific members; and

(ii) does not have an available personal support system. The need for this service level:

(I) must be identified by the grand staffing committee, per OAC 340:75-8-40; and

(II) requires the provider to market, recruit, screen, and train potential companions for the member identified.

(g) Authorization for payment of Agency Companion Service is contingent upon receipt of:

(1) the applicant's approval letter authorizing ACS for the identified member;

(2) an approved relief and emergency back-up plan addressing a back-up location and provider;

(3) the Plan;

(4) the POC; and

(5) the date the member moved to the companion home.

(h) The Plan reflects the amount of room and board the member pays to the companion. The provider must use the room and board reimbursement payment to meet the member's needs. Items purchased with the room and board reimbursement payment include housing and food. ~~If the amount exceeds $450, the additional amount must be:~~

~~(1) agreed upon by the member and, if when applicable, legal guardian;~~

~~(2) recommended by the Team; and~~

~~(3) approved by the DDSD area manager or designee.~~

<u>(i) If the amount exceeds $500, the additional amount must be:</u>

<u>(1) agreed upon by the member and, when applicable, legal guardian;</u>

<u>(2) recommended by the Team; and</u>

<u>(3) approved by the DDS area manager or designee.</u>

317:40-5-4. Selection of Agency Companion Services provider [REVOKED]

~~(a) The matching of the lifestyles and personalities of a companion and a service recipient and the overall compatibility of the companion with the service recipient are the most critical elements of the Agency Companion Services (ACS) program. The past and present relationship the service recipient has with the potential companion is the most important consideration in the companion selection process.~~

~~(b) In addition to considering the relationship between the service recipient and the companion, the case manager, the service recipient or legal guardian, and the service recipient's provider agency must reach consensus regarding the criteria listed in this Section before the approval process described in OAC 317:40-5-40 begins.~~

~~(1) The companion must have a relationship with the service recipient. Exceptions may be made by the service recipient's personal support team (Team) upon the recommendation of the Developmental Disabilities Services Division (DDSD) case manager, Division of Children and Family Services (DCFS) worker, or the Adult Protective Services (APS) worker, when appropriate.~~

~~(2) The companion must have the commitment and skills to meet the individual needs of the service recipient.~~

~~(3) The companion must understand the level of commitment required for the ACS program and how the commitment will affect the companion's personal life.~~

~~(4) The companion must understand how the commitment to the ACS program will impact the companion's family.~~

~~(5) The companion must demonstrate the ability to establish and maintain a positive relationship with the service recipient, particularly when stressful situations occur.~~

~~(6) The companion must demonstrate the ability to work collaboratively with others in the service process.~~

~~(7) Neither a service recipient's spouse nor the parent of a minor child may serve as that person's companion. A family member serving as companion must meet all requirements for the ACS program given in this Subchapter.~~

~~(8) The Chief Executive Officer (CEO) of a provider agency may not serve as a companion.~~

317:40-5-5. Agency Companion Services provider responsibilities

(a) ~~Providers of Agency Companion Services (ACS)~~ Companions are required to meet all applicable standards outlined in this subchapter and competency-based training ~~described in OAC~~ per Oklahoma Administrative Code(OAC) 340:100-3-38. The provider agency ensures ~~that~~ all companions meet the criteria in this Section.

(b) Failure to follow any rules or standards, failure to promote the independence of the member, or failure to follow recommendation(s) of the personal support team (Team) results in problem resolution, per OAC 340:100-3-27, for the companion, and ~~if~~ when warranted, revocation of approval of the companion.

(c) ~~In addition to the criteria given in OAC 317:40-5-4, the~~ The companion:

(1) ensures no other adult or child is cared for in the home on a regular or part-time basis, including other Oklahoma Department of Human Services ~~(OKDHS)~~ (DHS) placements, family members, or friends without prior written authorization from the ~~OKDHS~~ Developmental Disabilities Services ~~Division (DDSD)~~ (DDS)area manager or designee;

(2) meets the requirements of OAC 317:40-5-103~~, Transportation~~. Neither the companion nor the provider agency may claim transportation reimbursement for vacation travel;

(3) transports or arranges transportation for the member to and from school, employment programs, recreational activities, medical appointments, and therapy appointments;

(4) delivers services in a manner that contributes to the member's enhanced independence, self-sufficiency, community inclusion, and well-being;

(5) participates as a member of the member's Team and assists in the development of the member's Individual Plan(Plan) for service provision;

(6) ~~with assistance from the DDSD case manager and the provider agency program coordination staff,~~ develops, implements, evaluates, and revises the training strategies corresponding to the relevant outcomes for which the companion is responsible, as identified in the Plan~~;~~.

~~(A)~~ The companion ~~documents and provides monthly data and health care summaries to the provider agency program coordination staff~~may request assistance from the case manager or program coordinator.

~~(B) The agency staff provides monthly reports to the DDSD case manager or nurse.~~The companion documents and provides monthly data and health care summaries to the provider agency program coordination staff.

(7) delivers services at appropriate times as directed in the Plan;
(8) 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);
(9) is sensitive to and assists the member in participating in the member's chosen religious faith. No member is expected to attend any religious service against his or her wishes;
(10) participates in, and supports visitation and contact with the member's natural family, guardian, and friends, ~~provided this~~ when visitation is desired by the member;
(11) obtains permission from the member's legal guardian, ~~if~~ when a guardian is assigned, and notifies the family, the provider agency program coordination staff, and the case manager prior to:
  (A) traveling out of state;
  (B) overnight visits; or
  (C) involvement of the member in any publicity;
(12) serves as the member's health care coordinator per OAC 340:100-5-26;
(13) ensures the monthly room and board contribution received from the member is used toward the cost of operating the household;
(14) assists the member in accessing entitlement programs for which the member may be eligible and maintains records required for the member's ongoing eligibility;
(15) works closely with the provider agency program coordination staff and the ~~DDSD~~ DDS case manager, to ensure all aspects of the member's program are implemented to the satisfaction of the member, the member's family or legal guardian, when appropriate, and the member's Team;
(16) assists the member ~~in achieving~~ to achieve the member's maximum level of independence;
(17) submits, in a timely manner, to the provider agency program coordination staff all necessary information regarding the member;
(18) ensures ~~that~~ the member's confidentiality is maintained per OAC 340:100-3-2;
(19) supports the member in forming and maintaining friendships with neighbors, co-workers, and peers, including people who do not have disabilities;
(20) implements training and provides supports that enable the member to actively join in community life;
(21) does not serve as representative payee for the member

without a written exception from the ~~DDSD~~ DDS area manager or designee~~;~~.

(A) The written exception is retained in the member's home record.

(B) When serving as payee, the companion complies with ~~the requirements of~~ OAC 340:100-3-4 requirements~~.~~;

(22) ensures the member's funds are properly safeguarded~~.~~;

(23) obtains prior approval from the member's representative payee when making a purchase of over $50~~.00~~ with the member's funds;

(24) allows ~~the~~ provider agency and DDS staff ~~and DDSD staff~~ to make announced and unannounced visits to the home;

(25) develops an Evacuation Plan, using ~~OKDHS~~ DHS Form 06AC020E, Evacuation/Escape Plan, for the home and conducts training with the member;

(26) conducts fire and weather drills at least quarterly and documents the fire and weather drills using Form 06AC021E, Fire and Weather Drill Record;

(27) develops and maintains a personal possession inventory for personal possessions and adaptive equipment, using Form 06AC022E, Personal Possession Inventory;

(28) supports the member's employment program by:

(A) assisting the member to wear appropriate work attire; and

(B) contacting the member's employer as outlined by the Team and in the Plan; ~~and~~

(29) is responsible for the cost of ~~their~~ the member's meals and entertainment during recreational and leisure activities. Activities must be affordable to the member. Concerns about affordability are presented to the Team for resolution;

(30) for adults, reports suspected maltreatment including abuse, verbal abuse, sexual abuse, neglect, financial neglect, and/or exploitation of a vulnerable adult per Section 10-104 of Title 43A of the Oklahoma Statutes to the DHS Office of Client Advocacy (OCA);

(31) for children, reports abuse, neglect, sexual abuse, or sexual exploitation per Section 1-2-101 of Title 10A of the Oklahoma Statutes to the Child Abuse and Neglect Hotline at 1-800-522-3511; ~~and~~

(32) follows all applicable rules promulgated by the Oklahoma Health Care Authority and ~~DDSD~~ DDS, including:

(A) OAC 340:100-3-40;

(B) OAC 340:100-5-50 through 100-5-58;

(C) OAC 340:100-5-26;

(D) OAC 340:100-5-34;

(E) OAC 340:100-5-32;

(F) OAC 340:100-5-22.1;
(G) OAC 340:100-3-27;
(H) OAC 340:100-3-38; and
(I) OAC 340:100-3-34;

(33) is neither the member's spouse, nor when the member is a minor child, the member's parent. A family member servicing as companion must meet all requirements listed in this Subchapter; and

(34) is not the Chief Executive Officer of a provider agency.

317:40-5-6. Agency Companion ~~Services provider~~ contractor requirements

(a) The service recipient or legal guardian, the provider agency, ~~and~~ or the Oklahoma Department of Human ~~Services'~~ Services Developmental Disabilities Services ~~Division (DDSD)~~ (DDS)case manager may identify an applicant to be screened for approval to serve as ~~the~~ companion.

(b) Approval by ~~DDSD~~ DDS for a person to provide contracted Agency Companion Services (ACS) requires ~~that~~ the applicant:

(1) is 21 years of age or older;

(2) has attended the ~~DDSD~~ DDS or provider agency ACS orientation;

(3) ~~is employed by, or~~ contracts with~~,~~ a provider agency having a current contract with the Oklahoma Health Care Authority to provide ACS;

(4) submits the completed ~~DDSD~~ DDS application packet ~~in accordance with OAC~~ per Oklahoma Administrative Code (OAC) 317:40-5-40 within the required time period to designated ~~DDSD~~ DDS staff or the provider agency staff;

(5) cooperates with ~~the~~ designated ~~DDSD staff~~ DDS or ~~the~~ provider agency staff in the development and completion of the home profile approval process ~~described in~~ per OAC 317:40-5-40; and

(6) has completed all training required by OAC 340:100-3-38, including medication administration training, and all provider agency pre-employment training ~~as described in~~ per OAC 317:40-5-40.

317:40-5-9. Payment authorization for Agency Companion Services [REVOKED]

~~Authorization for payment of Agency Companion Services (ACS) is contingent upon receipt of:~~

~~(1) the applicant's approval letter authorizing ACS for the identified member;~~

~~(2) approved relief and emergency back-up plan;~~

~~(3) revised Individual Plan;~~

~~(4) revised Plan of Care; and~~

~~(5) placement of the member in the ACS home.~~

317:40-5-10. Agency companion services (ACS) annual review [REVOKED]

~~(a) In addition to the requirements of OAC 317:40-5-40, Oklahoma Department of Human Services Developmental Disabilities Services Division (DSSD) ACS staff annually review services provided by the companion to determine:~~

~~(1) continued compliance of the companion and home environment with DDSD and Oklahoma Health Care Authority rules;~~

~~(2) the satisfaction of the service recipient with the living arrangement; and~~

~~(3) continued use of the home.~~

~~(b) The annual review contains:~~

~~(1) written comments of the ACS staff from interviews with the service recipient that highlight the service recipient's thoughts and feelings about his or her companion and the ACS placement;~~

~~(2) written comments from the companion regarding program changes and issues of concern;~~

~~(3) summaries of the information obtained from the companion, the service recipient, the provider agency program coordination staff, and the DDSD case manager;~~

~~(4) recommendations for continued service;~~

~~(5) information received from Child Welfare or Adult Protective Services, if available; and~~

~~(6) identified areas of service that need improvement as well as areas of service that have been beneficial.~~

~~(c) A copy of the annual review is maintained in the DDSD area office with copies to the DDSD state office and the provider agency.~~

317:40-5-11. Termination of Agency Companion placement

(a) ~~Designated~~ Oklahoma Department of Human Services Developmental Disabilities Services ~~Division (DDSD)~~(DDS) staff may terminate an individual agency companion (AC) placement for reasons including, but not limited to the:

(1) ~~the~~ member's decision to move to a different residence;

(2) ~~the~~ request of the companion;and

(3) ~~the Team~~ personal support team determines the AC placement is no longer the most appropriate placement for the member;

~~(4) failure of the companion to complete tasks related to problem resolution, per OAC 340:100-3-27, as agreed;~~

~~(5) confirmed abuse, neglect, or exploitation of any person;~~

~~(6) breach of confidentiality;~~

~~(7) involvement of the companion in criminal activity, or criminal activity in the home;~~

~~(8) failure to provide for the care and well-being of the member;~~

~~(9) continued failure to implement the Individual Plan, per OAC 340:100-5-50 through 100-5-58;~~

~~(10) failure to complete and maintain training per OAC 340:10-3-38;~~

~~(11) failure to report changes in the household;~~

~~(12) failure or inability of the home to meet standards per OAC 317:40-5-40;~~

~~(13) continued failure to follow applicable Oklahoma Department of Human Services or Oklahoma Health Care Authority rules;~~

~~(14) decline of the companion's health to the point that he or she can no longer meet the needs of the member;~~

~~(15) employment by the companion without prior approval by the DDSD area programs manager for residential services; or~~

~~(16) domestic disputes which may result in emotional instability of the member.~~

(b) Upon termination of the placement~~:~~

~~(1) the property of the member or the state is removed immediately by the member or his or her designee; and~~

~~(2)~~ the Team meets to develop an orderly transition plan and arranges for the member's property to be moved as necessitated by the transition plan.

(c) ~~If an individual placement is terminated for reasons identified in (4)-(16) in this Section, DDSD staff will disapprove continued use of the companion.~~ Termination of an individual companion placement may also occur in conjunction with denial of a home profile per OAC 317:40-5-40.

317:40-5-13. Agency Companion Services provider agency responsibilities

(a) The agency providing Agency Companion Services (ACS) complies with Oklahoma Health Care Authority and Oklahoma Department of Human Services (DHS) policies and procedures governing all aspects of service provision.

(b) The provider agency is responsible for all ~~employee or~~ contract provider related activities detailed in this Subchapter.

(c) In the event the provider agency wishes to discontinue services immediately due to an emergency, the provider agency cooperates with the DHS Developmental Disabilities Services ~~Division (DDSD)~~ (DDS) to secure alternative services in the least restrictive environment.

(d) The provider agency ensures that services provided meet

requirements of ~~OAC~~ Oklahoma Administrative Code (OAC) 340:100-5-22.1, unless ~~different~~ other requirements are stated in this Section.

(e) ~~If~~ When the provider agency serves as the member's representative payee, the provider agency must adhere to ~~the requirements of~~ OAC 340:100-3-4.1 requirements.

(f) The provider agency acts immediately to remedy any situation posing a risk to the health, well-being, or provision of specified services to the member.

~~(1) In the event of such a risk, the provider agency immediately notifies DDSD of the nature of the situation and notifies DDSD upon the resolution of the threatening situation.~~

~~(2)~~ (1) The provider agency's program coordination staff ~~contacts and informs the DDSD case manager within 24 hours of an incident or injury. The provider agency~~ completes and submits incident and injury reports to ~~DDSD in accordance with~~ DDS per OAC 340:100-3-34.

~~(3)~~(2) A ~~companion~~ companion's contract is immediately terminated when a provider agency becomes aware ~~that~~ a companion's name appears on the Community Services Worker Registry per OAC 340:100-3-39.

(g) The provider agency ensures only one member is served in a provider home. Exceptions may be approved by the ~~DDSD~~ DDS area manager or designee.

(h) ~~When the provider agency has knowledge of problems occurring in the placement, the provider agency's program coordination staff immediately schedules a meeting with the companion, the member, the member's legal guardian or advocate, the DDSD case manager and other appropriate DDSD staff to resolve the issues involved. If resolution of the issues does not occur at the meeting, any participant is to contact the DDSD area manager or designee and the provider agency for resolution.~~ Team members, including the provider agency program coordinator, companion, member, legal guardian, advocate, and DDS case manager work together to resolve issues to ensure the member's needs are met and the shared living arrangement is successful.

~~(i) When a change in the provider agency is requested by the member or the companion, all participants attempt to resolve the issues. No change in the provider agency occurs unless the DDSD area manager or designee agrees that all issues have been or discussed.~~

~~(j)~~(i) The ~~decision to remain or terminate services with the provider agency is the~~ choice of provider agency is made by the member or his or her legal guardian.

~~(k)~~(j) When a member transfers from a provider agency, the

outgoing provider agency ensures ~~that~~ the member has a 30 calendar-day supply of medication and a seven-day supply of food, household ~~supplies~~, and personal supplies.

~~(l)~~(k) ~~The responsibilities of the provider~~ Provider agency's program coordination staff responsibilities are to:

(1) ~~to~~ visit the provider home daily during the first week of placement;

(2) ~~to visit the home~~ make a minimum of three ~~times~~ face to face visits per month per OAC 340:100-5-22.1;

(3) ~~to~~ allow the ~~needs of the member~~ member's needs to determine the frequency of all other visits;

(4) ~~to~~ coordinate and submit quarterly reports to the provider agency for submission to the ~~DDSD~~ DDS area office; and

(5) ~~to~~ communicate regularly with the ~~DDSD~~ DDS case manager regarding any changes in the household or any other program issues or concerns.

~~(m)~~(l) The provider agency, ~~works with the~~ companion, member, and guardian ~~to~~ develop a back-up plan identifying respite staff~~.~~ and an alternate location in the event the home becomes uninhabitable. The back-up plan:

(1) is submitted to the ~~DDSD~~ DDS case manager for approval;

(2) describes expected and emergency back-up support and program monitoring for the home; and

(3) is incorporated into the member's Individual Plan (Plan).

~~(n)~~(m) The respite provider is:

(1) knowledgeable about the member;

(2) trained to implement the member's Plan;

(3) trained per OAC 340:100-3-38;

(4) responsible for the cost of ~~their~~ the member's 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.

~~(o)~~(n) The spouse or other adult residing in the home is considered a natural support and may provide ACS in the absence of the companion, when trained per OAC 340:100-3-38.12.

~~(p)~~(o) The spouse or other adult residing in the home cannot serve as paid respite staff.

PART 3. GUIDELINES TO STAFF

317:40-5-40. Home profile process

(a) **Applicability.** This Section establishes procedures for the Developmental Disabilities Services (DDS) home profile process. 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 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)~~ (DDS) 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 provider qualifications ~~of the provider~~;
(C) health, safety, and environmental issues; and
(D) training required per ~~OAC~~ Oklahoma Administrative Code (OAC) 340:100-3-38;
(3) the Oklahoma Department of Human Services ~~(OKDHS)~~(DHS) Form 06AC012E, Specialized Foster Care/Agency Companion Services 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) an Oklahoma State Bureau of Investigation (OSBI) name and criminal records history search, including the Oklahoma Department of Public Safety (DPS), Sex 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 action;
(iv) search of all ~~OKDHS~~ DHS records, including Child Welfare Services records and the Community Services Worker Registry;
(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 continuously for the past five years. ~~The~~ A home is not approved without the results of the out-of-state maintained child abuse and neglect registry checks, ~~if~~ when a registry is maintained in the applicable state, for all adult household members

living in the home. ~~If no~~ When a child abuse and neglect registry is not maintained in the applicable state, a request for information is made to the applicable state; and

(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~~ when the applicant or any person residing in the applicant's home:

(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~~ in 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;

(V) a crime involving violence, including, but not limited to, rape, sexual assault, or homicide, including manslaughter, ~~but~~ excluding physical assault and battery~~.Homicide including manslaughter~~; or

(ii) does not meet ~~the requirements of~~ OAC 340:100-3-39 requirements;

(5) ~~OKDHS~~ DHS Form 06AC015E, Agency Companion/Specialized Foster Care Employment Record;

(6) ~~OKDHS~~ DHS Form 06AC016E, ~~DDSD~~ DDS Reference Information Waiver;

(7) ~~OKDHS~~ DHS Form 06AC029E, Employer Reference Letter; and

(8) ~~OKDHS~~ DHS Form 06AC013E, Pre-Screening for Specialized Foster Care/Agency Companion Services.

(c) **Home profile process.** ~~If~~ When the applicant meets the requirements of the prescreening, the initial 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 ~~DDSD~~ DDS address provided. Required forms include ~~OKDHS~~ DHS 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~~ when Form 06AC011E indicates conditions that may interfere with the provision of services;

(G) 06AC017E, Insurance Information; and

(H) 06AC020E, Evacuation/Escape Plan.

(2) ~~If~~ When an incomplete form or other information is returned to ~~DDSD~~ DDS, designated ~~DDSD~~ 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 ~~DDSD~~ DDS.

(3) Designated ~~DDSD~~ DDS staff completes the home profile when all required forms are completed and provided to ~~DDSD~~ DDS.

(4) For each reference provided by the applicant, designated ~~DDSD~~ DDS staff completes ~~OKDHS~~ DHS Form 06AC058E, Reference Letter;

(5) Designated ~~DDSD~~ DDS staff, through interviews, visits, and phone calls, gathers information required to complete ~~OKDHS~~ DHS Form 06AC047E, Home Profile Notes.

(6) ~~OKDHS~~ DHS Form 06AC069E, Review of Policies and Areas of Responsibilities, is dated and signed by the applicant and designated ~~DDSD~~ DDS staff.

(7) The ~~DDSD~~ 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~~ and home profile are denied.

(8) ~~DDSD~~ 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 applicant's or 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 the 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.~~

(iv) allow adequate space for the recreational and social 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 ~~DDSD~~ 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 insurance.

(2) **Sanitation.**

(A) Sanitary facilities must be adequate and safe, including toilet and bathing facilities, water supply, and garbage and sewer disposal.

(B) ~~If~~ When 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 for household pets 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 used for ventilation 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~~ when 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.~~ (i)Exception to allow members to share a bedroom may be made by DDS area residential program manager, when DDS determines sharing a bedroom is in the best interest of the member. Minor members must not share bedrooms with adults.

~~(iii) Exceptions to allow members to share a bedroom may be made by the DDSD area residential programs manager, when DDSD determines sharing a bedroom is in the best interest of the members;~~ (ii) A member must not share a bedroom with more than one other person;

(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~~ egress. 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, 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 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 the 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 ~~DDSD~~ DDS and, ~~if~~ when 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~~ egress.

(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 DDSD~~;

(iv) ~~has a written back-up plan for temporary housing in the event of an emergency; and~~ makes fire and severe weather drill documentation available for review by DDS;

(v) ~~is responsible to re-establish a residence, if the home becomes uninhabitable.~~ has a written back-up plan for temporary housing in the event of an emergency; and

(vi) 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 per OAC 340:100-5-32.

(e) **Evaluating the applicant and home.** The initial home profile evaluation 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, and 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. ~~DDSD~~ 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;~~
assesses the overall compatibility of the applicant and the service recipient, ensuring the lifestyles and personalities of each are compatible for the shared living arrangement. The applicant must:

(i) express a long term commitment to the service member unless the applicant will only be providing respite services;
(ii) demonstrate the skills to meet the individual needs of the member;
(iii) express an understanding of the commitment required as a provider of services;
(iv) express an understanding of the impact the arrangement will have on personal and family life;
(v) demonstrate the ability to establish and maintain positive relationships, especially during stressful situations; and
(vi) demonstrates the ability to work collaboratively and cooperatively with others in a team process;

(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;~~
approves only applicants who can fulfill the expectations of the role of service provider;

(D) ~~notifies the applicant in writing of the final recommendation; and~~ when the applicant does not meet

standards per OAC 317:40-5-40, ensures the final recommendation includes:

(i) a basis for the denial decision; and

(ii) an effective date for determining the applicant does not meet standards. Reasons for denying a request to be a provider may include, but are not limited to:

(I) a lack of stable, adequate income to meet the applicant's own or total family needs or poor management of the 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 that are unstable and unsatisfactory;

(V) the mental health of the applicant or other family or household member that impedes the applicant's ability to provide appropriate care for a member;

(VI) references who are guarded or have reservations in recommending the applicant;

(VII) the applicant failed to complete the application, required training, or verifications in a timely manner as requested or provided incomplete, inconsistent, or untruthful information;

(VIII) the home is determined unsuitable for the member requiring placement;

(IX) confirmed abuse, neglect, or exploitation of any person;

(X) breach of confidentiality;

(XI) involvement of the applicant or provider involvement in criminal activity or criminal activity in the home;

(XII) failure to complete training per OAC 340:100-3-38;

(XIII) failure of the home to meet standards per subsection (d) of this Section;

(XIV) failure to follow applicable DHS or Oklahoma Health Care Authority (OHCA)rules;

(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) DDSD 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.~~
notifies the applicant in writing of the final approval or denial of the home profile;

(F) when an application is canceled or withdrawn prior to completion of the home profile, completes a final written assessment that includes the:

(i) reason the application was canceled or withdrawn; and
(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, and a copy is included in local and State Office records.

(f) **Frequency of evaluation.** ~~Homes are assessed for~~ Home profile evaluations are completed for initial approval or denial of an applicant. After an initial approval, a home profile review is conducted annually and as needed for compliance and continued 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.~~ DDS area residential services staff conduct at least biannual home visits to specialized foster care providers. The annual ~~evaluation~~ home profile review is a comprehensive review of the living arrangement, the provider's continued ability to meet standards~~.~~, the needs of the member and the home to ensure ongoing compliance with home standards. A home profile review is conducted when a provider notifies DDS of his or her intent to move to a new residence. DDS staff asses the home to ensure the new home meets home standards and is suitable to meet the member's needs. The annual home profile review;

(1) ~~The annual evaluation consists of~~ includes information specifically related to the provider's home and is documented on ~~OKDHS~~ DHS Form 06AC024E, Annual Review~~.~~;
(2) ~~OKDHS~~ includes ~~FORM~~ form 06AC010E,Medical Examination Report, ~~must be~~ completed a minimum of every three years following the initial approval, unless medical circumstances warrant more frequent completion~~.~~;

(3) ~~Input~~ includes information from the ~~DDSD~~ DDS case manager, the provider of agency companion or SFC services, the Child Welfare ~~worker~~ specialist, Adult Protective Services ~~staff~~, and Office of Client Advocacy staff, and the provider agency program coordinator ~~is included in the evaluation, if~~ when applicable.

(4) ~~The background investigation per OAC 317:40-5-40(b) is repeated every year, except the FBI national criminal history search.~~ includes information from the service member indicating satisfaction with service and a desire to continue the arrangement;

(5) ~~Providers are notified in writing of the continued recommendation of the use of the home.~~ addresses areas of service where improvement is needed;

(6) ~~Copies of OKDHS Forms 06AC024E and, if applicable, 06AC010E, are included in local and State Office records.~~ includes areas of service where progress was noted or were of significant benefit to the member;

(7) ensures background investigation per OAC 317:40-5-40(b) is repeated every year, except for the OSBI and FBI national criminal history search;

(8) ensures the FBI national criminal history search per OAC 317:40-5-40(b)(4)(A)(ii) is repeated every five years;

(9) includes written notification to providers and agencies, when applicable, of the continued approval of the provider.

(10) includes written notification to providers and agencies, when the provider or agency fails to comply with the home standards per OAC 317:40-5-40 including deadlines for correction of the identified standards; and includes copies of DHS Forms 06AC024E and, when applicable, 06AC010E, in local and State Office records.

(g) Reasons a home profile review may be denied include, but are not limited to:

(1) lack of stable, adequate income to meet the provider's own or total family needs or poor management of available income;

(2) a physical facility that is inadequate to accommodate the addition of a member to the home or presents health or safety concerns;

(3) the age, health, or any other condition of the provider that impedes the provider's ability to provide appropriate care for a member;

(4) relationships in the provider's household that are unstable and unsatisfactory;

(5)the mental health of the provider or other family or household member impedes the provider's ability to provide appropriate care for a member;

(6) the provider fails to complete required training, or verifications in a timely manner as requested or provides incomplete, inconsistent, or untruthful information;
(7) the home is determined unsuitable for the member;
(8) failure of the provider to complete tasks related to problem resolution, as agreed, per OAC 340:100-3-27;
(9) failure of the provider to complete a plan of action, as agreed, per OAC 317:40-5-63;
(10) confirmed abuse, neglect, or exploitation of any person;
(11) breach of confidentiality;
(12) involvement of the applicant or provider involvement in the criminal activity or criminal activity in the home;
(13) failure to provide for the care and well-being of the service member;
(14) failure or continued failure to implement the individual Plan, per OAC 340:100-5-50 through 100-5-58;
(15) failure to complete and maintain training per OAC 340:100-3-38;
(16) failure to report changes in the household;
(17) failure to meet standards of the home per subsection (d) of this Section;
(18) failure or continued failure to follow applicable DHS or OHCA rules;
(19) decline of the provider's health to the point he or she can no longer meet the needs of the service member;
(20) employment by the provider without prior approval of the DDS area programs manager for residential services; or
(21) domestic disputes that cause emotional distress to the member.

(h) **Termination of placement.** When an existing placement is terminated for any reason:
(1) the Team meets to develop an orderly transition plan; and
(2) DDS staff ensures the property of the member and state is removed promptly and appropriately by the member or his or her designee.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
SUBCHAPTER 15. PERSONAL CARE SERVICES

317:35-15-1. Overview of long-term medical care services; relationship to QMBP, SLMB, and other SoonerCare service eligibility

Long-term medical care for the categorically needy includes care in a nursing facility (refer to OAC 317:35-19), public and private intermediate care facility for ~~the mentally retarded~~individuals with intellectual disabilities (refer to OAC 317:35-9), persons age 65 years or older in mental health hospitals (refer to OAC 317:35-9), Home and Community Based Waiver Services for the Intellectually Disabled (refer to OAC 317:35-9), Home and Community Based Waiver Services for the ADvantage program (refer to OAC 317:35-17), and Personal Care services (refer to this subchapter). Personal Care provides services in the member's own home. Any time an individual is certified as eligible for SoonerCare coverage of long-term care, the individual is also eligible for other SoonerCare services. Another application is not required. Any time an aged, blind, or disabled individual is determined eligible for long-term care, a separate determination must be made to see if eligibility conditions as a Qualified Medicare Beneficiary~~ (QMB)~~Plus (QMBP) or Specified Low-Income Medicare Beneficiary (SLMB) are met. Another application for ~~QMB~~QMBP or SLMB benefits is not required.

317:35-15-2. Personal Care services

(a) Personal Care is assistance to an individual 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 or errands~~ directly related to the member's personal care needs~~, to assure personal health and safety of the individual or~~ to prevent or minimize physical health regression or deterioration. The Personal Care service requires a skilled nursing assessment of need, development of a care plan to meet identified personal care needs, care plan oversight and periodic re-assessment and updating, if necessary, of the care plan. Personal Care services do not include technical services such as~~,~~ tracheal suctioning, bladder catheterization, colostomy irrigation, ~~and~~or the operation of equipment of a technical nature such as a patient lift.

(b) ~~Personal Care services support informal care being provided in the member's home. A rented apartment, room or shelter shared with others is considered "the member's home". A facility which meets the definition of a nursing facility, room and board,~~

~~licensed residential care facility, group home, rest home or a specialized home as set forth in O.S. Title 63, Section 1-819 et seq., Section 1-899.1 et seq., and Section 1-1902 et seq., and/or in any other typed of settings prohibited under applicable federal or state statutes, rules, regulations, or other written instruments that have the effect of law is not considered the "the member's home" for delivery of SoonerCare Personal Care Program services.~~Personal Care members may receive services in limited types of living arrangements. The specific living arrangements are set forth below.

(1) Personal Care members are not eligible to receive services while residing in an institutional setting including, but not limited to, licensed facilities, such as a hospital, nursing facility, licensed residential care facility or licensed assisted living facility, or in an unlicensed institutional living arrangement, such as a room and board home or facility.

(2) Additional living arrangements in which members may receive Personal Care services are the member's own home, apartment, or a family or friend's home or apartment. A home or apartment unit is defined as a self-contained living space having a lockable entrance to the unit including a bathroom and food storage/preparation amenities in addition to bedroom/living space.

(3) For Personal Care members who are full-time students, a dormitory room qualifies as an allowable living arrangement in which to receive Personal Care services for the period during which the member is a student.

(4) With prior approval of the OKDHS area nurse, Personal Care services may be provided in an educational or employment setting to assist the member in achieving vocational goals identified in the care plan.

(c) Personal Care services may be provided by an individual employed by the member referred to as ~~a~~an Individual Personal Care Assistant ~~(PCA)~~(IPCA) or by a ~~qualified employee of a~~Personal Care Assistant (PCA) employed by a home care agency that is certified to provide Personal Care services and contracted with the OHCA to provide Personal Care services. OKDHS must determine ~~a PCA~~an IPCA to be qualified to provide Personal Care services before they can provide services. Persons eligible to serve as either IPCAs or PCAS must meet the following criteria:

(1) are at least 18 years of age;

(2) have no pending notation related to abuse, neglect, or exploitation as reported by the Oklahoma State Department of Health Nurse Aide Registry;

(3) are not included in the OKDHS Community Services Worker Registry;

(4) have not been convicted of a crime or have any criminal

background history or registry listings that prohibit employment as defined in O.S. Title 63, Section 1-1950.1;
(5) demonstrate the ability to understand and carry out assigned tasks;
(6) are not a legally responsible family member, such as a spouse, legal guardian, or parent of a minor child of the member being served (exceptions may be made for a legal guardian to provide services only with prior approval from the OKDHS Aging Services Division);
(7) have a verifiable work history and/or personal references, verifiable identification; and
(8) meet any additional requirements as outlined in the contract and certification requirements with the OHCA.

(d) Eligibility for Personal Care is contingent on an individual requiring one or more of the services offered at least monthly that include personal care, meal preparation, housekeeping, laundry, shopping or errands, or specified special tasks to meet Activities of Daily Living or Instrumental Activities of Daily Living assessed needs.

317:35-15-3. Application for Personal Care

(a) **Requests for Personal Care.** A request for Personal Care is made to the local OKDHS office or ADvantage Administration (AA). A written financial application is not required for an individual who has an active SoonerCare case. A financial application for Personal Care ~~consists of the Medical Assistance Application form~~is initiated when there is no active SoonerCare case. The ~~form~~application is signed by the applicant, parent, spouse, guardian or someone else acting on the applicant's behalf. All conditions of financial eligibility must be verified and documented in the case record. When current information already available in the local office establishes eligibility, the 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.

(b) **Date of application.**

(1) The date of application is:
(A) the date the applicant or someone acting on his/her behalf signs the application in the county office;
(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 SoonerCare is made orally and the financial application form is signed later.

(2) An exception to paragraph (1) of this subsection would occur when OKDHS has contracts with certain providers to take applications and obtain documentation. After the documentation

is obtained, the contract provider forwards the application and documentation to the OKDHS county office of the applicant's county of residence for SoonerCare eligibility determination. The application date is the date the applicant signed the application form for the provider.

(c) **Eligibility status.** Financial and medical eligibility must be established before services can be initiated.

317:35-15-4. Determination of medical eligibility for Personal Care

(a) **Eligibility.** The OKDHS area nurse~~, or designee, utilizes the UCAT criteria and professional judgment in determining medical eligibility and level of care. To be eligible for Personal Care services, the individual must:~~<u>determines medical eligibility for Personal Care services based on the UCAT and the determination that the member has unmet care needs that require Personal Care services. Personal Care services are initiated to support the informal care that is being provided in the member's home. Personal Care services are not intended to take the place of regular care and general maintenance tasks or meal preparation shared or done for one another by natural supports such as spouses or other adults who live in the same household. Additionally, Personal Care services are not furnished when they principally benefit the family unit. To be eligible for Personal Care services, the individual must:</u>

(1) have adequate informal supports that contribute to care, or decision making ability as documented on the UCAT, to remain in his/her home without risk to his/her health, safety, and well-being:

(A) the individual must have the decision making ability to respond appropriately to situations that jeopardize his/her health and safety or available supports that compensate for his/her lack of ability as documented on the UCAT, or

(B) the individual who has his/her decision making ability, but lacks the physical capacity to respond appropriately to situations that jeopardize health and safety and has been informed by the OKDHS nurse of potential risks and consequences may be eligible;

(2) require a plan of care involving the planning and administration of services delivered under the supervision of professional personnel;

(3) have a physical impairment or combination of physical and mental impairments <u>as documented on the UCAT</u>. An individual who poses a threat to self or others as supported by professional documentation may not be approved for Personal Care services;

(4) not have 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;

(5) lack the ability to meet personal care needs without additional supervision or assistance, or to communicate needs to others; and

(6) require assistance, not of a technical nature, to prevent or minimize physical health regression and deterioration.

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

(1) **"ADL"** means the activities of daily living. Activities of daily living are activities that reflect the member's ability to perform self-care tasks essential for sustaining health and safety such as:

(A) bathing,
(B) eating,
(C) dressing,
(D) grooming,
(E) transferring (includes activities such as getting in and out of a tub, bed to chair, etc.),
(F) mobility,
(G) toileting, and
(H) bowel/bladder control.

(2) **"ADLs score of three or greater"** means the member cannot do at least one ADL at all or needs some help with two or more ADLs.

~~(3) **"ADLs score is two"** means the member needs some help with one ADL.~~

~~(4) **"Client**~~(3) **"Consumer support very low need"** means the member's UCAT ~~Client~~Consumer Support score is zero which indicates, in the UCAT assessor's clinical judgment, formal and informal sources are sufficient for present level of member need in most functional areas.

~~(5) **"Client**~~(4) **"Consumer support low need"** means the member's UCAT ~~Client~~Consumer Support score is ~~5~~five which indicates, in the UCAT assessor's clinical judgment, support from formal and informal sources are nearly sufficient for present level of member need in most functional areas. The member, family, or informal supports are meeting most needs typically expected of family or household members to share or do for one another, such as general household maintenance. There is little risk of institutional placement with loss of current supports.

~~(6) **"Client**~~(5) **"Consumer support moderate need"** means the UCAT ~~Client~~Consumer score is 15~~,~~ which indicates, in the UCAT assessor's clinical judgment, formal and informal support is available, but overall, it is inadequate, changing, fragile, or otherwise problematic. The member requires additional

assistance that usually includes personal care assistance with one or more ADL tasks not available through Medicare, the Veterans Administration, or other federal entitlement programs. Support provided by informal caregivers is of questionable reliability due to one or more of the following:

A. care or support is required continuously with no relief or backup available;

B. informal support lacks continuity due to conflicting responsibilities such as work or child care;

C. care or support is provided by persons with advanced age or disability; or

D. institutional placement can reasonably be expected with any loss of existing support

~~(7) "**Client**~~(6) **"Consumer support high need"** means the member's UCAT ~~Client~~Consumer score is 25 which indicates, in the UCAT assessor's clinical judgment, formal and informal supports are not sufficient as there is very little or no support available to meet a high degree of member need.

~~(8)~~(7) **"Community Services Worker"** means any person employed by or under contract with a community services provider who provides, for compensation or as a volunteer, health-related services, training, or supportive assistance to frail elderly, disabled person(s), or person(s) with developmental disabilities, and who is not a licensed health professional.

~~(9)~~(8) **"Community Services Worker Registry"** means a registry established by the ~~Oklahoma Department of Human Services~~OKDHS, as required by Section 1025.1 et seq. of Title 56 of the Oklahoma Statutes, to list community services workers against whom a final investigative finding of abuse, neglect, or exploitation, as defined in Section 10-103 of Title 43A of the Oklahoma Statutes, involving a frail elderly, disabled person(s), or person(s) with developmental disabilities has been made by OKDHS or an administrative law judge, amended in 2002, to include the listing of SoonerCare ~~personal care assistants~~PCAs providing personal care services.

~~(10)~~(9) **"Instrumental activities of daily living (IADL)"** means those activities that reflect the member's ability to perform household chores and tasks within the community essential for sustaining health and safety such as:

(A) shopping,
(B) cooking,
(C) cleaning,
(D) managing money,
(E) using a telephone,
(F) doing laundry,
(G) taking medication, and
(H) accessing transportation.

~~(11) "**IADL**" means the instrumental activities of daily living.~~

~~(12)~~(10) "**IADLs score is at least six**" means the member needs some help with at least three IADLs or cannot do two IADLs at all.

~~(13)~~(11) "**IADLs score of eight or greater**" means the member needs some help with at least four IADLs or the member cannot do two IADLs at all and needs some help with one or more other IADLs.

~~(14) **"SoonerCare personal care services provider"** means a program, corporation, or individual who provides services under the state's SoonerCare personal care program or ADvantage Waiver to individuals who are elderly or who have a physical disability.~~

~~(15)~~(12) **"MSQ"** means the mental status questionnaire.

~~(16)~~(13) **"MSQ moderate risk range"** means a total weighted score of seven ~~or more~~to eleven which indicates an orientation-memory-concentration impairment or ~~a~~ memory impairment.

~~(17)~~(14) **"Nutrition moderate risk"** means the total weighted UCAT Nutrition score is ~~8~~eight or more which indicates poor appetite or weight loss combined with special diet requirements, medications, or difficulties in eating.

~~(18)~~(15) **"Social resources score is eight or more"** means the member lives alone or has no informal support when sick or needs assistance, or has little or no contact with others.

(c) **Medical eligibility minimum criteria for Personal Care.** The medical eligibility minimum criteria for Personal Care ~~is~~are the minimum UCAT score criteria which a member must meet for medical eligibility for personal care and are:

(1) ~~functional~~ ADLs score is a five or greater; or IADLs score of eight or greater; or Nutrition score is eight or greater; or the MSQ score is seven or greater; or the ADLs score is three and IADLs score is at least six~~,~~; and

(2) ~~Client~~Consumer Support is ~~moderate risk~~15 or more; or ~~Client~~Consumer Support score is five and the Social Resources score is eight or more.

(d) **Medical eligibility determination.** Medical eligibility for Personal Care is determined by the ~~Oklahoma Department of Human Services~~OKDHS. The medical decision for Personal Care is made by the OKDHS area nurse~~, or designee,~~ utilizing the ~~Uniform Comprehensive Assessment Tool (UCAT)~~UCAT.

~~(1) When Personal Care services are requested, the local office is responsible for completing the UCAT, Part III.~~

~~(2)~~(1) Categorical relationship must be established for determination of eligibility for Personal Care. If categorical relationship to Aid to the Disabled has not already been established, but there is an extremely emergent need for Personal Care and current medical information is not available, the local office authorizes a medical examination.

When authorization is necessary, the county director issues the Authorization for Examination, OKDHS form 08MA016E, and the Report of Physician's Examination, OKDHS form 08MA02E, to a licensed medical or osteopathic physician (refer to OAC 317:30-5-1). The physician cannot be in a medical facility intern, residency, or fellowship program or in the full time employment of the Veterans Administration, Public Health Service, or other agency. The OKDHS county worker submits the information to the Level of Care Evaluation Unit (LOCEU) to request a determination of eligibility for categorical relationship. LOCEU renders a decision on categorical relationship using the same definition used by SSA. A follow-up is required by the OKDHS county worker with the Social Security Administration (SSA) to be sure that SSA's disability decision agrees with the decision of LOCEU.
~~(3)~~(2) Approved contract agencies or the AA may complete the UCAT Part I for intake and screening and forward the form to the county office.
~~(4) When the OKDHS county office does not receive a UCAT from the AA, a UCAT I is initiated by the DHS county staff upon receipt of the referral.~~(3) Upon receipt of the referral, OKDHS county staff may initiate the UCAT, Part I.
~~(5) The OKDHS nurse completes the assessment visit within 10 working days of receipt of the referral for Personal Care from the OKDHS county worker or receipt of the UCAT I (Intake and Screening) request for Personal Care for the member who is SoonerCare eligible at the time of the request. The OKDHS nurse completes the assessment visit within 20 working days of SoonerCare application for the applicant who has not been determined financially SoonerCare eligible at the time of the request. The OKDHS county worker is responsible for contacting the applicant within three working days from the date of the receipt of the request for services to initiate the financial eligibility process.~~(4) The OKDHS nurse is responsible for completing the UCAT assessment visit within 10 working days of the Personal Care referral for the applicant who is SoonerCare eligible at the time of the request. The OKDHS nurse completes the assessment visit within 20 working days of the referral for the applicant not determined SoonerCare eligible at the time of the request. If the UCAT Part I indicates the request is from an individual who resides at home and an immediate response is required to ensure the health and safety of the person (emergency situation) or to avoid institutional placement, the UCAT Part III assessment visit has top priority for scheduling.
~~(6)~~(5) During the assessment visit, the OKDHS nurse completes the UCAT ~~III~~ and reviews with the member rights to privacy, fair hearing, ~~and~~ provider choice, and the pre-service

acknowledgement agreement. The OKDHS nurse informs the ~~member~~applicant of medical eligibility criteria and provides information about ~~the different~~ OKDHS long-term care service options. The OKDHS nurse documents on the UCAT III whether the member wants to be considered for nursing facility level of care services or if the member is applying for a specific service program. If, based upon the information obtained during the assessment, the OKDHS nurse determines the member may be at risk for health and safety, an immediate referral is made to Adult Protective Services (APS). The referral is documented on the UCAT.

(A) If the ~~member's~~applicant's needs cannot be met by Personal Care services alone, the OKDHS nurse informs the ~~member~~applicant of the other community ~~long term~~long-term care service options. The OKDHS nurse assists the ~~member~~applicant in accessing service options selected by the ~~member~~applicant in addition to, or in place of, Personal Care services.

(B) If multiple household members are applying for SoonerCare Personal Care services, the UCAT assessment is done for all the household members at the same time.

(C) The OKDHS nurse informs the ~~member~~applicant of the qualified agencies in their local area available to provide services and obtains the ~~member's~~applicant's primary and secondary choice of agencies. If the ~~member~~applicant or family declines to choose a primary personal care service agency, the OKDHS nurse selects an agency from a list of all available agencies, using a round-robin system. The OKDHS nurse documents the name of the selected personal care ~~service~~provider agency.

~~(7)~~(6) The OKDHS nurse completes the UCAT ~~III~~ within three working days of the assessment visit and sends it to the OKDHS area nurse~~, or designee,~~ for medical eligibility determination. Personal ~~care~~Care service eligibility is established as ~~of~~ the date ~~that both~~when medical eligibility is approved and financial eligibility is established. This date serves as the certification date for services to be initiated.

(A) If the length of time from the date the initial assessment to the date of service eligibility determination exceeds ~~60~~90 days, ~~the assessment must be updated as necessary including a new signature and date. A~~a new UCAT and assessment visit is required ~~if the length of time exceeds 90 days.~~

(B) ~~Upon establishment of Personal Care service eligibility, the OKDHS nurse contacts the member's preferred personal care service agency, or if necessary, the secondary agency or the agency selected by the~~

~~rotation system.~~The OKDHS area nurse assigns a medical certification period of not more than 36 months. The service plan period under the Service Authorization Model (SAM) is for a period of 12 months and is provided by the OKDHS nurse.

~~(C) Within one working day of agency acceptance, the OKDHS nurse forwards the referral to the personal care service agency for Service Authorization Model (SAM) packet development. [Refer to OAC 317:35-15-8(a)]. The date the referral is forwarded is the certification effective date.~~

~~(8) Following the development of the Service Authorization Model (SAM) packet by the personal care service agency, and within three working days of receipt of the packet from the agency, the OKDHS nurse reviews the packet to ensure agreement with the plan. Once agreement is established, the packet is forwarded to the OKDHS area nurse or designees for review.~~(7) The OKDHS area nurse notifies the OKDHS county worker via ELDERS of the Personal Care certification. The authorization line is open via automation from ELDERS and five visits by a skilled nurse are automatically authorized.

~~(9) Within 10 working days of receiving the Service Authorization Model (SAM) packet from the OKDHS nurse, the OKDHS area nurse, or designee, certifies or denies the Service Authorization Model (SAM) packet. If there is certification, the OKDHS area nurse enters into the system the units authorized. Service Authorization Model (SAM) packets that fail to meet authorization are returned to the OKDHS nurse for revision or further justification by the personal care service agency.~~(8) Upon establishment of Personal Care certification, the OKDHS nurse contacts the member's preferred provider agency, or when necessary, the secondary provider agency, or the provider agency selected by the round robin system. Within one working day of provider agency acceptance, the OKDHS nurse forwards the referral information to the provider agency for SAM plan development (see OAC 317:35-15-8(a)).

~~(10) The OKDHS area nurse, or designee, assigns a medical certification period of not more than 36 months. The service plan certification period under the Service Authorization Model (SAM) is for a period of 12 month.~~(9) Following the SAM packet development by the provider agency, and within three working days of receipt of the packet from the agency, the OKDHS nurse reviews the documentation to ensure agreement with the plan. Once agreement is established, the packet is authorized by the designee or submitted to the area nurse for review.

~~(11) Once the OKDHS nurse is notified of the service plan authorization, and within one working day, forwards copies of~~

~~the certified Personal Care Service Plan [OKDHS form 02AG031E (AG-6)] to the agency.~~(10) Within 10 working days of receipt of the SAM case from the OKDHS nurse, the OKDHS area nurse either authorizes or denies the SAM units. If the SAM case fails to meet standards for authorization, the case is returned to the OKDHS nurse for revision for further justification.

~~(12) The OKDHS nurse notifies the OKDHS county worker in writing of the service and the number of authorized personal care service units including the start and end dates. The OKDHS county worker opens the service authorization. These steps are automated via ELDERS. Once the authorization is opened, five Service Authorization Model (SAM) visits by a skilled nurse are automatically authorized.~~(11) Within one working day of knowledge of the authorization, the OKDHS nurse forwards the service plan authorization to the provider agency.

317:35-15-7. Certification for Personal Care

(a) **Personal Care certification period.** The first month of the Personal Care certification period must be the first month the member was determined eligible for Personal Care, both financially and medically.

(1) As soon as eligibility or ineligibility for Personal Care is established, the local office updates the computer form and the appropriate notice is computer generated. Notice information is retained on the notice file for county use.

(2) An applicant approved for Personal Care under SoonerCare as categorically needy is mailed a Medical Identification Card.

(b) **Financial certification period for Personal Care Services.** The financial certification period for Personal Care services is 12 months. Redetermination of eligibility is completed according to the categorical relationship.

~~(b)~~(c) **Medical certification period for Personal Care services.** A medical certification period of not more than 36 months is assigned for an individual who is approved for Personal Care. The certification period for Personal Care is based on the UCAT evaluation and clinical judgment of the OKDHS area nurse or designee.

317:35-15-8. Agency Personal Care Service Authorization and Monitoring

(a) Within ten working days of receipt of the referral for Personal Care services, the Personal Care ~~Assessment/Service Planning Nurse~~provider agency nurse completes a ~~Service Authorization Model (SAM)~~SAM visit in the home to assess the member's Personal Care service needs, completes a ~~Service~~

~~Authorization Model (SAM)~~SAM packet based on the member's needs and submits the packet to the OKDHS nurse. The member's ~~Service Authorization Model (SAM)~~SAM packet includes:

(1) ~~State Plan~~ Personal Care Progress Notes (OKDHS form 02AG044E);

(2) Personal Care Planning Schedule/Service Plan [OKDHS form 02AG030E (AG-5)/02AG031E (AG-6)]; and

(3) Personal Care Plan [OKDHS form 02AG029E (AG-4)]~~; and~~.

~~(4) Personal Care Service Plan [02AG031E (AG-6)].~~

(b) If more than one person in the household has been referred to receive Personal Care services, all household members' ~~Service Authorization Model (SAM)~~SAM packets are discussed and developed with the eligible members so service delivery can be coordinated to achieve the most efficient use of resources. The number of units of Personal Care service authorized for each individual is distributed between all eligible family members to assure that the absence of one family member does not adversely affect the family member(s) remaining in the home. If one or more persons in the same household with a Personal Care member have been referred or are receiving other formal services, then those services are coordinated as well.

(c) The Personal Care ~~service~~provider agency receives ~~a certified Service Plan [OKDHS form 02AG031E (AG-6)]~~documentation from OKDHS as authorization to begin services. The agency delivers a copy of the care plan [OKDHS form 02AG029E(AG-4)] and ~~service plan~~the Personal Care Planning Schedule/Service Plan to the member upon initiating services.

(d) Prior to placing a ~~Personal Care attendant~~PCA in the member's home or other service-delivery setting, an ~~OSBI~~Oklahoma State Bureau of Investigation (OSBI) background check, ~~and~~an Oklahoma State Department of Health Registry check, and an OKDHS Community Services Worker Registry must be completed in accordance with Sections 1-1944 through 1-1948 of Title 63 of the Oklahoma Statutes. Payment is made for PCAs who provide Personal Care services who also meet the criteria as defined in OAC 317:35-15-2(c)(1)(1 through 8).

(e) The ~~Personal Care Assessment/Service Planning Nurse~~provider agency nurse monitors their member's plan of care.

(1) The Personal Care ~~service~~ provider agency contacts the member within five working days of receipt of the ~~approved care Service Plan [OKDHS form 02AG031E (AG-6)]~~authorized document in order to ~~make sure~~ensure that services have been implemented and the needs of the member are being met.

(2) The ~~Personal Care Assessment/Service Planning Nurse~~provider agency nurse makes a ~~Service Authorization Model (SAM)~~SAM home visit at least every six months to assess the member's satisfaction with their care and to evaluate the ~~Service Authorization Model (SAM)~~SAM packet for adequacy of

goals and ~~units~~ authorized units. Whenever a home visit is made, the ~~Personal Care Assessment/Service Planning Nurse~~the provider agency nurse documents their findings in the ~~State Plan~~ Personal Care Progress Notes~~ (OKDHS form 02AG044E)~~. The ~~personal care~~provider agency forwards a copy of the Progress Notes to the OKDHS nurse for review within 5 business days of the visit. The monitoring visit may be conducted by ~~an LPN. If an LPN or social worker conducts the monitoring visit, an RN must~~a Licensed Practical Nurse only when the PCA is not performing hands-on personal care. A Registered Nurse must also co-sign the progress notes.

(3) Requests by the ~~Personal Care service~~provider agency nurse to change the number of units authorized in the ~~Service Authorization Model (SAM)~~SAM packet are submitted to OKDHS and are approved or denied by the OKDHS area nurse, or designee, prior to implementation of the changed number of units.

(4) Annually, or more frequently if the member's needs change, the ~~Personal Care Assessment/Service Planning Nurse~~provider agency nurse re-assesses the member's need and develops a new ~~Service Authorization Model (SAM) eligibility~~ SAM packet to meet ~~personal care~~the member's needs. The provider agency nurse conducts a home visit and completes and submits the annual reassessment documents to the OKDHS nurse no sooner than 60 days before the existing service plan end-date, but sufficiently in advance of the end-date.

(5) If the member is unstaffed, the ~~Personal Care service~~ provider agency communicates with the member and makes efforts to ~~restaff.~~re-staff. It is recommended the provider agency contacts unstaffed members weekly by telephone to actively monitor the health and safety of the member and documents ongoing efforts to provide staff. If the member is unstaffed for 30 calendar days, the provider agency notifies the OKDHS nurse on an OKDHS form 02AG032E~~ (AG-7)~~, Provider Communication Form. The OKDHS nurse contacts the member and if the member chooses, initiates a transfer of the member to another ~~Personal Care service~~provider agency that can provide staff.

317:35-15-8.1. Agency Personal Care services; billing, and issue resolution

The ~~ADvantage Administration (AA)~~AA certifies qualified Personal Care ~~service~~provider agencies and facilitates the execution of the agencies' SoonerCare contracts on behalf of the OHCA. The OHCA will check the list of providers that have been barred from Medicare/SoonerCare participation to ensure that the Personal Care services agency is not listed.

(1) **Payment for Personal Care.** Payment for Personal Care

services is ~~generally~~ made for care provided in the member's "own home" or in other limited types of living arrangements in accordance with OAC 317:35-15-2(b)(1 through 4). ~~In addition to an owned or rented home, a rented apartment, room or shelter shared with others is considered to be the member's "own home". A facility that meets the definition of a nursing facility, room and board, licensed residential care facility, licensed assisted living facility, group home, rest home or a specialized home as set forth in O.S. Title 63, Section 1-819 et seq., Section 1-890.1 et seq., and Section 1-1902 et seq., and/or in any other type of settings prohibited under applicable federal or state statutes, rules, regulations, or other written instruments that have the effect of law is not a setting that qualifies as the member's "own home" for delivery of Personal Care services through SoonerCare. With prior approval of the OKDHS area nurse, Personal Care services may be provided in an educational or employment setting to assist the member in achieving vocational goals identified on the care plan.~~

(A) **Use of ~~Personal Care service~~provider agency.** To provide Personal Care services, an agency must be licensed by the Oklahoma State Department of Health, meet certification standards identified by OKDHS, and possess a current SoonerCare contract.

(B) **Reimbursement.** Personal Care services payment on behalf of a member is made according to the type of service and number of units of Personal Care services authorized in the ~~Service Authorization Model (SAM)~~SAM packet.

(i) The amount paid to ~~Personal Care services providers~~ provider agencies for each unit of service is according to the established SoonerCare rates for the Personal Care services. Only authorized units contained in each eligible member's individual ~~Service Authorization Model (SAM)~~SAM packet are eligible for reimbursement. ~~Providers~~Provider agencies serving more than one Personal Care service member residing in the same residence will assure that the members' ~~Service Authorization Model (SAM)~~SAM packets combine units in the most efficient manner possible to meet the needs of all eligible persons in the residence.

(ii) Payment for Personal Care services is for tasks performed in accordance with OAC 317:30-5-951 only when listed on an authorized plan of care. Payment for Personal Care skilled nursing service is made on behalf of the member for assessment/evaluation and associated service planning per ~~assessment/service planning~~SAM nursing visit ~~by the Personal Care~~

~~Assessment/Service Planning Nurse~~.

(2) **Issue resolution.**

(A) The provider agency provides a written copy of their grievance process to each member at the commencement of services. The written grievance process includes the name and phone number of a provider agency contact person who is responsible for responding to such complaints and grievances. If the member is dissatisfied with the Personal Care ~~services~~ provider agency or the assigned PCA~~,~~ and has exhausted attempts to work with the Personal Care ~~services~~provider agency's grievance process without resolution, the member may contact the OKDHS nurse to attempt to resolve the ~~issues~~issue(s). The OKDHS nurse is to contact the State Plan Care unit for issues that cannot be resolved between the OKDHS nurse and the Personal Care Provider agency. The member has the right to appeal to the OHCA in accordance with OAC 317:2-1-2. ~~For members receiving ADvantage services, the member or family should contact their case manager for the problem resolution. If the problem remains unresolved, the member or family should contact the Consumer Inquiry System (CIS). Providers are required to provide the CIS contact number to every member.~~ ~~The ADvantage Program member also has the right to appeal to the OHCA in accordance with OAC 317:2.~~

(B) When a problem with performance of the ~~Personal Care attendant~~PCA is identified, the provider agency staff will conduct a counseling conference with the member and/or the ~~attendant~~PCA as appropriate. ~~Agency~~The Provider agency staff will counsel the ~~attendant~~PCA regarding problems with his/her performance.

(3) **Persons ineligible to serve as ~~Personal Care Assistants~~PCAs.** Payment from SoonerCare funds for Personal Care services may not be made to an individual who is a legally responsible family member ~~(spouse, legal guardian or parent of a minor child)~~ of the member, such as a spouse, legal guardian, or parent of minor child, to whom he/she is providing personal care services.

317:35-15-9. Redetermination of financial eligibility for Personal Care

The OKDHS county ~~worker~~Social Services Specialist must complete a redetermination of financial eligibility before the end of the certification period. A notice is generated only if there is a change which affects the ~~client's~~member's financial eligibility.

317:35-15-10. Redetermination of medical eligibility for Personal Care services

(a) **Medical eligibility redetermination.** The OKDHS area nurse~~, or designee,~~ must complete a redetermination of medical eligibility before the end of the long-term care medical certification period.
(b) **Recertification.** The OKDHS nurse re-assesses the Personal Care services member for medical re-certification based on the member's needs and level of caregiver support required, using the UCAT at least every 36 months. During this re-certification assessment, the OKDHS nurse informs the member of the state's other SoonerCare long-term care options. The OKDHS nurse submits the re-assessment to the OKDHS area nurse~~, or designee,~~ for re-certification. Documentation is sent to the OKDHS area nurse~~, or designee,~~ no later than the tenth day of the month in which the certification expires. When the OKDHS area nurse~~, or designee~~ determines medical eligibility for Personal Care services, a re-certification review date is entered on the system.
(c) **Change in amount of units or tasks~~ within Personal Care service for Personal Care service members~~.** When the Personal Care ~~services~~provider agency determines a need for a change in the amount of units or tasks within the Personal Care service, a new ~~Personal Care Service Authorization Model (SAM)~~SAM packet is completed and submitted to OKDHS within five calendar days of identifying the assessed need. The change is approved or denied by the OKDHS area nurse, or designee, prior to implementation.
(d) **Voluntary closure of Personal Care services.** If a member decides Personal Care services are no longer needed to meet his/her needs, a medical decision is not needed. The member and the OKDHS nurse or OKDHS county ~~worker~~Social Services Specialist completes and signs OKDHS form 02AG038E, ~~AG-17, Voluntary Action of Personal Care Case Closure form~~ADv-2, State Plan Personal Care/ADvantage Program Voluntary Withdrawal Request. The OKDHS nurse submits closure notification to the provider agency.
(e) **Resuming Personal Care services.** If a member approved for Personal Care services has been without Personal Care services for less than 90 days but still has a current ~~Personal Care services~~ medical and SoonerCare financial eligibility approval, Personal Care services may be resumed using the member's previously approved ~~Service Authorization Model (SAM)~~SAM packet. The Personal Care ~~service~~provider agency submits a Personal Care services skilled nursing re-assessment of need within ten working days of the resumed plan start date using the State Plan Personal Care Progress Notes, OKDHS form 02AG044E. If the member's needs dictate, the Personal Care ~~services~~provider agency may submit a request for a change in authorized Personal Care services units with a ~~Service Authorization Model (SAM)~~SAM packet to OKDHS.
(f) **Financial ineligibility.** ~~Anytime~~When the OKDHS determines a Personal Care services member does not meet the SoonerCare financial eligibility criteria, the ~~local~~ OKDHS office notifies the

~~member, Personal Care service provider, and the OKDHS nurse of financial ineligibility.~~OKDHS area nurse to initiate the closure process due to financial ineligibility. Individuals determined financially ineligible for Personal Care services are notified by OKDHS in writing of the determination and of their right to appeal the decision. The OKDHS nurse submits closure notification to the provider agency.

(g) **Closure due to medical ineligibility.** ~~If the local OKDHS office is notified through the system that a member is no longer medically eligible for Personal Care, the OKDHS county worker notifies the member of the decision. The OKDHS nurse notifies the Personal Care service agency.~~Individuals determined medically ineligible for Personal Care services are notified by OKDHS in writing of the determination and of their right to appeal the decision. The OKDHS nurse submits closure notification to the provider agency.

(h) **Termination of State Plan Personal Care Services.**

(1) Personal Care services may be discontinued if:

(A) the member poses a threat to self or others as supported by professional documentation; or

(B) 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 member or other household visitors; or

(C) the member or family member fails to cooperate with Personal Care service delivery or to comply with OHCA or OKDHS rules as supported by professional documentation; or

(D) the member's health or safety is at risk as supported by professional documentation; or

(E) additional services, either "formal" (i.e., paid by SoonerCare or some other funding source) or "informal" (i.e., unpaid) are provided in the home eliminating the need for SoonerCare Personal Care services~~.~~; or

(F) the individual's living environment poses a physical threat to self or others as supported by professional documentation where applicable, and measures to correct hazardous conditions or assist the person to move are unsuccessful or are not feasible; or

(G) the member refuses to select and/or accept the services of a provider agency or PCA for 90 consecutive days as supported by professional documentation.

~~(2) The member refuses to select and/or accept the services of a Personal Care service agency or PCA for 90 consecutive days as supported by professional documentation.~~

~~(3)~~(2) For persons receiving Personal Care services, the Personal Care ~~services~~provider agency submits documentation with the recommendation to discontinue services to OKDHS. The OKDHS nurse reviews the documentation and submits it to the

OKDHS Area Nurse for determination. The OKDHS nurse notifies ~~the member and~~ the Personal Care ~~service~~provider agency or PCA, and the local OKDHS county worker of the decision to terminate services. The member is sent an official closure notice informing them of their appropriate member rights to appeal the decision to discontinue services.

317:35-15-13.1. Individual Personal Care service management

(a) An ~~individual PCA~~IPCA may be utilized to provide ~~PC~~Personal Care services when it is documented to be in the best interest of the member to have an ~~individual personal care attendant (PCA)~~IPCA or when there are no qualified ~~PC service~~Personal Care provider agencies available in the member's local area. ~~When an individual PCA is utilized, the OKDHS nurse explains OHCA form HCA-66, Authorization for Withholding of FICA Tax in Personal Care, to the member and obtains his/her signature.~~ OHCA will check the list of providers that have been barred from Medicare/Medicaid participation to ensure that the ~~individual provider~~IPCA is not listed.

(b) After ~~PC~~Personal Care services eligibility is established and prior to implementation of ~~PC~~Personal Care services using an ~~individual PAC~~IPCA, the OKDHS nurse reviews the care plan with the member and ~~individual PCA~~IPCA and notifies the member and ~~PCA~~IPCA to begin ~~PC~~Personal Care services delivery. The OKDHS nurse maintains the original care plan and forwards a copy of the care plan to the ~~chosen PCA~~selected IPCA and member within one working day of ~~notice~~receipt of approval.

(c) The OKDHS nurse contacts the member within five working days to ensure services are in place and meeting the member's needs and also monitors the care plan for members with an ~~individual PCA~~IPCA. For any member receiving ~~PC~~Personal Care services utilizing an ~~individual PCA~~IPCA, the OKDHS nurse makes a home visit at least every ~~180 days~~six months beginning within 90 days of the date of ~~PC~~Personal Care service initiation. OKDHS assesses the member's satisfaction with their ~~PC~~Personal Care services and evaluates the care plan for adequacy of goals and units allocated. Requests for changes in the units authorized in the care plan must be approved by the OKDHS area nurse, or designee, prior to implementation of the changed number of units.

~~(d) If a member requires an individual PCA and is also approved for ADvantage waiver, the ADvantage case manager develops and monitors PC service delivery as part of the ADvantage service plan. The ADvantage case manager reviews the care plan with the member and forwards a copy to the individual PCA. The ADvantage case manager contacts the member within five calendar days of service plan certification by the AA in order to make sure that services have been implemented. The ADvantage case manager contacts the member within 30 calendar days of service plan~~

~~certification by the AA in order to make sure the needs of the member are being met. Requests for changes in authorized PC services units are submitted by the ADvantage case manager for approval or denial by the AA or designee, prior to implementation of the changes in units. The ADvantage case manager contacts the member monthly and makes a home visit at least every 90 days to evaluate the care plan for adequacy of goals and units allocated.~~
~~(e) With the exception of members served by the ADvantage or any other Home and Community Based Services (HCBS) Waiver, the OKDHS nurse is responsible for assessing and monitoring the provision of personal care for Individual Personal Care members. This function involves advocacy, service planning, coordination, monitoring and problem solving with service providers and with families in the provision of services.~~
~~(f) Under certain circumstances, the use of informal supports as individual PCAs may be the only available option for providing services to the member. The ADvantage Program consumer's interdisciplinary team authorizes the use of informal supports for the PC program.~~

~~(1) Components built into the care plan to prevent failure/burnout of informal supports may include, but are not limited to, the following:~~

~~(A) utilization of additional informal supports, other than the one providing PCA services; and~~

~~(B) provision of home-delivered meals, adult day care, or PC services by an agency.~~

~~(2) The ADvantage Program case manager routinely reviews the care plan to ensure the services authorized meet the member's needs and to assess the stability of the informal support system. For members who receive services from an individual PCA, the case manager may increase the frequency of these reviews.~~

317:35-15-13.2. ~~Individual Personal Care~~IPCA provider contractor; billing, training, and problem resolution

While OHCA is the contractor authorized under federal law, the ~~Oklahoma Department of Human Services (OKDHS)~~OKDHS initiates initial contracts with qualified individuals for provision of Personal Care services as defined in OAC 317:35-15-2. The contract renewal for the ~~PCA~~IPCA is the responsibility of the ~~Oklahoma Health Care Authority (OHCA)~~OHCA.

(1) **Payment for ~~Personal Care~~IPCA.** Payment for Personal Care services is ~~generally~~ made for care provided in the member's "own home" or in other limited types of living arrangements in accordance with OAC 317:35-15-2(b)(1 through 4).~~ A facility that meets the definition of a nursing facility, room and board, licensed residential care facility, licensed assisted living facility, group home, rest home or a specialized home~~

~~as set forth in O.S. Title 63, Section 1-819 et seq., Section 1-890.1 et seq., and Section 1-1902 et seq., does not constitute a suitable substitute home. Personal Care may not be approved if the member lives in the PCA's home except with the interdisciplinary team's written approval. The potential individual PCA must meet the minimum requirements under (2) of this subsection. With OKDHS area nurse approval, or for ADvantage waiver members, with service plan authorization and ADvantage Program Manager approval, Personal Care services may be provided in an educational or employment setting to assist the member in achieving vocational goals identified on the service plan.~~

(A) **Reimbursement**. Personal Care payment for a member is made according to the number of units of service identified in the service plan.

(i) The unit amounts paid to individual contractors is according to the established rates. A service plan will be developed for each eligible individual in the home and units of service assigned to meet the needs of each member. The service plans will combine units in the most efficient manner to meet the needs of all eligible persons in the household.

(ii) From the total amounts billed by the ~~individual PCA~~IPCA in (i) of this subparagraph, the OHCA (acting as agent for the member-employer) withholds the appropriate percentage of FICA tax and sends it to the Internal Revenue Service as the individual contractor's contribution toward Social Security coverage. To assure that the individual contractor's social security account may be properly credited, it is vital that the individual contractor's social security number be entered correctly on each claim. ~~In order for the OHCA to withhold FICA tax, the LTC nurse must obtain a signed OHCA Form HCA-66, Authorization for Withholding of FICA Tax in Personal Care, from the member as soon as the area nurse, or designee, has approved Personal Care. A copy of the signed HCA-66 must be in the case record. A signed OHCA-0026, Personal Care Program Individual Contract, must be on file with the OHCA before the individual contractor's first claim can be submitted.~~

(iii) The contractor payment fee covers all Personal Care services included on the service and care plans developed by the ~~LTC~~OKDHS nurse~~ or ADvantage case manager~~. Payment is made for direct services and care of the eligible member(s) only. The area nurse, or designee, authorizes the number of units of service the member receives ~~each month~~.

(iv) A member may select more than one ~~individual contractor~~IPCA. This may be necessary as indicated by the service and care plans.

(v) The ~~individual contractor~~IPCA may provide SoonerCare Personal Care services for several households during one week, as long as the daily number of paid service units do not exceed eight per day. The total number of hours per week cannot exceed 40.

(B) **Release of wage and/or employment information for ~~individual contractors~~IPCAs.** Any inquiry received by the local office requesting wage and/or employment information for an ~~individual Personal Care contractor~~IPCA will be forwarded to the OHCA, Claims Resolution.

(2) **Member selection of ~~individual PCA~~IPCA.** Members and/or family members recruit, interview, conduct reference checks, and select the individual to be considered as an ~~individual contractor~~IPCA. Prior to placing a Personal Care service provider in the member's home, an OSBI background check and registry check must be completed in accordance with Section 1-1944 through 1-1948 of Title 63 of the Oklahoma Statutes. The OKDHS ~~LTC~~ nurse must also check the Certified Nurse ~~Aid~~Aide Registry. The OKDHS ~~LTC~~ nurse must affirm that the applicant's name is not contained on any of the registries. The ~~LTC~~OKDHS nurse will notify the OHCA if the applicant is on the registry.

(A) **Persons eligible to serve as individual Personal Care Assistants.** Payment is made for Personal Care Services to ~~an individual who:~~IPCAs who provide Personal Care services who also meet the criteria as defined in OAC 317:35-15-2(c)(1 through 8).

~~(i) is at least 18 years of age,~~

~~(ii) has no pending notation related to abuse, neglect or exploitation as reported by the Oklahoma State Department of Health Nurse Aide Registry,~~

~~(iii) has no criminal background history or registry listings that prohibit employment,~~

~~(iv) demonstrates the ability to understand and carry out assigned tasks,~~

~~(v) is not a legally responsible family member (spouse, legal guardian, or parent of a minor child) of the member being served,~~

~~(vi) has a verifiable work history and/or personal references, verifiable identification, and~~

~~(vii) meets any additional requirements as outlined in the contract and certification requirements with the Oklahoma Health Care Authority.~~

(B) **Persons ineligible to serve as ~~Personal Care Assistants~~IPCAs.** Payment from SoonerCare funds for

Personal Care services may not be made to an individual who is a legally responsible family member (spouse, legal guardian, or parent of a minor child) of the member ~~to whom he/she is providing personal care services~~being served (exceptions to legal guardian are made only with prior approval from Aging Services Division).

(i) Payment cannot be made to ~~a~~an OKDHS or OHCA employee. Payment cannot be made to an immediate family member of an OKDHS employee who works in the same county without OKDHS/Aging Services Division approval. When a family member relationship exists between an OKDHS ~~LTC~~ nurse and ~~a PCA~~an IPCA in the same county, the ~~LTC~~OKDHS nurse cannot manage services for a member whose ~~individual provider~~IPCA is a family member of the ~~LTC~~OKDHS nurse.

(ii) If it is determined that an OKDHS or OHCA employee is interfering in the process of providing Personal Care ~~Services~~services for personal or family benefit, he/she will be subject to disciplinary action.

(3) **Orientation of the ~~Personal Care Assistant~~IPCA.** When a member selects an ~~individual PCA~~IPCA, the ~~LTC~~OKDHS nurse contacts the individual to report to the county office to complete the ~~ODH~~Oklahoma State Department of Health form 805, Uniform Employment Application for Nurse Aide Staff, and the OKDHS form 06PE039E, Employment Application Supplement, and for a determination of qualifications and orientation. ~~This~~For Personal Care members, this process is the responsibility of the ~~LTC~~OKDHS nurse. The ~~PCA~~IPCA can begin work when:

(A) he/she has been interviewed by the member,

(B) he/she has been oriented by the ~~LTC~~OKDHS nurse,

(C) he/she has executed a contract (OHCA-0026) with the OHCA,

(D) the effective service date has been established,

(E) all registries have been checked and the ~~PCA's~~IPCA's name is not listed,

(F) the Oklahoma State Department of Health Nurse Aide Registry has been checked and no notations were found, and

(G) the OSBI background check has been completed.

(4) **Training of ~~Personal Care Assistants~~IPCAs.** It is the responsibility of the ~~LTC~~OKDHS nurse to make sure ~~for each client,~~ that the ~~PCA~~IPCA has the training needed to carry out the plan of care prior to service initiation for each member.

(5) **Problem resolution related to the performance of the ~~Personal Care Assistant~~IPCA.** When it comes to the attention of the ~~LTC~~OKDHS nurse or ~~worker~~OKDHS Social Services Specialist that there is a problem related to the performance of the ~~PCA~~IPCA, a counseling conference is held between the

member, ~~LTC~~OKDHS nurse, and worker. The ~~LTC~~OKDHS nurse will counsel the ~~PCA~~IPCA regarding problems with his/her performance. Counseling is considered when ~~the~~ staff ~~believe~~believes that counseling will result in improved performance.

(6) **Termination of the ~~PCA~~IPCA Provider Agreement.**

(A) A recommendation for the termination of ~~a PCA's~~an IPCA's contract is submitted to the OHCA and the services of the ~~PCA~~IPCA are suspended immediately when:

(i) ~~a PCA's~~an IPCA's performance is such that his/her continued participation in the program could pose a threat to the health and safety of the member or others; or

(ii) the ~~PCA~~IPCA failed to comply with the expectations outlined in the PCA Provider Agreement and counseling is not appropriate or has not been effective; or

(iii) ~~a PCA's~~an IPCA's name appears on the OKDHS Community Services Worker Registry, any of the registries listed in Section 1-1947 of Title 63 of the Oklahoma Statutes, even though his/her name may not have appeared on the Registry at the time of application or hiring.

(B) The ~~LTC~~OKDHS nurse makes the recommendation for the termination of the ~~PCA~~IPCA to the OKDHS State Office Aging Services Division who then notifies the OHCA Legal Division of the recommendation. When the problem is related to allegations of abuse, neglect, or exploitation, OKDHS Adult Protective Services, State Attorney General's Medicaid Unit, the OHCA, and the Oklahoma State Department of Health are notified by the ~~LTC~~OKDHS nurse.

(C) When the problem is related to allegations of abuse, neglect or exploitation, the ~~LTC~~OKDHS nurse follows the process as outlined in OAC 340:100-3-39.

317:35-15-14. Billing procedures for Personal Care

Billing procedures for Personal Care Services are contained in the OKMMIS Billing and Procedure Manual. Questions regarding billing procedures that cannot be resolved through a study of the manual are referred to the OHCA. Contractors for Personal Care bill on CMS-1500. The ~~OKDHS county office~~OHCA provides instructions to an ~~individual PCA~~IPCA for completion of the claim at the time of the contractor orientation. ~~Each Personal Care contractor~~The contracted provider submits a claim for each member. The ~~contractor~~contracted provider prepares claims for services provided and submits the claims to the fiscal agent who is responsible for assuring that the claims have been properly completed. All Personal Care contractors must have a unique provider number. New ~~contractors~~contracted providers will be

mailed the provider number after they have been placed on the claims processing contractor's provider file. Service time of Personal Care and Nursing is documented solely through the Interactive Voice Response Authentication (IVRA) system after access to the system is made available by OKDHS. The IVRA system provides alternate backup solutions should the automated system be unavailable. In the event of IVRA backup system failure, the provider will document time in accordance with their provider agency backup plan. The provider agency's backup procedures are only permitted when the IVRA system is unavailable.

317:35-15-15. Referral for social services

In many situations, ~~adults~~members who are receiving medical services through SoonerCare need social services. The OKDHS nurse may make referrals for social services to the OKDHS worker in the local office. In addition to these referrals, a request for social services may be initiated by a member or by another individual acting upon behalf of a member.

(1) The OKDHS ~~county worker~~Social Services Specialist is responsible for providing the indicated services or for referral to the appropriate resource outside the Department if the services are not available within the Department.

(2) Among the services provided by the OKDHS ~~worker~~Social Services Specialist are:

(A) Services that will enable individuals to attain and/or maintain as good physical and mental health as possible;

(B) Services to assist patients who are receiving care outside their own homes in planning for and returning to their own homes or to other alternate care;

(C) Services to encourage the development and maintenance of family and community interest and ties;

(D) Services to promote maximum independence in the management of their own affairs;

(E) Protective services, including evaluation of need for and arranging for guardianship; and

(F) Appropriate family planning services, which include assisting the family in acquiring means to responsible parenthood. Services are offered in making the necessary referral and follow-up.

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 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.~~

317:30-3-41. Home and Community Based Services Waivers for persons with physical disabilities

(a) **ADvantage Waiver**. The ADvantage Waiver Program is a Medicaid Home and Community Based Services (HCBS) Waiver used to finance ~~noninstitutional~~non-institutional long-term care services through Oklahoma's SoonerCare program for elderly and disabled individuals in specific waiver areas. To receive 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 Program members must be SoonerCare eligible and reside in the designated service area. The number of members in the ADvantage Waiver is limited.

(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.~~

CHAPTER 50. HOME AND COMMUNITY BASED SERVICES WAIVERS
SUBCHAPTER 3. MY LIFE, MY CHOICE

317:50-3-1. Purpose [REVOKED]

~~The My Life, My Choice 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. To be considered for My Life, My Choice Waiver Program services, individuals must meet the basic criteria set forth under 317:50-3-3.~~

317:50-3-2. Definitions [REVOKED]

~~The following words and terms when used in this subchapter, shall have the following meaning, unless the context clearly indicates otherwise:~~

~~**"ADL"** means the activities of daily living. Activities of daily living are activities that reflect the member's ability to perform self-care tasks essential for sustaining health and safety such as:~~

~~(A) bathing,~~
~~(B) eating,~~
~~(C) dressing,~~
~~(D) grooming,~~
~~(E) transferring (includes getting in and out of a tub, bed to chair, etc.),~~
~~(F) mobility,~~
~~(G) toileting, and~~
~~(H) bowel/bladder control.~~

~~**"ADLs score in high risk range"** means the member's total weighted UCAT ADL score is 10 or more which indicates the member needs some help with 5 ADLs or that the member cannot do 3 ADLs at all plus the member needs some help with 1 other ADL.~~

~~**"ADLs score at the high end of the moderate risk range"** means member's total weighted UCAT ADL score is 8 or 9 which indicates the member needs help with 4 ADLs or the member cannot do 3 ADLs at all.~~

~~**"Cognitive Impairment"** means that the person, as determined by the clinical judgment of the LTC Nurse does not have the capability to think, reason, remember or learn required for self-care, communicating needs, directing care givers and/or using appropriate judgment for maintenance of their own health or safety. The clinical judgment of cognitive impairment is based on MSQ performance in combination with a more general evaluation of cognitive function from interaction with the person during the UCAT assessment.~~

~~**"Developmental Disability"** means a severe, chronic disability of an individual that:~~

~~(A) is attributable to a mental or physical impairment or~~

combination of mental and physical impairments;

(B) is manifested before the individual attains age 22;

(C) is likely to continue indefinitely;

(D) results in substantial functional limitations in three or more of the following areas of major life activity:

(E) self-care;

(F) receptive and expressive language;

(G) learning;

(H) mobility;

(I) self-direction;

(J) capacity for independent living;

(K) economic self-sufficiency; and

(L) reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services, supports, or other assistance that is of lifelong or extended duration and is individually planned and coordinated.

"Environment high risk" means member's UCAT Environment score is 25 which indicates in the UCAT assessor's clinical judgment, the physical environment is strongly negative or hazardous.

"Environment moderate risk" means member's UCAT Environment score is 15 which indicates in the UCAT assessor's clinical judgment, many aspects of the physical environment are substandard or hazardous.

"Health Assessment high risk" means member's UCAT health assessment score is 25 which indicates in the UCAT assessor's clinical judgment, the member has one or more chronic health conditions, whose symptoms are rapidly deteriorating, uncontrolled, or not well controlled and requiring a high frequency or intensity of medical care/oversight to bring under control and whose functional capacity is so limited as to require full time assistance or care performed daily, by, or under the supervision of professional personnel and has multiple unmet needs for services available only through the My Life, My Choice program or a Nursing Facility (NF) and requires NF placement immediately if these needs cannot be met by other means.

"Health Assessment low risk" means member's health assessment score is 5 which indicates, in the UCAT assessor's clinical judgment, the member has one or more chronic, stable, health conditions, whose symptoms are controlled or nearly controlled, which benefit from available, or usually available, medical treatment or corrective measures, and may have an unmet need for a service available only through the My Life, My Choice program or a Nursing Facility (NF) but is not likely to enter a NF if these needs are not met.

"Health Assessment moderate risk" means member's UCAT Health Assessment score is 15 which indicates in the UCAT assessor's

clinical judgment, the member has one or more chronic changing health conditions, whose symptoms are fragile or worsening and require medical care/oversight, to bring under control or to maintain in a stable, controlled state and has multiple unmet needs for services available only through the My Life, My Choice program or a Nursing Facility (NF) and is likely to enter a NF if these needs are not met.

"IADL" means the instrumental activities of daily living.

"IADLs score in high risk range" means member's total weighted UCAT IADL score is 12 or more which indicates the member needs some help with 6 IADLs or cannot do 4 IADLs at all.

"Instrumental activities of daily living" means those activities that reflect the member's ability to perform household chores and tasks within the community essential for sustaining health and safety such as:

(A) shopping,
(B) cooking,
(C) cleaning,
(D) managing money,
(E) using a telephone,
(F) doing laundry,
(G) taking medication, and
(H) accessing transportation.

"Member Support high risk" means member's UCAT Member Support score is 25 which indicates in the UCAT assessor's clinical judgment, excluding from consideration existing Ryan White CARE Act, Indian Health Service, Medicaid NF, My Life, My Choice and/or State Plan Personal Care services, very little or no support is available from informal and formal sources and the member requires additional care that is not available through Medicare, Veterans Administration, or other Federal entitlement programs.

"Member Support moderate risk" means member's UCAT Member Support score is 15 which indicates in the UCAT assessor's clinical judgment, excluding from consideration existing Ryan White CARE Act, Indian Health Service, Medicaid NF, My Life, My Choice and/or State Plan Personal Care services, support from informal and formal sources is available, but overall, it is inadequate, changing, fragile or otherwise problematic and the member requires additional care that is not available through Medicare, Veterans Administration, or other federal entitlement programs.

"Mental Retardation" means that the person has, as determined by a PASRR level II evaluation, substantial limitations in functional ability due to significantly sub-average intellectual functioning related to an event occurring before the age of 18.

"MSQ" means the mental status questionnaire.

"MSQ score in high risk range" means the member's total

~~weighted UCAT MSQ score is 12 or more which indicates a severe orientation-memory-concentration impairment, or a severe memory impairment.~~

~~**"MSQ score at the high end of the moderate risk range"** means the member's total weighted UCAT MSQ score is (10) or (11) which indicates an orientation-memory-concentration impairment, or a significant memory impairment.~~

~~**"Nutrition high risk"** means a total weighted UCAT Nutrition score is 12 or more which indicates the member has significant eating difficulties combined with poor appetite, weight loss, and/or special diet requirements.~~

~~**"Progressive degenerative disease process that responds to treatment"** means a process such as, but not limited to, Multiple Sclerosis (MS), Parkinson's Disease, Human Immunodeficiency Virus (HIV), or Acquired Immunodeficiency Syndrome (AIDS), that, untreated, systematically impairs normal body function which leads to acute illness and/or disability but that reacts positively to a medically prescribed treatment intervention (usually medication) which arrests or significantly delays the destructive action of the process.~~

~~**"Social Resources high risk"** means a total weighted UCAT Social Resources score is 15 or more, which indicates the member lives alone, combined with none or very few social contacts and no supports in times of need.~~

317:50-3-3. My Life, My Choice program overview [REVOKED]

~~(a) The My Life, My Choice program is a Medicaid Home and Community Based Waiver used to finance non-institutional long-term care services for a targeted group of physically disabled adults. My Life, My Choice services are outside the scope of state plan Medicaid services. The 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 Appendix C-1, Schedule VIII. B. 1.) and without such services would be institutionalized.~~

~~(1) To be considered for My Life, My Choice services, individuals must meet the following criteria:~~

~~(A) be 20 to 64 years of age;~~

~~(B) be physically disabled; and~~

~~(C) have transitioned to a home and community based setting through the Living Choice Program;~~

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

~~(A) The UCAT documents need for assistance to sustain health and safety as demonstrated by:~~

~~(i) either the ADLs or MSQ score is in the high risk range; or~~

~~(ii) any combination of two or more of the following:~~

~~(I) ADLs score is at the high end of moderate risk range; or~~

~~(II) MSQ score is at the high end of moderate risk range; or~~

~~(III) IADLs score is in the high risk range; or~~

~~(IV) Nutrition score is in the high risk range; or~~

~~(V) Health Assessment is in the moderate risk range, and, in addition;~~

~~(B) The UCAT documents absence of support or adequate environment to meet the needs to sustain health and safety as demonstrated by:~~

~~(i) Individual Support is moderate risk; or~~

~~(ii) Environment is high risk; or~~

~~(iii) Environment is moderate risk and Social Resources is in the high risk range; or, regardless of whether criteria under (A) of need and (B) of absence of support are met;~~

~~(C) The UCAT documents that:~~

~~(i) the individual has a clinically documented progressive degenerative disease process that will produce health deterioration to an extent that the person will meet OAC 317:50-3-3(a)(2)(A)criteria if untreated; and~~

~~(ii) the individual previously has required hospital or NF level of care services for treatment related to the condition; and~~

~~(iii) a medically prescribed treatment regimen exists that will significantly arrest or delay the disease process; and~~

~~(iv) only by means of My Life, My Choice Program eligibility will the individual have access to the required treatment regimen to arrest or delay the disease process.~~

~~(3) **NF Level of Care Services.** To be eligible for NF level of care services, meeting the minimum UCAT criteria demonstrates the individual must:~~

~~(A) require a treatment plan involving the planning and administration of services that require the skills of licensed or otherwise certified technical or professional personnel, and are provided directly or under the supervision of such personnel;~~

~~(B) have a physical impairment or combination of physical, mental and/or functional impairments;~~

~~(C) require professional nursing supervision (medication, hygiene and/or dietary assistance);~~

~~(D) lack the ability to adequately and appropriately care for self or communicate needs to others;~~

~~(E) require medical care and treatment in order to~~

minimize physical health regression or deterioration;
(F) require care that is not available through family and friends, Medicare, Veterans Administration, or other federal entitlement program with the exception of Indian Health Services; and
(G) require care that cannot be met through Medicaid State Plan Services, including Personal Care, if financially eligible.

(4) Meet service eligibility criteria [see OAC 317:50-3-3(c)].

(5) Meet program eligibility criteria [see OAC 317:50-3-3(d)].

(b) Services provided through the My Life, My Choice Waiver are:

(1) case management;
(2) institutional transition services;
(3) respite;
(4) adult day health care;
(5) environmental modifications;
(6) specialized medical equipment and supplies;
(7) physical therapy;
(8) occupational therapy;
(9) respiratory therapy;
(10) speech therapy;
(11) assistive technology;
(12) audiology treatment and evaluation;
(13) dental services and treatment up to $1,000 annually;
(14) family counseling;
(15) family training;
(16) independent living skills training;
(17) nutrition services;
(18) psychiatry;
(19) psychological services;
(20) vision services;
(21) pharmacological evaluations;
(22) agency companion;
(23) advanced supportive/restorative assistance;
(24) skilled nursing and private duty nursing;
(25) home delivered meals;
(26) hospice care;
(27) medically necessary prescription drugs within the limits of the waiver;
(28) My Life, My Choice personal care;
(29) Personal Emergency Response System (PERS);
(30) Self Directed personal care, respite and advanced supportive/restorative assistance;
(31) Self Directed Goods and Services (SD-GS);
(32) Assisted Living; and
(33) all other SoonerCare medical services within the scope

~~of the State Plan, including SoonerRide non-emergency transportation.~~

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

~~(1) an open My Life, My Choice 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 My Life, My Choice Waiver slots are filled, the individual cannot be certified as eligible for My Life, My Choice Waiver services and the individual's name is placed on a waiting list for entry as an open slot becomes available. My Life, My Choice Waiver slots and corresponding waiting lists, if necessary, are maintained.~~

~~(2) the individual is in the My Life, My Choice Waiver targeted service group. The target group is an individual who is age 20 to 64 with a physical disability.~~

~~(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.~~

~~(d) The My Life, My Choice 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 My Life, My Choice 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 My Life, My Choice 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 My Life, My Choice Waiver services to be met, or if the individual would not require institutionalization if~~

~~needs are not met.~~

~~(5) if, after the service 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.~~

~~(e) 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 My Life, My Choice 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.~~

~~(f) Individuals determined ineligible for My Life, My Choice Waiver program services are notified in writing of the determination and of their right to appeal the decision.~~

317:50-3-4. Application for My Life, My Choice Waiver services [REVOKED]

~~(a) Within 60 days of completion of the Living Choice demonstration program, members choosing to stay in a home and community based setting may apply for transition into the My Life, My Choice Waiver. In order to transition from the Living Choice demonstration program to the My Life, My Choice Waiver, a recertification of eligibility is required. The member must meet all financial and medical eligibility requirements for recertification. The same application and eligibility processes used to certify members for SoonerCare long term care and Living Choice services will be reviewed to ensure any changes in member status will not affect eligibility for the My Life, My Choice Waiver. The original application and eligibility processes are set forth in 317:50-3-4(a)(1) through 317:50-3-6 below.~~

~~(1) 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 is a SoonerCare member at the time of application. A financial application for My Life, My Choice Waiver services consists of the Medical Assistance Application form. The form is signed by the applicant, parent, spouse, guardian or someone else acting on the applicant's behalf.~~

~~(A) All conditions of financial eligibility must be verified and documented in the case record. When current information is already available that establishes financial eligibility, such information may be used by recording source and date of information. If the applicant also wishes to apply for a State Supplemental Payment, either the applicant or his/her guardian must sign the application form.~~

~~(B) An individual 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 SoonerCare application is not being made. The individual and/or spouse must provide documentation of resources. The assessment reflects all countable resources of the couple (owned individually or as a couple) and establishes the spousal share to be protected when subsequent determination of SoonerCare long-term care eligibility is made.~~

~~(C) When SoonerCare application is being made, an assessment of resources must be completed if it was not completed when the individual entered the NF or began receiving home and community based services. For applicants of the My Life, My Choice waiver, those resources owned by the couple the month the application was made determines the spousal share of resources. If the individual applied for SoonerCare at the time of entry into the Living Choice Program, Form MA-11 is not appropriate. However, the spousal share must be determined using the resource information provided on the SoonerCare application form and computed using OKDHS form MA-12, Title XIX Worksheet.~~

~~(2) The date of application is the date the signed application is received or the date when the request for SoonerCare is made orally and the financial application form is signed later. The date of the oral request is noted above the date the form is signed.~~

~~(b) **My Life, My Choice Waiver waiting list procedures.** My Life, My Choice Waiver Program capacity is the number of members that may be enrolled in the Program without exceeding, on an annualized basis, the maximum number authorized by the waiver to be served in the waiver year. If available waiver capacity has been realized, requests for services are not processed as applications, but placed on a waiting list. As available capacity permits, the OHCA selects in chronological order (first on, first off) requests for services from the waiting list to forward for application processing. When waiver capacity exceeds the number on the waiting list and after all persons on the waiting list have been processed, waiting list procedures are suspended.~~

317:50-3-5. My Life, My Choice Waiver program medical eligibility determination [REVOKED]

~~A medical eligibility determination is made for My Life, My Choice Waiver program services based on the Uniform Comprehensive Assessment Tool (UCAT) III assessment, professional judgment and the determination that the member has~~

~~unmet care needs that require My Life, My Choice Waiver Program, or NF level services to assure member health and safety. My Life, My Choice Waiver services are designed to be a continuation of support for the informal care that is being provided in the member's home. These services are not intended to take the place of regular care provided by family members and/or by significant others. When there is an informal (not paid) system of care available in the home, My Life, My Choice Waiver service provision will supplement the system within the limitations of My Life, My Choice Waiver Program policy.~~

~~(1) Categorical relationship must be established for determination of eligibility for My Life, My Choice Waiver services. If categorical relationship to disability has not already been established, the Level of Care Evaluation Unit (LOCEU) will render a decision on categorical relationship to the disabled using the same definition used by SSA. A follow-up is required with the Social Security Administration to be sure their disability decision agrees with the decision of LOCEU.~~

~~(2) Community agencies complete the UCAT, Part I and forward the form to the OHCA. If the UCAT, Part I indicates that the applicant does not qualify for SoonerCare long-term care services, the applicant is referred to appropriate community resources.~~

~~(3) If the UCAT indicates member qualification for SoonerCare services and the needs of the member require an immediate interdisciplinary team (IDT) meeting with home health agency nurse participation to develop a care plan and service plan, the need is documented.~~

~~(4) If, based upon the information obtained during the assessment, the nurse determines that the member may be at risk for health and safety, OKDHS Adult Protective Services (APS) staff are notified immediately and the referral is documented on the UCAT.~~

~~(5) Within ten (10) working days of receipt of a complete My Life, My Choice Waiver application, medical eligibility is determined using level of care criteria and service eligibility criteria.~~

~~(6) Once eligibility has been established, notification is given to the member and the case management provider so that care plan and service plan development may begin. The member's case management provider is notified of the member's name, address, case number and social security number, the units of case management and, if applicable, the number of units of home health agency nurse evaluation authorized for care plan and service plan development, whether the needs of the member require an immediate IDT meeting with home health agency nurse participation and the effective date for member entry into the My Life, My Choice Waiver Program.~~

(7) If the member has a current certification and requests a change to My Life, My Choice Waiver services, a new UCAT is required. The UCAT is also updated when a member requests a change from My Life, My Choice Waiver services to State Plan Personal Care services. If a member is receiving My Life, My Choice Waiver services and requests to go to a nursing facility, a new medical level of care decision is not needed.

(8) When a UCAT assessment has been completed more than 90 days prior to submission for determination of a medical decision, a new assessment is required.

317:50-3-6. Determining financial eligibility for the My Life, My Choice Waiver program [REVOKED]

Financial eligibility for My Life, My Choice Waiver services is determined using the rules on income and resources according to the category to which the individual is related. Only individuals who are categorically related to ABD may be served through the My Life, My Choice Waiver. Income, resources and expenses are evaluated on a monthly basis for all individuals requesting payment for the My Life, My Choice Waiver Program. In determining income and resources for the individual categorically related to ABD, the "family" includes the individual and spouse, if any. However, consideration is not given to the income and resources of a spouse included in a TANF case. If an individual and spouse cease to live together for reasons other than institutionalization, income and resources are considered available to each other through the month in which they are separated. Mutual consideration ceases with the month after the month in which the separation occurs. Any amounts which are actually contributed to the spouse after the mutual consideration has ended are considered. Financial eligibility for individuals in My Life, My Choice Waiver Program services is as follows:

(1) **Individual without a spouse**. For an individual without a spouse, the following rules are used to determine financial eligibility.

(A) **Income eligibility**. To determine the income of the individual, the rules in (i) through (iii) of this subparagraph apply.

(i) If payment of income is made to the individual and another person(s), the income is considered in proportion to the individual's interest.

(ii) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.

(iii) After determination of income, the gross income of the individual cannot exceed the categorically needy standard in OKDHS form 08AX001E, Schedule VIII. B. 1.,

~~to be eligible for My Life, My Choice Waiver services. If the individual's gross income exceeds that standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust OAC 317:35-5-41.6(6)(B)].~~

~~(B) **Resource eligibility**. In order for an individual without a spouse to be eligible for My Life, My Choice Waiver services, his/her countable resources cannot exceed the maximum resource standard for an individual listed in OKDHS form 08AX001E, Schedule VIII. D.~~

~~(C) **Equity in capital resources**. If the equity in the individual's capital resources is in excess of the maximum resource standards, certification is delayed up to 30 days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources can not reasonably be expected to come within standards in one month, the application is denied.~~

~~(2) **Individual with a spouse who receives HCBW services, or is institutionalized in a NF or ICF/MR, or is 65 or over and in a mental health hospital.** For an individual with a spouse who receives HCBW services, or is institutionalized in a NF or ICF/MR, or is 65 or over and in a mental health hospital, resources are determined for each individual as the amount owned by each individual plus one-half of the jointly owned resources of the couple. Once this separation of assets is made, a resource of either spouse is not considered available to the other during the receipt of HCBW program services.~~

~~(A) **Income eligibility.** Income is determined separately for an individual and his/her spouse if the spouse is in a HCBW program, or is institutionalized in a NF or ICF/MR, or is 65 or older and in a mental health hospital. The income of either spouse is not considered as available to the other during the receipt of My Life, My Choice Waiver services. The rules in (i) - (v) of this subparagraph apply in this situation:~~

~~(i) If payment of income is made solely to one or the other, the income is considered available only to that individual.~~

~~(ii) If payment of income is made to both, one-half is considered for each individual.~~

~~(iii) If payment of income is made to either one or both and another person(s), the income is considered in proportion to either spouse's interest (if payment is to that spouse) or one-half of the joint interest if no interest is specified.~~

~~(iv) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.~~

~~(v) After determination of income, the gross income of the individual cannot exceed the categorically needy standard in OKDHS form 08AX001E, Schedule VIII. B. 1., to be eligible for My Life, My Choice Waiver services. If the individual's gross income exceeds this standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust OAC 317:35-5-41.6(6)(B)].~~

~~(B) **Resource eligibility.** In order for an individual with a spouse who receives HCBW services, or is institutionalized in a NF or ICF/MR, or is 65 or older and in a mental health hospital to be eligible for the My Life, My Choice Waiver services, his/her countable resources cannot exceed the maximum resource standard for an individual listed in OKDHS form 08AX001E, Schedule VIII. D.~~

~~(C) **Equity in capital resources.** If the equity in the individual's capital resources is in excess of the maximum resource standards, certification is delayed up to 30 days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources can not reasonably be expected to come within standards in one month, the application is denied.~~

~~(3) **Individual with a spouse in the home who is not in a Home and Community Based Waiver Program**. When only one individual of a couple in their own home is in a HCBW Program, income and resources are determined separately. However, the income and resources of the individual who is not in the HCBW program (community spouse) must be included on the application form. At redetermination of eligibility, the community spouse's income must be included in the review process. During any month that the individual is in My Life, My Choice Waiver program services, the income of the community spouse is not considered available to that individual. The following rules are used to determine the income and resources of each:~~

~~(A) **Income eligibility**. To determine the income of both spouses, the rules in (i) - (v) of this subparagraph apply.~~

~~(i) If payment of income is made solely to one or the other, the income is considered available only to that individual.~~

~~(ii) If payment of income is made to both, one-half is~~

~~considered for each individual.~~

~~(iii) If payment of income is made to either one or both and another person(s), the income is considered in proportion to either spouse's interest (if payment is to that spouse) or one-half of the joint interest if no interest is specified.~~

~~(iv) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.~~

~~(v) After determination of income, the gross income of the individual in the My Life, My Choice Waiver program cannot exceed the categorically needy standard in OKDHS form 08AX001E, Schedule VIII. B. 1., to be eligible for care. If the individual's gross income exceeds this standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust OAC 35-5-41.6(6)(B)].~~

~~(B) **Resource eligibility**. To determine resource eligibility, it is necessary to determine the amount of resources for both spouses for the month of the individual's application for the My Life, My Choice Waiver program. Of the resources available to the couple (both individual and joint ownership) an amount will be protected for the community spouse which will not be considered available to the spouse receiving My Life, My Choice Waiver program services. The amount determined as the spousal share is used for all subsequent applications for SoonerCare, regardless of changes in the couple's resources. The protected spousal share cannot be changed for any reason. When application for SoonerCare is made at the same time the individual begins receiving My Life, My Choice program services, OKDHS Form 08MA012E, Title XIX Worksheet, is used.~~

~~(i) The first step in the assessment process is to establish the total amount of resources for the couple during the month of application of the spouse into the My Life, My Choice Waiver program (regardless of payment source).~~

~~(ii) The community spouse's share is equal to one-half of the total resources of the couple not to exceed the maximum amount of resource value that can be protected for the community spouse, as shown on OKDHS form 08AX001E, Schedule XI.~~

~~(iii) The minimum resource standard for the community spouse, as established by the OHCA, is found on OKDHS form 08AX001E, Schedule XI. When the community spouse's share is less than the minimum standard, an amount may be deemed from the other spouse's share to ensure the minimum resource standard for the community~~

~~spouse. If the community spouse's share equals or exceeds the minimum resource standard, deeming cannot be done.~~

~~(iv) If deeming is necessary to meet the minimum resource standard for the community spouse, the amount that is deemed must be legally transferred to the community spouse within one year of the effective date of certification for SoonerCare. At the first redetermination of eligibility, the worker must document that the resources have been transferred. After the first year of SoonerCare eligibility, resources of the community spouse will not be available to the other spouse and resources cannot be deemed to the community spouse.~~

~~(v) After the month in which the institutionalized spouse and community spouse have met the resource standard and the institutionalized spouse is determined eligible for benefits, no resources of the community spouse, regardless of value, will be considered available to the institutionalized spouse. If the resources of the community spouse grow to exceed the original deemed amount, the State cannot require the community spouse to apply any of these excess resources toward the cost of the care of the institutionalized spouse.~~

~~(vi) When determining eligibility for SoonerCare, the community spouse's share of resources is protected and the remainder considered available to the spouse receiving My Life, My Choice Waiver program services.~~

~~(vii) The resources determined in (i) - (vi) of this subparagraph for the individual receiving My Life, My Choice Waiver program services cannot exceed the maximum resource standard for an individual as shown in OKDHS form 08AX001E, Schedule VIII. D.~~

~~(viii) Once the dollar value of the community spouse's share of resources is established for the month of the other spouse's entry into the My Life, My Choice Waiver program, that amount is used when determining resource eligibility for a subsequent SoonerCare application for Long-Term Care for either spouse.~~

~~(ix) Once a determination of eligibility for SoonerCare is made, either spouse is entitled to a fair hearing. A fair hearing regarding the determination of the community spouse's resource allowance is held within 30 days of the date of the request for the hearing. Either spouse is entitled to a fair hearing if dissatisfied with a determination of:~~

~~(I) the community spouse's monthly income allowance;~~

~~(II) the amount of monthly income otherwise available to the community spouse;~~
~~(III) determination of the spousal share of resource;~~
~~(IV) the attribution of resources (amount deemed); or~~
~~(V) the determination of the community spouse's resource allowance.~~

~~(x) The rules on determination of income and resources are applicable only when an individual receiving My Life, My Choice Waiver program services is likely to remain under care for 30 consecutive days. The 30-day requirement is considered to have been met even if a hospital stay interrupts it or the individual is deceased before the 30-day period ends.~~

~~(C) **Excess resources**. If the equity in the individual's capital resources is in excess of the maximum resource standards, certification is delayed up to 30 days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources cannot reasonably be expected to come within standards in one month, the application is denied.~~

~~(4) **Transfer of assets on or after August 11, 1993 but before February 8, 2006.** An institutionalized individual, an institutionalized individual's spouse, the guardian or legal representative of the individual or individual's spouse who disposes of assets on or after August 11, 1993 but before February 8, 2006 for less than fair market value on or after the look-back date specified in (A) of this paragraph subjects the individual to a penalty period for the disposal of such assets.~~

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

~~(B) For purposes of this paragraph, an "institutionalized" individual is one who is receiving HCBW program services.~~

~~(C) The penalty period begins the first day of the first month during which assets have been transferred and which does not occur in any other period of ineligibility due to an asset transfer. When there have been multiple transfers, all transferred assets are added together to determine the penalty.~~

~~(D) The penalty period consists of a period of ineligibility (whole number of months) determined by dividing the total uncompensated value of the asset by the average monthly cost ($2,000) to a private patient in an NF or Hospital level of care in Oklahoma. In this calculation, any partial month is dropped. There is no limit to the length of the penalty period for these transfers. Uncompensated value is defined as the difference between the fair market value at the time of transfer less encumbrances and the amount received for the resource.~~

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

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

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

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

~~(F) A penalty would not apply if:~~

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

~~(I) the spouse;~~

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

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

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

~~(ii) the individual can show satisfactorily that the intent was to dispose of assets at fair market value or that the transfer was exclusively for a purpose other than eligibility. It is presumed that any transfer of assets made for less than fair market value was made in order to qualify the individual for SoonerCare. In order to rebut this presumption, the individual must present compelling evidence that a transfer was made for reasons other than to qualify for SoonerCare. It~~

~~is not sufficient for an individual to claim that assets were transferred solely for the purposes of allowing another to have them with ostensibly no thought of SoonerCare if the individual qualifies for SoonerCare as a result of the transfer.~~

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

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

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

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

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

~~(G) The individual is advised by a written notice of a period of ineligibility due to transfer of assets. The notice explains the period of ineligibility for payment of My Life, My Choice Waiver program services and the continuance of eligibility for other SoonerCare services.~~

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

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

~~(J) The restoration or commensurate return will not entitle the member to benefits for the period of time that the asset remained transferred. An applicant cannot be certified for My Life, My Choice Waiver program services for a period of asset ineligibility.~~

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

~~(L) When a transfer of assets by the spouse of an individual results in a period of ineligibility and the spouse who made such transfer subsequently becomes~~

~~institutionalized, the period of ineligibility will be apportioned between the two institutionalized spouses.~~

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

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

~~(B) For purposes of this paragraph, an "institutionalized" individual is one who is receiving My Life, My Choice program services.~~

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

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

~~(ii) the date on which the individual is:~~

~~(I) eligible for medical assistance; and~~

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

~~(D) The penalty period:~~

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

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

~~(iii) when there have been multiple transfers, all transferred assets are added together to determine the penalty.~~

~~(E) The penalty period consists of a period of ineligibility determined by dividing the total uncompensated value of the asset by the average monthly cost to a private patient in a nursing facility in Oklahoma shown on OKDHS form 08AX001E. In this calculation, the penalty must include a partial month disqualification based upon the relationship between that fractional amount and the average monthly cost to a private patient in a nursing facility in Oklahoma. There is no limit to the length of the penalty period for these transfers. Uncompensated value is defined as the~~

~~difference between the fair market value at the time of transfer less encumbrances and the amount received for the resource.~~

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

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

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

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

~~(G) Special Situations.~~

~~(i) Separate Maintenance or Divorce.~~

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

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

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

~~(IV) The applicant or member may rebut the presumption of transfer by showing compelling evidence that the uneven division of income or resources was the result of factors unrelated to SoonerCare eligibility.~~

~~(ii) Inheritance from a spouse.~~

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

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

~~does not then elect to receive the statutory share in probate proceedings.~~

~~(H) A penalty would not apply if:~~

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

~~(I) the spouse; or~~

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

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

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

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

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

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

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

~~institutionalized) during his or her expected life.~~

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

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

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

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

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

~~(I) The individual is advised by a written notice of a period of ineligibility due to transfer of assets, a timely process for determining whether an undue hardship waiver will be granted and a process for an adverse determination appeal. The notice explains the period of ineligibility for payment of My Life, My Choice Waiver program services and the continuance of eligibility for other SoonerCare services.~~

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

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

~~(L) The restoration or commensurate return will not entitle the member to benefits for the period of time that the asset remained transferred. An applicant cannot be certified for My Life, My Choice Waiver program services for a period of asset ineligibility.~~

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

this rule is if ownership of a joint account is divided according to the amount contributed by each owner.

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

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

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

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

317:50-3-7. Certification for My Life, My Choice Waiver program services [REVOKED]

(a) **Financial certification period for My Life, My Choice Waiver program services**. The financial certification period for the My Life, My Choice Waiver program is 12 months.

(b) **Medical Certification period for My Life, My Choice Waiver program services**. The medical certification period for My Life, My Choice Waiver program services is 12 months. Reassessment and redetermination of medical eligibility is completed in coordination with the annual recertification of the member's service plan. If documentation supports a reasonable expectation that the member will not continue to meet medical eligibility criteria or have a need for long term care services for more than 12 months, an independent evaluation of medical eligibility is completed before the end of the current medical certification period.

317:50-3-8. Redetermination of eligibility for My Life, My Choice Waiver services [REVOKED]

A redetermination of medical and financial eligibility must be completed prior to the end of the certification period.

317:50-3-9. Member annual level of care re-evaluation and annual re-authorization of service plan [REVOKED]

~~(a) Annually, the case manager reassesses the member's needs and the service plan, especially with respect to progress of the member toward service plan goals and objectives. Based on the reassessment, the case manager develops a new service plan with the member and service providers, as appropriate, and submits the new service plan for certification along with the supporting documentation and the assessment of the existing service plan. The case manager initiates the fourth quarter monitoring to allow sufficient time for certification of a new service plan prior to the expiration date on the existing service plan.~~

~~(b) At a maximum of every 11 months, the case manager makes a home visit to evaluate the My Life, My Choice Waiver member using the UCAT, Parts I and III and other information as necessary as part of the annual service plan development process.~~

~~(1) The case manager's assessment of a member done within a 60-day period prior to the existing service plan end date is the basis for medical eligibility redetermination.~~

~~(2) As part of the service plan recertification process, the member is evaluated for the continued need for Nursing Facility level of care.~~

~~(3) Based on evaluation of the UCAT, a determination of continued medical eligibility is made and recertification of medical eligibility is done prior to the expiration date of current medical eligibility certification. If medical eligibility recertification is not made prior to current medical eligibility expiration, the existing medical eligibility certification is automatically extended until recertification is determined or for 60 days, whichever is less. If the member no longer meets medical eligibility, upon making the level of care determination, the member's "medical eligibility end date" is updated in the system. The member's case manager is notified that the member has been determined to no longer meet medical eligibility for My Life, My Choice Waiver services as of the effective date of the eligibility determination. The member is notified and if the member requests, the case manager helps the member arrange alternate services in place of My Life, My Choice Waiver services.~~

317:50-3-10. My Life, My Choice Waiver services during hospitalization or nursing facility placement [REVOKED]

~~If a member requires hospital or nursing facility services, the case manager assists the member in accessing institutional care, periodically monitors the member's progress during the institutional stay and, as appropriate, updates the service plan and prepares services to start on the date the member is~~

~~discharged from the institution and returns home.~~

~~(1) **Hospital discharge.** When the member returns home from a hospital or when notified of the member's anticipated discharge date, the case manager notifies relevant providers and coordinates the resumption of services.~~

~~(2) **NF placement of less than 30 days.** When the member returns home from a NF stay of 30 days or less or when notified of the member's anticipated discharge date the case manager notifies relevant providers and coordinates the resumption of My Life, My Choice Waiver services in the home.~~

~~(3) **NF placement greater than 30 days.** When the member is scheduled to be discharged and return home from a NF stay that is greater than 30 days, the member's case manager expedites the restart of My Life, My Choice Waiver services for the member.~~

317:50-3-11. Closure or termination of My Life, My Choice Waiver services [REVOKED]

~~(a) **Voluntary closure of My Life, My Choice Waiver services**. If the member requests a lower level of care than My Life, My Choice Waiver services or if the member agrees that My Life, My Choice Waiver services are no longer needed to meet his/her needs, a medical decision is not needed. The closure request is completed and signed by the member and the case manager and placed in the member's case record. Documentation is made of all circumstances involving the reasons for the voluntary termination of services and alternatives for services if written request for closure cannot be secured.~~

~~(b) **Closure due to financial or medical ineligibility**. The process for closure due to financial or medical ineligibility is described in this subsection.~~

~~(1) **Financial ineligibility**. Anytime it is determined that a member does not meet the financial eligibility criteria, the member and provider are notified of financial ineligibility. A medical eligibility redetermination is not required when a financial ineligibility period does not exceed the medical certification period.~~

~~(2) **Medical ineligibility.** When the member is found to no longer be medically eligible for My Life, My Choice Waiver services, the individual and provider are notified of the decision.~~

~~(c) **Closure due to other reasons**. Refer to OAC 317:50-3-3(d).~~

~~(d) **Resumption of My Life, My Choice Waiver services.** If a member approved for My Life, My Choice Waiver services has been without services for less than 90 days and has a current medical and financial eligibility determination, services may be resumed using the previously approved service plan. If a member decides he/she desires to have his/her services restarted after 90 days,~~

~~the member must request the services.~~

317:50-3-12. Eligible providers [REVOKED]

~~My Life, My Choice Program service providers, must be certified by the Oklahoma Health Care Authority (OHCA) and all providers must have a current signed SoonerCare contract on file.~~

~~(1) The provider programmatic certification process verifies that the provider meets licensure, certification and training standards as specified in the Waiver document and agrees to My Life, My Choice Program Conditions of Participation. Providers must obtain programmatic certification to be My Life, My Choice Program certified.~~

~~(2) The provider financial certification process verifies that the provider uses sound business management practices and has a financially stable business.~~

~~(3) Providers may fail to gain or may lose Waiver Program certification due to failure to meet either programmatic or financial standards.~~

~~(4) At a minimum, provider financial certification is reevaluated annually.~~

~~(5) Providers of Medical Equipment and Supplies, Environmental Modifications, Personal Emergency Response Systems, Hospice, and NF Respite services do not have a programmatic evaluation after the initial certification.~~

~~(6) OHCA may authorize a legally responsible family member (spouse or legal guardian) of an adult member to be SoonerCare reimbursed under the My Life, My Choice Program as a service provider, if the provider meets all of the following authorization criteria and monitoring provisions:~~

~~(A) Authorization for a legally responsible family member to be the care provider for a member may occur only if the member is offered a choice of providers and documentation demonstrates that:~~

~~(i) either no other provider is available; or~~

~~(ii) available providers are unable to provide necessary care to the member; or~~

~~(iii) the needs of the member are so extensive that the spouse or legal guardian who provides the care is prohibited from working outside the home due to the member's need for care.~~

~~(B) The service must:~~

~~(i) meet the definition of a service/support as outlined in the federally approved Waiver document;~~

~~(ii) be necessary to avoid institutionalization;~~

~~(iii) be a service/support that is specified in the individual service plan;~~

~~(iv) be provided by a person who meets the provider~~

~~qualifications and training standards specified in the Waiver for that service;~~

~~(v) be paid at a rate that does not exceed that which would otherwise be paid to a provider of a similar service and does not exceed what is allowed by the OHCA for the payment of personal care or personal assistance services;~~

~~(vi) not be an activity that the spouse or legal guardian would ordinarily perform or is responsible to perform. If any of the following criteria are met, assistance or care provided by the spouse or guardian will be determined to exceed the extent and/or nature of the assistance they would be expected to ordinarily provide in their role as spouse or guardian:~~

~~(I) spouse or guardian has resigned from full-time/part-time employment to provide care for the member; or~~

~~(II) spouse or guardian has reduced employment from full-time to part-time to provide care for the member; or~~

~~(III) spouse or guardian has taken a leave of absence without pay to provide care for the member; or~~

~~(IV) spouse or guardian provides assistance/care for the member 35 or more hours per week without pay and the member has remaining unmet needs because no other provider is available due to the nature of the assistance/care, special language or communication, or intermittent hours of care requirements of the member.~~

~~(C) The spouse or legal guardian who is a service provider will comply with the following:~~

~~(i) not provide more than 40 hours of services in a seven day period;~~

~~(ii) planned work schedules must be available in advance to the member's Case Manager, and variations to the schedule must be noted and supplied two weeks in advance to the Case Manager unless change is due to an emergency;~~

~~(iii) maintain and submit time sheets and other required documentation for hours paid; and~~

~~(iv) be documented in the service plan as the member's care provider.~~

~~(D) In addition to case management, monitoring, and reporting activities required for all Waiver services, the state is obligated to additional monitoring requirements when members elect to use a spouse or legal guardian as a paid service provider. The OHCA will monitor through~~

documentation submitted by the Case Manager the following:

(i) at least quarterly reviews by the Case Manager of expenditures and the health, safety, and welfare status of the individual member; and

(ii) face-to-face visits with the member by the Case Manager on at least a semi annual basis.

(7) The OHCA periodically performs a programmatic audit of Case Management, Home Care (providers of Skilled Nursing, State Plan Personal Care, In-Home Respite, Advanced Supportive/Restorative Assistance and Therapy Services), and Self-Directed service providers. If due to a programmatic audit, a provider Plan of Correction is required, the OHCA stops new case referrals to the provider until the Plan of Correction has been approved and implemented. Depending on the nature and severity of problems discovered during a programmatic audit, at the discretion of the OHCA, members determined to be at risk for health or safety may be transferred from a provider requiring a Plan of Correction to another provider.

(8) As additional providers are certified or if a provider loses certification, the OHCA provides notice to appropriate personnel in counties affected by the certification changes.

317:50-3-13. Coverage [REVOKED]

Individuals receiving Waiver services must have been determined to be eligible for the program and must have an approved plan of care. Any My Life, My Choice Program service provided must be listed on the approved plan of care and must be necessary to prevent institutionalization of the member. Waiver services which are expansions of Oklahoma Medicaid State Plan services may only be provided after the member has exhausted these services available under the State Plan.

(1) To allow for development of administrative structures and provider capacity to adequately deliver Self-Directed services and Supports, availability of Self-Direction is limited to My Life, My Choice Program members that reside in counties that have sufficient provider capacity to offer the Self-Directed Service option as determined by OHCA.

(2) Case Managers within the Self-Directed Services approved area will provide information and materials that explain the service option to the members. The OHCA provides information and material on Self-Direction to Case Managers for distribution to members.

(3) The member may request to Self-Direct their services from their Case Manager or call the My Life, My Choice Program toll-free number to request the Self-Directed Services option.

317:50-3-14. Description of services [REVOKED]

~~Services included in the My Life, My Choice Waiver Program are as follows:~~

~~(1) **Case Management.**~~

~~(A) Case Management services are services that assist a member in gaining access to medical, social, educational or other services, regardless of payment source of services, that may benefit the member in maintaining health and safety. Case managers initiate and oversee necessary assessments and reassessments to establish or reestablish Waiver program eligibility. Case managers develop the member's comprehensive plan of care, 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 My Life, My Choice Waiver Program minimum requirements for qualification and training prior to providing services to members. Prior to providing services to members choosing to Self-Direct their services, Case Managers are required to receive training and demonstrate knowledge regarding the Self-Directed Service delivery model.~~

~~(B) Providers may only claim time for billable Case Management activities described as follows:~~

~~(i) A billable case management activity is any task or function defined under OAC 317:50-3-14(1)(A) that only a My Life, My Choice 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 OHCA identified zip codes in Osage County adjacent to metropolitan areas of Tulsa and Washington Counties. Services to these members are prior authorized and billed using the Standard rate.~~

~~(iii) The latest United States Census, Oklahoma Counties population data is the source for determination of whether a member resides in a county with a population density equal to or less than 25 persons per square mile, or resides in a county with a population density greater than 25 persons per square mile.~~

~~(2) **Institutional Transition Services.**~~

~~(A) Institutional Transition Case Management Services are Services required by the member's plan of care, which are necessary to ensure the health, welfare and safety of the member, or to enable the member to function with greater independence in the home, and without which, the member would continue to require institutionalization.~~

~~(B) Waiver Transition Case Management services assist institutionalized members that are eligible to receive waiver services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services to assist the transition, regardless of the funding source for the services which access is gained.~~

~~(C) Transition Case Management services may be authorized for periodic monitoring of a waiver member's progress during an institutional stay, and for assisting the member transition from institution to home by updating the services plan, including preparing for necessary services and supports to be in place or to start on the date the member is discharged from the institution.~~

~~(3) **Respite.**~~

(A) Respite services are provided to members who are unable to care for themselves. They are provided on a short-term basis because of the absence or need for relief of the primary caregiver. Payment for respite care does not include room and board costs unless more than seven hours are provided in a nursing facility. Respite care will only be utilized when other sources of care and support have been exhausted. Respite care will only be listed on the plan of care 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.

(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 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.~~

~~(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 include 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 My Life, My Choice Waiver case manager in accordance with review schedule determined in consultation between the Case Manager and the Skilled Nurse, to report the member's condition or other significant information concerning each advanced supportive/restorative care member.~~

~~(i) The case manager may recommend authorization of Skilled Nursing services as part of the interdisciplinary team planning for the member's service plan and/or assessment/evaluation of:~~

~~(I) the member's general health, functional ability and needs and/or~~

~~(II) the adequacy of personal care and/or advanced supportive/restorative assistance services to meet the member's needs including providing on-the-job training and competency testing for personal care or advanced supportive/restorative care aides in accordance with rules and regulations for delegation of nursing tasks as established by the Oklahoma Board of Nursing.~~

~~(ii) In addition to assessment/evaluation, the case manager may recommend authorization of Skilled Nursing services for the following:~~

~~(I) preparing a one-week supply of insulin syringes for a blind diabetic, who can safely self-inject the medication but cannot fill his/her own syringe. This service would include monitoring the member's continued ability to self-administer the insulin;~~

~~(II) preparing oral medications in divided daily compartments for a member who self-administers prescribed medications but needs assistance and monitoring due to a minimal level of disorientation or confusion;~~

~~(III) monitoring a member's skin condition when a member is at risk for skin breakdown due to immobility or incontinence, or the member has a chronic stage II decubitus ulcer requiring maintenance care and monitoring;~~

~~(IV) providing nail care for the diabetic member or member with circulatory or neurological compromise;~~

~~(V) providing consultation and education to the member, member's family and/or other informal caregivers identified in the service plan, regarding the nature of the member's chronic condition. Provide skills training (including return skills demonstration to establish competency) to the~~

member, family and/or other informal caregivers as specified in the service plan for preventive and rehabilitative care procedures.

(C) Nursing service can be billed for service plan development and/or assessment/evaluation services or, for other services within the scope of the Oklahoma Nursing Practice Act including private duty nursing. Nursing services are billed per 15-minute unit of service. A specific procedure code is used to bill for assessment/evaluation/service plan development skilled nursing services and other procedure codes are used to bill for all other authorized nursing services. A maximum of eight units per day of skilled nursing for assessment/evaluation and/or service plan development are allowed. An agreement by a provider to perform a nurse evaluation is also an agreement, to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted. Reimbursement for a nurse evaluation is denied if the provider that produced the nurse evaluation fails to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted.

(8) **Home Delivered Meals.**

(A) Home Delivered Meals provide one meal per day. A home delivered meal is a meal prepared in advance and brought to the member's home. Each meal must have a nutritional content equal to at least one third of the Recommended Daily Allowance as established by the Food and Nutrition Board of the National Academy of Sciences. Meals are only provided to members who are unable to prepare meals and lack an informal provider to do meal preparation.

(B) Home Delivered Meals are billed per meal, with one meal equaling one unit of service. The limit of the number of units a member is allowed to receive is limited on the member's plan of care. The provider must obtain a signature from the member or the member's representative at the time the meals are delivered. In the event that the member is temporarily unavailable (i.e., doctor's appointment, etc.) and the meal is left, the provider must document the reason a signature is not obtained. The signature logs must be available for review.

(9) **Occupational Therapy services.**

(A) Occupational Therapy services are those services that increase functional independence by enhancing the development of adaptive skills and performance capacities of members with physical disabilities and related psychological and cognitive impairments. Services are

~~provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Treatment involves the therapeutic use of self-care, work and play activities and may include modification of the tasks or environment to enable the member to achieve maximum independence, prevent further disability, and maintain health. Under a physician's order, a licensed occupational therapist evaluates the member's rehabilitation potential and develops an appropriate written therapeutic regimen. The regimen utilizes paraprofessional occupational therapy assistant services, within the limits of their practice, working under the supervision of the licensed occupational therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.~~

~~(B) Occupational Therapy services are billed per 15-minute unit of service. Payment is not allowed solely for written reports or record documentation.~~

~~(10) **Physical Therapy services.**~~

~~(A) Physical Therapy services are those services that prevent physical disability through the evaluation and rehabilitation of members disabled by pain, disease or injury. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Treatment involves use of physical therapeutic means such as massage, manipulation, therapeutic exercise, cold or heat therapy, hydrotherapy, electrical stimulation and light therapy. Under a physician's order, a licensed physical therapist evaluates the member's rehabilitation potential and develops an appropriate, written therapeutic regimen. The regimen utilizes paraprofessional physical therapy assistant services, within the limits of their practice, working under the supervision of the licensed physical therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.~~

(B) Physical Therapy services are billed per 15-minute units of service. Payment is not allowed solely for written reports or record documentation.

(11) **Speech and Language Therapy services.**

(A) Speech/Language Therapy services are those that prevent speech and language communication disability through the evaluation and rehabilitation of members disabled by pain, disease or injury. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Services involve use of therapeutic means such as evaluation, specialized treatment, and/or development and oversight of a therapeutic maintenance program. Under a physician's order, a licensed Speech/Language Pathologist evaluates the member's rehabilitation potential and develops an appropriate, written therapeutic regimen. The regimen utilizes paraprofessional therapy assistant services within the limits of their practice, working under the supervision of the licensed Speech/Language Pathologist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The Pathologist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Speech/Language Therapy services are billed per 15-minute unit of service. Payment is not allowed solely for written reports or record documentation.

(12) **Respiratory Therapy services.**

(A) Respiratory therapy services are provided for a member who, but for the availability of in-home respiratory services, would require respiratory care as an inpatient in a hospital or nursing facility. Services are provided in the member's home under the care of a physician who is familiar with the technical and medical components of home ventilator support and the physician must determine medically that in-home respiratory care is safe and feasible for the member. Treatment involves use of therapeutic means such as: evaluation, respiratory treatments, chest physiotherapy, and/or development and oversight of a therapeutic maintenance program. Under a physician's order, a registered respiratory therapist evaluates the member and develops an appropriate, written therapeutic regimen. The regimen includes education and training for informal caregivers to assist with and/or

~~maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.~~

~~(B) Respiratory Therapy services are billed per 15-minute unit of service. Payment is not allowed solely for written reports or record documentation.~~

~~(13)~~ **Hospice services**~~.~~

~~(A) Hospice is palliative and/or comfort care provided to the member and his/her family when a physician certifies that the member has a terminal illness and has six months or less to live and orders hospice Care. My Life, My Choice Hospice Care is authorized for a six month period and requires a physician certification of a terminal illness and orders of hospice care. If the member requires more than six months of hospice care, a physician or nurse practitioner must have a face-to-face visit with the member thirty days prior to the initial hospice authorization end date and re-certify that the member has a terminal illness and has six months or less to live and orders additional hospice care. After the initial authorization period, additional periods of hospice may be authorized for a maximum of 60 day increments with physician certification that the member has a terminal illness and has six months or less to live. A member's service plan that includes hospice care must comply with waiver requirements to be within total service plan cost limits.~~

~~(B) A hospice program offers palliative and supportive care to meet the special needs arising out of the physical, emotional and spiritual stresses which are experienced during the final stages of illness and during dying and bereavement. The member signs a statement choosing hospice care instead of routine medical care that has the objective to treat and cure the member's illness. Once the member has elected hospice care, the hospice medical team assumes responsibility for the member's medical care for the terminal illness in the home environment. Hospice care services include nursing care, physician services, medical equipment and supplies, drugs for symptom control and pain relief, home health aide and personal care services, physical, occupational and/or speech therapy, medical social services, dietary counseling and grief and bereavement counseling to the member and/or family. A Hospice plan of care must be developed by the hospice team in conjunction with the~~

member's case manager before hospice services are provided. The hospice services must be related to the palliation or management of the member's terminal illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills. Hospice may be provided to the member in a Nursing Facility (NF) only when the member is placed in the NF for My Life, My Choice 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 My Life, My Choice Hospice services.

(C) Hospice services are billed per diem of service for days covered by a Hospice plan of care and during which the hospice provider is responsible for providing hospice services as needed by the member or member's family.

(14) **My Life, My Choice Waiver Personal Care.**

(A) My Life, My Choice 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) My Life, My Choice Home Care Agency Skilled Nursing staff working in coordination with a Case Manager are responsible for development and monitoring of the member's Personal Care plan.

(C) My Life, My Choice Personal Care services are prior authorized and billed per 15-minute unit of service with units of service limited to the number of units on the approved plan of care.

(15) **Assisted Living Services.**

(A) Assisted Living Services are personal care and supportive services that are furnished to the member 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.

(B) Assisted Living Services includes services of personal care, housekeeping, laundry, meal preparation, periodic nursing evaluation, 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 coordination of transportation to and from medical appointments.~~

~~(C) Services, except for planned programs for socialization, activities and exercise, are to meet specific needs of the member as determined throughout individualized assessment and documented on the member=s service plan.~~

~~(D) Payment is not made for 24 hour skilled care.~~

~~(16) **Adult Day Health**. Adult Day Health services are scheduled for one or more days per week, in a community setting, encompassing both health and social services needed in order to provide optimal functioning of the member.~~

~~(17) **Assistive Technology**. Assistive technology enables the member to maintain or increase functional capabilities. Assistive technology devices are in addition to equipment and supplies readily available through traditional State Plan services and exclude items that are not of direct medical or remedial benefit to the member. Assistive technology includes the purchase, rental, customization, maintenance and repair of such devices.~~

~~(18) **Audiology Treatment and Evaluation.** Services include evaluation, treatment and consultation related to auditory functioning and are intended to maximize the member's hearing abilities.~~

~~(19) **Agency Companion.** Agency companion services provide a living arrangement developed to meet the specific needs of the member that include a live-in companion providing supervision, supportive assistance, and training in daily living skills provided in a shared home owned or rented by the member, companion, or in a mutually rented or owned home;~~

~~(20) **Dental services**. Dental services include maintenance or improvement of dental health as well as relief of pain and infection. Coverage of dental services may not exceed $1,000 per plan year of care. These services may include:~~

~~(A) oral examination;~~

~~(B) bite-wing x-rays;~~

~~(C) prophylaxis;~~

~~(D) topical fluoride treatment;~~

~~(E) development of a sequenced treatment plan that prioritizes:~~

~~(i) elimination of pain;~~

~~(ii) adequate oral hygiene; and~~

~~(iii) restoration or improved ability to chew;~~

~~(F) routine training of member or primary caregiver~~

~~regarding oral hygiene; and~~
~~(G) preventive restorative, replacement and repair services to achieve or restore functionality are provided after appropriate review if applicable.~~

~~(21) **Family Training.** Family training services are for families of the member being served through the waiver. For purposes of this service, "family" is defined as the persons who live with or provide care to a waiver member and may include a parent, spouse, children relatives, foster family or in-laws. Training includes instruction for the family member in skills and knowledge pertaining to the support and assistance of the waiver member. This training is specific to an individual member's needs. It is intended to allow the member's family to become more proficient in meeting the needs of the member. Specific family training services are included in the member's service plan.~~

~~(22) **Family Counseling.** Family counseling helps to develop and maintain healthy, stable relationships among all family members in order to support meeting the needs of the member. Emphasis is placed on the acquisition of coping skills by building upon family strengths. Knowledge and skills gained through family counseling services increase the likelihood that the member remains in or returns to his or her own home. Services are intended to maximize the member/family's emotional/social adjustment and well-being. All family counseling needs are documented in the member's plan of care. Individual counseling cannot exceed 400, 15-minute units per plan of care year. Group counseling cannot exceed 225, 30-minute units per plan of care year. Case Managers assist the member to identity other alternatives to meet identified needs above the limit.~~

~~(23) **Nutritional Education services.** Nutritional Education services focus on assisting the member and/or primary caregiver with the dietary aspects of the member's disease management. These services include dietary evaluation and consultation with individuals or their care provider. Services are provided in the member's home or when appropriate in a class situation. Services are intended to maximize the individual's nutritional health. Services must be expressly for diagnosing, treating or preventing, or minimizing the effects of illness.~~

~~(24) **Vision services.** Vision services must be listed in the member's plan of care and include a routine eye examination for the purpose of prescribing glasses or visual aids, determination of refractive state, treatment of refractive errors or purchase of glasses to include lenses and frames; exceptions are made on the individual basis as deemed medically necessary. Amount, frequency and duration of~~

~~services is prior authorized in accordance with the member's service plan, with a limit of one pair of glasses to include lenses and frames annually.~~

~~(25) **Independent Living Skills training.** Independent living skills training is a service to support the individual's self-care, daily living, adaptive skills and leisure skills needed to reside successfully in the community. Services are provided in community based settings in a manner that contributes to the individual_s independence, self-sufficiency, community inclusion and well-being. This service is intended to train members with significant cognitive problems living skills such as selecting clothing, dressing, and personal shopping.~~

~~(26) **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 a My Life, My Choice 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 My Life, My Choice approved plan of care.~~

(27) **Prescription drugs.** Members are eligible for a maximum of six prescriptions per month with a limit of three brand name prescriptions. Seven additional generic prescriptions per month are allowed if medically necessary. Medically necessary prescriptions beyond the three brand name or thirteen total prescriptions will be covered with prior authorization. More information on prescription drugs is provided at 317:30-5-72.

(28) **Psychiatry.** Psychiatry provides outpatient psychiatric services provided by a licensed psychiatrist and will be comprised of diagnosis, treatment and prevention of mental illness. These services will also include review, assessment and monitoring of psychiatric conditions, evaluation of the current plan of treatment and recommendations for a continued and/or revised plan of treatment and/or therapy, including required documentation. Psychiatrists may provide instruction and training to individuals, family members, case management staff and/or provider staff in recognition of psychiatric illness and adverse reactions to medications.

(29) **Psychological services.** Psychological services include evaluation, psychotherapy, consultation and behavioral treatment. Services are provided in any community setting as specified in the member's service plan. Services are intended to maximize the member's psychological and behavioral well-being. Services are provided in both individual and group (8 person maximum) formats. The OHCA Care Management Team will review service plans to ensure that duplication of services does not occur.

(30) **Pharmacological Evaluations.** Pharmacological evaluations are provided to waiver members to ensure proper management of medications. The evaluations consist of:

(A) An initial medication assessment performed in conjunction with the case manager and member.

(B) A written report after completion of both the initial visit and medication assessment to be provided to the case manager and prescribing physician(s). The report will contain the initial medication assessment and recommendations when appropriate.

(C) Follow-up visit, assessments and reports will be arranged with the case manager every four months after the initial visits, assessment and report for the first year the member is in the community. This will result in a total of three follow-up visits, assessments and reports per member.

(31) **Non-emergency Transportation.** Non-emergency, non-ambulance transportation services are available through the SoonerRide Non-Emergency Transportation (NET) program. SoonerRide NET is available on a statewide basis to all

eligible members. SoonerRide NET includes non-emergency, non-ambulance transportation for members to and from SoonerCare providers of health care services. The NET must be for the purpose of accessing medically necessary covered services for which a member has available benefits. Additionally, SoonerRide NET may also be provided for eligible members to providers other than SoonerCare providers if the transportation is to access medically necessary services covered by SoonerCare. More information on SoonerRice NET services is located at 317:30-5-326.

(32) **Self-Direction**.

(A) Self-Direction is a method of service delivery that allows waiver members to determine supports and services they need to live successfully in a home or community based setting. A member choosing Self-Direction is the employer of record for his/her Personal Care and Advanced Supportive/Restorative Care service providers and must have an approved plan of care prior to initiation of any Self-Directed activities.

(B) The OHCA uses the following criteria to determine a member's service eligibility to participate in the Self-Directed Services program:

(i) residence in the Self-Directed services area;

(ii) member's health and safety with Self-Directed services can reasonably be assured based on a review of service history records and a review of member capacity and readiness to assume employer responsibilities under Self-Direction with any one of the following findings as basis to deny a request for Self-Direction due to inability to assure member health and safety;

(I) the member does not have the ability to make decisions about his/her care or service planning and the member's "authorized representative" is not willing to assume Self-Directed services responsibilities, or

(II) the member is not willing to assume responsibility, or to enlist an "authorized representative" to assume responsibility, in one or more areas of Self-Direction such as in service planning, or in assuming the role of employer of the Personal Services Assistant (PSA) or Advanced Personal Services Assistant (APSA) service provider, or in monitoring and managing health or in preparation for emergency backup, or

(III) the member has a recent history of self-neglect or self-abuse as evidenced by Adult Protective Services intervention within the past 12 months and does not have an "authorized

~~representative" with capacity to assist with Self-Direction responsibilities;~~

~~(C) The member voluntarily makes an informed choice to Self-Direct services. As part of the informed choice, decision making process for Self-Direction, the OHCA staff or the Case Manager provides consultation and assistance as the member completes a self-assessment of preparedness to assume the role of employer for their Personal Services Assistant. The orientation and enrollment process will provide the member with a basic understanding of what will be expected of them under Self-Direction, the supports available to assist them to successfully perform employer responsibilities and an overview of the potential risks involved.~~

~~(D) The OHCA uses the following criteria to determine that based upon documentation, a person is no longer allowed to participate in the Self-Directed Services option:~~

~~(i) the member does not have the ability to make decisions about his/her care or service planning and the member's "authorized representative" is not willing to assume Self-Direction responsibilities; or~~

~~(ii) the member is not willing to assume responsibility, or to enlist an "authorized representative" to assume responsibility, in one or more areas of Self-Direction such as in service planning, or in assuming the role of employer of the PSA or APSA service providers, or in monitoring and managing health or in preparation for emergency backup; or~~

~~(iii) the member has a recent history of self-neglect or self-abuse as evidenced by Adult Protective Services intervention and does not have an "authorized representative" with capacity to assist with Self-Direction responsibilities; or~~

~~(iv) the member abuses or exploits their employee; or~~

~~(v) the member falsifies time-sheets or other work records; or~~

~~(vi) the member, even with Case Manager and Financial Management Services assistance, is unable to operate successfully within their Individual Budget Allocation; or~~

~~(vii) inferior quality of services provided by member/employer's employee, or the inability of the member/employer's employee to provide the number of service units the member requires, jeopardizes the member's health and/or safety.~~

~~(E) The member may designate a family member or friend as an "authorized representative" to assist in the service~~

~~planning process and in executing member employer responsibilities. If the member chooses to designate an "authorized representative", the designation and agreement identifying the "willing adult" to assume this role and responsibility is documented with dated signatures of the member, the designee and the member's Case Manager or the OHCA staff.~~

~~(i) A person having guardianship or power of attorney or other court sanctioned authorization to make decisions on behalf of the member has legal standing to be the member's designated "authorized representative".~~

~~(ii) An individual hired to provide Personal Services Assistance to a member may not be designated the "authorized representative" for the member.~~

~~(F) Self-Directed Services are delivered as authorized on the service plan and are limited to Personal Care, Advanced Supportive/Restorative Care and Respite. The member employs the Respite or Personal Services Assistant (PSA) and/or the Advanced Personal Services Assistant (APSA) and is responsible, with assistance from the Administrative Financial Management Services (FMS), for ensuring that the employment complies with State and Federal Labor Law requirements. The member:~~

~~(i) recruits, hires and, as necessary, discharges the PSA and APSA;~~

~~(ii) provides instruction and training to the PSA or APSA on tasks to be done and works with the Case Manager to obtain skilled nursing services assistance with training when necessary. Prior to performing an Advanced Personal Services Assistance 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 APSA=s personnel file;~~

~~(iii) determines where and how the PSA or APSA works, hours of work, what is to be accomplished and, within Individual Budget Allocation limits, wages to be paid for the work;~~

~~(iv) supervises and documents employee work time; and,~~

~~(v) provides tools and materials for work to be accomplished.~~

~~(G) Financial Management Services are program administrative services provided to participating Self-Directed Service employer/members by agencies contracted with the OHCA. Financial Management Services are employer related assistance that provides Internal Revenue Service (IRS) fiscal reporting agent and other financial~~

~~management tasks and functions including, but not limited to:~~

~~(i) employer payroll, at a minimum of semi monthly, and associated withholding for taxes, or for other payroll withholdings performed on behalf of the member as employer of the PSA or APSA;~~

~~(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 Respite or Personal Services Assistant or Advanced Personal Services Assistant; and~~

~~(H) The service of Respite 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.~~

~~(I) 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.~~

~~(J) Self-Directed Services rates are determined using the Individual Budget Allocation (IBA) Expenditure Accounts Determination process for each member. The IBA Expenditure Accounts Determination process includes consideration and decisions about the following:~~

~~(i) The Individual Budget Allocation (IBA) Expenditure Accounts Determination constrains total SoonerCare reimbursement for Self-Directed services to be less than expenditures for equivalent services using agency providers.~~

~~(ii) The PSA and APSA service unit rates are calculated by the OHCA during the Self-Directed service eligibility determination process. The OHCA sets the PSA and APSA unit rates at a level that is not less than 80 percent and not more than 95 percent of the comparable Agency Personal Care (for PSA) or Advanced Supportive/Restorative (for APSA) service rate. The allocation of portions of the PSA and/or APSA rate to~~

cover salary, mandatory taxes, and optional benefits (including Worker's Compensation insurance, if available) is determined individually for each member using the Self-Directed Services Individualized Budget Allocation Expenditure Accounts Determination Process.

(iii) The IBA Expenditure Accounts Determination process defines the level of program financial resources required to meet the member's need for Self-Directed services. If the member's need for services changes due to a change in health/disability status and/or a change in the level of support available from other sources, the Case Manager, based upon an updated assessment, amends the service plan to increase Self-Directed service units appropriate to meet additional member need. The OHCA, upon favorable review, authorizes the amended plan and updates the member's IBA. Service amendments based on changes in member need for services do not change an existing PSA or APSA rate. The member, with assistance from the FMS, reviews and revises the IBA Expenditure Accounts calculation annually or more often to the extent appropriate and necessary.

(33) **Self-Directed Goods and Services (SD-GS)**.

(A) Self-Directed Goods and Services (SD-GS) are incidental, non-routine goods and services that promote the member's self-care, daily living, adaptive functioning, general household activity, meal preparation and leisure skills needed to reside successfully in the community and do not duplicate other services authorized in the member's plan of care.

(B) These goods and services are purchased from the self-directed budget.

317:50-3-15. Reimbursement [REVOKED]

Rate methodologies for Waiver services are set in accordance with the rate setting process by the State Plan Amendment Rate Committee (SPARC) and approved by the Oklahoma Health Care Authority Board. Rates for Waiver services are set by one of the methodologies below:

(1) A fixed and uniform SoonerCare Rate. When a Waiver service is similar or the same as a Medicaid State Plan service for which a fee schedule has been established, the current SoonerCare rate is utilized.

(2) The current Medicare rate. When the waiver service mirrors an existing Medicare service the current Medicare rate is utilized.

(3) Individual rates. Certain services because of their variables do not lend themselves to a fixed and uniform rate.

~~Payment for these services is made on an individual basis following a uniform process approved by the OHCA.~~

317:50-3-16. Billing procedures for My Life, My Choice Waiver services [REVOKED]

~~(a) Billing procedures for long-term care medical services are contained in the OKMMIS Billing and Procedure Manual. Questions regarding billing procedures which cannot be resolved through a study of the manual should be referred to the OHCA.~~

~~(b) The approved My Life, My Choice Waiver service plan is the basis for the MMIS service prior authorization, specifying:~~

~~(1) service;~~

~~(2) service provider;~~

~~(3) units authorized; and~~

~~(4) begin and end dates of service authorization.~~

~~(c) As part of My Life, My Choice Waiver quality assurance, provider audits are used to evaluate whether paid claims are consistent with service plan authorizations and documentation of service provision. Evidence of paid claims that are not supported by service plan authorization and/or documentation of service provision will be turned over to the OHCA Provider Audit Unit for follow-up investigation.~~

~~(d) Service time of Personal Care, Case Management, Nursing, Advanced Supportive/Restorative Assistance, In-Home Respite and Self Direction may be documented through the Interactive Voice Response Authentication (IVRA) system when provided in the home. The IVRA system provides alternate backup solutions should the automated system be unavailable. In the event of IVRA backup system failure, the provider will document time in accordance with their agency backup plan. The agency's backup procedures are only permitted when the IVRA system is unavailable.~~

SUBCHAPTER 5. SOONER SENIORS

317:50-5-1. Purpose [REVOKED]

~~The Sooner Seniors 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. To be considered for Sooner Seniors Waiver Program services, individuals must meet all criteria set forth under 317:50-5-3.~~

317:50-5-2. Definitions [REVOKED]

~~The following words and terms when used in this subchapter, shall have the following meaning, unless the context clearly indicates otherwise:~~

~~**"ADL"** means the activities of daily living. Activities of daily living are activities that reflect the member's ability to~~

~~perform self-care tasks essential for sustaining health and safety such as:~~

~~(A) bathing,~~

~~(B) eating,~~

~~(C) dressing,~~

~~(D) grooming,~~

~~(E) transferring (includes getting in and out of a tub, bed to chair, etc.),~~

~~(F) mobility,~~

~~(G) toileting, and~~

~~(H) bowel/bladder control.~~

~~**"ADLs score in high risk range"** means the member's total weighted UCAT ADL score is 10 or more which indicates the member needs some help with 5 ADLs or that the member cannot do 3 ADLs at all plus the member needs some help with 1 other ADL.~~

~~**"ADLs score at the high end of the moderate risk range"** means member's total weighted UCAT ADL score is 8 or 9 which indicates the member needs help with 4 ADLs or the member cannot do 3 ADLs at all.~~

~~**"Cognitive Impairment"** means that the person, as determined by the clinical judgment of the LTC Nurse does not have the capability to think, reason, remember or learn required for self-care, communicating needs, directing care givers and/or using appropriate judgment for maintenance of their own health or safety. The clinical judgment of cognitive impairment is based on MSQ performance in combination with a more general evaluation of cognitive function from interaction with the person during the UCAT assessment.~~

~~**"Environment high risk"** means member's UCAT Environment score is 25 which indicates in the UCAT assessor's clinical judgment, the physical environment is strongly negative or hazardous.~~

~~**"Environment moderate risk"** means member's UCAT Environment score is 15 which indicates in the UCAT assessor's clinical judgment, many aspects of the physical environment are substandard or hazardous.~~

~~**"Health Assessment high risk"** means member's UCAT health assessment score is 25 which indicates in the UCAT assessor's clinical judgment, the member has one or more chronic health conditions, whose symptoms are rapidly deteriorating, uncontrolled, or not well controlled and requiring a high frequency or intensity of medical care/oversight to bring under control and whose functional capacity is so limited as to require full time assistance or care performed daily, by, or under the supervision of professional personnel and has multiple unmet needs for services available only through the Sooner Seniors program or a Nursing Facility (NF) and requires NF placement immediately if these needs cannot be met by other means.~~

~~**"Health Assessment low risk"** means member's health assessment score is 5 which indicates, in the UCAT assessor's clinical judgment, the member has one or more chronic, stable, health conditions, whose symptoms are controlled or nearly controlled, which benefit from available, or usually available, medical treatment or corrective measures, and may have an unmet need for a service available only through the Sooner Seniors program or a Nursing Facility (NF) but is not likely to enter a NF if these needs are not met.~~

~~**"Health Assessment moderate risk"** means member's UCAT Health Assessment score is 15 which indicates in the UCAT assessor's clinical judgment, the member has one or more chronic changing health conditions, whose symptoms are fragile or worsening and require medical care/oversight, to bring under control or to maintain in a stable, controlled state and has multiple unmet needs for services available only through the Sooner Seniors program or a Nursing Facility (NF) and is likely to enter a NF if these needs are not met.~~

~~**"IADL"** means the instrumental activities of daily living.~~

~~**"IADLs score in high risk range"** means member's total weighted UCAT IADL score is 12 or more which indicates the member needs some help with 6 IADLs or cannot do 4 IADLs at all.~~

~~**"Instrumental activities of daily living"** means those activities that reflect the member's ability to perform household chores and tasks within the community essential for sustaining health and safety such as:~~

~~(A) shopping,~~

~~(B) cooking,~~

~~(C) cleaning,~~

~~(D) managing money,~~

~~(E) using a telephone,~~

~~(F) doing laundry,~~

~~(G) taking medication, and~~

~~(H) accessing transportation.~~

~~**"Member Support high risk"** means member's UCAT Member Support score is 25 which indicates in the UCAT assessor's clinical judgment, excluding from consideration existing Ryan White CARE Act, Indian Health Service, Medicaid NF, Sooner Seniors and/or State Plan Personal Care services, very little or no support is available from informal and formal sources and the member requires additional care that is not available through Medicare, Veterans Administration, or other Federal entitlement programs.~~

~~**"Member Support moderate risk"** means member's UCAT Member Support score is 15 which indicates in the UCAT assessor's clinical judgment, excluding from consideration existing Ryan White CARE Act, Indian Health Service, Medicaid NF, Sooner Seniors and/or State Plan Personal Care services, support from informal and formal sources is available, but overall, it is~~

~~inadequate, changing, fragile or otherwise problematic and the member requires additional care that is not available through Medicare, Veterans Administration, or other federal entitlement programs.~~

~~**"Intellectual Disability"** means that the person has, as determined by a PASRR level II evaluation, substantial limitations in functional ability due to significantly sub-average intellectual functioning related to an event occurring before the age of 18.~~

~~**"MSQ"** means the mental status questionnaire.~~

~~**"MSQ score in high risk range"** means the member's total weighted UCAT MSQ score is 12 or more which indicates a severe orientation-memory-concentration impairment, or a severe memory impairment.~~

~~**"MSQ score at the high end of the moderate risk range"** means the member's total weighted UCAT MSQ score is (10) or (11) which indicates an orientation-memory-concentration impairment, or a significant memory impairment.~~

~~**"Nutrition high risk"** means a total weighted UCAT Nutrition score is 12 or more which indicates the member has significant eating difficulties combined with poor appetite, weight loss, and/or special diet requirements.~~

~~**"Progressive degenerative disease process that responds to treatment"** means a process such as, but not limited to, Multiple Sclerosis (MS), Parkinson's Disease, Human Immunodeficiency Virus (HIV), or Acquired Immunodeficiency Syndrome (AIDS), that, untreated, systematically impairs normal body function which leads to acute illness and/or disability but that reacts positively to a medically prescribed treatment intervention (usually medication) which arrests or significantly delays the destructive action of the process.~~

~~**"Social Resources high risk"** means a total weighted UCAT Social Resources score is 15 or more, which indicates the member lives alone, combined with none or very few social contacts and no supports in times of need.~~

317:50-5-3. Sooner Seniors program overview [REVOKED]

~~(a) The Sooner Seniors program is a Medicaid Home and Community Based Waiver used to finance non-institutional long-term care services for a targeted group of elderly adults. Sooner Seniors services are outside the scope of state plan Medicaid services. The 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 Appendix C-1, Schedule VIII. B. 1.) and without such services would be institutionalized.~~

~~(1) To be considered for Sooner Seniors services, individuals must meet the following criteria:~~

~~(A) be age 65 years or older;~~

~~(B) have a clinically documented, progressive degenerative disease process that responds to treatment and requires Sooner Seniors Waiver services to maintain the treatment regimen to prevent health deterioration and remain in a home and community based setting;~~

~~(C) have transitioned to a home and community based setting through the Living Choice Program;~~

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

~~(A) The UCAT documents need for assistance to sustain health and safety as demonstrated by:~~

~~(i) either the ADLs or MSQ score is in the high risk range; or~~

~~(ii) any combination of two or more of the following:~~

~~(I) ADLs score is at the high end of moderate risk range; or~~

~~(II) MSQ score is at the high end of moderate risk range; or~~

~~(III) IADLs score is in the high risk range; or~~

~~(IV) Nutrition score is in the high risk range; or~~

~~(V) Health Assessment is in the moderate risk range, and, in addition;~~

~~(B) The UCAT documents absence of support or adequate environment to meet the needs to sustain health and safety as demonstrated by:~~

~~(i) Individual Support is moderate risk; or~~

~~(ii) Environment is high risk; or~~

~~(iii) Environment is moderate risk and Social Resources is in the high risk range; or, regardless of whether criteria under (A) of need and (B) of absence of support are met;~~

~~(C) The UCAT documents that:~~

~~(i) the individual has a clinically documented progressive degenerative disease process that will produce health deterioration to an extent that the person will meet OAC 317:50-5-3(a)(2)(A) criteria if untreated; and~~

~~(ii) the individual previously has required hospital or NF level of care services for treatment related to the condition; and~~

~~(iii) a medically prescribed treatment regimen exists that will significantly arrest or delay the disease process; and~~

~~(iv) only by means of Sooner Seniors Program eligibility will the individual have access to the required treatment regimen to arrest or delay the disease process.~~

~~(3) **NF Level of Care Services**. To be eligible for NF level~~

~~of care services, meeting the minimum UCAT criteria demonstrates the individual must:~~

~~(A) require a treatment plan involving the planning and administration of services that require the skills of licensed or otherwise certified technical or professional personnel, and are provided directly or under the supervision of such personnel;~~

~~(B) have a physical impairment or combination of physical, mental and/or functional impairments;~~

~~(C) require professional nursing supervision (medication, hygiene and/or dietary assistance);~~

~~(D) lack the ability to adequately and appropriately care for self or communicate needs to others;~~

~~(E) require medical care and treatment in order to minimize physical health regression or deterioration;~~

~~(F) require care that is not available through family and friends, Medicare, Veterans Administration, or other federal entitlement program with the exception of Indian Health Services; and~~

~~(G) require care that cannot be met through Medicaid State Plan Services, including Personal Care, if financially eligible.~~

~~(4) Meet service eligibility criteria [see OAC 317:50-5-3(c)].~~

~~(5) Meet program eligibility criteria [see OAC 317:50-5-3(d)].~~

~~(b) Services provided through the Sooner Seniors Waiver are:~~

~~(1) case management;~~

~~(2) institutional transition services;~~

~~(3) respite;~~

~~(4) adult day health care;~~

~~(5) environmental modifications;~~

~~(6) specialized medical equipment and supplies;~~

~~(7) physical therapy;~~

~~(8) occupational therapy;~~

~~(9) respiratory therapy;~~

~~(10) speech therapy;~~

~~(11) dental services and treatment up to $1,000 annually;~~

~~(12) family training services;~~

~~(13) nutritional education services;~~

~~(14) vision services;~~

~~(15) pharmacological evaluations;~~

~~(16) agency companion;~~

~~(17) advanced supportive/restorative assistance;~~

~~(18) skilled nursing and private duty nursing;~~

~~(19) home delivered meals;~~

~~(20) hospice care;~~

~~(21) medically necessary prescription drugs within the limits~~

~~of the waiver;~~

~~(22) Sooner Seniors personal care;~~

~~(23) Personal Emergency Response System (PERS);~~

~~(24) Self Directed personal care, respite and advanced supportive/restorative assistance;~~

~~(24) Self Directed Goods and Services (SD-GS);~~

~~(25) Assisted Living; and~~

~~(26) All other SoonerCare medical services within the scope of the State Plan, including SoonerRide non-emergency transportation.~~

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

~~(1) an open Sooner Seniors 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 Sooner Seniors Waiver slots are filled, the individual cannot be certified as eligible for Sooner Seniors Waiver services and the individual's name is placed on a waiting list for entry as an open slot becomes available. Sooner Seniors Waiver slots and corresponding waiting lists, if necessary, are maintained.~~

~~(2) the individual is in the Sooner Seniors Waiver targeted service group. The target group is an individual who is age 65 or older with a chronic medical condition.~~

~~(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.~~

~~(d) The Sooner Seniors 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 Sooner Seniors 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 Sooner Seniors 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 Sooner Seniors Waiver services to be met, or if the individual would not require institutionalization if needs are not met.

(5) if, after the service 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.

(e) 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 Sooner Seniors 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.

(f) Individuals determined ineligible for Sooner Seniors Waiver program services are notified in writing of the determination and of their right to appeal the decision.

317:50-5-4. Application for Sooner Seniors Waiver services [REVOKED]

(a) Within 60 days of completion of the Living Choice demonstration program, members choosing to stay in a home and community based setting may apply for transition into the Sooner Seniors Waiver. In order to transition from the Living Choice demonstration program to the Sooner Seniors Waiver, a recertification of eligibility is required. The member must meet all financial and medical eligibility requirements for recertification. The same application and eligibility processes used to certify members for SoonerCare long term care and Living Choice services will be reviewed to ensure any changes in member status will not affect eligibility for the Sooner Seniors Waiver. The original application and eligibility processes are set forth in 317:50-5-4(a)(1) through 317:50-5-6 below.

(1) 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 is a SoonerCare member at the time of application. A financial application for Sooner Seniors Waiver services consists of the Medical Assistance Application form. The form is signed by the applicant, parent, spouse, guardian or someone else acting on the applicant's behalf.

~~(A) All conditions of financial eligibility must be verified and documented in the case record. When current information is already available that establishes financial eligibility, such information may be used by recording source and date of information. If the applicant also wishes to apply for a State Supplemental Payment, either the applicant or his/her guardian must sign the application form.~~

~~(B) An individual 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 SoonerCare application is not being made. The individual and/or spouse must provide documentation of resources. The assessment reflects all countable resources of the couple (owned individually or as a couple) and establishes the spousal share to be protected when subsequent determination of SoonerCare long-term care eligibility is made.~~

~~(C) When SoonerCare application is being made, an assessment of resources must be completed if it was not completed when the individual entered the NF or began receiving home and community based services. For applicants of the Sooner Seniors waiver, those resources owned by the couple the month the application was made determines the spousal share of resources. If the individual applied for SoonerCare at the time of entry into the Living Choice Program, Form MA-11 is not appropriate. However, the spousal share must be determined using the resource information provided on the SoonerCare application form and computed using OKDHS form MA-12, Title XIX Worksheet.~~

~~(2) The date of application is the date the signed application is received or the date when the request for SoonerCare is made orally and the financial application form is signed later. The date of the oral request is noted above the date the form is signed.~~

~~(b) **Sooner Seniors Waiver waiting list procedures.** Sooner Seniors Waiver Program capacity is the number of members that may be enrolled in the Program without exceeding, on an annualized basis, the maximum number authorized by the waiver to be served in the waiver year. If available waiver capacity has been realized, requests for services are not processed as applications, but placed on a waiting list. As available capacity permits, the OHCA selects in chronological order (first on, first off) requests for services from the waiting list to forward for application processing. When waiver capacity exceeds the number on the waiting list and after all persons on the waiting list have been processed, waiting list procedures~~

~~are suspended.~~

317:50-5-5. Sooner Seniors Waiver program medical eligibility determination [REVOKED]

~~A medical eligibility determination is made for Sooner Seniors Waiver program services based on the Uniform Comprehensive Assessment Tool (UCAT) III assessment, professional judgment and the determination that the member has unmet care needs that require Sooner Seniors Waiver Program, or NF level services to assure member health and safety. Sooner Seniors Waiver services are designed to be a continuation of support for the informal care that is being provided in the member's home. These services are not intended to take the place of regular care provided by family members and/or by significant others. When there is an informal (not paid) system of care available in the home, Sooner Seniors Waiver service provision will supplement the system within the limitations of Sooner Seniors Waiver Program policy.~~

~~(1) Categorical relationship must be established for determination of eligibility for Sooner Seniors Waiver services. If categorical relationship to disability has not already been established, the Level of Care Evaluation Unit (LOCEU) will render a decision on categorical relationship to the disabled using the same definition used by SSA. A follow-up is required with the Social Security Administration to be sure their disability decision agrees with the decision of LOCEU.~~

~~(2) Community agencies complete the UCAT, Part I and forward the form to the OHCA. If the UCAT, Part I indicates that the applicant does not qualify for SoonerCare long-term care services, the applicant is referred to appropriate community resources.~~

~~(3) If the UCAT indicates member qualification for SoonerCare services and the needs of the member require an immediate interdisciplinary team (IDT) meeting with home health agency nurse participation to develop a care plan and service plan, the need is documented.~~

~~(4) If, based upon the information obtained during the assessment, the nurse determines that the member may be at risk for health and safety, OKDHS Adult Protective Services (APS) staff are notified immediately and the referral is documented on the UCAT.~~

~~(5) Within ten (10) working days of receipt of a complete Sooner Seniors Waiver application, medical eligibility is determined using level of care criteria and service eligibility criteria~~

~~(6) Once eligibility has been established, notification is given to the member and the case management provider so that~~

~~care plan and service plan development may begin. The member's case management provider is notified of the member's name, address, case number and social security number, the units of case management and, if applicable, the number of units of home health agency nurse evaluation authorized for care plan and service plan development, whether the needs of the member require an immediate IDT meeting with home health agency nurse participation and the effective date for member entry into the Sooner Seniors Waiver Program.~~

~~(7) If the member has a current certification and requests a change to Sooner Seniors Waiver services, a new UCAT is required. The UCAT is also updated when a member requests a change from Sooner Seniors Waiver services to State Plan Personal Care services. If a member is receiving Sooner Seniors Waiver services and requests to go to a nursing facility, a new medical level of care decision is not needed.~~

~~(8) When a UCAT assessment has been completed more than 90 days prior to submission for determination of a medical decision, a new assessment is required.~~

317:50-5-6. Determining financial eligibility for the Sooner Seniors Waiver program [REVOKED]

~~Financial eligibility for Sooner Seniors Waiver services is determined using the rules on income and resources according to the category to which the individual is related. Only individuals who are categorically related to ABD may be served through the Sooner Seniors Waiver. Income, resources and expenses are evaluated on a monthly basis for all individuals requesting payment for the Sooner Seniors Waiver Program. In determining income and resources for the individual categorically related to ABD, the "family" includes the individual and spouse, if any. However, consideration is not given to the income and resources of a spouse included in a TANF case. If an individual and spouse cease to live together for reasons other than institutionalization, income and resources are considered available to each other through the month in which they are separated. Mutual consideration ceases with the month after the month in which the separation occurs. Any amounts which are actually contributed to the spouse after the mutual consideration has ended are considered. Financial eligibility for individuals in Sooner Seniors Waiver Program services is as follows:~~

~~(1) **Individual without a spouse**. For an individual without a spouse, the following rules are used to determine financial eligibility.~~

~~(A) **Income eligibility**. To determine the income of the individual, the rules in (i) through (iii) of this subparagraph apply.~~

~~(i) If payment of income is made to the individual and another person(s), the income is considered in proportion to the individual's interest.~~

~~(ii) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.~~

~~(iii) After determination of income, the gross income of the individual cannot exceed the categorically needy standard in OKDHS form 08AX001E, Schedule VIII. B. 1., to be eligible for Sooner Seniors Waiver services. If the individual's gross income exceeds that standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [OAC 317:35-5-41.6(6)(B)].~~

~~(B) **Resource eligibility**. In order for an individual without a spouse to be eligible for Sooner Seniors Waiver services, his/her countable resources cannot exceed the maximum resource standard for an individual listed in OKDHS form 08AX001E, Schedule VIII. D.~~

~~(C) **Equity in capital resources**. If the equity in the individual's capital resources is in excess of the maximum resource standards, certification is delayed up to 30 days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources can not reasonably be expected to come within standards in one month, the application is denied.~~

~~(2) **Individual with a spouse who receives HCBW services, or is institutionalized in a NF or ICF/MR, or is 65 or over and in a mental health hospital.** For an individual with a spouse who receives HCBW services, or is institutionalized in a NF or ICF/MR, or is 65 or over and in a mental health hospital, resources are determined for each individual as the amount owned by each individual plus one-half of the jointly owned resources of the couple. Once this separation of assets is made, a resource of either spouse is not considered available to the other during the receipt of HCBW program services.~~

~~(A) **Income eligibility.** Income is determined separately for an individual and his/her spouse if the spouse is in a HCBW program, or is institutionalized in a NF or ICF/MR, or is 65 or older and in a mental health hospital. The income of either spouse is not considered as available to the other during the receipt of Sooner Seniors Waiver services. The rules in (i) - (v) of this subparagraph apply in this situation:~~

~~(i) If payment of income is made solely to one or the other, the income is considered available only to that~~

individual.

(ii) If payment of income is made to both, one-half is considered for each individual.

(iii) If payment of income is made to either one or both and another person(s), the income is considered in proportion to either spouse's interest (if payment is to that spouse) or one-half of the joint interest if no interest is specified.

(iv) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.

(v) After determination of income, the gross income of the individual cannot exceed the categorically needy standard in OKDHS form 08AX001E, Schedule VIII. B. 1., to be eligible for Sooner Seniors Waiver services. If the individual's gross income exceeds this standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [OAC 317:35-5-41.6(6)(B)].

(B) **Resource eligibility.** In order for an individual with a spouse who receives HCBW services, or is institutionalized in a NF or ICF/MR, or is 65 or older and in a mental health hospital to be eligible for the Sooner Seniors Waiver services, his/her countable resources cannot exceed the maximum resource standard for an individual listed in OKDHS form 08AX001E, Schedule VIII. D.

(C) **Equity in capital resources.** If the equity in the individual's capital resources is in excess of the maximum resource standards, certification is delayed up to 30 days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources can not reasonably be expected to come within standards in one month, the application is denied.

(3) **Individual with a spouse in the home who is not in a Home and Community Based Waiver Program**. When only one individual of a couple in their own home is in a HCBW Program, income and resources are determined separately. However, the income and resources of the individual who is not in the HCBW program (community spouse) must be included on the application form. At redetermination of eligibility, the community spouse's income must be included in the review process. During any month that the individual is in Sooner Seniors Waiver program services, the income of the community spouse is not considered available to that individual. The following rules are used to determine the income and

~~resources of each:~~

~~(A) **Income eligibility**. To determine the income of both spouses, the rules in (i) - (v) of this subparagraph apply.~~

~~(i) If payment of income is made solely to one or the other, the income is considered available only to that individual.~~

~~(ii) If payment of income is made to both, one-half is considered for each individual.~~

~~(iii) If payment of income is made to either one or both and another person(s), the income is considered in proportion to either spouse's interest (if payment is to that spouse) or one-half of the joint interest if no interest is specified.~~

~~(iv) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.~~

~~(v) After determination of income, the gross income of the individual in the Sooner Seniors Waiver program cannot exceed the categorically needy standard in OKDHS form 08AX001E, Schedule VIII. B. 1., to be eligible for care. If the individual's gross income exceeds this standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [OAC 317:35-5-41.6(6)(B)].~~

~~(B) **Resource eligibility**. To determine resource eligibility, it is necessary to determine the amount of resources for both spouses for the month of the individual's application for the Sooner Seniors Waiver program. Of the resources available to the couple (both individual and joint ownership) an amount will be protected for the community spouse which will not be considered available to the spouse receiving Sooner Seniors Waiver program services. The amount determined as the spousal share is used for all subsequent applications for SoonerCare, regardless of changes in the couple's resources. The protected spousal share cannot be changed for any reason. When application for SoonerCare is made at the same time the individual begins receiving Sooner Seniors program services, OKDHS Form 08MA012E, Title XIX Worksheet, is used.~~

~~(i) The first step in the assessment process is to establish the total amount of resources for the couple during the month of application of the spouse into the Sooner Seniors Waiver program (regardless of payment source).~~

~~(ii) The community spouse's share is equal to one-half of the total resources of the couple not to exceed the~~

maximum amount of resource value that can be protected for the community spouse, as shown on OKDHS form 08AX001E, Schedule XI.

(iii) The minimum resource standard for the community spouse, as established by the OHCA, is found on OKDHS form 08AX001E, Schedule XI. When the community spouse's share is less than the minimum standard, an amount may be deemed from the other spouse's share to ensure the minimum resource standard for the community spouse. If the community spouse's share equals or exceeds the minimum resource standard, deeming cannot be done.

(iv) If deeming is necessary to meet the minimum resource standard for the community spouse, the amount that is deemed must be legally transferred to the community spouse within one year of the effective date of certification for SoonerCare. At the first redetermination of eligibility, the worker must document that the resources have been transferred. After the first year of SoonerCare eligibility, resources of the community spouse will not be available to the other spouse and resources cannot be deemed to the community spouse.

(v) After the month in which the institutionalized spouse and community spouse have met the resource standard and the institutionalized spouse is determined eligible for benefits, no resources of the community spouse, regardless of value, will be considered available to the institutionalized spouse. If the resources of the community spouse grow to exceed the original deemed amount, the State cannot require the community spouse to apply any of these excess resources toward the cost of the care of the institutionalized spouse.

(vi) When determining eligibility for SoonerCare, the community spouse's share of resources is protected and the remainder considered available to the spouse receiving Sooner Seniors Waiver program services.

(vii) The resources determined in (i) - (vi) of this subparagraph for the individual receiving Sooner Seniors Waiver program services cannot exceed the maximum resource standard for an individual as shown in OKDHS form 08AX001E, Schedule VIII. D.

(viii) Once the dollar value of the community spouse's share of resources is established for the month of the other spouse's entry into the Sooner Seniors Waiver program, that amount is used when determining resource eligibility for a subsequent SoonerCare application for

~~Long-Term Care for either spouse.~~

~~(ix) Once a determination of eligibility for SoonerCare is made, either spouse is entitled to a fair hearing. A fair hearing regarding the determination of the community spouse's resource allowance is held within 30 days of the date of the request for the hearing. Either spouse is entitled to a fair hearing if dissatisfied with a determination of:~~

~~(I) the community spouse's monthly income allowance;~~

~~(II) the amount of monthly income otherwise available to the community spouse;~~

~~(III) determination of the spousal share of resource;~~

~~(IV) the attribution of resources (amount deemed); or~~

~~(V) the determination of the community spouse's resource allowance.~~

~~(x) The rules on determination of income and resources are applicable only when an individual receiving Sooner Seniors Waiver program services is likely to remain under care for 30 consecutive days. The 30-day requirement is considered to have been met even if a hospital stay interrupts it or the individual is deceased before the 30-day period ends.~~

~~(C) **Excess resources**. If the equity in the individual's capital resources is in excess of the maximum resource standards, certification is delayed up to 30 days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources cannot reasonably be expected to come within standards in one month, the application is denied.~~

~~(4) **Transfer of assets on or after August 11, 1993 but before February 8, 2006.** An institutionalized individual, an institutionalized individual's spouse, the guardian or legal representative of the individual or individual's spouse who disposes of assets on or after August 11, 1993 but before February 8, 2006 for less than fair market value on or after the look-back date specified in (A) of this paragraph subjects the individual to a penalty period for the disposal of such assets.~~

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

~~look back date is 60 months.~~

~~(B) For purposes of this paragraph, an "institutionalized" individual is one who is receiving HCBW program services.~~

~~(C) The penalty period begins the first day of the first month during which assets have been transferred and which does not occur in any other period of ineligibility due to an asset transfer. When there have been multiple transfers, all transferred assets are added together to determine the penalty.~~

~~(D) The penalty period consists of a period of ineligibility (whole number of months) determined by dividing the total uncompensated value of the asset by the average monthly cost ($2,000) to a private patient in an NF or Hospital level of care in Oklahoma. In this calculation, any partial month is dropped. There is no limit to the length of the penalty period for these transfers. Uncompensated value is defined as the difference between the fair market value at the time of transfer less encumbrances and the amount received for the resource.~~

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

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

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

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

~~(F) A penalty would not apply if:~~

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

~~(I) the spouse;~~

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

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

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

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

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

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

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

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

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

~~(G) The individual is advised by a written notice of a period of ineligibility due to transfer of assets. The notice explains the period of ineligibility for payment of Sooner Seniors Waiver program services and the continuance of eligibility for other SoonerCare services.~~

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

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

~~(J) The restoration or commensurate return will not entitle the member to benefits for the period of time that the asset remained transferred. An applicant cannot be certified for Sooner Seniors Waiver program services for a~~

~~period of asset ineligibility.~~

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

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

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

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

~~(B) For purposes of this paragraph, an "institutionalized" individual is one who is receiving Sooner Seniors program services.~~

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

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

~~(ii) the date on which the individual is:~~

~~(I) eligible for medical assistance; and~~

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

~~(D) The penalty period:~~

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

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

~~(iii) when there have been multiple transfers, all transferred assets are added together to determine the penalty.~~

~~(E) The penalty period consists of a period of ineligibility determined by dividing the total~~

~~uncompensated value of the asset by the average monthly cost to a private patient in a nursing facility in Oklahoma shown on OKDHS form 08AX001E. In this calculation, the penalty must include a partial month disqualification based upon the relationship between that fractional amount and the average monthly cost to a private patient in a nursing facility in Oklahoma. There is no limit to the length of the penalty period for these transfers. Uncompensated value is defined as the difference between the fair market value at the time of transfer less encumbrances and the amount received for the resource.~~

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

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

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

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

~~(G) Special Situations.~~

~~(i) Separate Maintenance or Divorce.~~

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

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

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

~~(IV) The applicant or member may rebut the presumption of transfer by showing compelling evidence that the uneven division of income or resources was the result of factors unrelated to SoonerCare eligibility.~~

~~(ii) Inheritance from a spouse.~~

~~(I) Oklahoma law provides that a surviving spouse is~~

~~entitled to a minimum portion of a deceased spouse's probate estate. The amount depends on several factors.~~

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

~~(H) A penalty would not apply if:~~

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

~~(I) the spouse; or~~

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

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

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

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

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

~~(iv) the asset was transferred to the individual's child who is blind or totally disabled as determined by~~

~~Social Security. The transfer may be to a trust established for the benefit of the individual's child.~~

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

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

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

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

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

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

~~(I) The individual is advised by a written notice of a period of ineligibility due to transfer of assets, a timely process for determining whether an undue hardship waiver will be granted and a process for an adverse determination appeal. The notice explains the period of ineligibility for payment of Sooner Seniors Waiver program services and the continuance of eligibility for other SoonerCare services.~~

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

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

~~(L) The restoration or commensurate return will not~~

~~entitle the member to benefits for the period of time that the asset remained transferred. An applicant cannot be certified for Sooner Seniors Waiver program services for a period of asset ineligibility.~~

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

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

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

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

~~(6) **Commensurate return.** Commensurate return for purposes of this Section is defined as actual money payment or documentation of money spent on the member's behalf; i.e., property taxes, medical debts, nursing care expenses, etc., corresponding to the market value of the transferred property. The definition does not include personal services, labor or provision of rent-free shelter. It also does not include a monetary value assigned and projected for future payment either by cash or provision of services. Any transfer of property within the five years prior to application or during receipt of assistance must be analyzed in regard to commensurate return as well as determination of intent.~~

317:50-5-7. Certification for Sooner Seniors Waiver program services [REVOKED]

~~(a) **Financial certification period for Sooner Seniors Waiver program services**. The financial certification period for the Sooner Seniors Waiver program is 12 months.~~

~~(b) **Medical Certification period for Sooner Seniors Waiver program services**. The medical certification period for Sooner Seniors Waiver program services is 12 months. Reassessment and redetermination of medical eligibility is completed in coordination with the annual recertification of the member's service plan. If documentation supports a reasonable expectation that the member will not continue to meet medical eligibility criteria or have a need for long term care services for more~~

~~than 12 months, an independent evaluation of medical eligibility is completed before the end of the current medical certification period.~~

317:50-5-8. Redetermination of eligibility for Sooner Seniors Waiver services [REVOKED]

~~A redetermination of medical and financial eligibility must be completed prior to the end of the certification period.~~

317:50-5-9. Member annual level of care re-evaluation and annual re-authorization of service plan [REVOKED]

~~(a) Annually, the case manager reassesses the member's needs and the service plan, especially with respect to progress of the member toward service plan goals and objectives. Based on the reassessment, the case manager develops a new service plan with the member and service providers, as appropriate, and submits the new service plan for certification along with the supporting documentation and the assessment of the existing service plan. The case manager initiates the fourth quarter monitoring to allow sufficient time for certification of a new service plan prior to the expiration date on the existing service plan.~~

~~(b) At a maximum of every 11 months, the case manager makes a home visit to evaluate the Sooner Seniors Waiver member using the UCAT, Parts I and III and other information as necessary as part of the annual service plan development process.~~

~~(1) The case manager's assessment of a member done within a 60-day period prior to the existing service plan end date is the basis for medical eligibility redetermination.~~

~~(2) As part of the service plan recertification process, the member is evaluated for the continued need for Nursing Facility level of care.~~

~~(3) Based on evaluation of the UCAT, a determination of continued medical eligibility is made and recertification of medical eligibility is done prior to the expiration date of current medical eligibility certification. If medical eligibility recertification is not made prior to current medical eligibility expiration, the existing medical eligibility certification is automatically extended until recertification is determined or for 60 days, whichever is less. If the member no longer meets medical eligibility, upon making the level of care determination, the member's "medical eligibility end date" is updated in the system. The member's case manager is notified that the member has been determined to no longer meet medical eligibility for Sooner Seniors Waiver services as of the effective date of the eligibility determination. The member is notified and if the member requests, the case manager helps the member arrange alternate services in place of Sooner Seniors Waiver services.~~

317:50-5-10. Sooner Seniors Waiver services during hospitalization or nursing facility placement [REVOKED]

~~If a member requires hospital or nursing facility services, the case manager assists the member in accessing institutional care, periodically monitors the member's progress during the institutional stay and, as appropriate, updates the service plan and prepares services to start on the date the member is discharged from the institution and returns home.~~

~~(1) **Hospital discharge.** When the member returns home from a hospital or when notified of the member's anticipated discharge date, the case manager notifies relevant providers and coordinates the resumption of services.~~

~~(2) **NF placement of less than 30 days.** When the member returns home from a NF stay of 30 days or less or when notified of the member's anticipated discharge date the case manager notifies relevant providers and coordinates the resumption of Sooner Seniors Waiver services in the home.~~

~~(3) **NF placement greater than 30 days.** When the member is scheduled to be discharged and return home from a NF stay that is greater than 30 days, the member's case manager expedites the restart of Sooner Seniors Waiver services for the member.~~

317:50-5-11. Closure or termination of Sooner Seniors Waiver services [REVOKED]

~~(a) **Voluntary closure of Sooner Seniors Waiver services**. If the member requests a lower level of care than Sooner Seniors Waiver services or if the member agrees that Sooner Seniors Waiver services are no longer needed to meet his/her needs, a medical decision is not needed. The closure request is completed and signed by the member and the case manager and placed in the member's case record. Documentation is made of all circumstances involving the reasons for the voluntary termination of services and alternatives for services if written request for closure cannot be secured.~~

~~(b) **Closure due to financial or medical ineligibility**. The process for closure due to financial or medical ineligibility is described in this subsection.~~

~~(1) **Financial ineligibility**. Anytime it is determined that a member does not meet the financial eligibility criteria, the member and provider are notified of financial ineligibility. A medical eligibility redetermination is not required when a financial ineligibility period does not exceed the medical certification period.~~

~~(2) **Medical ineligibility.** When the member is found to no longer be medically eligible for Sooner Seniors Waiver services, the individual and provider are notified of the~~

~~decision.~~

~~(c) **Closure due to other reasons**. Refer to OAC 317:50-5-3(d).~~

~~(d) **Resumption of Sooner Seniors Waiver services.** If a member approved for Sooner Seniors Waiver services has been without services for less than 90 days and has a current medical and financial eligibility determination, services may be resumed using the previously approved service plan. If a member decides he/she desires to have his/her services restarted after 90 days, the member must request the services.~~

317:50-5-12. Eligible providers [REVOKED]

~~Sooner Seniors Program service providers, must be certified by the Oklahoma Health Care Authority (OHCA) and all providers must have a current signed SoonerCare contract on file.~~

~~(1) The provider programmatic certification process verifies that the provider meets licensure, certification and training standards as specified in the Waiver document and agrees to Sooner Seniors Program Conditions of Participation. Providers must obtain programmatic certification to be Sooner Seniors Program certified.~~

~~(2) The provider financial certification process verifies that the provider uses sound business management practices and has a financially stable business.~~

~~(3) Providers may fail to gain or may lose Waiver Program certification due to failure to meet either programmatic or financial standards.~~

~~(4) At a minimum, provider financial certification is reevaluated annually.~~

~~(5) Providers of Medical Equipment and Supplies, Environmental Modifications, Personal Emergency Response Systems, Hospice, and NF Respite services do not have a programmatic evaluation after the initial certification.~~

~~(6) OHCA may authorize a legally responsible family member (spouse or legal guardian) of an adult member to be SoonerCare reimbursed under the Sooner Seniors Program as a service provider, if the provider meets all of the following authorization criteria and monitoring provisions:~~

~~(A) Authorization for a legally responsible family member to be the care provider for a member may occur only if the member is offered a choice of providers and documentation demonstrates that:~~

~~(i) either no other provider is available; or~~

~~(ii) available providers are unable to provide necessary care to the member; or~~

~~(iii) the needs of the member are so extensive that the spouse or legal guardian who provides the care is prohibited from working outside the home due to the member's need for care.~~

~~(B) The service must:~~

~~(i) meet the definition of a service/support as outlined in the federally approved Waiver document;~~

~~(ii) be necessary to avoid institutionalization;~~

~~(iii) be a service/support that is specified in the individual service plan;~~

~~(iv) be provided by a person who meets the provider qualifications and training standards specified in the Waiver for that service;~~

~~(v) be paid at a rate that does not exceed that which would otherwise be paid to a provider of a similar service and does not exceed what is allowed by the OHCA for the payment of personal care or personal assistance services;~~

~~(vi) not be an activity that the spouse or legal guardian would ordinarily perform or is responsible to perform. If any of the following criteria are met, assistance or care provided by the spouse or guardian will be determined to exceed the extent and/or nature of the assistance they would be expected to ordinarily provide in their role as spouse or guardian:~~

~~(I) spouse or guardian has resigned from full-time/part-time employment to provide care for the member; or~~

~~(II) spouse or guardian has reduced employment from full-time to part-time to provide care for the member; or~~

~~(III) spouse or guardian has taken a leave of absence without pay to provide care for the member; or~~

~~(IV) spouse or guardian provides assistance/care for the member 35 or more hours per week without pay and the member has remaining unmet needs because no other provider is available due to the nature of the assistance/care, special language or communication, or intermittent hours of care requirements of the member.~~

~~(C) The spouse or legal guardian who is a service provider will comply with the following:~~

~~(i) not provide more than 40 hours of services in a seven day period;~~

~~(ii) planned work schedules must be available in advance to the member's Case Manager, and variations to the schedule must be noted and supplied two weeks in advance to the Case Manager unless change is due to an emergency;~~

~~(iii) maintain and submit time sheets and other required documentation for hours paid; and~~

~~(iv) be documented in the service plan as the member's care provider.~~

~~(D) In addition to case management, monitoring, and reporting activities required for all Waiver services, the state is obligated to additional monitoring requirements when members elect to use a spouse or legal guardian as a paid service provider. The OHCA will monitor through documentation submitted by the Case Manager the following:~~

~~(i) at least quarterly reviews by the Case Manager of expenditures and the health, safety, and welfare status of the individual member; and~~

~~(ii) face-to-face visits with the member by the Case Manager on at least a semi annual basis.~~

~~(7) The OHCA periodically performs a programmatic audit of Case Management, Home Care (providers of Skilled Nursing, State Plan Personal Care, In-Home Respite, Advanced Supportive/Restorative Assistance and Therapy Services), and Self-Directed service providers. If due to a programmatic audit, a provider Plan of Correction is required, the OHCA stops new case referrals to the provider until the Plan of Correction has been approved and implemented. Depending on the nature and severity of problems discovered during a programmatic audit, at the discretion of the OHCA, members determined to be at risk for health or safety may be transferred from a provider requiring a Plan of Correction to another provider.~~

~~(8) As additional providers are certified or if a provider loses certification, the OHCA provides notice to appropriate personnel in counties affected by the certification changes.~~

317:50-5-13. Coverage [REVOKED]

~~Individuals receiving Waiver services must have been determined to be eligible for the program and must have an approved plan of care. Any Sooner Seniors Program service provided must be listed on the approved plan of care and must be necessary to prevent institutionalization of the member. Waiver services which are expansions of Oklahoma Medicaid State Plan services may only be provided after the member has exhausted these services available under the State Plan.~~

~~(1) To allow for development of administrative structures and provider capacity to adequately deliver Self-Directed services and Supports, availability of Self-Direction is limited to Sooner Seniors Program members that reside in counties that have sufficient provider capacity to offer the Self-Directed Service option as determined by OHCA.~~

~~(2) Case Managers within the Self-Directed Services approved area will provide information and materials that explain the service option to the members. The OHCA provides information~~

~~and material on Self-Direction to Case Managers for distribution to members.~~

~~(3) The member may request to Self-Direct their services from their Case Manager or call the Sooner Seniors Program toll-free number to request the Self-Directed Services option.~~

317:50-5-14. Description of services [REVOKED]

~~Services included in the Sooner Seniors Waiver Program are as follows:~~

~~(1) **Case Management.**~~

~~(A) Case Management services are services that assist a member in gaining access to medical, social, educational or other services, regardless of payment source of services, that may benefit the member in maintaining health and safety. Case managers initiate and oversee necessary assessments and reassessments to establish or reestablish Waiver program eligibility. Case managers develop the member's comprehensive plan of care, 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 Sooner Seniors Waiver Program minimum requirements for qualification and training prior to providing services to members. Prior to providing services to members choosing to Self-Direct their services, Case Managers are required to receive training and demonstrate knowledge regarding the Self-Directed Service delivery model.~~

~~(B) Providers may only claim time for billable Case Management activities described as follows:~~

~~(i) A billable case management activity is any task or function defined under OAC 317:50-5-14(1)(A) that only a Sooner Seniors 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 OHCA identified zip codes in Osage County adjacent to metropolitan areas of Tulsa and Washington Counties. Services to these members are prior authorized and billed using the Standard rate.~~

~~(iii) The latest United States Census, Oklahoma Counties population data is the source for determination of whether a member resides in a county with a population density equal to or less than 25 persons per square mile, or resides in a county with a population density greater than 25 persons per square mile.~~

~~(2) **Institutional Transition Services.**~~

~~(A) Institutional Transition Case Management Services are services required by the member's plan of care, which are necessary to ensure the health, welfare and safety of the member, or to enable the member to function with greater independence in the home, and without which, the member would continue to require institutionalization.~~

~~(B) Waiver Transition Case Management services assist institutionalized members that are eligible to receive waiver services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services to assist the transition, regardless of the funding source for the services which access is gained.~~

~~(C) Transition case management services may be authorized~~

~~for periodic monitoring of a waiver member's progress during an institutional stay, and for assisting the member transition from institution to home by updating the services plan, including preparing for necessary services and supports to be in place or to start on the date the member is discharged from the institution.~~

~~(3) **Respite.**~~

~~(A) Respite services are provided to members who are unable to care for themselves. They are provided on a short-term basis because of the absence or need for relief of the primary caregiver. Payment for respite care does not include room and board costs unless more than seven hours are provided in a nursing facility. Respite care will only be utilized when other sources of care and support have been exhausted. Respite care will only be listed on the plan of care 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.~~

~~(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 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.

(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 include 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 Sooner Seniors Waiver case manager in accordance with review schedule determined in consultation between the Case Manager and the Skilled Nurse, to report the member's condition or other significant information concerning each advanced supportive/restorative care member.~~

~~(i) The case manager may recommend authorization of Skilled Nursing services as part of the interdisciplinary team planning for the member's service plan and/or assessment/evaluation of:~~

~~(I) the member's general health, functional ability and needs and/or~~

~~(II) the adequacy of personal care and/or advanced supportive/restorative assistance services to meet the member's needs including providing on-the-job training and competency testing for personal care or advanced supportive/restorative care aides in accordance with rules and regulations for delegation of nursing tasks as established by the Oklahoma Board of Nursing.~~

~~(ii) In addition to assessment/evaluation, the case manager may recommend authorization of Skilled Nursing services for the following:~~

~~(I) preparing a one-week supply of insulin syringes for a blind diabetic, who can safely self-inject the medication but cannot fill his/her own syringe. This service would include monitoring the member's continued ability to self-administer the insulin;~~

~~(II) preparing oral medications in divided daily compartments for a member who self-administers prescribed medications but needs assistance and monitoring due to a minimal level of disorientation or confusion;~~

~~(III) monitoring a member's skin condition when a member is at risk for skin breakdown due to immobility or incontinence, or the member has a chronic stage II decubitus ulcer requiring maintenance care and monitoring;~~

~~(IV) providing nail care for the diabetic member or~~

member with circulatory or neurological compromise;
(V) providing consultation and education to the member, member's family and/or other informal caregivers identified in the service plan, regarding the nature of the member's chronic condition. Provide skills training (including return skills demonstration to establish competency) to the member, family and/or other informal caregivers as specified in the service plan for preventive and rehabilitative care procedures.

(C) Nursing service can be billed for service plan development and/or assessment/evaluation services or, for other services within the scope of the Oklahoma Nursing Practice Act including private duty nursing. Nursing services are billed per 15-minute unit of service. A specific procedure code is used to bill for assessment/evaluation/service plan development skilled nursing services and other procedure codes are used to bill for all other authorized nursing services. A maximum of eight units per day of skilled nursing for assessment/evaluation and/or service plan development are allowed. An agreement by a provider to perform a nurse evaluation is also an agreement, to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted. Reimbursement for a nurse evaluation is denied if the provider that produced the nurse evaluation fails to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted.

(8) **Home Delivered Meals.**

(A) Home Delivered Meals provide one meal per day. A home delivered meal is a meal prepared in advance and brought to the member's home. Each meal must have a nutritional content equal to at least one third of the Recommended Daily Allowance as established by the Food and Nutrition Board of the National Academy of Sciences. Meals are only provided to members who are unable to prepare meals and lack an informal provider to do meal preparation.

(B) Home Delivered Meals are billed per meal, with one meal equaling one unit of service. The limit of the number of units a member is allowed to receive is limited on the member's plan of care. 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 s 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. Sooner Seniors Hospice Care is authorized for a six month period and requires a physician certification of a terminal illness and orders of hospice care. If the member requires more than six months of hospice care, a physician or nurse practitioner must have a face-to-face visit with the member thirty days prior to the initial hospice authorization end date and re-certify that the member has a terminal illness and has six months or less to live and orders additional hospice care. After the initial authorization period, additional periods of hospice may be authorized for a maximum of 60 day increments with physician certification that the member has a terminal illness and has six months or less to live. A member's service plan that includes hospice care must comply with waiver requirements to be within total service plan cost limits.~~

~~(B) A hospice program offers palliative and supportive care to meet the special needs arising out of the physical, emotional and spiritual stresses which are experienced during the final stages of illness and during dying and bereavement. The member signs a statement choosing hospice care instead of routine medical care that has the objective to treat and cure the member's illness. Once the member has elected hospice care, the hospice medical team assumes responsibility for the member's medical care for the terminal illness in the home environment. Hospice care services include nursing care,~~

~~physician services, medical equipment and supplies, drugs for symptom control and pain relief, home health aide and personal care services, physical, occupational and/or speech therapy, medical social services, dietary counseling and grief and bereavement counseling to the member and/or family. A Hospice plan of care must be developed by the hospice team in conjunction with the member's case manager before hospice services are provided. The hospice services must be related to the palliation or management of the member's terminal illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills. Hospice may be provided to the member in a Nursing Facility (NF) only when the member is placed in the NF for Sooner Seniors 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 Sooner Seniors Hospice services.~~

~~(C) Hospice services are billed per diem of service for days covered by a Hospice plan of care and during which the hospice provider is responsible for providing hospice services as needed by the member or member's family.~~

~~(14) **Sooner Seniors Waiver Personal Care.**~~

~~(A) Sooner Seniors 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) Sooner Seniors Home Care Agency Skilled Nursing staff working in coordination with a Case Manager are responsible for development and monitoring of the member's Personal Care plan.~~

~~(C) Sooner Seniors Personal Care services are prior authorized and billed per 15-minute unit of service with units of service limited to the number of units on the approved plan of care.~~

~~(15) **Assisted Living Services.**~~

~~(A) Assisted Living Services are personal care and supportive services that are furnished to the member 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.~~

~~(B) Assisted Living Services includes services of personal care, housekeeping, laundry, meal preparation, periodic nursing evaluation, 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 coordination of transportation to and from medical appointments.~~

~~(C) Services, except for planned programs for socialization, activities and exercise, are to meet specific needs of the member as determined throughout individualized assessment and documented on the member=s service plan.~~

~~(D) Payment is not made for 24 hour skilled care.~~

~~(16) **Adult Day Health**. Adult Day Health services are scheduled for one or more days per week, in a community setting, encompassing both health and social services needed in order to provide optimal functioning of the member.~~

~~(17) **Agency companion.** Agency companion services provide a living arrangement developed to meet the specific needs of the member that include a live-in companion providing supervision, supportive assistance, and training in daily living skills provided in a shared home owned or rented by the member, companion, or in a mutually rented or owned home;~~

~~(18) **Dental services**. Dental services include maintenance or improvement of dental health as well as relief of pain and infection. Coverage of dental services may not exceed $1,000 per plan year of care. These services may include:~~

~~(A) oral examination;~~

~~(B) bite-wing x-rays;~~

~~(C) prophylaxis;~~

~~(D) topical fluoride treatment;~~

~~(E) development of a sequenced treatment plan that prioritizes:~~

~~(i) elimination of pain;~~

~~(ii) adequate oral hygiene; and~~

~~(iii) restoration or improved ability to chew;~~

~~(F) routine training of member or primary caregiver regarding oral hygiene; and~~

~~(G) preventive restorative, replacement and repair services to achieve or restore functionality are provided after appropriate review if applicable.~~

~~(19) **Family training.** Family training services are for families of the member being served through the waiver. For~~

~~purposes of this service, "family" is defined as the persons who live with or provide care to a waiver member and may include a parent, spouse, children relatives, foster family or in-laws. Training includes instruction for the family member in skills and knowledge pertaining to the support and assistance of the waiver member. This training is specific to an individual member's needs. It is intended to allow the member's family to become more proficient in meeting the needs of the member. Specific family training services are included in the member's service plan.~~

~~(20) **Nutritional Education services.** Nutritional Education services focus on assisting the member and/or primary caregiver with the dietary aspects of the member's disease management. These services include dietary evaluation and consultation with individuals or their care provider. Services are provided in the member's home or when appropriate in a class situation. Services are intended to maximize the individual's nutritional health. Services must be expressly for diagnosing, treating or preventing, or minimizing the effects of illness.~~

~~(21) **Vision services.** Vision services must be listed in the member's plan of care and include a routine eye examination for the purpose of prescribing glasses or visual aids, determination of refractive state, treatment of refractive errors or purchase of glasses to include lenses and frames; exceptions are made on the individual basis as deemed medically necessary. Amount, frequency and duration of services is prior authorized in accordance with the member's service plan, with a limit of one pair of glasses to include lenses and frames annually.~~

~~(22) **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 a Sooner Seniors 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 Sooner Seniors approved plan of care.~~

~~(23) **Prescription drugs.** Members are eligible for a maximum of six prescriptions per month with a limit of three brand name prescriptions. Seven additional generic prescriptions per month are allowed if medically necessary. Medically necessary prescriptions beyond the three brand name or thirteen total prescriptions will be covered with prior authorization. More information on prescription drugs is provided at 317:30-5-72.~~

~~(24) **Pharmacological Evaluations.** Pharmacological evaluations are provided to waiver members to ensure proper management of medications. The evaluations consist of:~~

~~(A) An initial medication assessment performed in conjunction with the case manager and member.~~

~~(B) A written report after completion of both the initial visit and medication assessment to be provided to the case manager and prescribing physician(s). The report will contain the initial medication assessment and recommendations when appropriate.~~

~~(C) Follow-up visit, assessments and reports will be arranged with the case manager every four months after the initial visits, assessment and report for the first year the member is in the community. This will result in a total of three follow-up visits, assessments and reports per member.~~

~~(25) **Non-emergency Transportation.** Non-emergency, non-ambulance transportation services are available through the SoonerRide Non-Emergency Transportation (NET) program. SoonerRide NET is available on a statewide basis to all eligible members. SoonerRide NET includes non-emergency, non-ambulance transportation for members to and from SoonerCare providers of health care services. The NET must be for the purpose of accessing medically necessary covered~~

~~services for which a member has available benefits. Additionally, SoonerRide NET may also be provided for eligible members to providers other than SoonerCare providers if the transportation is to access medically necessary services covered by SoonerCare. More information on SoonerRide NET services is located at 317:30-5-326.~~

~~(26) **Self-Direction**.~~

~~(A) Self-Direction is a method of service delivery that allows waiver members to determine supports and services they need to live successfully in a home or community based setting. A member choosing Self-Direction is the employer of record for his/her Personal Care and Advanced Supportive/Restorative Care service providers and must have an approved plan of care prior to initiation of any Self-Directed activities.~~

~~(B) The OHCA uses the following criteria to determine a member's service eligibility to participate in the Self-Directed Services program:~~

~~(i) residence in the Self-Directed services area;~~

~~(ii) member's health and safety with Self-Directed services can reasonably be assured based on a review of service history records and a review of member capacity and readiness to assume employer responsibilities under Self-Direction with any one of the following findings as basis to deny a request for Self-Direction due to inability to assure member health and safety;~~

~~(I) the member does not have the ability to make decisions about his/her care or service planning and the member's "authorized representative" is not willing to assume Self-Directed services responsibilities, or~~

~~(II) the member is not willing to assume responsibility, or to enlist an "authorized representative" to assume responsibility, in one or more areas of Self-Direction such as in service planning, or in assuming the role of employer of the Personal Services Assistant (PSA) or Advanced Personal Services Assistant (APSA) service provider, or in monitoring and managing health or in preparation for emergency backup, or~~

~~(III) the member has a recent history of self-neglect or self-abuse as evidenced by Adult Protective Services intervention within the past 12 months and does not have an "authorized representative" with capacity to assist with Self-Direction responsibilities;~~

~~(C) The member voluntarily makes an informed choice to Self-Direct services. As part of the informed choice,~~

~~decision making process for Self-Direction, the OHCA staff or the Case Manager provides consultation and assistance as the member completes a self-assessment of preparedness to assume the role of employer for their Personal Services Assistant. The orientation and enrollment process will provide the member with a basic understanding of what will be expected of them under Self-Direction, the supports available to assist them to successfully perform employer responsibilities and an overview of the potential risks involved.~~

~~(D) The OHCA uses the following criteria to determine that based upon documentation, a person is no longer allowed to participate in the Self-Directed Services option:~~

~~(i) the member does not have the ability to make decisions about his/her care or service planning and the member's "authorized representative" is not willing to assume Self-Direction responsibilities; or~~

~~(ii) the member is not willing to assume responsibility, or to enlist an "authorized representative" to assume responsibility, in one or more areas of Self-Direction such as in service planning, or in assuming the role of employer of the PSA or APSA service providers, or in monitoring and managing health or in preparation for emergency backup; or~~

~~(iii) the member has a recent history of self-neglect or self-abuse as evidenced by Adult Protective Services intervention and does not have an "authorized representative" with capacity to assist with Self-Direction responsibilities; or~~

~~(iv) the member abuses or exploits their employee; or~~

~~(v) the member falsifies time-sheets or other work records; or~~

~~(vi) the member, even with Case Manager and Financial Management Services assistance, is unable to operate successfully within their Individual Budget Allocation; or~~

~~(vii) inferior quality of services provided by member/employer's employee, or the inability of the member/employer's employee to provide the number of service units the member requires, jeopardizes the member's health and/or safety.~~

~~(E) The member may designate a family member or friend as an "authorized representative" to assist in the service planning process and in executing member employer responsibilities. If the member chooses to designate an "authorized representative", the designation and agreement identifying the "willing adult" to assume this role and~~

~~responsibility is documented with dated signatures of the member, the designee and the member's Case Manager or the OHCA staff.~~

~~(i) A person having guardianship or power of attorney or other court sanctioned authorization to make decisions on behalf of the member has legal standing to be the member's designated "authorized representative".~~

~~(ii) An individual hired to provide Personal Services Assistance to a member may not be designated the "authorized representative" for the member.~~

~~(F) Self-Directed Services are delivered as authorized on the service plan and are limited to Personal Care, Advanced Supportive/Restorative Care and Respite. The member employs the Respite or Personal Services Assistant (PSA) and/or the Advanced Personal Services Assistant (APSA) and is responsible, with assistance from the Administrative Financial Management Services (FMS), for ensuring that the employment complies with State and Federal Labor Law requirements. The member:~~

~~(i) recruits, hires and, as necessary, discharges the PSA and APSA;~~

~~(ii) provides instruction and training to the PSA or APSA on tasks to be done and works with the Case Manager to obtain skilled nursing services assistance with training when necessary. Prior to performing an Advanced Personal Services Assistance 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 APSA_s personnel file;~~

~~(iii) determines where and how the PSA or APSA works, hours of work, what is to be accomplished and, within Individual Budget Allocation limits, wages to be paid for the work;~~

~~(iv) supervises and documents employee work time; and,~~

~~(v) provides tools and materials for work to be accomplished.~~

~~(G) Financial Management Services are program administrative services provided to participating Self-Directed Service employer/members by agencies contracted with the OHCA. Financial Management Services are employer related assistance that provides Internal Revenue Service (IRS) fiscal reporting agent and other financial management tasks and functions including, but not limited to:~~

~~(i) employer payroll, at a minimum of semi monthly, and associated withholding for taxes, or for other payroll~~

~~withholdings performed on behalf of the member as employer of the PSA or APSA;~~

~~(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 Respite or Personal Services Assistant or Advanced Personal Services Assistant; and~~

~~(H) The service of Respite or 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.~~

~~(I) 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.~~

~~(J) Self-Directed Services rates are determined using the Individual Budget Allocation (IBA) Expenditure Accounts Determination process for each member. The IBA Expenditure Accounts Determination process includes consideration and decisions about the following:~~

~~(i) The Individual Budget Allocation (IBA) Expenditure Accounts Determination constrains total SoonerCare reimbursement for Self-Directed services to be less than expenditures for equivalent services using agency providers.~~

~~(ii) The PSA and APSA service unit rates are calculated by the OHCA during the Self-Directed service eligibility determination process. The OHCA sets the PSA and APSA unit rates at a level that is not less than 80 percent and not more than 95 percent of the comparable Agency Personal Care (for PSA) or Advanced Supportive/Restorative (for APSA) service rate. The allocation of portions of the PSA and/or APSA rate to cover salary, mandatory taxes, and optional benefits (including Worker's Compensation insurance, if available) is determined individually for each member using the Self-Directed Services Individualized Budget~~

Allocation Expenditure Accounts Determination Process.
(iii) The IBA Expenditure Accounts Determination process defines the level of program financial resources required to meet the member's need for Self-Directed services. If the member's need for services changes due to a change in health/disability status and/or a change in the level of support available from other sources, the Case Manager, based upon an updated assessment, amends the service plan to increase Self-Directed service units appropriate to meet additional member need. The OHCA, upon favorable review, authorizes the amended plan and updates the member's IBA. Service amendments based on changes in member need for services do not change an existing PSA or APSA rate. The member, with assistance from the FMS, reviews and revises the IBA Expenditure Accounts calculation annually or more often to the extent appropriate and necessary.

(27) **Self-Directed Goods and Services (SD-GS)**.

(A) Self-Directed Goods and Services (SD-GS) are incidental, non-routine goods and services that promote the member's self-care, daily living, adaptive functioning, general household activity, meal preparation and leisure skills needed to reside successfully in the community and do not duplicate other services authorized in the member's plan of care.

(B) These goods and services are purchased from the self-directed budget.

317:50-5-15. Reimbursement [REVOKED]

Rate methodologies for Waiver services are set in accordance with the rate setting process by the State Plan Amendment Rate Committee (SPARC) and approved by the Oklahoma Health Care Authority Board. Rates for Waiver services are set by one of the methodologies below:

(1) A fixed and uniform SoonerCare Rate. When a Waiver service is similar or the same as a Medicaid State Plan service for which a fee schedule has been established, the current SoonerCare rate is utilized.

(2) The current Medicare rate. When the waiver service mirrors an existing Medicare service the current Medicare rate is utilized.

(3) Individual rates. Certain services because of their variables do not lend themselves to a fixed and uniform rate. Payment for these services is made on an individual basis following a uniform process approved by the OHCA.

317:50-5-16. Billing procedures for Sooner Seniors Waiver

services [REVOKED]

~~(a) Billing procedures for long-term care medical services are contained in the OKMMIS Billing and Procedure Manual. Questions regarding billing procedures which cannot be resolved through a study of the manual should be referred to the OHCA.~~

~~(b) The approved Sooner Seniors Waiver service plan is the basis for the MMIS service prior authorization, specifying:~~

~~(1) service;~~

~~(2) service provider;~~

~~(3) units authorized; and~~

~~(4) begin and end dates of service authorization.~~

~~(c) As part of Sooner Seniors Waiver quality assurance, provider audits are used to evaluate whether paid claims are consistent with service plan authorizations and documentation of service provision. Evidence of paid claims that are not supported by service plan authorization and/or documentation of service provision will be turned over to the OHCA Provider Audit Unit for follow-up investigation.~~

~~(d) Service time of Personal Care, Case Management, Nursing, Advanced Supportive/Restorative Assistance, In-Home Respite and Self Direction may be documented through the Interactive Voice Response Authentication (IVRA) system when provided in the home. The IVRA system provides alternate backup solutions should the automated system be unavailable. In the event of IVRA backup system failure, the provider will document time in accordance with their agency backup plan. The agency's backup procedures are only permitted when the IVRA system is unavailable.~~

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
SUBCHAPTER 6. SOONERCARE FOR PREGNANT WOMEN AND FAMILIES WITH CHILDREN
PART 5. DETERMINATION OF ELIGIBILITY FOR SOONERCARE HEALTH BENEFITS FOR PREGNANT WOMEN AND FAMILIES WITH CHILDREN

317:35-6-38. Hospital Presumptive Eligibility

(a) **General.** Hospital Presumptive Eligibility (HPE) is a limited period of SoonerCare eligibility for individuals who are categorically related to certain MAGI eligibility groups listed in OAC 317:35-6-38(a)(1)(A)(i) through (vi) and are also determined by a qualified hospital (see OAC 317:35-6-38(a)(2)(A) through (L)) for the conditions of a qualified hospital), on the basis of preliminary information provided by the applicant on a completed HPE application, to be eligible for SoonerCare services. The rules in this section apply only to those individuals applying for, or qualified hospitals determining eligibility under, the HPE program.

(1) **Individuals eligible to participate in the HPE program.** To be eligible to participate in the HPE program, an individual must be categorically related to a MAGI eligibility group (see OAC 317:35-5-2 for categorical relationship criteria) and also meet the income standard and non-medical eligibility specified in this section.

(A) **MAGI Eligibility Groups**. The following MAGI eligibility groups are eligible to have a presumptive eligibility (PE) determination made by a qualified hospital participating in the HPE program:

(i) children;
(ii) pregnant women;
(iii) parents and caretaker relatives;
(iv) former foster care children;
(v) Breast and Cervical Cancer Treatment program; and
(vi) SoonerPlan Family planning.

(B) **Income standard.** The income that is counted in determining PE for an individual is that individual's household income. The income limit for the MAGI eligibility groups covered under the HPE program is the same as defined in OAC 317:35-6-39(b)(8) and is listed on the HPE application. The calculation of countable household income for an individual covered under the HPE program is the same as OAC 317:35-6-39, except that, in determining the individual's household composition, only the MAGI household composition non-filer rules listed under OAC 317:35-6-43 apply for all individuals applying

for the HPE program regardless of whether or not the individual is a tax filer, plans on filing taxes, or is a tax dependent.

(C) **Non-medical eligibility requirements.** Individuals covered under the HPE program must also meet the non-medical eligibility requirements described in OAC 317:35-5-25.

(D) **Pregnant women covered under the HPE program.** Coverage for pregnant women who are covered under the HPE program is limited to ambulatory prenatal care only, and the number of PE periods that may be authorized for pregnant women is one per pregnancy. Pregnant women who may be covered for the benefit of the unborn child(ren) under Title XXI are not eligible for the HPE program.

(E) **Other individuals covered under the HPE program.** Coverage for other individuals listed under OAC 317:35-6-38(a)(1)(A)(i) through (vi) who are covered under the HPE program, except for pregnant women, is the same as covered under the State Plan. The number of PE periods that may be authorized is one period every 365 days beginning on the date the individual is enrolled in HPE.

(2) **Qualified hospital.** The decision that a hospital is qualified to make PE determinations is made by the OHCA. In order to participate in the HPE program and make PE determinations, a qualified hospital must:

(A) Meet all the conditions of an eligible provider under OAC 317:30-5-40;

(B) Elect to participate in the HPE program by:

(i) Completing and submitting a HPE Statement of Intent and Memorandum of Understanding to the OHCA and agreeing to all the terms and conditions of the HPE program;

(ii) Amending its current contract with the OHCA to include participation in the HPE program;

(C) Assign and designate a hospital employee to serve as the HPE program administrator and point of contact;

(D) Assign and designate hospital employees to make PE determinations. The term Authorized Hospital Employee(s) (AHE) means all individuals making PE determinations on behalf of a hospital participating in the HPE program. The AHE must meet the following conditions:

(i) Be an employee of the hospital (i.e. the AHE may not be a third party contractor);

(ii) Attend, complete, and pass the HPE program training course provided and assessed by the OHCA;

(iii) The AHE certificate of HPE course completion must be kept in the worker's file at the hospital and must

be made available to the OHCA upon request;
(iv) Follow state and federal privacy and security requirements regarding patient confidentiality;
(v) Agree to abide by all the rules and guidelines of the HPE program established by the OHCA under this section.

(E) Notify the OHCA of any changes in the AHE's employment status or in the designation of that individual as the hospital's AHE;
(F) Abide by the rules and regulations of the Uniform Electronic Transaction Act as outlined in OAC 317:30-3-4.1;
(G) Keep internal records of all individuals for whom a PE determination was made and make those records available to the OHCA upon request;
(H) Agree to submit all completed HPE applications and PE determinations to the OHCA within 5 days of the PE determination;
(I) Notify the applicant in writing, or in cases where the HPE application was made on behalf of a child, notify the child's parent or caretaker of the PE determination outcome and provide and explain to eligible members the "HPE Program Policy and Enrollment" form;
(J) Assist HPE applicants with the completion of a full SoonerCare application within 15 days of the HPE application submission to the OHCA;
(K) Agree to adhere to the processes and procedures established by the OHCA regarding the operation and oversight of the HPE program; and
(L) Cooperate with the OHCA regarding audit and quality control reviews on PE determinations the hospital makes. The agency may terminate the HPE agreement with the hospital if the hospital does not meet the standards and quality requirements set by the OHCA.

(3) **Limited hospital PE determinations.** The agency limits the PE determinations that a hospital may make to only those eligibility groups described in OAC 317:35-6-38(a)(1)(A) using the MAGI methodology rules established for the HPE program. Additionally, PE determinations made for individuals categorically related to the Breast and Cervical Cancer Treatment program are limited to qualified hospitals that are also qualified entities through the NBCCEDP.

(b) **General provisions of the HPE program.** The agency provides SoonerCare coverage to eligible individuals covered during a period of PE.

(1) **PE period.** The PE period begins on the date a qualified hospital determines an individual to be eligible under the

HPE program. A qualified hospital has 5 days to notify the agency of its PE determination. The PE period ends with the earlier of:

(i) The day the agency receives the SoonerCare application form as described in OAC 317:35-5-60 and an eligibility determination is made by the agency; or

(ii) If a SoonerCare application is not received, the last day of the month following the month in which the PE determination was made.

(2) **Agency approval of PE.** When the OHCA receives a timely and completed HPE application, a case number and, if needed, SoonerCare member ID is assigned to the member by the agency. Qualified hospitals will be able to review member enrollment and eligibility, once those members have been entered into the system by the OHCA, for claims billing and member eligibility verification.

(3) **Incomplete HPE applications.** Upon receiving a HPE Application, the OHCA reviews it for completeness and correctness. The HPE application is considered incomplete if it is not filled out in its entirety (e.g., the applicant's first or last name is not provided on the application) or if the application is not filed timely with the OHCA. When the HPE application is determined to be incomplete, the HPE application is returned to the AHE or the HPE program administrator at the qualified hospital to correct the application errors or amend the HPE application. To maintain the original PE certification period, the qualified hospital must return the completed or corrected HPE application to the agency within five working days.

(4) **Applicant appeal.** The HPE applicant cannot appeal the PE determination made by a qualified hospital or the expiration date of the PE period.

(5) **Applicant ineligibility.** Applicants ineligible for the HPE program are individuals who do not meet the HPE criteria, individuals who have previously been enrolled in the HPE program within the last 365 days, and individuals currently enrolled in SoonerCare. Individuals currently enrolled in SoonerPlan Family Planning are not eligible for HPE family planning services, but may be eligible for other programs under HPE. When the OHCA receives a HPE application from a qualified hospital for an ineligible applicant (e.g., the applicant has been previously enrolled in the HPE program within the last 365 days), the OHCA will disenroll the individual from the HPE program immediately and notify the hospital of the error. The hospital will be responsible for following up with that individual to notify them of their disenrollment from the HPE program. If the applicant is not

currently enrolled into SoonerCare, the applicant may submit a full SoonerCare application and receive a full eligibility determination by the OHCA. HPE services provided to ineligible applicants, other than persons currently enrolled into SoonerCare or SoonerPlan Family Planning, may not be eligible for reimbursement by the OHCA.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 17. MEDICAL SUPPLIERS

317:30-5-211.1. Definitions

The following words and terms, when used in this Part, have the following meaning, unless the context clearly indicates otherwise.

"**Adaptive equipment**" means devices, aids, controls, appliances or supplies of either a communication or adaptive type, determined necessary to enable the person to increase his or her ability to function in a home and community based setting or private Intermediate Care Facilities for ~~the Mentally Retarded (ICF/MR)~~Individuals with Intellectual Disabilities (IFC/IID) with independence and safety.

"**Capped rental**" means monthly payments for the use of the Durable Medical Equipment (DME) for a limited period of time not to exceed 13 months. Items are considered purchased after 13 months of continuous rental.

"**Certificate of medical necessity (CMN)**" means a certificate required to help document the medical necessity and other coverage criteria for selected items~~, those~~. Those items are defined in this Chapter. The physician's certification must include the member's diagnosis, the reason the equipment is required, and the physician's estimate, in months, of the duration of its need.

"**Customized DME**" means items of DME which have been uniquely constructed or substantially modified for a specific member according to the description and orders of the member's treating physician. For instance, a wheelchair would be considered "customized" if it has been:

(A) measured, fitted, or adapted in consideration of the member's body size, disability, period of need, or intended use;

(B) assembled by a supplier or ordered from a manufacturer who makes available customized features, modifications, or components for wheelchairs; and

(C) intended for an individual member's use in accordance with instructions from the member's physician.

"**Durable medical equipment (DME)**" means equipment that can withstand repeated use~~, i.e.; the~~(e.g. a type of item that could normally be rented), is used to serve a medical purpose, is not useful to a person in the absence of an illness or injury, and is used in the most appropriate setting, including the home or workplace.

"**Invoice**" means a document that provides the following information when applicable~~;~~: the description of product,

quantity, quantity in box, purchase price~~ (less any discounts, rebates or commissions received)~~, NDC, strength, dosage, provider, seller's name and address, purchaser's name and address, and date of purchase. At times, visit notes will be required to determine how much of the supply was expended. When possible, the provider should identify the SoonerCare member receiving the equipment or supply on the invoice.

"**Medical supplies**" means an article used in the cure, mitigation, treatment, prevention, or diagnosis of illnesses. Disposable medical supplies are medical supplies consumed in a single usage and do not include skin care creams or cleansers. Medical supplies do not include surgical supplies or medical or surgical equipment.

"**OHCA CMN**" means a certificate required to help document the medical necessity and other coverage criteria for selected items. Those items are defined in this chapter. The physician's certification must include the member's diagnosis, the reason equipment is required, and the physician's estimate, in months, of the duration of its need. This certificate is used when the OHCA requires a CMN and one has not been established by CMS.

"**Orthotics**" means an item used for the correction or prevention of skeletal deformities.

"**Prosthetic devices**" means a replacement, corrective, or supportive device (including repair and replacement parts ~~for~~of the same) worn on or in the body~~,~~ to artificially replace a missing portion of the body, prevent or correct physical deformity or malfunction, or support a weak or deformed portion of the body.

317:30-5-211.3. Prior authorization (PA)

(a) **General**. Prior authorization is the electronic or written authorization issued by OHCA to a provider prior to the provision of a service. Providers should obtain a PA before providing services.

(b) **Requirements.** Billing must follow correct coding guidelines as promulgated by CMS or per uniquely and publicly promulgated OHCA guidelines. DME claims must include the most appropriate HCPCS code as assigned by the ~~Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC)~~Medicare Pricing, Data, Analysis, and Coding (PDAC) or its successor. Authorizations for services not properly coded will be denied. **The following services require prior authorization:**

(1) services that exceed quantity/frequency limits;

(2) medical need for an item that is beyond OHCA's standards of coverage;

(3) use of a Not Otherwise Classified (NOC) code or miscellaneous codes;

(4) services for which a less costly alternative may exist; and

(5) procedures indicating that a PA is required on the OHCA fee schedule.

(c) **Prior authorization requests.** Refer to OAC 317:30-5-216.

317:30-5-211.4. Rental and/or purchase

(a) **Purchase (New or Used).** Items may be purchased if they are inexpensive accessories for other DME or the equipment itself will be used for an extended period of time. The OHCA reserves the right to determine whether items of DMEPOS will be rented or purchased.

(b) **Rental.**

(1) **Continuous rental.** Items that require regular and ongoing servicing/maintenance are rented for the duration indicated by the physician's order and medical necessity. Examples include, but are not limited to, oxygen and volume ventilators. The rental payment includes routine servicing and all necessary repairs or replacements to make the rented item functional.

(2) **Capped rental.** Items are rented until the purchase price is reached. Capped rental items may be rented for a maximum of 13 months. If the member changes suppliers during or after the 13th continuous month rental period, this does not result in a new rental period. The supplier that provides the item to the member the 13th month of rental is responsible for supplying the equipment, as well as routine maintenance and servicing after the 13th month. If used equipment is issued to the member, the usual and customary charge reported to the OHCA~~,~~ must accurately reflect that the item is used.

(c) **Converting rental to purchase.** The majority of DME can be rented as a capped rental for up to a maximum of 13 continuous months. When an item is converted to a purchase during the rental period, the provider must subtract the amount already paid for the rental item from the total purchase price.

317:30-5-211.5. Repairs, maintenance, replacement, and delivery

(a) **Repairs.** Repairs to equipment that a member owns are covered when they are necessary to make the equipment usable. The repair charge includes the use of "loaner" equipment as required. If the expense for repairs exceeds the estimated expense of purchasing or renting another item of equipment for the remaining period of medical need, payment ~~can not~~cannot be made for the amount in excess. Repairs of rented equipment are not covered.

(b) **Maintenance.** Routine periodic servicing, such as testing, cleaning, regulating, and checking the member's equipment is considered maintenance and not a separate covered service.

DMEPOS suppliers must provide equipment-related services consistent with the manufacturer's specifications and in accordance with all federal, state, and local laws and regulations. Equipment-related services may include, but are not limited to, checking oxygen system purity levels and flow rates, changing and cleaning filters, and assuring the integrity of equipment alarms and back-up systems. However, more extensive maintenance, as recommended by the manufacturer and performed by authorized technicians, is considered repairs. This may include breaking down sealed components and performing tests that require specialized testing equipment not available to the member. The supplier of a capped rental item that supplied the item the 13th month must provide maintenance and service for the item. In very rare circumstances of malicious damage, culpable neglect, or wrongful disposition, the supplier may document the circumstances and be relieved of the obligation to provide maintenance and service.

(c) **Replacement.**

(1) If a capped rental item of equipment has been in continuous use by the member for the equipment's useful life or if the item is irreparably damaged, lost, or stolen, a prior authorization must be submitted to obtain new equipment. The reasonable useful ~~life~~lifetime for capped rental equipment cannot be less than five years. Useful life is determined by the delivery of the equipment to the member, not the age of the equipment.

(2) Replacement parts must be billed with the appropriate HCPCS code that represents the item or part being replaced~~,~~ along with a pricing modifier and replacement modifier. If a part that has not been assigned a HCPCS code is being replaced, the provider should use a miscellaneous HCPCS code to bill each part. Each claim that contains miscellaneous codes for replacement parts must include a narrative description of the item, the brand name, model name/number of the item, and an invoice.

(d) **Delivery.** DMEPOS products are set with usual maximum quantities and frequency limits. Suppliers are not expected to provide these amounts routinely, nor are members required to accept DMEPOS products at frequencies or in quantities that exceed the amount the member would typically use. Suppliers must not dispense a quantity of any DMEPOS product exceeding a member's expected utilization. The reordering or refilling of DMEPOS products should always be based on actual member usage. Suppliers should stay attuned to atypical utilization patterns on behalf of their members and verify with the ordering physician that the atypical utilization is warranted. Suppliers must exercise the following guidelines in regard to the delivery of DMEPOS products:

(1) For DMEPOS products that are supplied as refills to the original order, suppliers must contact the member prior to dispensing the refill. This shall be done to ensure that the refilled item is necessary and to confirm any changes/modifications to the order. Contact with the member regarding refills should take place no sooner than 7 days prior to the delivery/shipping date. For subsequent deliveries of refills, the supplier must deliver the DMEPOS product no sooner than 5 days prior to the end of the usage for the current product. This is regardless of which delivery method is utilized. A member must specifically request the refill before a supplier dispenses the product. Suppliers must not automatically dispense a quantity of supplies on a predetermined basis, even if the member has authorized this in advance. The supplier must have member contact documentation on file to substantiate that the DMEPOS product was refilled in accordance with this section.

(2) For DMEPOS products that are supplied via mail order, suppliers must bill using the appropriate modifier which indicates that the DMEPOS product was delivered via the mail. Reimbursement for DMEPOS products supplied and delivered via mail may be at a reduced rate.

(3) For DMEPOS products that are covered in the scope of the SoonerCare program, the cost of delivery is always included in the rate for the covered item(s).

317:30-5-211.9. Adaptive equipment

(a) **Residents of ~~ICF/MR~~ICF/IID facilities.** Payment is made for customized adaptive equipment for persons residing in private Intermediate Care Facilities for ~~the Mentally Retarded (ICF/MR)~~ Individuals with Intellectual Disabilities (ICF/IID). This means customized equipment or devices to assist in ambulation. Standard wheelchairs, walkers, eyeglasses, etc., would not be considered customized adaptive equipment. All customized adaptive equipment must be prescribed by a physician and requires prior authorization.

(b) **Members in home and community-based waivers.** Refer to OAC 317:40-5-100.

317:30-5-211.10. Durable medical equipment (DME)

(a) **DME**. DME includes, but is not limited to: medical supplies, orthotics and prosthetics, custom braces, therapeutic lenses, respiratory equipment, and other qualifying items when acquired from a contracted DME provider.

(b) **Certificate of medical necessity**. Certain items of DME require a CMN/OHCA CMN which should be submitted with the request for prior authorization. These items include, but are not limited to:

(1) hospital beds;
(2) support surfaces;
(3) patient lift devices;
(4) external infusions pumps;
(5) enteral and parenteral nutrition;~~ and~~
(6) Oxygen and oxygen related products; and
~~(6)~~(7) pneumatic compression devices.

(c) **Prior authorization.**

(1) **Rental.** Rental of hospital beds, support surfaces, oxygen and oxygen related products, continuous positive airway pressure devices (CPAP and BiPAP), pneumatic compression devices, and lifts require prior authorization and, except for CPAP and BiPAP devices, a completed CMN/OHCA CMN; medical necessity must be documented in the member's medical record, ~~and be~~ signed by the physician, and attached to the PA.

(2) **Purchase.** Equipment ~~will~~may be purchased when a member requires the equipment for an extended period of time. During the prior authorization review, the ~~PA consultant~~OHCA may change the authorization from a rental to a purchase or a purchase to a rental based on the documentation submitted. The provider must indicate whether the DME item provided is new or used.

(d) **Backup equipment.** Backup equipment is considered part of the rental cost and is not a covered service without prior authorization.

(e) **Home modification.** Equipment used for home modification is not a covered service.

317:30-5-211.17. Wheelchairs

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

(1) "**Assistive technology professional**" or "**ATP**" means a for-service provider who is involved in analysis of the needs and training of a consumer in the use of a particular assistive technology device or is involved in the sale and service of rehabilitation equipment or commercially available assistive technology products and devices.

(2) **"Custom seating system"** means a wheelchair seating system which is individually made for a member using a plaster model of the member, a computer generated model of the member (e.g., CAD-CAM technology), or the detailed measurements of the member to create either:

(A) a molded, contoured, or carved (foam or other suitable material) custom-fabricated seating system that is incorporated into the wheelchair base; or~~,~~

(B) a custom seating system made from multiple pre-fabricated components or a combination of custom fabricated materials and pre-fabricated components which have been configured and attached to the wheelchair base or incorporated into a wheelchair seat and/or back in a manner that the wheelchair could not be easily re-adapted for use by another individual.

(3) "**RESNA**" means the Rehabilitation Engineering and Assistive Technology Society of North America.

(4) "**Specialty evaluation**" means the determination and documentation of the consumer's pathology, history and prognosis, and the physiological, functional, and environmental factors that impact the selection of an appropriate wheeled mobility system.

(b) **Medical Necessity.** Medical necessity, pursuant to OAC 317:30-5-211.2, is required for a wheelchair to be covered and reimbursed by SoonerCare. Only one wheelchair is covered as medically necessary during its reasonable useful lifetime, unless the member's documented medical condition indicates the current wheelchair no longer meets the member's medical need. Backup wheelchairs are not covered items.

(c) **Prior authorization.** Prior authorization, pursuant to OAC 317:30-5-211.3, is required for ~~a wheelchair~~selected wheelchairs to be covered and reimbursed by SoonerCare. All prior authorization requests for the purchase of a wheelchair must indicate the length of the warranty period and what is covered under the warranty.

(1) Wheelchairs, wheelchair parts and accessories, and wheelchair modifications that are beneficial primarily in allowing the member to perform leisure or recreational activities are not considered medically necessary and will not be authorized.

(2) ~~Certain wheelchair~~Wheelchair parts, accessories, and/or modifications that are distinctly and separately requested and priced from the original wheelchair request may require prior authorization.

(3) The OHCA will deny prior authorization requests when the required forms have not been fully completed or the member's medical record does not provide sufficient information to establish medical necessity or to determine that the criteria for coverage has been met.

(d) **Coverage and limitations.**

(1) For a member who resides in a personal residence, assisted living facility, Intermediate Care Facility for ~~the Mentally Retarded (ICF/MR)~~Individuals with Intellectual Disabilities (ICF/IID), or long term care facility, the

following criteria must be met for the authorization to purchase a wheelchair.

(A) The member must have a prescription signed by a physician, a physician assistant, or an advanced registered nurse practitioner.

(B) The member must meet the requirements for medical necessity as determined and approved by the ~~Oklahoma Health Care Authority~~OHCA.

(C) The member must either have:

(i) a specialty evaluation that was performed by a licensed or certified medical professional, such as a physical therapist, occupational therapist, or a physician who has specific training and experience in rehabilitation wheelchair evaluations, and that documents the medical necessity for the wheelchair and its special features; or

(ii) a wheelchair provided by a supplier that employs a RESNA certified assistive technology professional who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the member.

(2) For members who reside in a long term care facility or ~~ICF/MR~~ICF/IID, only custom seating systems for wheelchairs are eligible for direct reimbursement to DME providers ~~of DME services~~. All standard manual and power wheelchairs are the responsibility of the facility and are considered part of the facility's per diem rate. Repairs and maintenance, except for custom seating systems, are not covered items for wheelchairs and are considered part of the facility's per diem rate.

(e) **Rental, repairs, maintenance, and delivery.** Refer to OAC 317:30-5-211.4 through 317:30-5-211.5.

(f) **Documentation.**

(1) The specialty evaluation or wheelchair selection documentation must be submitted with the prior authorization request.

(2) The specialty evaluation or wheelchair selection must be performed no longer than 90 days prior to the submission of the prior authorization request.

(3) The results of the specialty evaluation or wheelchair selection documentation must be supported by the information submitted on the member's medical record.

(4) A copy of the dated and signed written specialty evaluation or wheelchair selection document must be maintained by the wheelchair provider. The results of the specialty evaluation or wheelchair selection must be written, signed, and dated by the medical professional who evaluated

the member or the ATP who was involved in the wheelchair selection for the member.

317:30-5-217. Billing

(a) **Procedure codes.** It is the supplier's responsibility to ensure that claims for the supply or equipment are submitted with the most appropriate HCPCS code as assigned by the ~~Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC)~~Medicare PDAC or its successor. When the most appropriate procedure code is not used, the claim will be denied. When a specific procedure code has not been assigned to an item, an invoice is required which must contain a full description of the equipment or supply.

(b) **Rental**. Claims for rental should indicate the first date of service and the inclusive dates of rental as part of the description of services. The appropriate modifier must be included. Only one month's rental should be entered on each detail line.

(c) **Invoice.** ~~Once~~For manually priced items, after the service has been provided, the supplier is required to include a copy of the invoice documenting the supplier's cost of the item with the claim.

(d) **Place of service**. The appropriate indicator for the patient's place of residence must be entered.

(e) **Prescribing provider**. The name of the prescribing provider must be included for claims processing and entered in the appropriate block.

(f) **Proof of Delivery.** Items must be received by the member before billing OHCA. Proof of delivery must be retained by the provider in the member's file and provided to the OHCA upon request. In addition, for manually priced items, evidence of proof of delivery must be attached to the claim for adjudication.

317:30-5-218. Reimbursement

(a) **Medical equipment and supplies.** Reimbursement for durable medical equipment and supplies will be made using an amount derived from the lesser of the OHCA maximum allowable fee or the provider's usual and customary charge. The maximum allowable fee is the maximum amount that the OHCA will pay a provider for an allowable procedure. When a code is not assigned a maximum allowable fee for a unit of service, a fee will be established. The fee schedule will be reviewed annually and adjustments to the fee schedule may be made at any time based on efficiency, budget considerations, and quality of care as determined by the OHCA.

(b) **Oxygen equipment and supplies.**

(1) Payment for stationary oxygen systems (liquid oxygen systems, gaseous oxygen systems, and oxygen concentrators) is based on continuous rental, i.e., a continuous monthly payment that is made as long as it is medically necessary. The rental payment includes all contents and supplies, ~~i.e.,~~e.g. regulators, tubing, masks, etc. Portable oxygen systems are considered continuous rental. Ownership of the equipment remains with the supplier.
(2) Separate payment will not be made for maintenance, servicing, delivery, or for the supplier to pickup the equipment when it is no longer medically necessary.
(3) Payment for oxygen and oxygen equipment and supplies will not exceed the Medicare fee for the same procedure code. Reimbursement for members who reside in a nursing facility may be at a reduced rate. The fee schedule will be reviewed annually and adjustments to the fee schedule may be made at any time based on efficiency, budget considerations, and quality of care as determined by the OHCA.

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

317:30-5-696. Coverage by category

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

(1) **Adults.**

(A) Dental coverage for adults is limited to:

(i) medically necessary extractions and~~;~~ approved boney adjustments. ~~Surgical tooth~~Tooth extraction must have medical need documented ~~if not apparent on images of tooth. In the SoonerCare program, it is usually performed for those teeth which are damaged to such extent that no tooth is visible above the gum line, the tooth fractures, the tooth is impacted, or tooth can't be grasped with forceps.~~;

(ii) Smoking and Tobacco Use Cessation Counseling; and

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

(B) Payment is made for dental care for adults residing in private Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) and who have been approved for ~~ICF/MR~~ICF/IID 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 intellectually disabled.** All providers participating in the HCBWS must have a separate contract with the OHCA to provide services under the HCBWS. Dental services are defined in each waiver and must be prior authorized.

(3) **Children.** The OHCA Dental Program provides the basic medically necessary treatment. The services listed below are compensable for members under 21 years of age without prior authorization. All other dental services must be prior authorized. Anesthesia services are covered for children in the same manner as adults. All providers performing preventive services must be available to perform needed restorative services for those members receiving any evaluation and preventive services.

(A) **Comprehensive oral evaluation.** This procedure ~~is~~may be performed for any member every ~~not seen by any dentist for~~

~~more than 12~~36 months. An examination should precede any radiographs, and chart documentation must include radiographic interpretations, caries risk assessment and both medical and dental health history of member. The comprehensive treatment plan should be the final results of this procedure.

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

(C) **Emergency examination/limited oral evaluation.** This procedure is not compensable within two months of a periodic oral examination or if the member is involved in active treatment unless trauma or acute infection is the presenting complaint. This procedure is only compensable to the same dentist or practice for two visits prior to an examination being completed.

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

set.

(E) **Dental sealants.** Tooth numbers 2, 3, 14, 15, 18, 19, 30 and 31 must be caries free on the interproximal and occlusal surfaces to be eligible for this service. This service is available through 18 years of age and is compensable ~~only once per lifetime~~once every 36 months if medical necessity is documented. ~~Replacement of sealants is not a covered service under the SoonerCare program.~~

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

~~(G) **Composite restorations.**~~

~~(i) This procedure is compensable for primary incisors as follows:~~

~~(I) tooth numbers O and P to age 4 years;~~

~~(II) tooth numbers E and F to age 6 years;~~

~~(III) tooth numbers N and Q to 5 years; and~~

~~(IV) tooth numbers D and G to 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).~~

~~(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.~~

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

(i) Stainless steel crowns are allowed if:

(I) the child is five years of age or under;

(II) 70 percent or more of the root structure remains; or

(III) the procedure is provided more than 12 months prior to normal exfoliation.

(ii) Stainless steel crowns are treatment of choice for:

(I) primary teeth ~~with pulpotomies or pulpectomies~~treated with pulpal therapy, if the above conditions exist;

(II) primary teeth where three surfaces of extensive decay exist; or

(III) primary teeth where cuspal occlusion is lost due to decay or accident.

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

(iv) Placement of a stainless steel crown i~~ncludes all related follow up service~~is allowed once for a minimum period of ~~two years~~24 months. No other ~~restorative procedure~~restoration on that tooth is compensable during that period of time. A stainless steel crown is not a temporizing treatment to be used while a permanent crown is being fabricated.

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

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

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

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

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

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

(iii) Placement of a stainless steel crown ~~includes all related follow up service~~ excludes placement of any other type of crown for a period of ~~two years~~24 months. No other ~~restorative procedure~~restoration on that tooth is compensable during that period of time. A stainless steel crown is not a temporizing treatment to be used while a permanent crown is being fabricated.

(K) **Pulpotomies and pulpectomies.**

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

(I) Primary molars having at least 70 percent or more of their root structure remaining or more than 12 months prior to normal exfoliation;

(II) Tooth numbers O and P before age 5 years;

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

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

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

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

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

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

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

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

~~(iv) Teeth with less than 60 percent of clinical crown should not be treatment-planned for root canal therapy.~~

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

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

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

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

(M) **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 posterior teeth

bilaterally in the same arch, under the above guidelines, bilateral space maintainer is the treatment of choice.

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

(V) Post-operative bitewing x-rays must be available for review.

(VI) Bilateral band and loop space maintainer is allowed if member does not have eruption of the four mandibular anterior teeth in position or if sedation case that presents limitations to fabricate other space maintenance appliances.

(ii) **Lingual arch bar.** Payment is made for the services provided in accordance with the following:

(I) Lingual arch bar is used when permanent incisors are erupted and the second primary molar (K or T) is missing in the same arch.

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

~~(III) Multiple missing upper anterior primary incisors may be replaced with the appliance to age 4 years to prevent abnormal swallowing habits.~~

~~(IV)~~(III) 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 years.~~

(N) **Analgesia.** Analgesia services are reimbursable in accordance with the following:

(i) **Inhalation of nitrous oxide.** Use of nitrous oxide is compensable for four occurrences per year and is not separately reimbursable, if provided on the same date by the same provider as IV sedation, non-intravenous conscious sedation or general anesthesia. The medical need for this service must be documented in the member's record.

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

reimbursable when provided primarily for the convenience of the member and /or the dentist, it must be medically necessary.

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

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

~~(Q) **History and physical.** Payment is made for services for the purpose of admitting a patient to a hospital for dental treatment.~~

~~(R) **Local anesthesia.** This procedure is included in the fee for all services.~~

~~(S)~~(Q) **Smoking and Tobacco Use Cessation Counseling.** Smoking and Tobacco Use Cessation Counseling is covered when performed utilizing the five intervention steps of asking the member to describe his/her smoking, advising the member to quit, assessing the willingness of the member to quit, assisting with referrals and plans to quit, and arranging for follow-up. Up to eight sessions are covered per year per individual who has documented tobacco use. It is a covered service when provided by physicians, physician assistants, nurse practitioners, nurse midwives, Oklahoma State Health Department and FQHC nursing, and Maternal/Child Health Licensed Clinical Social Workers with a certification as a Tobacco Treatment Specialist Certification (CTTS) staff in addition to other appropriate services rendered. Chart documentation must include a separate note, separate signature, and the member specific information addressed in the five steps and the time spent by the practitioner performing the counseling. Anything under three minutes is considered part of a routine visit.

~~(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 member, or established 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 member, or if the member is under active treatment;~~
~~(iv) Radiographs as defined in OAC 317:30-5-696(3)(D);~~
~~(v) Dental prophylaxis as defined in OAC 317:30-5-696(3)(F);~~
~~(vi) Composite restorations:~~
~~(I) Any permanent tooth that has an opened lesion seen on radiograph or that is a documented food trap will be deemed medically necessary for this program and will be allowed for all anterior teeth.~~
~~(II) Class I One and two surface posterior composite resin restorations are allowed in posterior teeth that qualify;~~
~~(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~~
~~(viii) Analgesia. Analgesia services are reimbursable in accordance with OAC 317:30-5-696(3)(N).~~
~~(D) Services requiring prior authorization (Refer to OAC 317:30-5-698).~~
~~(E) Periodontal scaling and root. Procedure is designed for the removal of calculus or tissue that is contaminated and requires anesthesia and some soft tissue removal. This procedure requires that each tooth have 30 or more of the 6 point measurements 5 millimeters or greater, or have multiple areas of radiographic bone loss and subgingival calculus and must involve two or more teeth per quadrant for consideration. This procedure is not allowed on members under age 10. This procedure is not allowed in conjunction with any other periodontal surgery.~~
~~(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). Requests for dental services requiring prior authorization must be accompanied by sufficient documentation. ~~X-rays~~Images with an indication of the left side of member, six point periodontal charting and copy of the comprehensive treatment plans are required. Study models are usually not required, but models and narratives may be requested by OHCA or representatives of OHCA. If the quality of the supporting material is such that a determination of authorization cannot be made, the material is returned to the provider. Any new documentation must be provided at the provider's expense. Submitted documentation used to base a decision will not be returned.

(b) Requests for prior authorization are filed on the currently approved ADA form. OHCA notifies the provider on the determination of prior authorization using OHCA Prior Authorization Request Decision form. Prior authorized services must be billed exactly as they appear on the prior authorization. Payment is not made for any services provided prior to receiving authorization except for the relief of pain.

(c) Prosthodontic services provided to members who have become ineligible mid-treatment are covered if the member was eligible for SoonerCare on the date the final impressions were made.

(d) Listed below are examples of services requiring prior authorization for members under 21 and eligible ICF/IID residents. Minimum required records to be submitted with each request are right and left mounted bitewing x-rays or images and periapical films or images of tooth/teeth involved or the edentulous areas if not visible in the bitewings. X-rays must be submitted with film mounts and each film or print must be of diagnostic quality. X-rays and/or images must be identified by the tooth number and include date of exposure, member name, member ID, provider name, and provider ID. All x-rays or images, regardless of the media, must be submitted together with a completed and signed comprehensive treatment plan that details all needed treatment at the time of examination, and a completed current ADA form requesting all treatments requiring prior authorization. The film, digital media or printout must be of sufficient quality to clearly demonstrate for the reviewer, the pathology which is the basis for the authorization request. If radiographs are not taken, provider must include in narrative sufficient information to confirm diagnosis and treatment plan.

(1) **Endodontics.** Root canal therapy is not considered an emergency procedure unless due to trauma to an anterior tooth. The provider must document the member's oral hygiene and flossing ability over a minimum of two months, in the member's records. ~~Pulpotomy~~Pulpal debridement may be performed for the relief of pain while waiting for the decision from the OHCA on request for endodontics.

(A) Prior authorization is required for members who have a treatment plan requiring more than two anterior and/or two posterior root canals. All rampant, active caries must be removed prior to requesting anterior endodontics. Payment is made for services provided in accordance with the following:

(i) Permanent teeth only.

(ii) Accepted ADA materials must be used.

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

(iv) Providers are responsible for any follow-up treatment required by a failed endodontically treated tooth within 24 months post completion.

(v) A tooth will not be approved if it appears there is not adequate natural tooth structure remaining to establish good tooth/restorative margins or if crown to root ratio is poor.

(vi) An endodontic procedure may not be approved if the tooth requires a post and core to retain a crown.

(B) **Posterior endodontics.** The guidelines for this procedure are as follows:

(i) ~~The provider documents that the member has improved oral hygiene and flossing ability in this member's records.~~The provider must document the member's oral hygiene and flossing ability over a minimum of two months, in the member's records.

(ii) Teeth that ~~would require~~ require pre-fabricated post and cores to retain a restoration due to lack of natural tooth structure should not be treatment planned for root canal therapy.

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

(iv) Providers are responsible for any follow-up treatment required by a failed endodontically treated tooth within 24 months post completion.

(v) A tooth will not be approved if it appears there is not adequate natural tooth structure remaining to establish good tooth/restorative margins or if there is a poor crown to root ratio or weakened root furcation area. Approval of second molars is contingent upon

proof of medical necessity.

(vi) Only ADA accepted materials are acceptable under the OHCA policy.

(vii) Posterior endodontic procedure may not be approved if the tooth requires a post and core in order to present adequate structure to retain a crown.

(viii) Endodontics will not be considered if:

(I) an opposing tooth has super erupted;

(II) loss of tooth space is one third or greater;

(III) opposing second molars are involved unless prior authorized; or

(IV) the member has multiple teeth failing due to previous inadequate root canal therapy or follow-up~~.~~;

(V) all rampant, active caries must be removed prior to requesting posterior endodontics.

(ix) Endodontically treated teeth must be restored to limited occlusal function and all contours must be replaced. Core build-up code is only available for use if other restorative codes are not sufficient. These teeth will not be approved for a crown if it appears the apex is not adequately sealed.

(2) **Crowns for permanent teeth.** Crowns are compensable for restoration of natural teeth for members who are 16 years of age or older and adults residing in private Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) and who have been approved for (ICF/IID) level of care. Certain criteria and limitations apply.

(A) The following conditions must exist for approval of this procedure.

(i) all rampant, active caries must be removed prior to requesting any type of crown.

~~(i)~~(ii) The tooth must be decayed to such an extent to prevent proper cuspal or incisal function.

~~(ii)~~(iii) The clinical crown is fractured or destroyed by one-half or more.

~~(iii)~~(iv)Endodontically treated teeth must have three or more surfaces restored or lost due to carious activity to be considered for a crown.

(B) The conditions listed in (A)(i) through (A)~~(iii)~~(iv) 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. Non authorized restorative codes may be used if available.

(D) A crown will not be approved if adequate tooth

structure does not remain to establish cleanable margins, there is invasion of the biologic width, poor crown to root ratio, or the tooth appears to retain insufficient amounts of natural tooth structure. Cast dowel cores are not allowed for molar or pre-molar teeth.

(E) Preformed post(s) and core build-up(s) are not routinely provided with crowns for endodontically treated teeth.

(F) Provider is responsible for replacement or repair of all crowns if failure is caused by poor laboratory processes or procedure by provider for 48 months post insertion.

(3) **Cast frame partial dentures.** This appliance is the treatment of choice for replacement of missing anterior permanent teeth or two or more missing posterior teeth in the same arch for members 16 through 20 years of age. Provider must indicate which teeth will be replaced. Members must have excellent oral hygiene documented for at least 18 months in the requesting provider's records and submitted with prior authorization request to be considered. Provider is responsible for any needed follow up for a period of two years post insertion.

(4) **Acrylic partial.** This appliance is the treatment of choice for replacement of three or more missing teeth in the same arch for members 12 through 16 years of age. Provider must indicate tooth numbers to be replaced. This appliance includes all necessary clasps and rests.

(5) **Occlusal guard.** Narrative of medical necessity must be sent with prior authorization. Model should not be made or sent unless requested.

(6) **Fixed cast non-precious metal or porcelain/metal bridges.** Only members 17 through 20 years of age will be considered for this treatment. Destruction of healthy teeth to replace a single missing tooth is not considered medically necessary. Members must have excellent oral hygiene documented for at least 18 months in the requesting provider's records and submitted with prior authorization request to be considered. Provider is responsible for any needed follow up until member loses eligibility.

(7) **Periodontal scaling and root planing.** Procedure is designed for the removal of calculus or tissue that is contaminated and requires anesthesia and some soft tissue removal. This procedure requires that each tooth have 3 or more of the six point measurements 5 millimeters or greater, or have multiple areas of radiographic bone loss and subgingival calculus and must involve two or more teeth per quadrant for consideration. This procedure is not allowed on

members under the age 10. This procedure is not allowed in conjunction with any other periodontal surgery.

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~~

~~(b)~~(a) **Utilization parameters.** The Oklahoma Health Care Authority utilization parameters allow only one permanent restorative service to be provided per tooth per ~~18~~24 months. Additional restorations may be authorized upon approval of OHCA in cases of trauma. Teeth receiving a restoration are eligible within three months for consideration of single crown if endodontically treated. Providers must document type of isolation used in treatment progress notes. The provider is responsible for follow-up or any required replacement of a failed restoration, if the member is currently SoonerCare eligible. Fees paid for the original restorative services may be recouped if any additional treatments are required on the same tooth by a different provider within 12 months due to defective restoration or recurrent decay. If it is determined by the Dental Director that a member has received poorly rendered or insufficient treatment from a provider, the Dental Director may prior authorize corrective procedures by a second provider.

~~(c)~~(b)**Coverage for dental restorations.** Restoration of ~~incipent~~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.

317:30-5-700. Orthodontic services

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

(1) the member has had a caries free initial visit; or
(2) has all decayed areas restored and has remained caries free for ~~6~~12 months; and
(3) has demonstrated competency in maintaining an appropriate level of oral hygiene.

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

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

(1) a handicapping malocclusion, as measured on the Handicapping Labio-Lingual Deviation Index (HLD) with a minimum score of 30;
(2) any classification secondary to cleft palate or other maxillofacial deformity;
(3) if a single tooth or anterior crossbite is the only

medical need finding, service will be limited to interceptive treatment;
(4) fixed appliances only; and
(5) permanent dentition with the exception of cleft defects.

(d) Reimbursement for Orthodontic services is limited to:
(1) Orthodontists, or
(2) General or Pediatric dental practitioners who have completed at least 200 certified hours of continuing education in the field of orthodontics practice and submit for review at least 25 successfully completed comprehensive cases. Of these 25 comprehensive cases, ten or more must be extraction cases. An applicant for this certification must practice in an OHCA deemed under served 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.
(B) As with all dental or orthodontia treatment performed and reimbursed by SoonerCare, all pre and post orthodontic records must be available for review.
(C) The Oklahoma Health Care Authority requires all General dentists providing comprehensive orthodontic care to submit a copy of the Oklahoma Board of Dentistry continuing education report and verification that at least 20 continuing education hours in the field of orthodontics has been completed per reporting period. All verification reports must be submitted to OHCA Dental unit every three years, no later than August 30. In addition, verification of adequate progress for all active orthodontic cases will be reviewed by the OHCA Dental Unit upon completion of 24 months of therapy.

(e) The following limitations apply to orthodontic services:
(1) Cosmetic orthodontic services are not a covered benefit of the SoonerCare Program and no requests should be submitted;
(2) All orthodontic procedures require prior authorization for payment;
(3) Prior authorization for orthodontic treatment is not a

notification of the member's eligibility and does not guarantee payment. Payment for authorized services depends on the member's eligibility at the beginning of each treatment year. Treatment year is determined by date of banding;

(4) The member must be SoonerCare-eligible and under 18 years of age at the time the request for prior authorization for treatment is received by the OHCA. Services cannot be added or approved after eligibility has expired. It is the orthodontist's responsibility to verify that the member has current SoonerCare eligibility and the date of birth indicates the member is under age 18.

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

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

(h) Providers are not obligated to accept a member when it appears that the member will not cooperate in the orthodontic hygiene treatment program, does not return to the general dentist for preventive visits or is not willing to keep eligibility for SoonerCare current.

317:30-5-700.1. Orthodontic prior authorization

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

(1) Completed currently approved ADA dental claim form;

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

(3) Detailed description of any oral maxillofacial anomaly;

(4) Estimated length of treatment;

(5) Intraoral photographs showing teeth in centric occlusion and/or photographs of trimmed anatomically occluded diagnostic casts. A lingual view of casts may be included to verify impinging overbites;

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

(7) If diagnosed as a surgical case, submit an oral surgeon's written opinion that orthognathic surgery is indicated and

the surgeon is willing to provide this service;

(8) Additional pertinent information as determined necessary by the orthodontist or as requested by the OHCA.

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

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

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

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

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

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

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

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

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

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

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

authorizing the first year of treatment.

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

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

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

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

(2) Claim and payment are made as follows:

(A) Payment for comprehensive treatment includes the banding, wires, and adjustments as well as all ancillary services, including the removal of appliances, and the construction and placing of retainers.

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

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

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

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

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

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

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

(3) 3-D model images are preferred.

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

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

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

317:30-5-14. Injections

(a) Coverage for injections is limited to those categories of drugs included in the vendor drug program for SoonerCare. SoonerCare payment is not available for injectable drugs whose manufacturers have not entered into a drug rebate agreement with the Centers for Medicare and Medicaid Services (CMS). OHCA administers and maintains an open formulary subject to the provisions of Title 42, United States Code (U.S.C.), Section 1396r-8. The OHCA covers a drug that has been approved by the Food and Drug Administration (FDA) subject to the exclusions and limitations provided in OAC 317:30-5-72.1.

(1) **Immunizations for children.** An administration fee will be paid for vaccines administered by providers participating in the Vaccines for Children Program. For vaccines administered as part of the Vaccines for Children Program, only one administration fee is permitted per vaccine, regardless of the number of vaccine/toxoid components in the vaccine. Payment will not be made for vaccines covered by the Vaccines for Children Program. When the vaccine is not included in the program, the administration fee is separately payable.

(2) **Immunizations for adults.** Coverage for adults is provided as per the Advisory Committee on Immunization Practices (ACIP) guidelines. A separate payment will be made for the administration of a vaccine. Only one administration fee per vaccine is permitted, regardless of the number of vaccine/toxoid components in the vaccine.

(b) Providers must use the appropriate HCPCS code and National Drug Code (NDC). In addition to the NDC and HCPCS code, claims must contain the drug name, strength, and dosage amount.

~~(c) Payment is made for allergy injections for adults and children. When the contracted provider actually administers or supervises the administration of the injection, the administration fee is compensable. No payment is made for administration when the allergy antigen is self-administered by the member. When the allergy antigen is purchased by the physician, payment is made by invoice attached to the claim.~~

~~(d)~~(c) Rabies vaccine, Imovax, Human Diploid and Hyperab, Rabies Immune Globulin are covered under the vendor drug program and may be covered as one of the covered prescriptions per month. Payment can be made separately to the physician for administration. If the vaccine is purchased by the physician, payment is made by invoice attached to the claim.

~~(c)~~(d) Human Papillomavirus (HPV) vaccine is approved and covered under guidelines established by the ACIP for children and adults. Payment can be made separately to the physician for administration and the vaccine product.
~~(f)~~(e)Trigger point injections (TPI's) are covered using appropriate CPT codes. Modifiers are not allowed for this code. Payment is made for up to three injections (3 units) per day at the full allowable. Payment is limited to 12 units per month. The medical records must clearly state the reasons why any TPI services were medically necessary. All trigger point records must contain proper documents and be available for review. Any services beyond 12 units per month or 36 units per 12 months will require mandatory review for medical necessity. Medical records must be automatically submitted with any claims for services beyond 36 units.
~~(g)~~(f)If a physician bills separately for surgical injections and identifies the drugs used in a joint injection, payment will be made for the cost of the drug in addition to the surgical injection. The same guidelines apply to aspirations.
~~(h)~~(g) When IV administration in a Nursing Facility is filed by a physician, payment may be made for medication. Administration should be done by nursing home personnel.
~~(i)~~(h) Intravenous fluids used in the administration of IV drugs are covered. Payment for the set is included in the office visit reimbursement.
~~(j)~~(i) In the event a pandemic virus is declared by the Centers for Disease Control (CDC) and/or the Department of Health & Human Services, an administration fee will be paid to providers for administering the pandemic virus vaccine to adults and children as authorized by the Centers for Medicare and Medicaid Services (CMS).

317:30-5-14.1 Allergy Services

(a) **Allergy testing.** Allergy testing is the process of identifying allergen(s) that may cause an allergic or anaphylactic reaction and the degree of the reaction. By identifying the allergen(s), the member can avoid exposures and the allergic reaction can be managed appropriately. Treatment options for allergies are avoidance of the allergen(s), pharmacological therapy, and/or immunotherapy. OHCA may consider allergy testing medically necessary when a complete medical, immunological history, and physical examination is performed and indicates symptoms are suggestive of a chronic allergy. Allergy testing may also be determined medically necessary if diagnosis indicates an allergy and simple medical treatment and avoidance of the allergen(s) were tried and showed inadequate response.

(1) **Coverage.** OHCA will provide reimbursement for allergy testing when the following conditions are met:

(A) Testing is done in a hospital or providers office under direct supervision of an eligible provider;

(B) The diagnostic testing is based on the member's immunologic history and physical examination, which document that the antigen(s) being used for testing have a reasonable probability of exposure in the members environment;

(C) The member has significant life-threatening symptomatology or a chronic allergic state (e.g., asthma) which has not responded to conservative measures;

(D) The member's records document the need for allergy testing and the justification for the number of tests performed;

(E) The complete report of the test results, as well as controls, will be kept as part of the medical record; and

(F) The member is observed for a minimum of 20 minutes following allergy testing to monitor for signs of allergic or anaphylactic reactions.

(2) **Provider requirements.** Only contracted providers (a physician (MD or DO), physician's assistant, or advanced practice nurse) who are board certified or board eligible in allergy and immunology or have received training in allergy and immunology in an accredited academic institution for a minimum of one month clinical rotation (authenticated by supporting letter from institution or mentor).

(A) Follow-up administration of medically indicated allergy immunotherapy can be done by a practitioner other than an allergist.

(B) Allergy testing and/or immunotherapy for SoonerCare members younger than five years of age preferably should be performed by an allergy specialist.

(3) **Description of services.** There are a variety of tests to identify the allergen(s) that may be responsible for the member's allergic response. OHCA covers the following allergy test(s) for SoonerCare members:

(A) Direct skin tests:

(i) Percutaneous (i.e., scratch, prick, or puncture) tests are performed for inhalant allergies, suspected food allergies, hymenoptera allergies, or specific drug allergies.

(ii) Intra-cutaneous (i.e., intradermal) tests are performed commonly when a significant allergic history is obtained and results of the percutaneous test are negative or equivocal.

(B) Patch or application tests;

(C) Photo or photo patch skin tests;
(D) Inhalant bronchial challenge testing (not including necessary pulmonary function tests);
(E) Ingestion challenge tests (this test is used to confirm an allergy to a food or food additives); and
(F) Double-blind food challenge testing.
(G) Ophthalmic mucous membrane or direct nasal membrane tests, serum allergy tests, serial dilution endpoint tests, or any unlisted allergy procedure not stated above will require prior authorization.

(4) **Reimbursement.** Reimbursement for allergy testing is limited to a total of 60 tests every three years. Repeat allergy testing for the same allergen(s) within three years will require prior authorization. Any service related to allergy testing beyond predetermined limits must be submitted with the appropriate documentation to OHCA for prior authorization consideration.

(5) **Non-covered services.** OHCA does not cover allergy testing determined to be investigational or experimental in nature.

(b) **Allergy immunotherapy.** Allergy immunotherapy involves administration of allergenic extracts at periodic intervals, with the goal of reducing symptoms, including titrating to a dosage that is maintained as maintenance therapy. Allergy immunotherapy is initiated once the offending allergen(s) has been identified through exposure and/or allergy testing. The documented allergy should correspond to the allergen planned for immunotherapy. OHCA may consider allergy immunotherapy medically necessary for members who have significant life-threatening symptomology or a chronic allergic state that cannot be managed by medication, avoidance, or environmental control measures. Before beginning allergy immunotherapy, consideration must be given to other common medical conditions that could make allergy immunotherapy more risky.

(1) **Coverage requirements.** Allergy immunotherapy is covered when the following criteria are met and documented in the medical record:
(A) The member has allergic asthma, or
(B) Allergic rhinitis and/or conjunctivitis, or
(C) Life-threatening allergy to hymenoptera (stinging insect allergy), or
(D) There is clinical evidence of an inhalant allergen(s) sensitivity; and
(E) Documentation supports that the member's symptoms are not controlled with medications and avoidance of the allergen(s) are impractical.

(2) **Provider qualifications.** See OAC 317:30-5-14.1(A)(2) for provider qualifications.

(3) **Administering sites.** Allergy immunotherapy should be administered in a medical facility with trained staff and proper medical equipment available in the case of significant reaction. Should home administration be necessary, the following requirements must be met:

(A) Adequate documentation must be present in the member's record indicating why home administration is medically necessary;

(B) Documentation must indicate the member and/or family member have been properly trained in recognizing and treating anaphylactic and/or allergic reactions to allergy immunotherapy administration;

(C) Epinephrine kits must be available to the member and the family and the member and/or family have been instructed in its use;

(D) Documentation of member and/or family member having been properly trained in antigen(s) dosing plan, withdrawing of correct amount of antigen(s) from the vial and administration of allergy immunotherapy;

(E) The signed consent by the member or family member to administer allergy immunotherapy at home;

(F) The provider initiated allergy immunotherapy in their office and is planning to continue therapy at the member's home; and

(G) Signed acknowledgement by the member or family member of receiving antigen vial(s) as per treatment protocol.

(4) **Treatment period.** A "treatment period" is generally 90 days, and adequate documentation must be available for continuation of therapy after each treatment period. The length of allergy immunotherapy treatment depends on the demonstrated clinical efficacy of the treatment.

(5) **Reimbursement**. Payment is made for the administration of allergy injections as well as supervision and provision of antigen(s) for adults and children, with the following considerations:

(A) When a contracted provider actually administers or supervises administration of the allergy injections, the administration fee is compensable;

(B) Reimbursement for the administration only codes is limited to one per member, per day;

(C) No reimbursement is made for administration of allergy injections when the allergy injection is self-administered by the member; and

(D) For antigens purchased by the provider for supervision, preparation and provision for allergy immunotherapy, an invoice reflecting the purchase should be made available upon request for post-payment review.

(6) **Limitations.** The following limitations and restrictions apply to immunotherapy:

(A) A presumption of failure can be assumed if, after 12 months of allergy immunotherapy, the member does not experience any signs of improvement, and all other reasonable factors have been ruled out.

(B) Documented success of allergy immunotherapy treatment is evidenced by:

(i) A noticeable decrease of hypersensitivity symptoms, or

(ii) An increase in tolerance to the offending allergen(s), or

(iii) A reduction in medication usage.

(C) Very low dose immunotherapy or continued submaximal dose has not been shown to be effective and will be denied as not medically necessary.

(D) Liquid antigen(s) prepared for sublingual administration are not covered as they have not been proven to be safe and effective.

(E) Food and Drug Administration (FDA) approved oral desensitization therapies may be covered as part of the member's pharmacy benefits and requires prior authorization.

(F) If a provider is preparing single dose vials of antigens to be administered by a different provider, member or family member, only 30 units per treatment period of 90 days with a limit of 120 units per year is allowed. Additional units above the stated limits will require prior authorization.

(G) If using multi-dose vials, there is a limitation of 10 units per vial, with a maximum of 20 units allowed per 90 day treatment period. There is a limit of 80 units allowed per year. Additional units above the stated limits will require prior authorization.

(7) **Non-covered services.** Allergy immunotherapy determined by OHCA to be investigational or experimental will not be covered.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
SUBCHAPTER 1. GENERAL PROVISIONS

317:35-1-2. Definitions

The following words and terms, when used in this Chapter, have the following meaning, unless the context clearly indicates otherwise:

"Acute Care Hospital" means an institution that meets the requirements of 42 CFR, Section 440.10 and:

(A) is maintained primarily for the care and treatment of patients with disorders other than mental diseases;
(B) is formally licensed or formally approved as a hospital by an officially designated authority for state standard setting; and
(C) meets the requirements for participation in Medicare as a hospital.

"ADvantage Administration (AA)" means the Oklahoma Department of Human Services (OKDHS) which performs certain administrative functions related to the ADvantage Waiver.

"Aged" means an individual whose age is established as 65 years or older.

"Agency partner" means an agency or organization contracted with the OHCA that will assist those applying for services.

"Aid to Families with Dependent Children (AFDC)" means the group of low income families with children described in Section 1931 of the Social Security Act. The Personal Responsibility and Work Opportunity Act of 1996 established the new eligibility group of low income families with children and linked eligibility income and resource standards and methodologies and the requirement for deprivation for the new group to the State plan for Aid to Families with Dependent Children in effect on July 16, 1996. Oklahoma has elected to be less restrictive for all SoonerCare members related to AFDC. Effective January 1, 2014, children covered under Section 1931 are related to the children's group, and adults covered under Section 1931 are related to the parent and caretaker relative group. The Modified Adjusted Gross Income (MAGI) methodology is used to determine eligibility for these groups.

"Area nurse" means a registered nurse in the OKDHS Aging Services Division, designated according to geographic areas who evaluates the UCAT and determines medical eligibility for Personal Care, ADvantage Waiver, and Nursing Facility services. The area nurse also approves care plan and service plan implementation for Personal Care services.

"Area nurse designee" means a registered nurse selected by the area nurse who evaluates the UCAT and determines medical

eligibility for Personal Care, ADvantage Waiver, and Nursing Facility services.

"Authority" means the Oklahoma Health Care Authority (OHCA).

"Blind" means an individual who has central visual acuity of 20/200 or less in the better eye with the use of a correcting lens.

"Board" means the Oklahoma Health Care Authority Board.

"Buy-in" means the procedure whereby the OHCA pays the member's Medicare premium.

(A) **"Part A Buy-in"** means the procedure whereby the OHCA pays the Medicare Part A premium for individuals determined eligible as Qualified Medicare Beneficiaries Plus (QMBP) who are enrolled in Part A and are not eligible for premium free enrollment as explained under Medicare Part A. This also includes individuals determined to be eligible as Qualified Disabled and Working Individuals (QDWI).

(B) **"Part B Buy-in"** means the procedure whereby the OHCA pays the Medicare Part B premium for categorically needy individuals who are eligible for Part B Medicare. This includes individuals who receive TANF or the State Supplemental Payment to the Aged, Blind or Disabled, and those determined to be Qualified Medicare Beneficiary Plus (QMBP), Specified Low Income Medicare Beneficiaries (SLMB) or Qualifying Individual-1 (QI-1). Also included are individuals who continue to be categorically needy under the PICKLE amendment and those who retain eligibility after becoming employed.

"Caretaker relative" means a person other than the biological or adoptive parent with whom the child resides who meets the specified degree of relationship within the fifth degree of kinship.

"Case management" means the activities performed for members to assist them in accessing services, advocacy and problem solving related to service delivery.

"Categorically needy" means that income and, when applicable, resources are within the standards for the category to which the individual is related.

"Categorically related" or "related" means the individual meets basic eligibility requirements for an eligibility group.

"Certification period" means the period of eligibility extending from the effective date of certification to the date of termination of eligibility or the date of the next periodic redetermination of eligibility.

"County" means the Oklahoma Department of Human Services' office or offices located in each county within the State.

"Custody" means the custodial status, as reported by the Oklahoma Department of Human Services.

"Deductible/Coinsurance" means the payment that must be made by or on behalf of an individual eligible for Medicare before Medicare payment is made. The coinsurance is that part of the allowable medical expense not met by Medicare, which must be paid by or on behalf of an individual after the deductible has been met.

(A) For Medicare Part A (Hospital Insurance), the deductible relates to benefits for ~~in-patient~~inpatient services while the patient is in a hospital or nursing facility. After the deductible is met, Medicare pays the remainder of the allowable cost.

(B) For Medicare Part B (Medical Insurance), the deductible is an annual payment that must be made before Medicare payment for medical services. After the deductible is met, Medicare pays 80% of the allowable charge. The remaining 20% is the coinsurance.

"Disabled" means an individual who is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death, or which has lasted (or can be expected to last) for a continuous period of not less than 12 months.

"Disabled child" means for purposes of Medicaid Recovery a child of any age who is blind, or permanently and totally disabled according to standards set by the Social Security Administration.

"Estate" means all real and personal property and other assets included in the member's estate as defined in Title 58 of the Oklahoma Statutes.

"Gatekeeping" means the performance of a comprehensive assessment by the OKDHS nurse utilizing the Uniform Comprehensive Assessment Tool (UCAT) for the determination of Medical eligibility, care plan development, and the determination of Level of Care for Personal Care, ADvantage Waiver and Nursing Facility services.

"Local office" means the Oklahoma Department of Human Services' office or offices located in each county within the State.

"Ineligible Spouse" means an individual who is not eligible for SSI but is the husband or wife of someone who is receiving SSI.

"LOCEU" means the Oklahoma Health Care Authority's Level of Care Evaluation Unit.

"MAGI eligibility group" means an eligibility group whose financial eligibility is determined through the Modified Adjusted Gross Income (MAGI) methodology. The groups subject to MAGI are defined in 42 CFR 435.603 and listed in OAC 317:35-6-1.

"Modified Adjusted Gross Income (MAGI)" means the financial eligibility determination methodology established by the Patient

Protection and Affordable Care Act (PPACA) in 2009.

"Medicare" means the federally funded health insurance program also known as Title XVIII of the Social Security Act. It consists of four separate programs. Part A is Hospital Insurance, Part B is Medical Insurance, Part C is Medicare Advantage Plans, and Part D is Prescription Drug Coverage.

(A) **"Part A Medicare"** means Hospital Insurance that covers services for inpatient services while the patient is in a hospital or nursing facility. Premium free enrollment is provided for all persons receiving OASDI or Railroad Retirement income who are age 65 or older and for those under age 65 who have been receiving disability benefits under these programs for at least 24 months.

(i) Persons with end stage renal disease who require dialysis treatment or a kidney transplant may also be covered.

(ii) Those who do not receive OASDI or Railroad Retirement income must be age 65 or over and pay a large premium for this coverage. Under Authority rules, these individuals are not required to enroll for Part A to be eligible for SoonerCare benefits as categorically needy. They must, however, enroll for Medicare Part B. Individuals eligible as a QMBP or as a Qualified Disabled and Working Individual (QDWI) under Medicaid are required to enroll for Medicare Part A. The Authority will pay Part A premiums for QMBP individuals who do not qualify for premium free Part A and for all QDWI's.

(B) **"Part B Medicare"** means Supplemental Medical Insurance that covers physician and related medical services other than inpatient or nursing facility care. Individuals eligible to enroll in Medicare Part B are required to do so under OHCA policy. A monthly premium is required to keep this coverage in effect.

"Minor child" means a child under the age of 18.

"Nursing Care" for the purpose of Medicaid Recovery is care received in a nursing facility, an intermediate care facility for ~~the mentally retarded~~individuals with intellectual disabilities or other medical institution providing nursing and convalescent care, on a continuing basis, by professional personnel who are responsible to the institution for professional medical services.

"OCSS" means the Oklahoma Department of Human Services' Oklahoma Child Support Services (formerly Child Support Enforcement Division).

"OHCA" means the Oklahoma Health Care Authority.

"OHCA Eligibility Unit" means the group within the Oklahoma Health Care Authority that assists with the eligibility

determination process.

"OKDHS" means the Oklahoma Department of Human Services.

"OKDHS nurse" means a registered nurse in the OKDHS Aging Services Division who meets the certification requirements for UCAT Assessor and case manager, and who conducts the uniform assessment of individuals utilizing the Uniform Comprehensive Assessment Tool (UCAT) for the purpose of medical eligibility determination. The OKDHS nurse also develops care plans and service plans for Personal Care services based on the UCAT.

"Qualified Disabled and Working Individual (QDWI)" means individuals who have lost their Title II OASDI benefits due to excess earnings, but have been allowed to retain Medicare coverage.

"Qualified Medicare Beneficiary Plus (QMBP)" means certain aged, blind or disabled individuals who may or may not be enrolled in Medicare Part A, meet the Medicaid QMBP income and resource standards and meet all other Medicaid eligibility requirements.

"Qualifying Individual" means certain aged, blind or disabled individuals who are enrolled in Medicare Part A, meet the Medicaid Qualifying Individual income and resource standards and meet all other Medicaid eligibility requirements.

"Qualifying Individual-1" means a Qualified Individual who meets the Qualifying Individual-1 income and resource standards.

"Reasonably compatible" means that there is no significant discrepancy between information declared by a member or applicant and other information available to the agency. More specific policies and procedures for determining whether a declaration is reasonably compatible are detailed in Oklahoma's Verification Plan.

"Recipient lock-in" means when a member is restricted to one primary physician and/or one pharmacy. It occurs when the OHCA determines that a SoonerCare member has used multiple physicians and/or pharmacies in an excessive manner over a 12-month period.

"Scope" means the covered medical services for which payment is made to providers on behalf of eligible individuals. The Oklahoma Health Care Authority Provider Manual (OAC 317:30) contains information on covered medical services.

"Specified Low Income Medicare Beneficiaries (SLMB)" means individuals who, except for income, meet all of the eligibility requirements for QMBP eligibility and are enrolled in Medicare Part A.

"TEFRA" means the Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97-248). TEFRA provides coverage to certain disabled children living in the home who would qualify for SoonerCare if residents of nursing facilities, ~~ICF/MRs~~ICF/IIDs, or inpatient acute care hospital stays are expected to last not less than 60 days.

"Worker" means the OHCA or OKDHS worker responsible for assisting in eligibility determinations.

SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME
PART 1. DETERMINATION OF QUALIFYING CATEGORICAL RELATIONSHIPS

317:35-5-4. Determining categorical relationship to the disabled

An individual is related to disability if he/she is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death, or which has lasted (or can be expected to last) for a continuous period of not less than 12 months.

(1) **Determination of categorical relationship to the disabled by SSA.** The procedures outlined in (A) through (G) of this paragraph are applicable when determining categorical relationship based on a SSA disability decision:

(A) **Already determined eligible for Social Security disability benefits.** If the applicant states he/she is already receiving Social Security benefits on the basis of disability, the information is verified by seeing the applicant's notice of award or the Social Security benefit check. If the applicant states an award letter approving Social Security disability benefits has been received but a check has not been received, this information is verified by seeing the award letter. Such award letter or check establishes categorical relationship. The details of the verification used are recorded in the case record.

(B) **Already determined eligible for SSI on disability.** If the applicant, under age 65, states he/she is already receiving SSI on the basis of his/her disability (or that a written notice of SSI eligibility on disability has been received but has not yet received a check) this information is verified by seeing the written notice or check. If neither are available, the county clears on the terminal system for the Supplemental Data Exchange (SDX) record. The SDX record shows, on the terminal, whether the individual has been approved or denied for SSI. If the individual has been approved for such benefits, the county uses this terminal clearance to establish disability for categorical relationship. The details of the verification used are recorded in the case record.

(C) **Pending SSI/SSA application or has never applied for SSI.** If the applicant says he/she has a pending SSI/SSA application, an SDX record may not appear on the terminal. Therefore, it is requested that the applicant bring the notice regarding the action taken on his/her SSI/SSA application to the county office as soon as it is

received. The other conditions of eligibility are established while awaiting the SSI/SSA decision. When the SSI/SSA notice is presented, the details of the verification are recorded in the case record and the indicated action is taken on the Title XIX application. If the applicant says he/she has never applied for SSI/SSA but appears potentially eligible from the standpoint of unearned income and has an alleged disability which would normally be expected to last for a period of 12 months, he/she is referred to the SSA office to make SSI/SSA application immediately following the filing of the Title XIX application.

(D) **Already determined ineligible for SSI.** If the applicant says he/she has been determined ineligible for SSI, the written notice of ineligibility from SSA is requested to determine if the denial was based on failure to meet the disability definition. If the SSI notice shows ineligibility was due to not meeting the disability definition, and the applicant says the medical condition has not worsened since the SSI denial, the Title XIX application is denied for the same reason. If written notice is not available, the SDX record on the terminal system is used. This record shows whether the individual has been determined eligible or ineligible for SSI. If he/she has been determined ineligible, the payment status code for ineligibility is shown. The definition of this code is found on OKDHS Appendix Q in order to determine the reason for SSI ineligibility. If the reason for SSI ineligibility was based on failure to meet the disability definition, the Title XIX application is denied for the same reason and the details of the verification are recorded in the case record. If the reason for SSI ineligibility was based on some reason other than failure to meet the disability definition (and therefore, a determination of disability was not made), the Level of Care Evaluation Unit (LOCEU) must determine categorical relationship. In any instance in which an applicant who was denied SSI on "disability" states the medical condition has worsened since the SSI denial, he/she is referred to the SSA office to reapply for SSI immediately following the filing of the Title XIX application.

(E) **Already determined ineligible for Social Security disability benefits.** If the applicant says he/she has been determined ineligible for Social Security disability benefits, he/she is requested to provide written notice of ineligibility to determine if the denial was based on failure to meet the disability definition. If the SSA notice shows ineligibility was due to not meeting the

disability definition, and the applicant says the medical condition has not worsened since the denial, the Title XIX application is denied for the same reason. The details of the verification used are recorded in the case record. If the written notice is not available, TPQY procedure is used to verify the denial and the reason for ineligibility. If the reason for ineligibility was based on failure to meet the disability definition, the Title XIX application is denied for the same reason and the details of the verification are recorded in the case record. If the reason for ineligibility was based on some reason other than failure to meet the disability definition (and a determination of disability was, thus, not made), the LOCEU must determine categorical relationship. In any instance in which an applicant who was denied Social Security benefits on disability states the medical condition has worsened since the denial, he/she is referred to the SSA office to reapply immediately following the filing of the Title XIX application.

(F) **Determined retroactively eligible for SSA/SSI due to appeal.** If an individual becomes retroactively eligible for SSA/SSI due to a decision on an appeal, categorical relationship is established as of the effective date of the retroactive disability decision. Payment will be made for medical services only if the claim is received within 12 months from the date of medical services. If the effective date of the retroactive disability decision does not cover the period of the medical service because the SSA/SSI application was made subsequent to the service, a medical social summary with pertinent medical information is sent to the LOCEU for a categorical relationship decision for the time period of the medical service.

(G) **SSA/SSI appeal with benefits continued.** A Title XIX recipient who has filed an appeal due to SSA's determination that he/she is no longer disabled may continue to receive SSA benefits. The recipient has the option to have Title XIX benefits continued until the appeal decision has been reached. After the decision has been reached, the appropriate case action is taken. If SSA's decision is upheld, an overpayment referral is submitted for any Title XIX benefits the recipient received beginning with the month that SSA/SSI determined the recipient did not meet disability requirements.

(H) **Applicant deceased.** Categorical relationship to the disabled is automatically established if an individual dies while receiving a medical service or dies as a result of an illness for which he/she was hospitalized if death

occurs within two months after hospital release. The details of the verification used are recorded in the case record.

(2) **Determination of categorical relationship to the disabled by the LOCEU.**

(A) A disability decision from the LOCEU to determine categorical relationship to the disabled is required only when SSA makes a disability decision effective after medical services were received or when the SSA will not make a disability decision. The LOCEU is advised of the basis for the referral. SSA does not make disability decisions on individuals who:

(i) have been determined ineligible by SSA on some condition of eligibility other than disability,

(ii) have unearned income in excess of the SSI standard and, therefore, are not referred to SSA, or

(iii) do not have a disability which would normally be expected to last 12 months but the applicant disagrees.

(B) A disability decision from the LOCEU is not required if the disability obviously will not last 12 months and the individual agrees with the short term duration. The case record is documented to show the individual agrees with the short term duration.

(C) The local OKDHS office is responsible for submitting a medical social summary on OKDHS form ABCDM-80-D 08MA022E with pertinent medical information substantiating or explaining the individual's physical and mental condition. The medical social summary should include relevant social information such as the worker's personal observations, details of the individual's situation including date of onset of the disability, and the reason for the medical decision request. The worker indicates the beginning date for the categorical relationship to disability. Medical information submitted might include physical exam results, psychiatric, lab, and x-ray reports, hospital admission and discharge summaries, and/or doctors' notes and statements. Copies of medical and hospital bill and OKDHS Form 08MA005E are not normally considered pertinent medical information by themselves. Current (less than 90 days old) medical information is required for the LOCEU to make a decision on the client's current disability status. If existing medical information cannot be obtained without cost to the client, the county administrator authorizes either payment for existing medical information or one general physical examination by a medical or osteopathic physician of the client's choice. The physician cannot be in an intern, residency or fellowship program of a medical facility, or in the full-time employment of Veterans

Administration, Public Health Service or other Agency. Such examination is authorized by use of OKDHS form 08MA016E, Authorization for Examination and Billing. The OKDHS worker sends the 08MA016E and OKDHS form 08MA080E, Report of Physician's Examination, to the physician who will be completing the exam.

(i) **Responsibility of Medical Review Team in the LOCEU.** The responsibilities of the Medical Review Team in the LOCEU include:

(I) The decision as to whether the applicant is related to Aid to the Disabled.

(II) The effective date (month and year) of eligibility from the standpoint of disability. (This date may be retroactive for any medical service provided on or after the first day of the third month prior to the month in which the application was made.)

(III) A request for additional medical and/or social information when additional information is necessary for a decision.

(IV) Authorizing specialists' examinations as needed.

(V) Setting a date for re-examination, if needed.

(ii) **Specialist's examination.** If, on receipt of the medical information from the county office, the LOCEU needs additional medical information, the LOCEU may, at their discretion, make an appointment for a specialist's examination by a physician selected by the medical member of the team and authorize it on Form M-S-32, Request to Physician for Examination and Authorization for Billing, routing the original of the form to the examining physician and a copy to the county office. As soon as the county receives a copy of Form M-S-32, the worker immediately notifies the individual of the appointment and explains that failure to keep the appointment with the specialist without good cause will result in denial of the application (or closure of the case in instances of determination of continuing disability). The worker assists the individual in keeping the appointment, if necessary.

(I) If the specialist requires additional laboratory work or X-rays, he/she should call the LOCEU for authorization. The LOCEU is responsible for making the decision regarding the request. If additional medical services are authorized, another Form M-S-32 will be completed.

(II) If the individual notifies the worker at least 24 hours prior to the date of the examination that

he/she cannot keep the appointment, this constitutes good cause. In such an instance, the worker cancels the appointment, makes a new appointment, and submits information regarding the cancellation and the date of a new appointment to the LOCEU.

(III) When the individual fails to keep the appointment without advance notice, good cause must be determined. The worker determines the reasons and submits a memorandum to the LOCEU for a decision on good cause.

(IV) If the appointment was missed due to illness, the illness must be supported by a written statement from a physician. If missed for some reason other than illness, the reason must be supported by an affidavit signed by someone other than the individual or his/her representative and sworn to before a notary public or other person authorized to administer oaths. If, in the opinion of the LOCEU, good cause is established, the LOCEU and the county follow the same procedures as outlined in (2)(C)(ii) of this Section for any other specialist's examination. If, in the opinion of the LOCEU, good cause is not established, the LOCEU notifies the local office. The local office is responsible for denying the application or closing the case with notification to individual in accordance with OHCA and Department policy.

(D) When the LOCEU has made a determination of categorical relationship to disability and SSA later renders a different decision, the county uses the effective date of the SSA approval or denial as their date of disability approval or denial. No overpayment will occur based solely on the SSA denial superseding the LOCEU approval.

(E) Public Law 97-248, the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982, provides coverage to certain disabled children living in the home if they would qualify for Medicaid as residents of nursing facilities, ~~ICF/MRs~~ICF/IIDs, or inpatient acute care hospital stays expected to last not less than 60 days. In addition to disability, LOCEU determines the appropriate level of care and cost effectiveness.

(3) **Determination of categorical relationship to the disabled based on TB infection.** Categorical relationship to disability is established for individuals with a diagnosis of tuberculosis (TB). An individual is related to disability for TB related services if he/she has verification of an active TB infection established by a medical practitioner.

(4) **Determination of categorical relationship to the disabled**

for TEFRA. Section 134 of TEFRA allows states, at their option, to make Medicaid benefits available to children, under 19 years of age, living at home who are disabled as defined by the Social Security Administration, even though these children would not ordinarily be eligible for SSI benefits because of the deeming of parental income or resources. Under TEFRA, a child living at home who requires the level of care provided in an acute care hospital (for a minimum of 60 days), nursing facility or intermediate care facility for ~~the mentally retarded~~individuals with intellectual disabilities, is determined eligible using only his/her income and resources as though he/she were institutionalized.

317:35-5-4.1. Special level of care and cost effectiveness application procedures for TEFRA

(a) In order for a child to be eligible for TEFRA, he/she must require a level of care provided in an acute care hospital for a minimum of 60 days, or a nursing facility or intermediate care facility for ~~the mentally retarded~~individuals with intellectual disabilities for a minimum of 30 days. It must also be appropriate to provide care to the child at home. The level of care determination is made by LOCEU. The level of care certification period may be for any number of months that the LOCEU determines appropriate. At the time of application, an assessment form is provided to the applicant for completion by the child's physician. Once completed by the physician and returned to the OKDHS worker, the ~~Assessment~~assessment form is forwarded to the LOCEU along with the request for a disability determination (if needed).

(b) The estimated cost of caring for the child at home must not exceed the estimated cost of treating the child within an institution at the appropriate level of care, i.e., hospital, NF, or ~~ICF/MR~~ICF/IID. The initial cost analysis is established by LOCEU based on the information provided by the TEFRA-1 Assessment form, OKDHS worker, and medical information used in the relationship to disability determination.

(c) The level of care determination and cost effectiveness analysis are ~~posted~~reported by LOCEU ~~on MEDATS~~annually.

317:35-5-4.2. Determining nursing facility level of care for TEFRA children

In order to determine nursing facility level of care for TEFRA children:

(1) The child must be age 18 years or younger and expected to meet the following criteria for a minimum of 30 days.

(A) The child must:

(i) have a long-term medical or physical condition

which significantly diminishes his/her functional capacity;
(ii) require health-related services that are so inherently complex that it can only be safely and effectively provided by technical or professional medical personnel, such as a registered nurse, licensed practical nurse, etc., and are ordinarily provided in a nursing facility. Without these services, the child is at risk of being institutionalized within a nursing facility; and
(iii) the services needed are above general supervision but can be provided safely in the child's home. The services are usually required 24 hours per day and are ordinarily provided in a nursing facility inpatient basis (see 42 CFR 409.31-409.34 for the types of services and service frequencies that would be normally considered as nursing facility level of care).
(B) The service(s) needed has been ordered by a physician.
(2) The services needed by the child must be greater than the services provided by an ICF/IID and less than those provided in a hospital.

317:35-5-4.3. Determining acute hospital level of care for TEFRA children

In order to determine acute hospital level of care for TEFRA children:
(1) The child must be age 18 years or younger and expected to meet the following criteria for at least 60 days.
(A) The child must need services that:
(i) are ordinarily provided in a hospital setting for the care and treatment of inpatients; and
(ii) are provided in a hospital that is maintained primarily for the care and treatment of patients with disorders other than mental health diagnosis.
(B) The service(s) needed has been ordered by, and is provided under the direction of, a physician.
(2) The services needed by the child must be greater than the services provided by an ICF/IID and a nursing facility.

SUBCHAPTER 7. MEDICAL SERVICES
PART 7. CERTIFICATION, REDETERMINATION AND NOTIFICATION

317:35-7-61.1. Special redetermination procedures for TEFRA

~~The~~In addition to redetermining the level of care annually, the OHCA also conducts an annual cost effectiveness review for all active TEFRA children. The local county office is notified of the results of the review for any necessary case action. If OHCA determines the child does not meet any level of care, is no

longer disabled, or the estimated cost of care in the home is greater than the estimated cost of care in an institution, at the appropriate level of care, the case is closed.

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

PART 5. DETERMINATION OF MEDICAL ELIGIBILITY FOR ~~ICF/MR~~ICF/IID, ~~HCBW/MR~~HCBW/IID, AND INDIVIDUALS AGE 65 OR OLDER IN MENTAL HEALTH HOSPITALS

317:35-9-48.1 Determining ~~ICF/MR~~ICF/IID institutional level of care for TEFRA children

In order to determine ICF/IID level of care for TEFRA children:

(1) The child must be age 18 years or younger and expected to meet the following criteria for at least 30 days.

(A) Applicants under age three must:

(i) have a diagnosis of a developmental disability; and

(ii) have been evaluated by the SoonerStart Early Intervention Program and found to have severe dysfunctional deficiencies with findings of at least two standard deviations in at least two ~~developmental~~total domain areas.

(B) Applicants age three years and older must:

(i) have a diagnosis of intellectual disability or a developmental disability; and

(ii) have received a psychological evaluation by a licensed psychologist or school psychologist certified by the Oklahoma Department of Education (ODE) within the last 12 months. The evaluation must include intelligence testing that yields a full-scale intelligence quotient, and a full-scale functional or adaptive assessment that yields a composite functional age. Eligibility for TEFRA ~~ICF/MR~~ICF/IID level of institutional care requires an IQ of ~~75~~70 or less, ~~and~~or a full-scale functional assessment ~~(Vineland or Battelle)~~ indicating a functional age composite that does not exceed 50% of the child's chronological age. In no case shall eligibility be granted for a functional age greater than eight years.

(2) Psychological evaluations are required for children who are approved for TEFRA under ~~ICF/MR~~ICF/IID level of care. Children under age six will be required to undergo a full psychological evaluation, including both intelligence testing and adaptive/functional assessment, by a licensed psychologist or school psychologist certified by the ODE, at age three~~ and again at~~, age six, and, if medically necessary, thereafter to ascertain continued eligibility for TEFRA under the ~~ICF/MR~~

ICF/IID level of institutional care. The psychological evaluation must be completed and submitted to the LOCEU no later than 90 days following the child's third and sixth birthday, and, if medically necessary, thereafter.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME
PART 5. COUNTABLE INCOME AND RESOURCES

317:35-5-41.8. Eligibility regarding long-term care services
(a) **Home Property**. In determining eligibility for long-term care services for applications filed on or after January 1, 2006, home property is excluded from resources unless the individual's equity interest in his or her home exceeds $500,000 (increased by the annual percentage increase in the urban component of the consumer price index beginning in 2011, rounded to the nearest $1,000).

(1) Long-term care services include nursing facility services and other long-term care services. For purposes of this Section, other long-term care services include ~~services detailed in (A) through (B) of this paragraph.~~:

(A) A level of care in any institution equivalent to nursing facility services; and

(B) Home and community-based services furnished under a waiver.

(2) An individual whose equity interest exceeds $500,000 (increased by the annual percentage increase in the urban component of the consumer price index beginning in 2011, rounded to the nearest $1,000) is not eligible for long-term care services unless one of the following circumstances applies:

(A) The individual has a spouse who is lawfully residing in the individual's home;

(B) The individual has a child under the age of twenty-one who is lawfully residing in the individual's home;

(C) The individual has a child of any age who is blind or permanently and totally disabled who is lawfully residing in the individual's home; or

(D) The denial would result in undue hardship. Undue hardship exists when denial of SoonerCare long-term care services based on an individual's home equity exceeding $500,000 would deprive the individual of medical care such that the individual's health or life would be endangered; or of food, clothing, shelter, or other necessities of life.

(E) An individual may reduce their total equity interest in the home through the use of a reverse mortgage or home equity loan.

(3) Absence from home due to nursing facility care does not affect the home exclusion as long as the individual intends to return home within 12 months from the time he/she entered

the facility. The OKDHS Form 08MA010E, Acknowledgment of Temporary Absence/Home Property Policy, is completed at the time of application for nursing facility care when the applicant has home property. After an explanation of temporary absence, the member, guardian, or responsible person indicates whether there is or is not intent to return to the home and signs the form.

(A) If at the time of application the applicant states he/she does not have plans to return to the home, the home property is considered a countable resource. For members in nursing facilities, a lien may be filed in accordance with OAC 317:35-9-15 and OAC 317:35-19-4 on any real property owned by the member when it has been determined, after notice and opportunity for a hearing, that the member cannot reasonably be expected to be discharged and return home. However, a lien is not filed on the home property of the member while any of the persons described in OAC 317:35-9-15(b)(1) and OAC 317:35-19-4(b)(1) are lawfully residing in the home:

(B) If the individual intends to return home, he/she is advised that:

(i) the 12 months of home exemption begins effective with the date of entry into the nursing home regardless of when application is made for SoonerCare benefits, and

(ii) after 12 months of nursing care, it is assumed there is no reasonable expectation the member will be discharged from the facility and return home and a lien may be filed against real property owned by the member for the cost of medical services received.

(C) "Intent" in regard to absence from the home is defined as a clear statement of plans in addition to other evidence and/or corroborative statements of others.

(D) At the end of the 12-month period the home property becomes a countable resource unless medical evidence is provided to support the feasibility of the member to return to the home within a reasonable period of time (90 days). This 90-day period is allowed only if sufficient medical evidence is presented with an actual date for return to the home.

(E) A member who leaves the nursing facility must remain in the home at least three months for the home exemption to apply if he/she has to re-enter the facility.

(F) However, if the spouse, ~~minor child(ren) under 18, or relative who is aged, blind or disabled or a recipient of TANF~~minor child under 21, or child who is blind or permanently disabled resides in the home during the individual's absence, the home continues to be exempt as a

resource so long as the spouse~~ or relative~~, minor child, or child who is blind or permanently disabled lives there (regardless of whether the absence is temporary).

~~(G) For purpose of this reference a relative is defined as: son, daughter, grandson, granddaughter, stepson, stepdaughter, in-laws, mother, father, stepmother, stepfather, half-sister, half-brother, niece, nephew, grandmother, grandfather, aunt, uncle, sister, brother, stepbrother, or stepsister.~~

~~(H)~~(G) Once a lien has been filed against the property of an NF resident, the property is no longer considered as a countable resource.

(b) **Promissory notes, loans, or mortgages.** The rules regarding the treatment of funds used to purchase a promissory note, loan, or mortgage on or after February 8, 2006, are found in (1) through (2) of this subsection.

(1) Funds used to purchase a promissory note, loan, or mortgage on or after February 8, 2006, are treated as assets transferred~~ for less than fair market value in~~, and the value of such note, loan, or mortgage shall be the amount of the outstanding balance due on the note, loan, or mortgage as of the date of the individual's application for medical assistance unless the note, loan, or mortgage meets all of the conditions in paragraphs (A) through (C) of this paragraph.

(A) The note, loan, or mortgage has a repayment term that is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the United States Social Security Administration).

(B) The note, loan, or mortgage provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made.

(C) The note, loan, or mortgage prohibits the cancellation of the balance upon the death of the lender.

(2) Funds used to purchase a promissory note, loan, or mortgage for less than its fair market value are treated as assets transferred for less than fair market value regardless of whether:

(A) The note, loan, or mortgage was purchased before February 8, 2006; or

(B) The note, loan, or mortgage was purchased on or after February 8, 2006, and the conditions described in paragraph (1) of this subsection were met.

(c) **Annuities.** Treatment of annuities purchased on or after February 8, 2006.

(1) ~~The entire amount used to purchase an annuity on or after February 8, 2006, is treated as assets transferred for less than fair market value unless the annuity meets one of the~~

~~conditions described in (A) through (C) of this paragraph.~~ For purposes of this paragraph only, the term "assets" includes an annuity purchased by, or on behalf of, an annuitant who has applied for SoonerCare with respect to nursing facility services or other long-term care services. For annuities not purchased by, or on behalf of, anyone other than an applicant applying for long-term care services, the rules under OAC 317:35-5-41.8(c)(2) apply.

(A) The annuity is an annuity described in subsection (b) or (q) of Section 408 of the United States Internal Revenue Code of 1986.

(B) The annuity is purchased with proceeds from:

(i) An account or trust described in subsection (a), (c), or (p) of Section 408 of the United States Internal Revenue Code of 1986;

(ii) A simplified employee pension as defined in Section 408(k) of the United States Internal Revenue Code of 1986;

(iii) A Roth IRA described in Section 408A of the United States Internal Revenue Code of 1986~~.~~; or

(C) The annuity:

(i) is irrevocable and nonassignable;

(ii) is actuarially sound as determined in accordance with actuarial publications of the Office of the Chief Actuary of the United States Social Security Administration; and

(iii) provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made.

(2) ~~In addition, the entire amount used to purchase an annuity on or after February 8, 2006, is treated as a transfer of assets~~For purposes of this paragraph only, the purchase of an annuity not purchased by, or on behalf of, an annuitant applying for long-term care services shall be treated as the disposal of an asset for less than fair market value unless the Oklahoma Health Care Authority is named as the remainder beneficiary either:

(A) in the first position for at least the total amount of medical assistance paid on behalf of the institutionalized individual; or

(B) in the second position after the community spouse, child under 21 years of age, or disabled child and in the first position if the spouse or a representative of the child disposes of any of the remainder for less than fair market value.

(d) **Life Estates.** This subsection pertains to the purchase of a life estate in another individual's home.

(1) The entire amount used to purchase a life estate in

another individual's home on or after February 8, 2006, is treated as assets transferred for less than fair market value, unless the purchaser resides in the home for at least one year after the date of the purchase.

(2) Funds used to purchase a life estate in another individual's home for less than its fair market value are treated as assets transferred for less than fair market value regardless of whether:

(A) The life estate was purchased before February 8, 2006; or

(B) The life estate was purchased on or after February, 8, 2006, and the purchaser resided in the home for one year after the date of purchase.

(e) **Oklahoma Long-Term Care Partnership (LTCP) Program.** This subsection pertains to individuals with Oklahoma Long-Term Care Partnership policies. The Oklahoma Insurance Department approves long-term care insurance policies as Long-term Care Partnership Program policies. The face page of the policy document will indicate if the insurance qualifies as a ~~Long Term~~Long-Term Care Partnership Program policy.

(1) Benefits from the LTCP policy must be exhausted before the individual can be eligible for ~~long term~~long-term care under the SoonerCare program.

(2) Assets in an amount equal to the amount paid out under the LTCP policy can be protected for the insured individual once the LTCP policy benefits are exhausted. Protected assets are disregarded when determining eligibility for the SoonerCare program per 317:35-5-41.9(26). A record of the amount paid on behalf of the policy holder is available through the OHCA or insurance company holding the LTCP policy.

(A) At the time of application for SoonerCare the individual must determine the asset(s) to be protected. The protected asset(s) cannot be changed. If the value of the protected asset(s) decreases, the individual does not have the option to select additional assets to bring the total up to the protected amount.

(B) If the protected asset(s) are income-producing, the income earned while on SoonerCare is counted in accordance with 317:35-5-42.

(C) The individual can choose to transfer the protected asset without incurring a transfer of assets penalty.

(D) When determining resource eligibility for a couple when one of them enters the nursing home or applies for a HCBS waiver, the LTCP protected asset(s) are disregarded in determining the total amount of the couple's resources.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 6. INPATIENT PSYCHIATRIC HOSPITALS

317:30-5-95.4. Individual plan of care for adults ages 21 to 64

(a) Before admission to a psychiatric hospital or immediately after admission, the attending physician or staff physician must establish a written plan of care for each member age 21 to 64. The plan of care must include:

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

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

(3) Objectives;

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

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

(6) Plans for discharge.

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

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

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

317:30-5-95.14. Individual plan of care for persons over 65 years of age receiving inpatient acute psychiatric services

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

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

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

(3) Objectives;

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

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

(6) Plans for discharge.

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

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

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

317:30-5-95.33. Individual plan of care for children

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

(1) **"Licensed Behavioral Health Professional (LBHP)"** means licensed psychologists, licensed clinical social workers (LCSW), licensed marital and family therapists (LMFT), licensed professional counselors (LPC), licensed behavioral practitioners (LBP), licensed alcohol and drug counselors (LADC), and advanced practice nurses (APN).

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

(A) Psychology,

(B) Social Work (clinical specialty only),

(C) Professional Counselor,

(D) Marriage and Family Therapist,

(E) Behavioral Practitioner, or

(F) Alcohol and Drug Counselor.

~~(2)~~(3) **"Individual plan of Care (IPC)"** means a written plan developed for each member within four calendar days of any admission to an acute psychiatric facility or a PRTF and is the document that directs the care and treatment of that member. In Community Based Transitional RTC, the IPC must be completed within 7 days. The individual plan of care must be recovery focused, trauma informed, and specific to culture, age and gender and includes:

(A) ~~the complete record of the DSM-IV-TR five-axis diagnosis, including the corresponding symptoms, complaints, and complications indicating the need for admission;~~ A primary diagnosis from the most recent edition of "The Diagnostic and Statistical Manual of Mental Disorders" (DSM) with the exception of V-Codes, adjustment disorders, and substance abuse related disorders, accompanied by a detailed description of the symptoms supporting the diagnosis. Children 18-20 years of age may have a diagnosis of any personality disorder. Adjustment or substance related disorders may be a secondary diagnosis.

(B) the current functional level of the individual;

(C) treatment goals and measurable time limited objectives;

(D) any orders for psychotropic medications, treatments, restorative and rehabilitative services, activities, therapies, social services, diet and special procedures recommended for the health and safety of the member;

(E) plans for continuing care, including review and modification to the plan of care; and

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

(b) The individual plan of care:

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

(2) must be developed by a team of professionals as specified in OAC 317:30-5-95.35 in collaboration with the member, and his/her parents for members under the age of 18, legal guardians, or others in whose care he/she will be released after discharge;

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

(4) must establish measurable and time limited treatment objectives that reflect the expectations of the member served and parent/legal guardian (when applicable) as well as being age, developmentally and culturally appropriate. When modifications are being made to accommodate age, developmental level or a cultural issue, the documentation must be reflected

on the individual plan of care. The treatment objectives must be achievable and understandable to the member and the parent/guardian (when applicable). The treatment objectives also must be appropriate to the treatment setting and list the frequency of the service;
(5) must prescribe an integrated program of therapies, activities and experiences designed to meet the objectives;
(6) must include specific discharge and after care plans that are appropriate to the member's needs and effective on the day of discharge. At the time of discharge, after care plans will include referral to medication management, out-patient behavioral health counseling and case management to include the specific appointment date(s), names and addresses of service provider(s) and related community services to ensure continuity of care and reintegration for the member into their family, school, and community;
(7) must be reviewed every five to nine calendar days when in acute care and a regular PRTF, every 11 to 16 calendar days in the OHCA approved longer term treatment programs or specialty PRTF and every 30 days in Community Based Transitional treatment programs by the team specified to determine that services are being appropriately provided and to recommend changes in the individual plan of care as indicated by the member's overall adjustment, progress, symptoms, behavior, and response to treatment;
(8) development and review must satisfy the utilization control requirements for physician re-certification and establishment of periodic reviews of the individual plan of care; and,
(9) each individual plan of care review must be clearly identified as such and be signed and dated individually by the physician, LBHP or licensure candidate, member, parent/guardian (for members under the age of 18), registered nurse, and other required team members. All plans of care and plan of care reviews must be signed by the member upon completion, except when a member is too physically ill or their acuity level precludes them from signing. If the member was too physically ill or their acuity level precluded them from signing the plan of care and/or the plan of care review at the time of completion, the member must sign the plan when their condition improves but before discharge. Individual plans of care and individual plan of care reviews are not valid until completed and appropriately signed and dated. All requirements for the individual plan of care or individual plan of care reviews must be met or a partial per diem recoupment will be merited. If the member's parent/guardian is unable to sign the IPC or IPC review on the date it is completed, then within 72 hours the Provider must in good faith and with due diligence attempt to telephonically notify the parent/guardian of the document's completion and review it with them. Documentation of reasonable efforts to make contact with the member's parent/guardian must

be included in the clinical file. In those instances where it is necessary to mail or fax an Individual Plan of Care or Individual Plan of Care review to a parent or OKDHS/OJA worker for review, the parent and/or OKDHS/OJA worker may fax back their signature. The Provider must obtain the original signature for the clinical file within 30 days. Stamped or photocopied signatures are not allowed for any parent or member of the treatment team.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 83. RESIDENTIAL BEHAVIOR MANAGEMENT SERVICES IN FOSTER CARE SETTINGS

317:30-5-742.2. Individual plan of care and prior authorization of services

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

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

(1) **Assessment.**

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

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

(C) **Time requirements.** The minimum face-to-face time spent in assessment session(s) with the member and others for a low complexity Behavioral Health Assessment by a Non-Physician is one and one half hours.

(D) **Documentation requirements.** The assessment must include all elements and tools required by the OHCA. In the case of children under the age of 18, it is performed with the direct, active face-to-face participation of the child and parent or guardian. The child's level of participation is based on age, developmental and clinical appropriateness. The assessment must include all related diagnoses from the most recent DSM edition. The assessment must contain but is not limited to the following:

(i) Date, to include month, day and year of the assessment session(s);
(ii) Source of information;
(iii) Member's first name, middle initial and last name;
(iv) Gender;
(v) Birth Date;
(vi) Home address;
(vii) Telephone number;
(viii) Referral source;
(ix) Reason for referral;

(x) Person to be notified in case of emergency;
(xi) Presenting reason for seeking services;
(xii) Start and stop time for each unit billed;
(xiii) Signature of parent or guardian participating in face-to-face assessment. Signature required for members over the age of 14;
(xiv) Bio-Psychosocial information which must include:
(I) Identification of the member's strengths, needs, abilities and preferences;
(II) History of the presenting problem;
(III) Previous psychiatric treatment history, include treatment for psychiatric; substance use; drug and alcohol addiction; and other addictions;
(IV) Health history and current biomedical conditions and complications;
(V) Alcohol, Drug, and/or other addictions history;
(VI) Trauma, abuse, neglect, violence, and/or sexual assault history of self and/or others, including Department of Human Services involvement;
(VII) Family and social history, include MH, SA, Addictions, Trauma/Abuse/Neglect;
(VIII) Educational attainment, difficulties and history;
(IX) Cultural and religious orientation;
(X) Vocational, occupational and military history;
(XI) Sexual history, including HIV, AIDS, and STD at-risk behaviors;
(XII) Marital or significant other relationship history;
(XIII) Recreation and leisure history;
(XIV) Legal or criminal record, including the identification of key contacts, (e.g. attorneys, probation officers, etc.);
(XV) Present living arrangements;
(XVI) Economic resources;
(XVII) Current support system including peer and other recovery supports.
(xv) Mental status and Level of Functioning information, including questions regarding:
(I) Physical presentation, such as general appearance, motor activity, attention and alertness, etc.;
(II) Affective process, such as mood, affect, manner and attitude, etc.;
(III) Cognitive process, such as intellectual ability, social-adaptive behavior, thought processes, thought content, and memory, etc.; and
(IV)All related diagnoses from the most recent addition of the DSM.
(xvi) Pharmaceutical information to include the following

for both current and past medications;

(I) Name of medication;

(II) Strength and dosage of medication;

(III) Length of time on the medication; and

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

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

(xviii) Signature and credentials of ~~LBHP~~ the qualified practitioner who performed the face-to-face behavioral assessment.

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

(A) A written individual plan of care following a comprehensive evaluation for each member must be formulated by the provider agency staff within 30 days of admission with documented input from the member, legal guardian (OKDHS/OJA) staff, the foster parent (when applicable) and the treatment provider(s). It is acceptable in circumstances where it is necessary to fax a service plan to someone for review and have them fax back their signature; however, the provider must obtain the original signature for the clinical file within 30 days. No stamped or photocopied signatures are allowed. This plan must be revised and updated each 90 days with documented involvement of the legal guardian and resident.

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

(C) Requests for outpatient behavioral services in a foster care setting will be approved for a maximum of three months.

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

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

(F)Documentation requirements. Comprehensive and integrated service plan content must address the following:

(i) member strengths, needs, abilities, and preferences(SNAP);

(ii) identified presenting challenges, problems, needs and

diagnosis;
(iii) specific goals for the member;
(iv) objectives that are specific, attainable, realistic, and time-limited;
(v) each type of service and estimated frequency to be received;
(vi) the practitioner(s) name and credentials that will be providing and responsible for each service;
(vii) any needed referrals for service;
(viii) specific discharge criteria;
(ix) description of the member's involvement in, and responses to, the treatment plan, and his/her signature and date;
(x) updates to goals, objectives, service provider, services, and service frequency, must be documented within the individual plan of care until the review/update is due.
(xi) individual plan of care updates must address the following:
(I) update to the bio-psychosocial assessment, re-evaluation of diagnosis, individual plan of care goals and/ or objectives;
(II) progress, or lack of, on previous individual plan of care goals and/or objectives;
(III) a statement documenting a review of the current individual plan of care and an explanation if no changes are to be made to the individual plan of care and a statement addressing the status of identified problem behaviors that lead to placement must be included;
(IV) change in goals and/or objectives (including target dates) based upon member's progress or identification of new need, challenges and problems;
(V) change in frequency and/or type of services provided;
(VI) change in practitioner(s) who will be responsible for providing services on the plan;
(VII) change in discharge criteria;
(VIII) description of the member's involvement in, and responses to, the treatment plan, and his/her signature and date.

(3) **Description of Services.** Agency services include:
(A) **Individual, family and group therapy**. See OAC 317:30-5-241.2(a), (b), and (c).
(B) **Crisis/behavior management and redirection**. The provider agency must provide crisis/behavior redirection by agency staff as needed 24 hours per day, 7 days per week. The agency must ensure staff availability to respond to the residential foster parents in a crisis to stabilize members'

behavior and prevent placement disruption. This service is to be provided to the member by ~~a~~an LBHP.

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

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

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

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

(i) Definition. PSR services are face-to-face Behavioral Health Rehabilitation services which are necessary to improve the member's ability to function in the community. They are performed to improve the skills and abilities of

members to live interdependently in the community, improve self-care and social skills, and promote lifestyle change and recovery practices. Rehabilitation services may be provided individually or in group sessions, and they take the format of an agency approved curriculum based education and skills training.

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

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

(iv) Group sizes. The maximum staffing ratio is eight to one for children under the age of eighteen.

(v) Limitations.

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

(II) Eligibility for PSR services. PSR services are intended for children with Serious Emotional Disturbance (SED), and children with other emotional or behavioral disorders. Children under age 6, unless a prior authorization for children ages 4 and 5 has been granted by OHCA or its designated agent based on a finding of medical necessity, are not eligible for PSR

services.

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

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

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

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

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

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

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

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

(VII) Signature of the qualified provider; and

(VIII) Credentials of the qualified provider;

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

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

(I) room and board;

(II) educational costs;

(III) supported employment; and

(IV) respite.

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

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 6. INPATIENT PSYCHIATRIC HOSPITALS

317:30-5-95.6. Medical, psychiatric and social evaluations for adults age 21 to 64

The record for an adult member age 21 to 64 must contain complete medical, psychiatric and social evaluations.

(1) The evaluations must be completed as follows:

(A) History and Physical must be completed within ~~48~~24 hours of admission by a licensed independent practitioner [M.D., D.O., Advanced Practice Nurse (A.P.N.), or Physician Assistant (P.A.)].

(B) Psychiatric Evaluation must be completed within ~~48~~60 hours of admission by ~~a M.D. or D.O.~~an allopathic or osteopathic physician with a current license and a board certification/eligible in psychiatry.

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

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

317:30-5-95.16. Medical psychiatric and social evaluations for persons over 65 years of age receiving inpatient acute psychiatric services

The record of a member over 65 years of age receiving inpatient acute psychiatric services must contain complete medical, psychiatric and social evaluations.

(1) The evaluations must be completed as follows:

(A) History and Physical must be completed within ~~48~~24 hours of admission by a licensed independent practitioner [M.D., D.O., Advanced Practice Nurse (A.P.N.), or Physician Assistant (P.A.)].

(B) Psychiatric Evaluation must be completed within ~~48~~60 hours of admission by ~~a M.D. or D.O.~~an allopathic or osteopathic physician with a current license and a board certification/eligible in psychiatry.

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

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

317:30-5-95.37. Medical, psychiatric and social evaluations for inpatient services for children

The member's medical record must contain complete medical, psychiatric and social evaluations.

(1) These evaluations are considered critical documents to the integrity of care and treatment and must be completed as follows:

(A) History and physical evaluation must be completed within ~~48~~24 hours of admission by a licensed independent practitioner (M.D., D.O., A.P.N., or P.A.) and within 7 days in a CBT.

(B) Psychiatric evaluation must be completed within 60 hours of admission by ~~a M.D. or D.O~~an allopathic or osteopathic physician with a current license and a board certification/eligible in psychiatry and within 7 calendar days in a CBT.

(C) Psychosocial evaluation must be completed within 72 hours of an acute admission, within seven calendar days of admission to a PRTF and within 7 calendar days in a CBT by a licensed independent practitioner (M.D., D.O., A.P.N., or P.A.)~~ or ~~, a licensed behavioral health professional (LBHP), or Licensure Candidate as defined in OAC 317:30-5-240.3.

(2) Each of the evaluations must be clearly identified as such and must be signed and dated by the evaluators.

(3) Each of the evaluations must be completed when the member changes levels of care if the existing evaluation is more than 30 calendar days from admission. For continued stays at the same level of care, evaluations remain current for 12 months from the date of admission and must be updated annually within seven calendar days of that anniversary date.

~~(4) The history and physical evaluation, psychiatric evaluation and psychosocial evaluation must be completed within the time lines designated in this section or those days will be rendered non-compensable for SoonerCare until completed.~~

317:30-5-95.42. Service quality review of psychiatric facilities providing services to children

(a) The Service Quality Review conducted by OHCA or its designated agent meets the utilization control requirements as set forth in 42 CFR 456.

(b) There will be an on-site Service Quality Review (SQR) of each in-state psychiatric facility that provides care to SoonerCare eligible children which will be performed by the OHCA or its designated agent. Out-of-state psychiatric facilities

that provide care to SoonerCare eligible children will be reviewed according to the procedures outlined in the provider manual. The Oklahoma Health Care Authority will designate the members of the Service Quality Review team.
(c) The SQR team will consist of one to three team members and will be comprised of Licensed Behavioral Health Professionals (LBHP) or Registered Nurses.
(d) The review will include observation and contact with members. The Service Quality Review will consist of members present or listed as facility residents at the beginning of the Service Quality Review visit as well as members on which claims have been filed with OHCA for acute or PRTF levels of care. The review includes validation of certain factors, all of which must be met for the services to be compensable.
(e) Following the on-site inspection, the SQR Team will report its findings to the facility. The facility will be provided with written notification if the findings of the review have resulted in any deficiencies. A copy of the final report will be sent to the facility's accrediting agency.
(f) Deficiencies found during the SQR may result in a partial per-diem recoupment or a full per-diem recoupment of the compensation received. The following documents are considered to be critical to the integrity of care and treatment, must be completed within the time lines designated in OAC 317:30-5-95.37, and cannot be substituted with any other evaluation/assessments not specifically mentioned:

(1) History and physical evaluation;
(2) Psychiatric evaluation;
(3) Psychosocial evaluation; and
(4) Individual Plan of Care.

(g) For each day that the History and Physical evaluation, Psychiatric evaluation, Psychosocial evaluation and/or Individual Plan of Care are not contained within the member's records, those days will warrant a partial per-diem recoupment. ~~The total recoupment, however, will not exceed 10 percent of the total compensation received for the episode of care.~~
(h) If the review findings have resulted in a partial per-diem recoupment of $50.00 per event, the days of service involved will be reported in the notification. If the review findings have resulted in full per-diem recoupment status, the non-compensable days of service will be reported in the notification. In the case of non-compensable days full per diem or partial per diem, the facility will be required to refund the amount.
(i) In the event that CMS recoups from OHCA an amount that exceeds the provider's liability for findings described in this Section, the provider will not be held harmless and will be

required to reimburse OHCA the total federal amount identified by CMS and/or its designated audit contractor.

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

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS
AND CHILDREN-ELIGIBILITY
SUBCHAPTER 6. SOONERCARE FOR
PREGNANT WOMEN AND FAMILIES WITH CHILDREN
PART 7. CERTIFICATION, REDETERMINATION AND NOTIFICATION

317:35-6-62.1 Electronic Notices

(a) The agency allows SoonerCare members the choice to receive SoonerCare notices and information through electronic formats.

(1) SoonerCare members who elect to receive electronic notices will have this election confirmed by regular mail.

(2) SoonerCare members will be able to change this election by regular mail, telephone, or through the SoonerCare application.

(b) The agency will ensure all notices it generates will be posted to the member's individual account within one business day.

(1) The agency will send an email or other electronic communication alerting SoonerCare members that a notice has been posted to their member account.

(2) The agency will not include the member's confidential information in the email or electronic communication alert.

(3) The agency will send a notice by mail within three business days of a failed email or electronic alert that was undeliverable to the member.

(4) At the member's request, all notices that are posted to the member's account may also be provided through mail.

(c) Electronic notices that are posted to the member's account which require the member to take certain action, submit additional documentation, or contain eligibility, appeal, or SoonerCare benefits information are considered the same as if the notice was sent by mail to the member.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 6. INPATIENT PSYCHIATRIC HOSPITALS

317:30-5-95.24. Prior Authorization of inpatient psychiatric services for children

(a) All inpatient psychiatric services for members under 21 years of age must be prior authorized by the OHCA or its designated agent. All inpatient acute and residential psychiatric services will be prior authorized for an approved length of stay. Additional information will be required for a SoonerCare compensable approval on enhanced treatment units or in special population programs. ~~Residential treatment at this level is a longer term treatment that requires a higher staff to member ratio because it is constant, intense, and immediate reinforcement of new behaviors to develop an understanding of the behaviors. The environment of specialized residential treatment centers requires special structure and configuration (e.g., sensory centers for autistic members) and specialized training for the staff in the area of the identified specialty. The physician will see the child at least one time a week. A PRTF will not be considered a specialty treatment program for SoonerCare without prior approval of the OHCA behavioral health unit. A treatment program that has been approved as a specialized treatment program must maintain medical records that document the degree and intensity of the psychiatric care delivered to the children.~~

(b)Staffing ratios shall always be present for each individual unit not by facility or program. Patients shall be grouped for accommodation by gender, age, and treatment needs. At a minimum, children, adolescent, and adult treatment programs shall be separate with distinct units for each population. A unit is determined by separate and distinct sleeping, living, and treatment areas often separated by walls and/or doors. Each individual unit shall have assigned staff to allow for appropriate and safe monitoring of patients and to provide active treatment.

(c) Regular residential treatment programs require a staffing ratio of 1:6 during routine waking hours and 1:8 during time residents are asleep with 24 hour nursing care supervised by an RN for management of behaviors and medical complications.

(d)Specialty residential treatment at this level is a longer term treatment that requires a higher staff to member ratio because of the need for constant, intense, and immediate reinforcement of new behaviors to develop an understanding of the behaviors. The environment of specialized residential treatment centers requires special structure and configuration (e.g., sensory centers for autistic members) and specialized training for the staff in the area of the identified specialty. The physician will see the child at least one time a week.

(e) A PRTF will not be considered a specialty treatment program for

SoonerCare without prior approval of the OHCA behavioral health unit.
(f) A treatment program that has been approved as a specialized treatment program must maintain medical records that document the degree and intensity of the psychiatric care delivered to the children.
~~(b)~~(g) Criteria for classification as a specialized PRTF will require a staffing ratio of 1:3 at a minimum during ~~awake~~routine waking hours and 1:6 during time residents are asleep with 24 hour nursing care supervised by a RN for management of behaviors and medical complications. The PRTF will be a secure unit, due to the complexity of needs and safety considerations. Admissions will be restricted to children that meet the medical necessity criteria for RTC and also meet at least two or more of the following:

(1) Have failed at other levels of care or have not been accepted at other levels of care;

(2) Behavioral, emotional, and cognitive problems requiring secure residential treatment that includes 1:1, 1:2, or 1:3 staffing due to the member being a danger to themselves and others, for impairments in socialization problems, communication problems, and restricted, repetitive and stereotyped behaviors. These symptoms are severe and intrusive enough that management and treatment in a less restrictive environment places the child and others in danger but, do not meet acute medical necessity criteria. These symptoms which are exhibited across multiple environments must include at least two or more of the following:

(A) Marked impairments in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction;

(B) Inability to regulate impulse control with frequent displays of aggression or other dangerous behavior toward self and/or others regularly;

(C) Failure to develop peer relationships appropriate to developmental level;

(D) Lack of spontaneously seeking to share enjoyment, interests, or achievements with other people;

(E) Lack of social or emotional reciprocity;

(F) Lack of attachment to caretakers;

(G) Require a higher level of assistance with activities of daily living requiring multiple verbal cues 50 percent of the time to complete tasks;

(H) Delay, or total lack of, the development of spoken language which is not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime;

(I) Marked impairment in individuals with adequate speech in the ability to initiate or sustain a conversation with others;

(J) Stereotyped and repetitive use of language or idiosyncratic language;

(K) Lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level;
(L) Encompassing preoccupation with one or more stereotyped and restricted pattern and interest that is abnormal in intensity of focus;
(M) Inflexible adherence to specific, nonfunctional routines or rituals;
(N) Stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting or complex whole body movements);
(O) Persistent occupation with parts of objects;

(3) Member is medically stable, but has co-morbid medical conditions which require specialized medical care during treatment;
(4) Full scale IQ below 40 (profound mental retardation intellectual disability).

~~(c)~~(h) Non-authorized inpatient psychiatric services will not be SoonerCare compensable.
~~(d)~~(i) The designated agent will prior authorize all services for an approved length of stay based on the medical necessity criteria described in OAC 317:30-5-95.25 through 317:30-5-95.31.
~~(e)~~(j) Out of state placements must be approved by the agent designated by the OHCA and subsequently approved by the OHCA, Medical Services Behavioral Health Division. Requests for admission to Psychiatric Residential Treatment Facilities or acute care units will be reviewed for consideration of level of care, availability, suitability, and proximity of suitable services. A prime consideration for placements will be proximity to the family or guardian in order to involve the family or guardian in Active Treatment, including discharge and reintegration planning. Out of state facilities are responsible for insuring appropriate medical care as needed under SoonerCare provisions as part of the per-diem rate.~~ Out of state facilities are responsible for ensuring appropriate medical care as needed under SoonerCare provisions as part of the per-diem rate.~~
~~(f)~~(k) Inpatient psychiatric services in all acute hospitals and psychiatric residential treatment facilities are limited to the approved length of stay. OHCA, or its designated agent, will approve lengths of stay using the current OHCA Behavioral Health medical necessity criteria as described in OAC 317:30-5-95.25 through OAC 317:30-5-95.31. The approved length of stay applies to both hospital and physician services. The Child and Adolescent Level of Care Utilization System (CALOCUS®) is a level of care assessment that will be used as a tool to determine the most appropriate level of care treatment for a member by LBHPs in the community.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 41. FAMILY SUPPORT SERVICES

317:30-5-412. Description of services

Family support services include services identified in ~~paragraphs~~ (1) through (6) of this section. 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 per ~~OAC~~Oklahoma Administrative Code (OAC) 317:40-5-103.

(2) **Assistive technology (AT) devices and services.** ~~Assistive technology~~AT devices and services~~,~~ are provided ~~in accordance with~~per OAC 317:40-5-100.

(3) **Architectural modification.** Architectural modification services are provided per OAC 317:40-5-101.

(4) **Family training.**

(A) **Minimum qualifications.**

(i) Individual providers must have a ~~DDSD~~Developmental Disabilities Services (DDS) Family Training application and training curriculum approved by ~~DDSD~~DDS staff. Individual providers must hold current licensure, certification or a Bachelor's Degree in a human service field related to the approved training curriculum~~.~~, or other Bachelor's Degree combined with a minimum of five years' experience in the intellectual disabilities field. 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~~(DDS) Family Training application and training curriculum approved by ~~DDSD~~DDS staff. Agency or business provider training staff must hold current licensure, certification, or a ~~Bachelors Degree~~Bachelor's Degree in a human service field related to the approved training curriculum~~.,~~ or other Bachelor's Degree combined with a minimum of five years experience in the intellectual disabilities field. The credentials of new training staff hired by an approved ~~DDSD~~DDS HCBS Family Training agency or business provider must be submitted to and approved by the ~~DDSD program~~DDS programs manager for Family Training prior to new staff training members or ~~their~~members' families.

(B) **Description of services.** Family ~~training~~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 members served through ~~DDSD~~DDS 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~~.~~;

(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) ~~Individual~~individual family training; Limitation: $5,500 per Plan of Care year;

(ii) ~~Group~~group family training; Limitation: $5,500 per Plan of Care year;

(iii) ~~Session~~session rates for individual and group sessions ~~should~~do not exceed a range comparable to rates charged by persons with similar credentials providing similar services; and

(iv) ~~Rates~~rates must be justified based on costs incurred to deliver the service and ~~will be~~are evaluated to determine if costs are reasonable.

(D) **Documentation requirements.** Providers must maintain documentation fully disclosing the extent of services furnished that specifies:

(i) the service date;

(ii) the start and stop time for each session;

(iii) the signature of the trainer;

(iv) the credentials of the trainer;

(v) the specific issues addressed;

(vi) the methods used to address issues;

(vii) the progress made toward outcomes;

(viii) the member's response to the session or intervention; and

(ix) any new issues identified during the session.

(x) ~~Progress~~progress reports for each member served must be submitted to the ~~DDSD~~DDS case manager per OAC 340:100-5-52~~.~~; and

(xi) ~~An~~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 ~~DDSD program~~DDS programs 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~~workers, ~~psychologist~~psychologists, ~~or~~ licensed professional ~~counselor~~counselors (LPC)~~.~~, or licensed marriage and family therapists (LMFT).

(B) **Description of services.** Family counseling offered to members and ~~their~~ his or her 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 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) ~~Individual~~individual family counseling; ~~Unit~~unit: 15 minutes; ~~Limitation~~limitation: 400 units per Plan of Care year; and

(ii) ~~Group~~group, ~~(six person maximum)~~six person maximum, family counseling; ~~Unit~~unit: 30 minutes; ~~Limitation~~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) the service date;

(ii) the start and stop time for each session;

(iii) the signature of the therapist;

(iv) the credentials of the therapist;

(v) the specific issues addressed;

(vi) the methods used to address issues;

(vii) the progress made toward resolving issues and outcomes;

(viii) the 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 ~~DDSD~~DDS case manager per OAC 340:100-5-52.

(6) **Specialized medical supplies.** Specialized medical supplies are provided per OAC 317:40-5-104.

PART 43. AGENCY COMPANION, SPECIALIZED FOSTER CARE, DAILY LIVING SUPPORTS, GROUP HOMES, AND COMMUNITY TRANSITION SERVICES

317:30-5-422. Description of services

Residential supports include:

(1) agency companion services (ACS) per ~~OAC~~Oklahoma Administrative Code (OAC)317:40-5;

(2) specialized foster care (SFC) per OAC 317:40-5;

(3) daily living supports (DLS):

(A) Community Waiver per OAC 317:40-5-150; and

(B) Homeward Bound Waiver per OAC 317:40-5-153;

(4) group home services provided per OAC 317:40-5-152; and

(5) community transition services (CTS).

(A) Minimum qualifications. The provider must enter into contractual agreements with the Oklahoma Health Care Authority (OHCA) to provide ACS, habilitation training specialist (HTS) services, or DLS, in addition to a contract to provide CTS.

(B) Description of services. CTS is a one-time setup expense for members transitioning from an intermediate care facility for ~~the mentally retarded (ICF/MR)~~individuals with intellectual disabilities (ICF/IID) or provider-operated residential setting to the member's own home or apartment. The cost per member of ~~Community Transition Services~~CTS cannot exceed limitations set forth by OHCA. The member's name must be on the lease, deed or rental agreement. CTS:

(i) are furnished only when the member is unable to meet such expense and must be documented in the member's Individual Plan (IP);

(ii) include security deposits, essential furnishings, such as major appliances, dining table/chairs, bedroom set, sofa, chair, window coverings, kitchen pots/pans, dishes, eating utensils, bed/bath linens, kitchen dish towel/potholders, a one month supply of laundry/cleaning products, and setup fees or deposits for initiating utility service, including phone,

electricity, gas, and water . CTS also includes moving expenses, services/items necessary for the member's health and safety, such as pest eradication, allergen control, a one-time cleaning prior to occupancy, flashlight, smoke detector, carbon monoxide detector, first aid kit, fire extinguisher, and a tempering valve or other anti-scald device when determined by the Team necessary to ensure the member's safety; and

(iii) does not include:

(I) recreational items, such as television, cable, satellite, internet, video cassette recorder (VCR), digital video disc (DVD) player, compact disc (CD) player, MP3 player, or computer used primarily as a diversion or recreation;

(II) monthly rental or mortgage ~~expense~~expenses;

(III) food;

(IV) personal hygiene items;

(V) disposable items, such as paper plates/napkins, plastic utensils, disposable food storage bags, aluminum foil, and plastic wrap;

(VI) items that ~~could be~~are considered decorative, such as rugs, pictures, bread box, canisters, or ~~more than one basic~~a clock;

(VII) any item not considered an essential, ~~basic one time~~one-time expense; or

(VIII) regular ongoing utility charges~~.~~;

(iv) prior approval for exceptions and/or questions regarding eligible items and/or expenditures are directed to the ~~program manager~~programs manager for community transition services at ~~OKDHS/DDSD~~DHS DDS state office~~.~~;

(v) authorizations are issued for the date a member transitions;

(vi) may only be authorized for members approved for the Community Waiver;

and

(vii) may not be authorized for items purchased more than 30 days after the date of transition.

PART 51. HABILITATION SERVICES

317:30-5-482. Description of services

Habilitation services include the services identified in (1) through (15) of this section. Providers of ~~any~~ habilitation ~~service~~services must have an applicable agreement with the Oklahoma Health Care Authority (OHCA) to provide Developmental Disabilities Services ~~Division (DDSD)~~(DDS) Home and Community

Based Services (HCBS).

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

(A) **Minimum qualifications.** Providers of dental services must have non-restrictive licensure by the Board of Governors of Registered Dentists of Oklahoma to practice dentistry in Oklahoma ~~by the Board of Governors of Registered Dentists of Oklahoma~~.

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

(i) an oral examination;

(ii) bite-wing x-rays;

(iii) a prophylaxis;

(iv) topical fluoride treatment;

(v) development of a sequenced treatment plan that prioritizes:

(I) elimination of pain;

(II) adequate oral hygiene; and

(III) restoration or improved ability to chew;

(vi) routine training of member or primary caregiver regarding oral hygiene; and

(vii) preventive restorative, replacement, and repair services to achieve or restore functionality, that are provided after appropriate review ~~if~~when applicable, per OAC 317:40-5-112.

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

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

(3) **Occupational therapy services.**

(A) **Minimum qualifications.** Occupational therapists and occupational therapy assistants must have current, non-restrictive licensure by the Oklahoma State Board of Medical Licensure and Supervision. Occupational therapy assistants must be employed by the occupational therapist.

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

(i) Services are:

(I) intended to help the member achieve greater independence to reside and participate in the community; and

(II) rendered in any community setting as specified in the member's ~~IP~~individual plan (IP). The IP must include a practitioner's prescription.

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

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

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

(4) **Physical therapy services.**

(A) **Minimum qualifications.** Physical therapists and physical therapist assistants must have ~~a~~ current, non-restrictive licensure with the Oklahoma State Board of Medical Licensure and Supervision. The physical therapist ~~assistant~~ must ~~be~~ ~~employed by~~employ the physical therapist assistant.

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

(i) Services are intended to help the member achieve greater independence to reside and participate in the community. Services are provided in any community setting as specified in the member's IP. The IP must include a practitioner's prescription.

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

SoonerCare program.

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

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

(5) **Psychological services.**

(A) **Minimum qualifications.** Qualification as a provider of psychological services requires current, non-restrictive licensure as a psychologist by the Oklahoma Psychologist Board of Examiners, or licensing board in the state in which service is provided.

(B) **Description of services.** Psychological services include evaluation, psychotherapy, consultation, and behavioral treatment. Service is provided in any community setting as specified in the member's IP.

(i) Services are:

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

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

(ii) A minimum of 15 minutes for each individual encounter, ~~and~~ 15 minutes for each group encounter, and record documentation of each treatment session is included and required.

(C) **Coverage limitations.**

(i) Limitations for psychological services are:

(I)~~Description~~description:~~Psychotherapy~~psychotherapy services and behavior treatment services, ~~(individual)~~individual: ~~Unit~~unit: 15 minutes; and

(II)~~Description~~description:~~Cognitive~~cognitive/behavioral treatment, ~~(group)~~group: ~~Unit~~unit: 15 minutes.

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

(I) Initial authorization is obtained through the Developmental Disabilities Services ~~Division(DDSD)~~ (DDS) case manager, with review and approval by the ~~DDSD~~DDS case management supervisor.

(II) Initial authorization must not exceed 192 units, ~~(48 hours of service)~~48 hours of service.

(III) ~~Monthly~~Quarterly progress notes must include a statement of hours and ~~type~~types of ~~service~~services provided, and an empirical measure of member status as it relates to each objective in the member's IP.

(IV) ~~If~~When progress notes for each quarter of service provision are not submitted to the ~~DDSD~~DDS case manager ~~for each month of service provision~~, authorization for payment must be withdrawn until such time as progress notes are ~~completed~~submitted.

(iii) Treatment extensions may be authorized by the ~~DDSD~~DDS area manager, based upon evidence of continued need and effectiveness of treatment.

(I) Evidence of continued need of treatment, treatment effectiveness, or both, is submitted by the provider to the ~~DDSD~~DDS case manager and must include, at a minimum, completion of the Service Utilization and Evaluation protocol.

(II) When revising a protective intervention plan (PIP) to accommodate recommendations of a required committee review or an Oklahoma Department of Human Services ~~(OKDHS)~~(DHS) audit, the provider may bill for only one revision. The time for preparing the revision must be clearly documented and must not exceed four hours.

(III) Treatment extensions must not exceed 24 hours ~~(96 units)~~, 96 units, of service, per request.

(iv) The provider must develop, implement, evaluate, and revise the PIP corresponding to the relevant goals and objectives identified in the member's IP.

(v) No more than 12 hours ~~(48 units)~~, 48 units, may be billed for the preparation of a PIP. Any clinical document must be prepared within 45 calendar days of the request. Further, if the document is not prepared, payments are suspended until the requested document is provided.

(vi) Psychological technicians may provide up to 140 billable hours ~~(560 units)~~, 560 units, of service per month to members.

(vii) The psychologist must maintain a record of all billable services provided by a psychological technician.

(6) **Psychiatric services.**

(A) **Minimum qualifications.** Qualification as a provider of psychiatric services requires a current, non-restrictive license to practice medicine in Oklahoma. Certification by the Board of Psychiatry and Neurology or satisfactory completion of an approved residency program

in psychiatry is required.

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

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

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

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

(7) **Speech/language services.**

(A) **Minimum qualifications.** Qualification as a provider of speech and/or language services requires current, non-restrictive licensure as a speech and/or language pathologist by the State Board of Examiners for Speech Pathology and Audiology.

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

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

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

(C) **Coverage limitations.** A unit is 15 minutes, with a limit of 288 units, per Plan of Care year.

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

(A) **Minimum qualifications.** Providers must complete the ~~OKDHS DDSD~~DHS DDS sanctioned training curriculum. Residential habilitation providers:

(i) are at least 18 years of age;

(ii) are specifically trained to meet the unique needs of members;

(iii) have not been convicted of, pled guilty to, or pled nolo contendere to misdemeanor assault and

battery, or a felony per Section 1025.2 of Title 56 of the Oklahoma Statutes (56 O.S. § 1025.2), unless a waiver is granted per 56 O.S. § 1025.2; and

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

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

(i) Payment will not be made for:

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

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

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

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

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

(v) ~~DDSD~~DDS case management supervisor review and approval is required.

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

(I) provider ~~will receive~~receives DDS area staff

oversight ~~from DDSD~~ ~~area staff~~; and

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

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

(i) A unit is 15 minutes.

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

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

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

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

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

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

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

(11) **Audiology services.**

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

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

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

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

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

(12) **Prevocational services.**

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

(i) are at least 18 years of age;

(ii) complete the ~~OKDHS DDSD~~DHS DDS sanctioned training curriculum;

(iii) have not been convicted of, pled guilty to, or pled nolo contendere to misdemeanor assault and battery, or a felony per 56 O.S. §1025.2, unless a waiver is granted per 56 O.S. §1025.2; and

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

(B) **Description of services.** Prevocational services are not available to persons who can be served under a program funded per Section 110 of the Rehabilitation Act of 1973 or Section 602(16) and (17) of the Individuals with Disabilities Education Act (IDEA). Services are aimed at preparing a member for employment, but are not job-task oriented. Services include teaching concepts, such as compliance, attendance, task completion, problem solving, and safety.

(i) Prevocational services are provided to members who are not expected to:

(I) join the general work force; or

(II) participate in a transitional sheltered workshop within one year, excluding supported employment programs.

(ii) When compensated, members are paid at less than 50 percent of the minimum wage. Activities included in this service are not primarily directed at teaching specific job skills, but at underlying, habilitative goals, such as attention span and motor skills.

(iii) All prevocational services ~~will be~~are reflected in the member's IP as habilitative, rather than explicit employment objectives.

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

(v) Services include:

(I) center-based prevocational services ~~as specified in~~per OAC 317:40-7-6;

(II) community-based prevocational services ~~as specified in~~per OAC 317:40-7-5;

(III) enhanced community-based prevocational

services ~~as specified in~~per OAC 317:40-7-12; and

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

(C) **Coverage limitations.** A unit of center-based or community-based prevocational services is one hour and payment is based upon the number of hours the member participates in the service. All prevocational services and supported employment services combined may not exceed ~~$25,000~~$27,000, per Plan of Care year. The following services may not be provided to the same member at the same time as prevocational services:

(i) HTS;

(ii) Intensive Personal Supports;

(iii) Adult Day Services;

(iv) Daily Living Supports;

(v) Homemaker; or

(vi) therapy services such as occupational therapy, physical therapy, nutrition, speech, psychological services, family counseling, or family training except to allow the therapist to assess the individual's needs at the workplace or to provide staff training and as allowed per OAC 317:40-7-6.

(13) **Supported employment.**

(A) **Minimum qualifications.** Supported employment providers:

(i) are at least 18 years of age;

(ii) complete the ~~OKDHS DDSD~~DHS DDS sanctioned training curriculum;

(iii) have not been convicted of, pled guilty to, or pled nolo contendere to misdemeanor assault and battery, or a felony per 56 O.S. §1025.2, unless a waiver is granted per 56 O.S. §1025.2; and

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

(B) **Description of services.** Supported employment is conducted in a variety of settings, particularly work sites in which persons without disabilities are employed, and includes activities that are outcome based and needed to sustain paid work by members receiving services through HCBS ~~Waiver~~Waivers, including supervision and training.

(i) When supported employment services are provided at a work site in which persons without disabilities are employed, payment:

(I) is made for the adaptations, supervision, and training required by members as a result of their

disabilities; and
(II) does not include payment for the supervisory activities rendered as a normal part of the business setting.

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

(iii) Supported employment services furnished under HCBS ~~Waiver~~Waivers are not available under a program funded by the Rehabilitation Act of 1973 or IDEA.

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

(v) Federal financial participation (FFP) may not be claimed for incentive payment subsidies or unrelated vocational training expenses, such as:
(I) incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
(II) payments ~~that are~~ passed through to users of supported employment programs; or
(III) payments for vocational training ~~that are~~ not directly related to a member's supported employment program.

(C) **Coverage limitations.** A unit is 15 minutes and payment is made ~~in accordance with~~per OAC 317:40-7-1 through 317:40-7-21. All prevocational services and supported employment services combined cannot exceed ~~$25,000~~$27,000 per Plan of Care year. The ~~DDSD~~DDS case manager assists the member to identify other alternatives to meet identified needs above the limit. The following services may not be provided to the same member, at the same time, as supported employment services:
(i) HTS;
(ii) Intensive Personal Supports;
(iii) Adult Day Services;
(iv) Daily Living Supports;
(v) Homemaker; or
(vi) ~~Therapy~~therapy services, such as occupational therapy, physical therapy, nutrition, speech, psychological services, family counseling, or family

training except to allow the therapist to assess the individual's needs at the workplace or to provide staff training.

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

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

(i) are at least 18 years of age;

(ii) complete the ~~OKDHS DDSD~~DHS DDS sanctioned training curriculum;

(iii) have not been convicted of, pled guilty to, or pled nolo contendere to misdemeanor assault and battery, or a felony per 56 O.S. §1025.2, unless a waiver is granted per 56 O.S. §1025.2;

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

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

(B) **Description of services.**

(i) IPS:

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

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

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

(iii) ~~DDSD~~DDS case management supervisor review and approval is required.

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

(15) **Adult day services.**

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

(i) meet the licensing requirements ~~set forth in~~per 63 O.S.§§1-873 *et seq.* and comply with OAC 310:605; and

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

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

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

317:40-1-3. Requirements for Home and Community-Based Settings

(a) The Oklahoma Department of Human Services Developmental Disabilities Services Home and Community-Based Services (HCBS) Waiver settings have the following qualities defined in federal regulation per 42 CFR § 441.301(c)(4) based on the needs of the individual defined in his or her Individual Plan (Plan).

(1) The setting is integrated and supports full access of individuals receiving HCBS Waivers to the greater community, including opportunities to:

(i) seek employment and work in competitive integrated settings;

(ii) engage in community life;

(iii) control personal resources; and

(iv) receive services in the community, to the same degree as individuals not receiving Medicaid HBCS Waiver Services.

(2) The setting is selected by the member from options including non-disability settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and based on individual needs and preferences.

(3) For residential settings, the member must have income available for room and board.

(4) The setting ensures the member's rights of privacy, dignity, respect, and freedom from coercion and restraint.

(5) The setting optimizes individual initiative, autonomy, and independence in making life choices including, but not limited to:

(i) daily activities;

(ii) the physical environment; and

(iii) with whom to interact.

(6) The setting facilitates individual choice regarding services and supports, including who provides them.

(b) In a provider-owned or controlled residential setting, in addition to the attributes specified above, the additional conditions listed in (1) through (8) of this subsection must be met.

(1) The unit or dwelling is a specific, physical place, owned, rented, or occupied under a legally enforceable agreement by the member receiving services.

(2) The member has the same responsibilities and protections from eviction, that tenants have per the Residential Landlord and Tenant Act, 41 O.S. § 101, et seq.

(3) In settings where landlord tenant laws do not apply, the provider agency completes a lease, residency agreement, or other form of written agreement for each member. The document provides protections that address eviction processes and appeals comparable to those provided in the Residential Landlord and Tenant Act, 41 O.S. § 101, et seq.

(4) Each member has privacy in his or her sleeping or living unit, where:

(i) units have entrance doors lockable by the member, with only appropriate staff having keys to doors;

(ii) members sharing units have a choice of roommates; and

(iii) members have freedom to furnish and decorate his or her sleeping or living units within the lease or other agreement.

(5) Each member has the freedom and support to control his or her own schedules, activities, and access to food at any time.

(6) Each member may have visitors whenever he or she chooses.

(7) The setting is physically accessible to the member.

(8) Any modifications of the additional conditions specified in this subsection, must be supported by a specific, assessed need, and justified in the person-centered Plan and includes:

(i) an identified individualized assessed need;

(ii) documentation of the positive interventions and supports used prior to any modifications to the person-centered plan;

(iii) documentation of less intrusive methods tried, including those that did not work;

(iv) a clear description of the condition, proportionate to the specific assessed need;

(v) regular collection and review of data to measure the ongoing effectiveness of the modification;

(vi) established time limits for periodic reviews to determine if the modification continues to be necessary or can be terminated;

(vii) the informed consent of the member; and

(viii) an assurance the interventions and supports will cause no harm to the member.

(c) Any setting that isolates members from the broader community of individuals not receiving HCBS is not considered an HCBS.

(1) Settings that are not HCBS per 42 CFR § 441.301(c)(5)(v) include:

(i) a nursing facility;

(ii) an institution for mental diseases;

(iii) an intermediate care facility for individuals with intellectual disabilities;

(iv) a hospital; or

(v) any other locations with qualities of an institutional setting per 42 CFR § 441.301(c)(5)(v).

SUBCHAPTER 5. MEMBER SERVICES
PART 9. SERVICE PROVISIONS

317:40-5-100. Assistive technology (AT) devices and services
(a) **Applicability.** The rules in this Section apply to ~~assistive technology (AT)~~AT services and devices authorized by the Oklahoma Department of Human Services ~~(OKDHS)~~(DHS) Developmental Disabilities Services ~~Division (DDSD)~~DDS 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; and

(xi) specialized chairs; ~~and~~

(P) orthotic and prosthetic devices, including:

(i) braces;

(ii) prescribed modified shoes; and

(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~~.~~; and

(S) devices for the protection of the member's health and safety.

(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 member's 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~~Oklahoma Administrative Code OAC 580:15 and ~~OKDHS~~DHS 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~~when applicable.

(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, an AT retrieval program, Oklahoma 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~~.~~; and
(K) exceeds a cost of $50. AT devices or services with a cost of $50 or less, are not authorized through ~~DDSD~~DDS HCBS Waivers.

(8) The homeowner must sign a written agreement for any AT equipment that attaches to the home or property.

(c) **Assessments.** Assessments for AT devices or services are performed by a licensed professional service ~~provider(s)~~ provider 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~~member'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)~~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) a review of the device considered;
(B) availability of the device rental with discussion of advantages and disadvantages;

(C) how frequently, and in what situations the device will be used in daily activities and routines;

(D) how the member and caregiver(s) will be trained to safely use the AT device; and

(E) the 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~~.~~; and

(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~~DDS 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~~DDS 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~~DHS DDS 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 fit 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 calendar 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~~evaluates the need for AT, and individually ~~customize~~customizes 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;

(7) educational games and toys; or

(8) generators.

(i) **Approval or denial of AT.** ~~DDSD~~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 ~~DDSD~~DDS case manager sends the AT request to designated ~~DDSD~~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~~AT device or service.

(2) The designated area office resource development staff, with AT experience, approves or denies the AT request when the device ~~has a cost~~costs less than $2500~~, and the POC is below the State Office reviewer limit based on the scope of the program, as explained in subsection (b) 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~~of $2500~~,~~or more ~~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~~.

(4) Authorization for purchase or a written denial is provided within ~~ten working~~10 business 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~~When necessary, the case manager ~~will contact~~ contacts the licensed professional to request the additional documentation ~~and the licensed professional will supply further documentation~~.

(D) The authorization of a $2,500 or more AT ~~that is $2,500 or more~~ is ~~performed as in paragraph~~completed per (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 ~~DDSD~~DDS State Office AT programs manager within five ~~working~~business 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~~business days of receipt of all required documentation for the 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~~(1) through (3) of this subsection 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~~10-calendar year period per member. Authorization for more than one vehicle adaptation in a 10-year period must be approved by the ~~DDSD~~DDS division administrator or designee.

(k) **Denial.** Procedures for denial of an AT device or service are described in ~~this paragraph~~(1) through (3) of this subsection.

(1) The person denying the AT request provides a written denial, to the case manager citing the reason for denial per ~~policy~~OAC 317:40-5-100.

(2) The case manager sends DHS FORM 06MP004E, the Notice of Action, ~~OKDHS form 06MP004E,~~ to the member and his or her family or guardian.

(3) Denial of ~~assistive technology~~AT services may be appealed through the ~~OKDHS~~DHS hearing process, per OAC 340:2-5.

(l) **Return of an AT device.** ~~If~~When, during a trial use period or rental of a device, the therapist or Team including the

licensed professional ~~if~~when 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 ~~DDSD~~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~~purchasing the device or the licensed professional recommends a ~~trail~~trial period to determine if the device meets the member's 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, including the licensed professional, 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~~When a device is rented for a trial use period, the Team, including the licensed professional, decides within 90 calendar 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~~DHS DDS State Office programs manager for AT.

(1) The AT committee is comprised of:

(A) ~~DDSD~~DDS professional staff members of the appropriate therapy;

(B) ~~DDSD~~DDS AT ~~state office~~State Office programs manager;

(C) the ~~DDSD~~ DDS area manager or designee; and

(D) an AT expert not employed by ~~OKDHS~~DHS.

(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~~provided in this Section. Any endorsement or denial includes a written rationale for the decision and, if necessary, an alternative

~~solution(s)~~solution, directed to the case manager within 20 ~~working~~business days of the receipt of the request. Requests reviewed by the AT committee result in suspension of time frames specified ~~in~~per 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)~~DHS, Developmental Disabilities Services ~~Division (DDSD)~~DDS Home and Community Based Services (HCBS) Waivers.

(b) **General Information.** Transportation services include adapted, non-adapted, and public transportation.

(1) Transportation services 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 may be provided for each eligible person~~; or~~.

(B) Public transportation may be provided up to a maximum of $5,000 per Plan of Care year. The ~~director of DDSD~~DDS director or designee may approve requests for public transportation services totaling more than $5,000 per year when public transportation is the most cost-effective option. For the purposes of this Section, public transportation is defined as:

(i) services, such as an ambulance when medically necessary, a bus, or a taxi; or

(ii) a transportation program operated by the member's employment services or day services provider.

(3) 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) Personal Support Team(Team) consideration, 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 member's need, ~~in accordance with subsection~~per (d) of this Section; and

(B) the scope of transportation services as explained in

this Section.

(c) **Standards for transportation providers.** All drivers employed by contracted transportation providers must have a valid and current Oklahoma 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 members:

(A) meets the ~~needs of the member~~member's needs;

(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) ~~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.~~The provider ensures all members wear safety belts during transport.

(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 member transported; and~~

~~(D) the purpose of the trip.~~

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.

(5) ~~A family member, including a family member living in the same household, of an adult 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 member, as defined in~~

~~OAC 340:100-3-33.1.~~

Providers must maintain documentation, fully disclosing the extent of services furnished that specifies the:

(A) service date;

(B) location and odometer mileage reading at the starting point and destination;

(C) name of the member transported; and

(D) purpose of the trip.

(6) ~~Individual transportation providers must provide to the DDSD 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.~~A family member, including a family member living in the same household, of an adult 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 Plan as necessary to meet the needs of the member, per OAC 340:100-3-33.1.

(7) 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 a current and valid Oklahoma driver license and/or vehicle licensure may result in cancellation of the contract.

(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 member;

(6) transportation provided by the member's spouse;

(7) transportation provided by the biological, step or adoptive parents of the member or legal guardian, when the member is a minor;

(8) trips when the member is not in the vehicle;

(9) transportation claimed for more than one member per vehicle at the same time or for the same miles, except public transportation;

(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~~DDS area manager or designee;

(11) services ~~which~~that are mandated to be provided by the public schools pursuant to the Individuals with Disabilities Education Act;

(12) transportation that occurs during the performance of the member's paid employment, even if the employer is a contract provider; or

(13) transportation when a closer appropriate location was not selected.

(e) **Assessment and Team process.** At least annually, the Team addresses the member's transportation needs. The Team determines the most appropriate means of transportation based on the:

(1) present needs of the member. When addressing the possible need for adapted transportation, the Team considers the needs of the member only. The needs of other individuals living in the same household are considered separately;

(2) member's ability to access public transportation services; and

(3) the availability of other transportation resources including natural supports, and community agencies.

(f) **Adapted Transportation.** Adapted transportation may be transportation provided in modified vehicles with wheelchair or stretcher safe travel systems or lifts that meet medical needs of the member 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~~DDS HCBS provider agency.

(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~~DDS programs 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.

(4) The Team determines if the member needs adapted

transportation according to:

(A) the member's need for physical support when sitting;

(B) the member's need for physical assistance during transfers from one surface to another;

(C) the portability of the member's wheelchair;

(D) associated health problems the member may have; and

(E) less costly alternatives to meet the need.

(5) The transportation provider and the equipment vendor ensure that requirements of the Americans with Disabilities Act are met.

(6) The transportation provider ensures ~~that~~ all staff assisting with transportation ~~have~~has been trained according to the requirements specified by the Team and the equipment manufacturer.

(g) **Authorization of transportation services.** The limitations given in this subsection include the total of all transportation units on the Plan of Care, not ~~just~~only the units authorized for the identified residential setting ~~identified~~.

(1) Up to 12,000 units of transportation services may be authorized in a member's 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.

(3) The DDS 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.

(4) The DDS 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~~that 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~~$5,000 when ~~this~~it is the most cost effective service option for necessary transportation.

PART 11. OTHER COMMUNITY RESIDENTIAL SUPPORTS

317:40-5-152. Group home services for persons an intellectual disability or certain persons with related conditions

(a) **General Information.** Group homes provide a congregate living arrangement offering up to 24-hour per day supervision, supportive assistance, and training in daily living skills to persons who are eligible and 18 years of age or older. Upon approval of the Oklahoma Department of Human Services ~~(OKDHS)~~ DHS Developmental Disabilities Services ~~Division (DDSD)~~DDS director or designee, persons younger than 18 years of age may be served.

(1) Group homes ensure members reside and participate in the community. Services are provided in homes located in close proximity to generic community services and activities.

(2) Group homes must be licensed by ~~DDSD in accordance with~~ DHS per Section 1430.1 et seq. of Title 10 of the Oklahoma Statutes.

(3) Residents of group homes receive no other form of residential supports.

(4) Habilitation training specialist (HTS) services or homemaker services for residents of group homes may only be approved ~~only~~ by the ~~DDSD~~DDS director or designee ~~to resolve a temporary emergency when no other resolution exists.~~:

(A) for a resident of a group home to resolve a temporary emergency when no other resolution exists; or

(B) for a resident of a community living group home when the resident's needs are so extensive that additional supports are needed for identified specific activities; and

(C) weekly average of 56 hours of direct contact staff must be provided to the resident before HTS services may be approved.

(b) **Minimum provider qualifications.** Approved providers must have a current contract with the Oklahoma Health Care Authority (OHCA) to provide ~~DDSD~~DDS Home and Community-Based Services (HCBS) ~~Waiver~~ for persons with an intellectual disability or related conditions.

(1) Group home providers must have a completed and approved application to provide ~~DDSD~~DDS group home services.

(2) Group home staff must:

(A) complete the ~~OKDHS DDSD-sanctioned~~DHS DDS-sanctioned training curriculum per OAC 340:100-3-38; and

(B) fulfill requirements for pre-employment screening per OAC 340:100-3-39.

(c) **Description of services.**

(1) Group home services:

(A) meet all applicable requirements of OAC 340:100; and
(B) are provided in accordance with each member's Individual Plan (IP) developed per OAC 340:100-5-50 through 340:100-5-58.
(i) Health care services are secured for each member per OAC 340:100-5-26.
(ii) Members are offered recreational and leisure activities maximizing the use of generic programs and resources, including individual and group activities.
(2) Group home providers:
(A) follow protective intervention practices per OAC 340:100-5-57 and 340:100-5-58;
(B) in addition to the documentation required per OAC 340:100-3-40, must maintain:
(i) staff time sheets that document the hours each staff was present and on duty in the group home; and
(ii) documentation of each member's presence or absence on the daily attendance form provided by ~~DDSD~~DDS; and
(C) ensure program coordination staff (PCS) meet staff qualifications and supervise, guide, and oversee all aspects of group home services per OAC 340:100-5-22.6 and 340:100-6, as applicable.
(d) **Coverage limitations.** Group home services are provided up to 366 days per year.
(e) **Types of group home services.** ~~There are three~~Three types of group home services are provided through HCBS Waivers.
(1) **Traditional group homes.** Traditional group homes serve no more than 12 members per OAC 340:100-6.
(2) **Community living homes.** Community living homes serve no more than 12 members.
(A) Members who receive community living home services:
(i) have needs that cannot be met in a less structured setting; and
(ii) require regular, frequent, and sometimes constant assistance and support to complete daily living skills, such as bathing, dressing, eating, and toileting; or
(iii) require supervision and training in appropriate social and interactive skills, due to on-going behavioral issues to remain included in the community.
(B) Services offered in a community living home include:
(i) 24-hour awake supervision when a member's IP indicates it is necessary; and
(ii) program supervision and oversight including hands-on assistance in performing activities of daily living, transferring, positioning, skill-building, and training.
(C) Services may be approved for individuals in a

traditional group home at the community living service rate ~~if~~when the member has had a change in health status or behavior and meets the requirements to receive community living home services. Requests to receive community living home services are sent to the ~~DDSD~~DDS Community Services Residential Unit.

(3) **Alternative group homes.** Alternative group homes serve no more than four members who have evidence of behavioral or emotional challenges in addition to an intellectual disability and require extensive supervision and assistance in order to remain in the community.

(A) Members who receive alternative group home services must meet criteria per in OAC 340:100-5-22.6.

(B) A determination must be made by the ~~DDSD~~DDS Community Services Unit that alternative group home services are appropriate.

SUBCHAPTER 7. EMPLOYMENT SERVICES THROUGH HOME AND COMMUNITY-BASED SERVICES WAIVERS

317:40-7-15. Service requirements for employment services through Home and Community-Based Services Waivers

(a) The Oklahoma Department of Human Services (DHS) Developmental Disabilities Services ~~Division (DDSD)~~(DDS) case manager, member, a member's family or, ~~if~~when applicable, legal guardian, and provider develop a preliminary plan of services including the:

(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~~when those services occur in the residence or property of the member or provider-paid staff, including garages and sheds, whether ~~or not~~ the garage or shed is attached to the home or not.

(2) No exceptions to Oklahoma Administrative Code (OAC)~~OAC~~ 317:40-7-15(b) are authorized.

(c) The service provider is required to notify the ~~DDSD~~DDS 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~~when 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.

(d) The provider submits ~~Oklahoma Department of Human Services (OKDHS)~~a DHS Provider Progress Report per OAC 340:100-5-52, for each member receiving services.
(e) The cost of a member's employment services, excluding transportation and state-funded services per OAC 340:100-17-30, cannot exceed ~~$25,000~~$27,000 per Plan of Care year.
(f) 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, each week, excluding transportation to and from the member's residence.

(1) Thirty-hours of employment service each week ~~can~~may 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.

(2) Less than 30 hours of employment activities per week requires approval per OAC 317:40-7-21.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 6. INPATIENT PSYCHIATRIC HOSPITALS

317:30-5-95.34. Active treatment for children

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

(1) **"Discharge/Transition Planning"** means a patient-centered, interdisciplinary process that begins with an initial assessment of the patient's potential needs at the time of admission and continues throughout the patient's stay. Active collaboration with the patient, family and all involved outpatient practitioners and agencies should be ongoing throughout treatment so that effective connections remain intact. Needed services may consist of the Wraparound process through Systems of Care, counseling, case management and other supports in their community. The linkages with these supports should be made prior to discharge to allow for a smooth transition.

(2) **"Expressive group therapy"** means art, music, dance, movement, poetry, drama, psychodrama, structured therapeutic physical activities, experiential (ROPES), recreational, or occupational therapies that encourage the member to express themselves emotionally and psychologically.

(3) **"Family therapy"** means interaction between ~~a~~an LBHP or licensure candidate, member and family member(s) to facilitate emotional, psychological or behavioral changes and promote successful communication and understanding.

(4) **"Group rehabilitative treatment"** means behavioral health remedial services, as specified in the individual care plan which are necessary for the treatment of the existing primary behavioral health disorders and/or any secondary alcohol and other drug (AOD) disorders in order to increase the skills necessary to perform activities of daily living.

(5) **"Individual rehabilitative treatment"** means a face to face, one on one interaction which is performed to assist members who are experiencing significant functional impairment due to the existing primary behavioral health disorder and/or any secondary AOD disorder in order to increase the skills necessary to perform activities of daily living.

(6) **"Individual therapy"** means a method of treating existing primary behavioral health disorders and/or any secondary AOD disorders using face to face, one on one interaction between ~~a~~an LBHP or Licensure Candidate and a member to promote emotional or psychological change to alleviate disorders.

(7) **"Process group therapy"** means a method of treating existing primary behavioral health disorders and/or secondary AOD disorders using the interaction between ~~a~~an LBHP or licensure candidate as defined in OAC 317:30-5-240.3, and two or more members to promote positive emotional and/or behavioral change.

(b) Inpatient psychiatric programs must provide "Active Treatment". Active Treatment involves the member and their family or guardian from the time of an admission throughout the treatment and discharge process. Families and/or guardians must be notified of the dates and times of treatment team meetings and be welcomed to attend. Family members must attend family therapy weekly for continued SoonerCare reimbursement. Reasons for exceptions to this requirement must be well documented in the member's treatment plan. For individuals in the age range of 18 up to 21, it is understood that family members and guardians will not always be involved in the member's treatment. Active Treatment also includes an ongoing program of assessment, diagnosis, intervention, evaluation of care and treatment, and planning for discharge and aftercare under the direction of a physician. Evidence based practices such as trauma informed methodology should be utilized to minimize the use of seclusion and restraint.

(c) For individuals age 18 up to 21, the Active Treatment program must be appropriate to the needs of the member and be directed toward restoring and maintaining optimal levels of physical and psychiatric-social functioning. The services and individual plan of care must be recovery focused, trauma informed, specific to culture, age and gender, and provided face-to-face. Services, including type and frequency, will be specified in the Individual Plan of Care.

(d) For individuals under age 18, the components of Active Treatment consist of face-to-face integrated therapies that are provided on a regular basis and will remain consistent with the member's ongoing need for care. The services and individual plan of care must be recovery focused, trauma informed, and specific to culture, age, and gender. Individuals in acute care must receive seventeen (17) hours of documented active treatment services each week, with seven (7) of those hours being dedicated to core services as described in (1) below. Individuals in PRTFs must receive fourteen (14) hours of documented active treatment services each week, with four and a half (4.5) of those hours being dedicated to core services as described in (1) below. Individuals in Community Based Transitional (CBT) must receive ten (10) hours of documented active treatment services each week, with 4 of those hours being dedicated to core services as described in (1) below. The remainder of the active treatment services may include any or all of the elective services listed in (2) below or additional hours of any of the core services. Sixty minutes is the expectation

to equal one hour of treatment. When appropriate to meet the needs of the child, the 60 minute timeframe may be split into sessions of no less than 15 minutes each on the condition that the Active Treatment requirements are fully met by the end of the treatment week. The following components meet the minimum standards required for Active Treatment, although an individual child's needs for treatment may exceed this minimum standard:

(1) **Core Services.**

(A) **Individual treatment provided by the physician.** Individual treatment provided by the physician is required three times per week for acute care and one time a week in Residential Treatment Facilities. Individual treatment provided by the physician will never exceed ten calendar days between sessions in PRTFs, never exceed seven calendar days in a specialty PRTF and never exceed 30 calendar days in CBTs. Individual treatment provided by the physician may consist of therapy or medication management intervention for acute and residential programs.

(B) **Individual therapy.** LBHPs or licensure candidates performing this service must use and document an approach to treatment such as cognitive behavioral treatment, narrative therapy, solution focused brief therapy or another widely accepted theoretical framework for treatment. Ongoing assessment of the member's status and response to treatment as well as psycho-educational intervention are appropriate components of individual therapy. Individual therapy must be provided in a confidential setting. The therapy must be goal directed utilizing techniques appropriate to the individual member's plan of care and the member's developmental and cognitive abilities. Individual therapy must be provided two hours per week in acute care and one hour per week in residential treatment by ~~a~~an LBHP or licensure candidate as described in OAC 317:30-5-240.3. One hour of family therapy may be substituted for one hour of individual therapy at the treatment team's discretion.

(C) **Family therapy.** The focus of family therapy must be directly related to the goals and objectives on the individual member's plan of care. Family therapy must be provided one hour per week for acute care and residential. One hour of individual therapy addressing relevant family issues may be substituted for a family session in an instance in which the family is unable to attend a scheduled session by ~~a~~an LBHP or licensure candidate as described in OAC 317:30-5-240.3.

(D) **Process group therapy.** The focus of process group therapy must be directly related to goals and objectives on the individual member's plan of care. The individual member's

behavior and the focus of the group must be included in each member's medical record. This service does not include social skills development or daily living skills activities and must take place in an appropriate confidential setting, limited to the therapist, appropriate hospital staff, and group members. Group therapy must be provided three hours per week in acute care and two hours per week in residential treatment by ~~a~~an LBHP or licensure candidate as defined in OAC 317:30-5-240.3. In lieu of one hour of process group therapy, one hour of expressive group therapy provided by ~~a~~an LBHP~~ or~~, licensure candidate, or Licensed Therapeutic Recreation Specialist may be substituted.

(E) **Transition/Discharge Planning.** Transition/discharge planning must be provided one hour per week in acute care and thirty minutes per week in residential and CBT. Transition/Discharge planning can be provided by any level of inpatient staff.

(2) **Elective services.**

(A) **Expressive group therapy.** Through active expression, inner-strengths are discovered that can help the member deal with past experiences and cope with present life situations in more beneficial ways. The focus of the group must be directly related to goals and objectives on the individual member's plan of care. Documentation must include how the member is processing emotions/feelings. Expressive therapy must be a planned therapeutic activity, facilitated by staff with a relevant Bachelor's degree and/or staff with relevant training, experience, or certification to facilitate the therapy.

(B) **Group rehabilitative treatment.** Examples of educational and supportive services, which may be covered under the definition of group rehabilitative treatment services, are basic living skills, social skills (re)development, interdependent living, self-care, lifestyle changes and recovery principles. Each service provided under group rehabilitative treatment services must have goals and objectives, directly related to the individual plan of care.

(C) **Individual rehabilitative treatment.** Services will be for the reduction of psychiatric and behavioral impairment and the restoration of functioning consistent with the requirements of independent living and enhanced self-sufficiency. This service includes educational and supportive services regarding independent living, self-care, social skills (re)development, lifestyle changes and recovery principles and practices. Each individual rehabilitative treatment service provided must have goals and objectives

directly related to the individualized plan of care and the member's diagnosis.

(D) **Recreation therapy.** Services will be provided to reduce psychiatric and behavioral impairment as well as to restore, remediate and rehabilitate an individual's level of functioning and independence in life activities. Services will also be provided in such a way as to promote health and wellness as well as reduce or eliminate the activity limitations and restrictions to participation in life situations caused by an illness or disabling condition. Recreational therapy can be provided in an individual or group setting. If the only activities prescribed for the individual are primarily diversional in nature, (i.e. to provide some social or recreational outlet for the individual), it will not be regarded as active treatment. If provided, recreational therapy must be a planned therapeutic activity, facilitated by a Licensed Therapeutic Recreation Specialist.

(E) **Occupational therapy.** Services will be provided to address developmental and/or functional needs related to the performance of self-help skills, adaptive behavioral, and/or sensory, motor and postural development. Services include therapeutic goal-directing activities and/or exercises used to improve mobility and activities of daily living (ADL) functions when such functions have been impaired due to illness or injury. Services must be provided by an occupational therapist appropriately licensed in the state in which they practice.

(F) **Wellness resource skills development.** Services include providing direction and coordinating support activities that promote good physical health. The focus of these activities should include areas such as nutrition, exercise, support with averting or managing physical health concerns like heart disease, diabetes, and cholesterol, and support regarding the effects of medications have on physical health. Services can include support groups, exercise groups, and individual physical wellness plan development, implementation assistance and support.

(3) **Modifications to active treatment.** When a member is too physically ill or their acuity level precludes them from active behavioral health treatment, documentation must demonstrate that alternative clinically appropriate services were provided.

(e) The expectation is that active treatment will occur regularly throughout the treatment week. A treatment week in Acute is based on the number of days of acute service, beginning the day of admission (day 1). Required active treatment components will be based upon the length of stay as described below. A treatment week

in RTC, PRTF and CBT is considered to be a calendar week (i.e. Sunday through Saturday). When a child is admitted to RTC, PRTF or CBT level of care on a day other than Sunday, or discharges on a day other than Saturday, the week will be considered a partial week and services will be required as described below. Active treatment components do not include assessments/evaluations. Active treatment begins the day of admission. Days noted are calendar days.

(1) **Individual treatment provided by the physician.**

(A) In acute, by day two, 1 visit is required. By day 4, 2 visits are required. By day 7, 3 visits are required.

(B) In RTC, PRTF or CBT, one visit during admission week is required. In RTCs, 1 visit during the admission week is required, then once a week thereafter. In PRTFs, one visit during the admission week is required, then once a week thereafter. In CBT, 1 visit is required within 7 days of admission. Individual treatment provided by the physician will never exceed 10 days between sessions in PRTFs, never exceed 7 days in a specialty PRTF and never exceed 30 days in CBTs. ~~These visits do not include the Psychiatric Evaluation or History and Physical unless personally rendered by the physician.~~The completion of a psychiatric evaluation or a combined psychiatric evaluation and a History and Physical (H&P) evaluation may count as the first visit by the physician if the evaluation was personally rendered by the psychiatrist. If the member is admitted on the last day of the admission week, then the member must be seen by a physician within 24 hours of admission time.

(2) **Individual therapy.**

(A) In acute, by day 3, 30 minutes of treatment are required. By day 5, 1 hour of treatment is required. Beginning on day 7, 2 hours of treatment are required each week. This does not include admission assessments/evaluations or Psychosocial Evaluations unless personally (face to face) rendered by the LBHP or licensure candidate.

(B) In residential treatment (including PRTF and CBT), by day 6, 30 minutes of treatment must be documented. Beginning on day 7, 1 hour of treatment is required each week. This does not include admission assessment/ evaluation or Psychosocial Evaluations unless personally (face to face) rendered by the LBHP or licensure candidate.

(3) **Family therapy.**

(A) In acute, by day 6, 30 minutes of treatment must be documented. Beginning on day 7, 1 hour of treatment is required each week. This does not include admission assessments/evaluation or Psychosocial Evaluations unless personally (face to face) rendered by the LBHP or licensure candidate and the assessments/evaluation or Psychosocial

Evaluation has not been used to substitute the initial individual therapy requirement.

(B) In residential treatment (including PRTF and CBT), by day 6, 30 minutes of treatment must be documented. Beginning on day 7, 1 hour of treatment is required each week. This does not include admissions assessment/evaluation or Psychosocial Evaluations unless personally (face to face) rendered by the LBHP or licensure candidate and the assessment/evaluation or Psychosocial Evaluation has not been used to substitute the initial individual therapy requirement.

(f) When an individual is determined to be too ill to participate in treatment, as determined by medical/nursing staff (RN/LPN), documentation must be in the record clearly indicating the reason, limitations, and timeframe for those services to be excused without penalty.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 67. BEHAVIORAL HEALTH CASE MANAGEMENT SERVICES

317:30-5-595. Eligible providers

Services are provided by outpatient behavioral health agencies established for the purpose of providing behavioral health outpatient and case management services.

(1) **Provider agency requirements.** Services are provided by outpatient behavioral health agencies contracted with OHCA that meet the requirements under OAC 317:30-5-240. The agency must demonstrate its capacity to deliver behavioral health case management services in terms of the following items:

(A) OHCA reserves the right to obtain a copy of any accreditation audit and/or site visit reports from the provider and/or the accreditation agency.

(B) Agencies that are eligible to contract with OHCA to provide behavioral health case management services to eligible individuals must be community based.

(C) The agency must be able to demonstrate the ability to develop and maintain appropriate patient records including but not limited to assessments, service plans, and progress notes.

(D) An agency must agree to follow the Oklahoma Department of Mental Health and Substance Abuse Services established behavioral health case management rules found in OAC 450:50.

(E) An agency's behavioral health case management staff must serve the target group on a 24 hour on call basis.

(F) Each site operated by a behavioral health outpatient and case management facility must have a separate provider number, per OAC 317:30-5-240.2.

(2) **Provider Qualifications.** For behavioral health case management services to be compensable by SoonerCare, the provider performing the service must be ~~a~~an LBHP, Licensure Candidate, CADC, or have and maintain a current certification as a Case Manager II (CM II) or Case Manager I (CM I) from the ODMHSAS. The requirements for obtaining these certifications are as follows:

(A) Certified Behavioral Health Case Manager II (CM II) must meet the requirements in (i), (ii) ~~or~~ , (iii) or (iv) below:

(i) Possess a Bachelor's or Master's degree in a behavioral health related field earned from a regionally accredited college or university recognized by the United States Department of Education (USDE) or

a Bachelor's or Master's degree in education; and complete web-based training for behavioral health case management and behavioral health rehabilitation as specified by ODMHSAS; and complete one day of face-to-face behavioral health case management training and two days of face-to-face behavioral health rehabilitation training as specified by ODMHSAS; and pass web-based competency exams in behavioral health case management and behavioral health rehabilitation.

(ii) Possess a current license as a registered nurse in the State of Oklahoma with experience in behavioral health care; complete web-based training for behavioral health case management and behavioral health rehabilitation as specified by ODMHSAS; complete one day of face-to-face behavioral health case management training and two days of face-to-face behavioral health rehabilitation training as specified by ODMHSAS; and pass web-based competency exams for behavioral health case management and behavioral health rehabilitation.

(iii) Possess a Bachelor's or Master's degree in any field earned from a regionally accredited college or university recognized by the USDE and a current certification or Children's Certificate in Psychiatric Rehabilitation from the US Psychiatric Rehabilitation Association (USPRA); complete the behavioral health case management web-based training as specified by ODMHSAS; complete one day of face-to-face behavioral health case management training; and pass web-based competency exams for behavioral health case management. Applicants who have not received a certificate in children's psychiatric rehabilitation from the US Psychiatric Association (USPRA) must also complete the behavioral health rehabilitation web-based training as specified by ODMHSAS.

(iv) Possess a Bachelor's or Master's degree in any field and proof of active progression toward obtaining a clinical licensure Master's or Doctoral degree at a regionally accredited college or university recognized by the USDE~~.~~ and complete web-based training for behavioral health case management and behavioral health rehabilitation as specified by ODMHSAS; complete one day of face-to-face behavioral health case management training and two days of face-to-face behavioral health rehabilitation training as specified by ODMHSAS; and pass web-based competency exams in behavioral health case management and behavioral health rehabilitation.

(B) Certified Behavioral Health Case Manager I meets the requirements in either (i) or (ii), and (iii):

(i) completed 60 college credit hours; or

(ii) has a high school diploma with 36 total months of experience working with persons who have a mental illness and/or substance abuse. Documentation of experience on file with ODMHSAS; and

(iii)Completes two days of ODMHSAS specified behavioral health case management training and passes a web-based competency exam for behavioral health case management.

(C) **Wraparound Facilitator Case Manager.** LBHP, Licensure Candidate, CADC, or meets the qualifications for CM II and has the following:

(i) Successful completion of the ODMHSAS training for wraparound facilitation within six months of employment; and

(ii) Participate in ongoing coaching provided by ODMHSAS and employing agency; and

(iii) Successfully complete wraparound credentialing process within nine months of beginning process; and

(iv) Direct supervision or immediate access and a minimum of one hour weekly clinical consultation with a Qualified Mental Health Professional, as required by ODMHSAS;.

(D) **Intensive Case Manager**. LBHP, Licensure Candidate, CADC or meets the provider qualifications of a Case Manager II and has the following:

(i) A minimum of two years Behavioral Health Case Management experience, crisis diversion experience, and

(ii) must have attended the ODMHSAS six hours Intensive case management training.

(E) All certified case managers must fulfill the continuing education requirements as outlined under OAC 450:50-5-4.

317:30-5-596. Coverage by category

Payment is made for behavioral health case management services as set forth in this Section.

(1) Payment is made for services rendered to SoonerCare members as follows:

(A) **Description of behavioral health case management services**. Services under behavioral health case management are not comparable in amount, duration and scope. The target group for behavioral health case management services are persons under age 21 who are in imminent risk of out-of-home placement for psychiatric or substance abuse reasons or are in out-of-home placement due to

psychiatric or substance abuse reasons and chronically and/or severely mentally ill adults who are institutionalized or are at risk of institutionalization. All behavioral health case management services will be subject to medical necessity criteria.

(i) Behavioral health case management services are provided to assist eligible individuals in gaining access to needed medical, social, educational and other services essential to meeting basic human needs. The behavioral health case manager provides assessment of case management needs, development of a case management care plan, referral, linkage, monitoring and advocacy on behalf of the member to gain access to appropriate community resources. The behavioral health case manager must monitor the progress in gaining access to services and continued appropriate utilization of necessary community resources. Behavioral case management is designed to promote recovery, maintain community tenure, and to assist individuals in accessing services for themselves following the case management guidelines established by ODMHSAS. In order to be compensable, the service must be performed utilizing the Strengths Based model of case management. This model of case management assists individuals in identifying and securing the range of resources, both environmental and personal, needed to live in a normally interdependent way in the community. The focus for the helping process is on strengths, interests, abilities, knowledge and capacities of each person, not on their diagnosis, weakness or deficits. The relationship between the service member and the behavioral health case manager is characterized by mutuality, collaboration, and partnership. Assistive activities are designed to occur primarily in the community, but may take place in the behavioral health case manager's office, if more appropriate. The community based behavioral health case management agency will coordinate with the member and family (if applicable) by phone or face-to-face, to identify immediate needs for return to home/community no more than 72 hours after notification that the member/family requests case management services. For member's discharging from a higher level of care than outpatient, the higher level of care facility is responsible for scheduling an appointment with a case management agency for transition and post discharge services. The case manager will make contact with the member and family (if applicable) for transition from

the higher level of care than outpatient back to the community, within 72 hours of discharge, and then conduct a follow-up appointment/contact within seven days. The case manager will provide linkage/referral to physicians/medication services, counseling services, rehabilitation and/or support services as described in the case management service plan. Case Managers may also provide crisis diversion (unanticipated, unscheduled situation requiring supportive assistance, face-to-face or telephone, to resolve immediate problems before they become overwhelming and severely impair the individual's ability to function or maintain in the community) to assist member(s) from progression to a higher level of care. During the follow-up phase of these referrals or links, the behavioral health case manager will provide aggressive outreach if appointments or contacts are missed within two business days of the missed appointments. Community/home based case management to assess the needs for services will be scheduled as reflected in the case management service plan, but not less than one time per month. The member/parent/guardian has the right to refuse behavioral health case management and cannot be restricted from other services because of a refusal of behavioral health case management services.
(ii) An eligible member/parent/guardian will not be restricted and will have the freedom to choose a behavioral health case management provider as well as providers of other medical care.
(iii) In order to ensure that behavioral health case management services appropriately meet the needs of the member and family and are not duplicated, behavioral health case management activities will be provided in accordance with an individualized plan of care.
(iv) The individual plan of care must include general goals and objectives pertinent to the overall recovery of the member's (and family, if applicable) needs. Progress notes must relate to the individual plan of care and describe the specific activities to be performed. The individual plan of care must be developed with participation by, as well as, reviewed and signed by the member, the parent or guardian (if the member is under 18), the behavioral health case manager, and a Licensed Behavioral Health Professional or Licensure Candidate as defined in OAC ~~317:30-5-240(d).~~317:30-5-240.3(a) and (b).

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

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

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

(III) Face-to-face meetings with treatment or service providers, necessary for the implementation of activities delineated in the individual plan of care.

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

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

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

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

(VIII) Transitioning from institutions to the community. Behavioral Health Case Management is available to individuals transitioning from institutions to the community (except individuals ages 22 to 64 who reside in an institution for mental diseases (IMD) or individuals who are inmates of public institutions). Individuals are considered to be transitioning to the community during the last 30 consecutive days of a covered institutional stay. This time is to distinguish case management services that are not within the scope of the institution's discharge planning activities from case management required for transitioning individuals with complex, chronic, medical needs to the community. Transition services provided while the individual is in the institution are to be claimed as delivered on the day of discharge from the institution.

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

(i) Basic Case Management/Resource Coordination. Resource coordination services are targeted to adults with serious and persistent mental illness and children and adolescents with mental illness or serious emotional disturbance, and their families, who need assistance in accessing, coordination, and monitoring of resources and services. Services are provided to assess an individual's strengths and meet needs in order to achieve stability in the community. Standard managers have ~~with~~ caseloads of 30 - 35 members. Basic case management/resource coordination is limited to 25 units per member per month.

(ii) Intensive Case Management (ICM)/Wraparound Facilitation Case Management (WFCM). Intensive Case Management is targeted to adults with serious and persistent mental illness (including members in PACT programs) and Wraparound Facilitation Case Management is targeted to children with serious mental illness and emotional disorders (including members in a System of Care Network) who are deemed high risk and in need of more intensive CM services. It is designed to ensure access to community agencies, services, and people whose functions are to provide the support, training and assistance required for a stable, safe, and healthy community life, and decreased need for higher levels of care. To produce a high fidelity wraparound process, a facilitator can facilitate between 8 and 10 families. To ensure that these intense needs are met, case manager caseloads are limited between 10-15 caseloads. The ICM shall be a Certified Behavioral Health Case Manager, have a minimum of 2 years Behavioral Health Case Management experience, crisis diversion experience, must have attended the ODMHSAS 6 hours ICM training, and 24 hour availability is required. ICM/WFCM is limited to 54 units per member per month.

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

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

(ii) Managing finances; or

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

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

(v) Counseling, rehabilitative services, psychiatric assessment, or discharge planning; or
(vi) Filling out forms, applications, etc., on behalf of the member when the member is not present; or
(vii) Filling out SoonerCare forms, applications, etc.;
(viii) Mentoring or tutoring;
(ix) Provision of behavioral health case management services to the same family by two separate behavioral health case management agencies;
(x) Non face-to-face time spent preparing the assessment document and the service plan paperwork;
(xi) monitoring financial goals;
(xii) services to nursing home residents;
(xiii) psychotherapeutic or rehabilitative services, psychiatric assessment, or discharge; or
(xix) services to members residing in ICF/IID facilities.

(D) **Excluded Individuals.** The following SoonerCare members are not eligible for behavioral health case management services:
(i) Children/families for whom behavioral health case management services are available through OKDHS/OJA staff without special arrangements with OKDHS, OJA, and OHCA;
(ii) Members receiving Residential Behavior Management Services (RBMS) in a foster care or group home setting unless transitioning into the community;
(iii) Residents of ICF/IID and nursing facilities unless transitioning into the community;
(iv) Members receiving services under a Home and Community Based services (HCBS) waiver program.

(E) Case management services provided to Medicare eligible members should be filed directly with the fiscal agent.

(F) **Documentation requirements.** The service plan must include general goals and objectives pertinent to the overall recovery needs of the member. Progress notes must relate to the service plan and describe the specific activities performed. Behavioral health case management service plan development is compensable time if the time is spent communicating with the participation by, as well as, reviewed and signed by the member, the behavioral health case manager, and a licensed behavioral health professional or licensure candidate as defined at OAC 317:30-5-240.3(a) and (b). All behavioral health case management services rendered must be reflected by documentation in the records. In addition to a complete behavioral health case management service, plan

documentation of each session must include but is not limited to:

(i) date;

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

(iii) start and stop times for each service;

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

(v) credentials of the service provider;

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

(vii) specific activities performed by the behavioral health case manager on behalf of the child related to advocacy, linkage, referral, or monitoring used to address needs, goals and/or objectives;

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

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

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

(xi) member satisfaction with staff intervention.

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

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 35. MEIDCAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME
PART 3. NON-MEDICAL ELIGIBILITY REQUIREMENTS

317:35-5-25. Citizenship/alien status and identity verification requirements

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

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

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

(B) Certificate of Naturalization issued by U.S. Citizenship & Immigration Services (USCIS)(Form N-550 or N-570);

(C) Certificate of Citizenship issued by USCIS (Form N-560 or N-561);

(D) Copy of the Medicare card or printout of a BENDEX or SDX screen showing receipt of Medicare benefits, Supplemental Security Income or disability benefits from the Social Security Administration; or

(E) Tribal membership card or Certificate of Degree of Indian Blood (CDIB) card, with a photograph of the individual.

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

(A) Most reliable forms of citizenship verification are:

(i) A U.S. public Birth Certificate showing birth in one of the 50 states, the District of Columbia, Puerto Rico (on or after 1/13/1941), Guam (on or after 4/10/1899), the U.S. Virgin Islands (on or after 1/17/1917), American Samoa, Swain's Island, or the Northern Mariana Islands after 11/4/1986. For Puerto Ricans whose

eligibility is being determined for the first time on or after October 1, 2010 and using a birth certificate to verify citizenship, the birth certificate must be a certified birth certificate issued by Puerto Rico on or after July 1, 2010;

(ii) A Report of Birth Abroad of a U.S. citizen issued by the Department of Homeland Security or a Certification of birth issued by the State Department (Form FS-240, FS-545 or DS-1350);

(iii) A U.S. Citizen ID Card (Form I-179 or I-197);

(iv) A Northern Mariana Identification Card (Form I-873) (Issued by the INS to a collectively naturalized citizen of the U.S. who was born in the Northern Mariana Islands before 11/3/1986);

(v) An American Indian Card issued by the Department of Homeland Security with the classification code "KIC" (Form I-872);

(vi) A Final Adoption Decree showing the child's name and U. S. place of birth;

(vii) Evidence of U.S. Civil Service employment before 6/1/1976;

(viii) An Official U.S. Military Record of Service showing a U.S. place of birth (for example a DD-214);

(ix) Tribal membership card or Certificate of Degree of Indian Blood (CDIB) card, without a photograph of the individual, for Native Americans;

(x) Oklahoma Voter Registration Card; or

(xi) Other acceptable documentation as approved by OHCA.

(B) Other less reliable forms of citizenship verification are:

(i) An extract of a hospital record on hospital letterhead established at the time of the person's birth that was created five years before the initial application date and that indicates a U.S. place of birth. For children under 16 the evidence must have been created near the time of birth or five years before the date of application;

(ii) Life, health, or other insurance record showing a U.S. place of birth that was created at least five years before the initial application date and that indicates a U.S. place of birth;

(iii) Federal or State census record showing U.S. citizenship or a U.S. place of birth (generally for persons born 1900 through 1950). The census record must also show the applicant's/member's age; or

(iv) One of the following items that show a U.S. place of birth and was created at least five years before the application for SoonerCare. This evidence must be one

of the following and show a U.S. place of birth:

(I) Seneca Indian tribal census record;

(II) Bureau of Indian Affairs tribal census records of the Navajo Indians;

(III) U.S. State Vital Statistics official notification of birth registration;

(IV) An amended U.S. public birth record that is amended more than five years after the person's birth; or

(V) Statement signed by the physician or midwife who was in attendance at the time of birth.

(3) Acceptable evidence of identity that must accompany citizenship evidence listed in (A) and (B) of paragraph (2) of this subsection includes:

(A) A driver's license issued by a U.S. state or territory with either a photograph of the individual or other identifying information such as name, age, sex, race, height, weight, or eye color;

(B) A school identification card with a photograph of the individual;

(C) An identification card issued by Federal, state, or local government with the same information included on driver's licenses;

(D) A U.S. military card or draft record;

(E) A U.S. military dependent's identification card;

(F) A Native American Tribal document including Certificate of Degree of Indian Blood, or other U.S. American Indian/Alaska Native Tribal document with a photograph of the individual or other personal identifying information;

(G) A U.S. Coast Guard Merchant Mariner card;

(H) A state court order placing a child in custody as reported by the OKDHS;

(I) For children under 16, school records may include nursery or daycare records;

(J) If none of the verification items on the list are available, an affidavit may be used for children under 16. An affidavit is only acceptable if it is signed under penalty of perjury by a parent or guardian stating the date and place of the birth of the child and cannot be used if an affidavit for citizenship was provided.

(b) **Reasonable opportunity to obtain citizenship verification.**

(1) When the applicant/member is unable to obtain citizenship or alienage verification, a reasonable opportunity is afforded to the applicant/member to obtain the evidence as well as assistance in doing so. A reasonable opportunity is afforded to the applicant/member before taking action affecting the individual's eligibility for SoonerCare. ~~The reasonable opportunity 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~~The reasonable opportunity timeframe afforded to SoonerCare members is the same as authorized under Section 1902(ee) of the Social Security act and is stated on the documentation request the agency sends to the applicant/member.

(2) The following methods of verification are the least reliable forms of verification and should only be used as a last resort:

(A) Institutional admission papers from a nursing facility, skilled care facility or other institution. Admission papers generally show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth;

(B) Medical (clinic, doctor, or hospital) record created at least five 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 of citizenship does not exist or cannot be readily obtained, the affidavit must contain this information as well;

(v) The State must obtain a separate affidavit from the applicant/member or other knowledgeable individual (guardian or representative) explaining why the evidence does not exist or cannot be obtained; and

(vi) The affidavits must be signed under penalty of perjury.

(c) **Alienage verification requirements.** SoonerCare services are provided as listed to the defined groups as indicated in this subsection if they meet all other factors of eligibility.

(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. All other eligibility requirements must be met to qualify for SoonerCare services. If these individuals do not meet one of the categorical relationships, they may apply and be determined eligible for Refugee Medical Assistance. Afghan special immigrants are considered lawful permanent residents.
(4) **Iraqi Special Immigrants.** Iraqi special immigrants, as defined in Public Law 110-181, who have special immigration status after January 28, 2008, are exempt from the five year period of ineligibility for SoonerCare services. All other eligibility requirements must be met to qualify for SoonerCare services. If these individuals do not meet one of the categorical relationships, they may apply and be determined eligible for Refugee Medical Assistance. Iraqi special immigrants are considered lawful permanent residents.
(5) **Undocumented aliens.** Undocumented aliens who do not meet any of the definitions in (1)-(2) of this subsection are eligible for emergency services only when the individual has a medical condition (including emergency labor and delivery) with acute symptoms which may result in placing his/her health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of body organ or part without immediate medical attention. 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.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 45. INSURE OKLAHOMA
SUBCHAPTER 1. GENERAL PROVISIONS

317:45-1-3. Definitions

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

"Carrier" means:

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

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

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

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

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

"College Student" means an Oklahoma resident between the age of 19 through 22 that is a full-time student at an Oklahoma accredited University or College.

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

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

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

"Employer" means the business entity that pays earned income to employees.

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

"EOB" means an Explanation of Benefits.

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

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

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

~~**"Gross Household Income" or "Annual Gross Household Income"** means the countable income (earned or unearned) that is computed pursuant to OHCA's waiver.~~

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

"In-network" means providers or health care facilities that are part of a health plan's network of providers with which it has negotiated a discount, and services provided by a physician or other health care provider with a contractual agreement with the insurance company paid at the highest benefit level.

"Insure Oklahoma" 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 IP" means the Individual Plan program.

"Insure Oklahoma ESI" means the Employer Sponsored Insurance program.

"Member" means an individual enrolled in the Insure Oklahoma ESI or IP program.

"Modified Adjusted Gross Income (MAGI)" means the financial eligibility determination methodology established by the Patient Protection and Affordable Care Act (PPACA) in 2009.

"OESC" means the Oklahoma Employment Security Commission.

"OHCA" means the Oklahoma Health Care Authority.

"OKDHS" means the Oklahoma Department of Human Services.

"PCP" means Primary Care Provider.

"PEO" or "Professional Employer Organization" 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 with the Oklahoma Health Care Authority to provide primary care services, including all medically necessary referrals.

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

"~~Qualified Health Plan(QHP)~~Qualified Benefit Plan (QHP)" means a health plan that has been approved by the OHCA for participation in the Insure Oklahoma program.

"Qualifying Event" means the occurrence of an event that permits individuals to join a group health 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.

SUBCHAPTER 9. INSURE OKLAHOMA ESI EMPLOYEE ELIGIBILITY

317:45-9-1. Employee eligibility requirements

(a) Employees must complete and submit the OHCA required forms and application to be considered for participation in the program.

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

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

(1) ~~have an annual gross household income at or below 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;~~have countable income at or

below the appropriate standard according to the family size on the Insure Oklahoma ESI Income Guidelines form;

(A) Effective January 1, 2016, financial eligibility for Insure Oklahoma ESI health benefits is determined using the MAGI methodology. Unless questionable, the income of applicants does not require verification. See OAC 317:35-6-39 through OAC 317:35-6-54 for the applicable MAGI rules for determining household composition and countable income.

(B) Income is evaluated on a monthly basis for all individuals included in the case for Insure Oklahoma ESI Health Benefits.

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

(3) be Oklahoma residents;

(4) ~~provide social security number for all household members~~furnish, or show documentation of an application for, a Social Security number at the time of application for Insure Oklahoma ESI health benefits;

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

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

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

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

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

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

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

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

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

(2) the employee is eligible;

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

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

(e) If an employee or their covered dependents are eligible for multiple 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.~~College students may enroll in the Insure Oklahoma ESI program as covered dependents. Effective January 1, 2016, financial eligibility for Insure Oklahoma ESI health benefits for college students is determined using the MAGI methodology. See OAC 317:35-6-39 through OAC 317:35-6-54 for the applicable MAGI rules for determining household composition and countable income.

(g) ~~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.~~Covered dependent children must have countable income at the appropriate standard according to the family size on the Insure Oklahoma ESI Income Limits Guidelines form. Effective January 1, 2016, financial eligibility for Insure Oklahoma ESI health benefits is determined using the MAGI methodology. See OAC 317:35-6-39 through OAC 317:35-6-54 for the applicable MAGI rules for determining household composition and countable income.

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

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

~~(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~~10 days of the change.
(i) When the agency responsible for determining eligibility for the member becomes aware of a change in the member's circumstances, the agency will promptly redetermine eligibility for all household members whose eligibility is affected by the change.

SUBCHAPTER 11. INSURE OKLAHOMA IP
PART 5. INSURE OKLAHOMA IP MEMBER ELIGIBILITY

317:45-11-20. Insure Oklahoma IP eligibility requirements
(a) Oklahoma employed working adults not eligible to participate in an employer's qualified health plan, employees of non-participating employers, self-employed, unemployed seeking work, workers with a disability, and qualified college students may apply for the Individual Plan. Applicants cannot obtain IP coverage if they are eligible for ESI. Applicants, unless a qualified college student, must be engaged in employment as defined under state law, must be considered self-employed as defined under federal and/or state law, or must be considered unemployed as defined under state law.
(b) The eligibility determination will be processed within 30 days from the date the complete application is received. The applicant will be notified ~~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 317:45-11-22~~, at the time they make application~~;
(2) be a US citizen or alien as described in 317:35-5-25;
(3) be an Oklahoma resident;
(4) ~~provide social security numbers for all household members~~furnish, or show documentation of an application for, a Social Security number at the time of application for Insure Oklahoma IP health benefits;
(5) be not currently enrolled in~~, or have an open application for~~ SoonerCare or Medicare;
(6) be age 19 through 64~~ or an emancipated minor~~;
(7) make premium payments by the due date on the invoice;
(8) not have full-time employment with any employer who does not meet the eligible employer guidelines listed in 317:45-7-1(a)(1)-(2);
(9) be not currently covered by a private health insurance policy or plan; and

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

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

(1) ~~have annual gross household income at or below 100 percent of the Federal Poverty Level.~~have countable income at or below the appropriate standard according to the family size on the Insure Oklahoma IP Income Guidelines form.

(A) Effective January 1, 2016, financial eligibility for Insure Oklahoma IP health benefits is determined using the MAGI methodology. Unless questionable, the income of applicants do not require verification. See OAC 317:35-6-39 through OAC 317:35-6-54 for the applicable MAGI rules for determining household composition and countable income.

(B) Income is evaluated on a monthly basis for all individuals included in the case for Insure Oklahoma IP Health Benefits;

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

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

(e) If employed and working for an employer who does not offer a qualified health plan, the applicant must meet the requirements in subsection (c) of this Section and ~~have an annual gross household income at or below 100 percent of the Federal Poverty Level. 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.~~have countable income at or below the appropriate standard according to the family size on the Insure Oklahoma IP Income Guidelines form.

(1) Effective January 1, 2016, financial eligibility for Insure Oklahoma IP health benefits is determined using the MAGI methodology. Unless questionable, the income of applicants does not require verification. See OAC 317:35-6-39 through OAC 317:35-6-54 for the applicable MAGI rules for determining household composition and countable income.

(2) Income is evaluated on a monthly basis for all individuals included in the case for Insure Oklahoma IP Health Benefits.

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

(1) ~~must have an annual gross household income at or below 100 percent of the Federal Poverty Level. 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)~~have countable income at or below the appropriate standard according to the family size on the Insure Oklahoma IP Income Guidelines form.

(A) Effective January 1, 2016, financial eligibility for Insure Oklahoma IP health benefits is determined using the MAGI methodology. Unless questionable, the income of applicants does not require verification. See OAC 317:35-6-39 through OAC 317:35-6-54 for the applicable MAGI rules for determining household composition and countable income.

(B) Income is evaluated on a monthly basis for all individuals included in the case for Insure Oklahoma IP Health Benefits.

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

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

(1) ~~Applicant must have an annual gross household income at or below 100 percent of the Federal Poverty Level. 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~~ Applicants must have countable income at or below the appropriate standard according to the family size on the Insure Oklahoma IP Income Guidelines form.

~~(2) 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.~~

(2) Effective January 1, 2016, financial eligibility for Insure Oklahoma IP health benefits is determined using the MAGI methodology. Unless questionable, the income of applicants does not require verification. See OAC 317:35-6-39

through OAC 317:35-6-54 for the applicable MAGI rules for determining household composition and countable income.
(3) Income is evaluated on a monthly basis for all individuals included in the case for Insure Oklahoma IP Health Benefits.

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

(1) ~~Applicant must have an annual gross household income at or below 100 percent of the Federal Poverty Level based on a family size of one~~Applicants must have countable income at or below the appropriate standard according to the family size on the Insure Oklahoma IP Income Guidelines form.
~~(2) Applicant must verify eligibility by providing a copy of their:~~
~~(A) ticket to work, or~~
~~(B) ticket to work offer letter.~~
(2) Applicants may need to verify eligibility of their enrollment in the Ticket to Work program.
(3) Effective January 1, 2016, financial eligibility for Insure Oklahoma IP health benefits is determined using the MAGI methodology. Unless questionable, the income of applicants does not require verification. See OAC 317:35-6-39 through OAC 317:35-6-54 for the applicable MAGI rules for determining household composition and countable income.
(4) Income is evaluated on a monthly basis for all individuals included in the case for Insure Oklahoma IP Health Benefits.

(i) IP approved individuals must notify the OHCA of any changes, including household status and income, that might impact individual and/or dependent eligibility in the program within ~~30 calendar~~10 days of the change.

(j) When the agency responsible for determining eligibility for the member becomes aware of a change in the member's circumstances, the agency will promptly redetermine eligibility for all household members whose eligibility is affected by the change.

317:45-11-21. Dependent eligibility

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

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

(c) The covered dependent of an applicant approved according to the guidelines listed in 317:45-11-20(h) does not become automatically eligible for Insure Oklahoma IP.
(d) The applicant and the dependents' eligibility are tied together. If the applicant no longer meets the requirements for Insure Oklahoma IP, then the associated covered dependent enrolled under that applicant is also ineligible.
(e) ~~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.~~ College students may enroll in the Insure Oklahoma IP program. Effective January 1, 2016, financial eligibility for Insure Oklahoma IP health benefits for college students is determined using the MAGI methodology. See OAC 317:35-6-39 through OAC 317:35-6-54 for the applicable MAGI rules for determining household composition and countable income.
(f) IP approved individuals must notify the OHCA of any changes, including household status and income, that might impact individual and/or dependent eligibility in the program within ~~30 calendar~~10 days of the change.
(g) When the agency responsible for determining eligibility for the member becomes aware of a change in the covered dependents circumstances, the agency will promptly redetermine eligibility for all household members whose eligibility is affected by the change.

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 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~~thorough medical assessment or problems in the member's understanding of telemedicine, hands-on-assessment and/or in person care must be provided for the member. ~~Quality of health care must be maintained regardless of the mode of delivery.~~Any service delivered using telehealth technology must be appropriate for telemedicine delivery and be of the same quality and otherwise on par with the same service delivered in person. A telemedicine encounter must comply with the Health Information Portability and Accountability Act (HIPAA) ~~and shall include an originating site, distant site, and certified or licensed attendant to present the member at the originating site to the rendering provider located at the distant site~~. For purposes of SoonerCare reimbursement telemedicine is the use of interactive audio, video or other electronic media for the purpose of diagnosis, consultation or treatment that occur in real-time and when the member is actively participating during the transmission. Telemedicine does not include the use of audio only telephone, electronic mail, or facsimile transmission. Transfer of data from one site to another through the use of a camera or similar device that records (stores) an image that is sent (forwarded) via telecommunication to another site for consultation. Asynchronous or "store and forward" applications would not be considered telemedicine but may be utilized to deliver services.

~~(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.~~

~~(c) **Coverage.** SoonerCare coverage for telemedicine technology is limited to consultations, office visits, individual psychotherapy, psychiatric diagnostic interview examinations and testing, behavioral health assessments, behavioral health service plan development, pharmacologic management, and services for medically high risk pregnancies.~~

~~(1) An interactive telecommunications system is required as a condition of coverage.~~

~~(2) Coverage for telemedicine services is limited to members in rural areas or geographic areas where there is a lack of~~

~~medical specialty, psychiatric or behavioral 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, excluding professionals under supervision, are contracted:~~

~~(A) Physicians;~~

~~(B) Advanced Registered Nurse Practitioners;~~

~~(C) Physicians Assistants;~~

~~(D) Genetic Counselors;~~

~~(E) Licensed Behavioral Health Professionals;~~

~~(F) Dieticians; 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, but are not limited to:~~

~~(1) Telephone conversation;~~

~~(2) Electronic mail message;~~

~~(3) Facsimile.;~~

~~(4) Unencrypted, non-HIPAA complaint Internet-based communications;~~

~~(5) Video cell phone interactions;~~

~~(6) Outpatient surgical services;~~

~~(7) Home Health services;~~

~~(8) Well child checkups, and preventive visits;~~

~~(9) Laboratory services;~~

~~(10) Audiologist services;~~

~~(11) Care coordination services; and~~

~~(12) Physical, speech, or occupational therapy services.~~

~~(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)~~(b) **Conditions.** The following conditions apply to all services rendered via telemedicine.

(1) Interactive audio and video telecommunications must be used, permitting encrypted real-time communication between the ~~distant site~~ physician or practitioner and the SoonerCare member. The telecommunication service must be secure and adequate to protect the confidentiality and integrity of the telemedicine information transmitted. As a condition of payment the member must ~~be physically present at the originating site and must~~actively participate in the telemedicine visit. ~~The originating site must provide pertinent medical information and/or records to the distant site provider via a secure HIPAA compliant transmission.~~

~~(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)~~(2) The telemedicine equipment and transmission speed and image 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)~~(3) The medical or behavioral health related service must be provided~~ by a distant site provider that is located at an approved HIPAA compliant site, or site in compliance with HIPAA Security Standards.~~at an appropriate site for the delivery of telemedicine services. ~~A telemedicine approved~~An appropriate telemedicine site is one that has the proper security measures in place~~,~~; the appropriate administrative, physical and technical safeguards should be in place that ensure the confidentiality, integrity, and security of electronic protected health information. ~~The physical environments at both the originating and distant site are clinical environments and the spaces should reflect that.~~ The location of the room for the encounter at both ends should ensure comfort, privacy, and confidentiality. Both visual and audio privacy are important, placement and selection of the rooms should consider this. ~~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.~~Appropriate telemedicine equipment and networks must be used considering factors such as appropriate screen size, resolution, and security. Providers and/or members may provide or receive telemedicine services outside of Oklahoma when medically necessary.

(4) The provider must be contracted with SoonerCare and appropriately licensed for the service to be provided. If the provider is outside of Oklahoma, the provider must comply with all laws and regulations of the provider's location, including health care and telemedicine requirements.

~~(6)~~(5) The health care practitioner must obtain written consent from the SoonerCare member that states ~~they agree~~he or she agrees 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)~~(6) 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)~~(7) The member retains the right to withdraw at any time.

~~(9)~~(8) All telemedicine activities must comply with the HIPAA Security Standards, OHCA policy, and all other applicable state and federal laws and regulations.

~~(10)~~(9) 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)~~(10) There will be no dissemination of any member images or information to other entities without written consent from the member.

~~(g)~~(c) **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)~~(1) 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.~~ ~~Coding and billing the appropriate modifier with a covered telemedicine procedure code, the distant site provider and/or practitioner certifies that the member was present at the originating site when the telemedicine service was furnished.~~

~~(3)~~(2) 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~~can be billed by the provider that provided that service. The professional component of the procedure and the appropriate visit code ~~are billed by the distant site~~should be billed by the provider that rendered that service.

~~(4) Reimbursement for telemedicine services is available only when the originating site is located in a geographic area where there is a lack of medical/psychiatric/behavioral health expertise and the distance from the originating and distant site is greater than 20 miles apart, with few exceptions. The OHCA may make an exception to this requirement based on geographic limitations and service constraints. The OHCA has discretion and the final authority to approve or deny any telemedicine services based on agency and/or SoonerCare members' needs. Services are not reimbursable when provided primarily for the convenience of the provider. Adequate documentation must be maintained as service is subject to post payment review. Post payment review may result in adjustments to payment when a telemedicine modifier is billed inappropriately or not billed when appropriate.~~

~~(5)~~(3) The cost of telemedicine equipment and transmission is not reimbursable by SoonerCare.

~~(h)~~(d) **Documentation.**

(1) Documentation must be maintained ~~at the originating and the distant locations~~ by the rendering provider to substantiate the services ~~provided~~rendered.

(2) Documentation must indicate the services were rendered via telemedicine, and the location of the ~~originating and distant sites, and which OHCA approved network was used~~services.
(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. Contracted networks must complete HIPAA Security Risk and Mobile Device Analysis associated with remote access to, and offsite use of, Electronic Protected Health Information (ePHI). Networks must develop and implement risk management measures to assure the safeguard of ePHI. The OHCA has discretion and the final authority to approve or deny any telemedicine network based on agency and/or SoonerCare members' needs.~~

~~(j) **Telemedicine provider responsibilities.** Providers must adhere to privacy standards for the confidentiality, integrity, and security of ePHI. Privacy standards include but are not limited to the following:~~
~~(1) Complying with Health Insurance Portability and Accountability Act (HIPAA) and security protection for the member in connection with the telemedicine communication and related records.~~
~~(2) Submitting a Mobile Device Security Assessment to the OHCA Provider Enrollment Unit, to assure that SoonerCare members' ePHI will not be compromised. Providers are required to attest to compliance with applicable provisions of HIPAA and submit one of the following:~~
~~(A) A completed OHCA Provider HIPAA Mobile Device Security Assessment form; or~~
~~(B) A copy of the provider's most recent HIPAA Security Assessment, mobile device section only, with any risk compromising wording redacted.~~
~~(3) Obtaining and maintaining technology used in the telemedicine communication that is compliant with privacy and security standards in HIPAA, and OHCA Provider and Network Contracts.~~
~~(4) Ensuring policies and procedures are in place to prevent a breach in privacy or exposure of patient health information or records to unauthorized persons.~~
~~(5) Maintaining clinical documentation.~~

(e) The OHCA has discretion and the final authority to approve or deny any telemedicine services based on agency and/or SoonerCare members' needs.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 3. GENERAL PROVIDER POLICIES
PART 3. GENERAL MEDICAL PROGRAM INFORMATION

317:30-3-64. Payment for lodging and meals

(a) Payment for lodging and/or meals assistance for an eligible member and/or an approved medical escort is provided only when medically necessary in connection with transportation to and from SoonerCare compensable services. The member and/or medical escort must make a reasonable effort to secure lodging at a hospital or non-profit organization. The Oklahoma Health Care Authority (OHCA) has discretion and final authority to approve or deny any lodging and/or meal services.

(1) Lodging and/or meals are reimbursable when prior approved. Payment for lodging and/or meals is limited to a period of up to 24 hours prior to the start of member's medical services and up to 24 hours after the services end. Lodging is approved for the member and/or one approved medical escort. The following factors may be considered by the OHCA when approving reimbursement for a member and/or one medical escort:

(A) travel is to obtain specialty care; and

(B) the trip cannot be completed during SoonerRide operating hours; and/or

(C) the trip is 100 miles or more from the member's residence, as listed in the OHCA system, to the medical facility; and/or

(D) the member's medical treatment requires an overnight stay, or the condition of the member discourages traveling.

(2) When a member is not required to have a PCP or when a PCP referral is not required to obtain a SoonerCare covered service, a member may go to any provider they choose but SoonerCare will not reimburse for transportation, lodging, or meals if the distance is beyond what is considered the nearest appropriate facility.

(3) ~~Meals will be reimbursed only if lodging criteria is met.~~Meals will be reimbursed if lodging criteria is met. Duration of the trip must be 18 hours or greater.

(4) Reimbursement for meals is based on a daily per diem and may be used for breakfast, lunch or dinner, or all three meals, whichever is required.

(5) During inpatient or outpatient medical stays, lodging and/or meals services are reimbursed for a period of up to 14 days without prior approval; stays exceeding the 14 day period must be prior approved. A member may not receive

reimbursement for lodging and/or meals services for days the member is an inpatient in a hospital or medical facility.

(6) For eligible members in the Neonatal Intensive Care Unit (NICU) a minimum visitation of 6 hours per day for the approved medical escort is required for reimbursement of lodging and/or meals services. Non-emergency transportation services for medically necessary visitation may be provided for eligible medical escorts.

(b) Lodging must be with a SoonerCare contracted Room and Board provider, when available, before direct reimbursement to a member and/or medical escort can be approved. If lodging and/or meals assistance with contracted Room and Board providers are not available, the member and/or medical escort may request reimbursement assistance by submitting the appropriate travel reimbursement forms. The travel reimbursement forms may be obtained by contacting SoonerCare Care Management division. Any lodging and/or meal expenses claimed on the travel reimbursement forms must be documented with the required receipts and medical records to document the lodging criteria have been met. Reimbursement must not exceed state per diem amounts. The OHCA has discretion and the final authority to approve or deny lodging and/or meals reimbursement.

(c) Payment for transportation and lodging and/or meals of one medical escort may be approved if the service is required.

(d) If the Oklahoma Department of Human Services (OKDHS) removes a child from his/her home, a court must appoint a temporary guardian. During this time the temporary guardian is eligible for medical escort related lodging and/or meals services. ~~The custodial parent, if under investigation, is not eligible.~~ It is the responsibility of the OHCA to determine this necessity. The decision should be based on the following circumstances:

(1) when the individual's health or disability does not permit traveling alone; and

(2) when the individual seeking medical services is a minor child.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 32. SOONERRIDE NON-EMERGENCY TRANSPORTATION

317:30-5-327. Eligibility for SoonerRide NET

Transportation is provided when medically necessary in connection with examination and treatment to the nearest appropriate facility in accordance with 42 CFR 440.170. As the Medicaid Agency, the Oklahoma Health Care Authority (OHCA) is the payer of last resort, with few exceptions. When other resources are available, those resources must first be utilized. Exceptions to this policy are those receiving medical treatment through Indian Health Services and those eligible for the Crime

Victims Compensation Act. Individuals considered fully dual eligible qualify for SoonerRide. However, SoonerRide excludes those individuals who are categorized as:

(1) Qualified Medicare Beneficiaries(QMB);

(2) Specified Low Income Medicare Beneficiaries (SLMB) only;

(3) Qualifying Individuals-1 and individuals who are in an institution for mental disease (IMD);

(4) inpatient;

(5) institutionalized~~(i.e. long-term care facility)~~;

(6) Home and Community Based Waiver members, with the exception of the In-home Supports Waiver for Children, the Advantage Waiver, the Living Choice demonstration, ~~the Sooner Seniors Waiver, the My Life; My Choice Waiver~~ and the Medically Fragile Waiver.

317:30-5-327.1. SoonerRide NET Coverage

(a) SoonerRide NET is available for SoonerCare covered admission and discharge into inpatient hospital care, outpatient hospital care, services from physicians/approved practitioners, diagnostic services, clinic services, pharmacy services, eye care and dental care under the following conditions:

(1) Transportation is to the nearest appropriate facility or medical provider capable of providing the necessary services.

(A) The nearest appropriate facility or provider is not considered appropriate if the member's condition requires a higher level of care or specialized services available at the more distant facility. However, a legal impediment barring a member's admission would mean that the institution did not have "appropriate facilities". For example, the nearest transplant center may be in another state and that state's law precludes admission of nonresidents.

(B) The nearest appropriate facility is not considered appropriate if no bed or provider is available. However, the medical records must be properly documented.

(C) Services should be available within 45 miles of the members' residence with exceptions. The OHCA has discretion and the final authority to approve or deny travel greater than 45 miles to access services.

(i) Members seeking self-referred services are limited to the 45 mile radius.

(ii) Native Americans seeking services at a tribal or I.H.S facility may be transported to any facility within a 45 mile radius equipped for their medical needs with exceptions. Trips to out-of-state facilities require prior approval.

~~(iii) Veterans may be transported to the nearest Veterans Affairs (VA) facility equipped for their~~

~~medical needs. Trips to out-of-state VA facilities require prior approval.~~

~~(iv)~~(iii) Duals may be transported to any facility within a 45 mile radius equipped for their medical needs with exceptions. Trips to out-of-state facilities require prior approval.

(2) The service provided must be a SoonerCare covered service provided by a medical provider who is enrolled in the SoonerCare program; and

(3) Services requiring prior authorization must have been authorized (e.g. travel that exceeds the 45 mile radius, out-of-state travel, meals and lodging services).

(b) SoonerRide NET is available on a statewide basis to all eligible members.

(c) SoonerRide NET may also be provided for eligible members to providers other than SoonerCare providers if the transportation is to access medically necessary services covered by SoonerCare.

(d) SoonerRide NET is available if a member is being discharged from a facility to their home. The facility is responsible for scheduling the transportation.

(e) In documented medically necessary instances, a medical escort may accompany the member.

(1) SoonerRide NET is not required to transport any additional individuals other than the one approved individual providing the escort services. In the event that additional individuals request transportation, the SoonerRide broker may charge those family members according to the SoonerRide broker's policies which have been approved by the OHCA.

(2) A medical escort is not eligible for direct compensation by the SoonerRide broker or SoonerCare.

317:30-5-327.3. Coverage for residents of nursing facilities

(a) An attendant must accompany members during SoonerRide Non-Emergency Transportation (NET). An attendant must be at least at the level of a nurse's aide, and must have the appropriate training necessary to provide any and all assistance to the member, including physical assistance needed to seat the member in the vehicle. The attendant must have the ability to interface with health care providers as appropriate. An attendant must be of an age of legal majority recognized under State law.

(1) The nursing facility must provide an attendant to accompany members receiving NET services.

(2) The attendant will be responsible for any care needed by the member(s) during transport and any assistance needed by the member(s) to assure the safety of all passengers and the driver of the vehicle. An attendant leaves the vehicle at its destination and remains with the member(s).

(3) When multiple members residing in the same nursing facility are being transported to the same provider for health care services, the nursing facility may provide one qualified attendant for each three members unless other circumstances indicate the need for additional attendants. Such circumstances might include but are not limited to:

(A) the physical and/or mental status of the member(s),

(B) difficulty in getting the member(s) in and out of the vehicle,

(C) the amount of time that a member(s) would have to wait unattended, etc.

(4) SoonerRide is not responsible for arranging for an attendant. The services of the attendant are not directly reimbursable by the SoonerRide program or SoonerCare. The cost for the attendant is included in the SoonerCare nursing facility per diem rate.

(5) In certain instances, a family member or legal guardian may wish to accompany the member for health care services. In such instances, the family member or legal guardian may accompany the member in place of the attendant. Only one escort may accompany a member. The escort must be able to provide any services and assistance necessary to assure the safety of the member in the vehicle.

(A) When an escort wishes to accompany the member in place of an attendant provided by the nursing facility, the escort and the nursing facility must sign a release form stating that an escort will be traveling with the member and performing the services which would normally be performed by the attendant. This release must be faxed to the SoonerRide broker's business office prior to the date of the transport.

(B) If an escort is used in place of an attendant provided by the nursing facility, that escort cannot be counted as an escort for any other member who is traveling in the same vehicle.

(C) SoonerRide is not required to transport any additional family members other than the one family member providing escort services. In the event that additional family members request transportation, the SoonerRide broker may charge those family members according to the SoonerRide broker's policies approved by the OHCA.

(D) An escort is not eligible for direct compensation by the SoonerRide broker or SoonerCare.

(b) For members who require non-emergency transportation for dialysis, one attendant is required to accompany a group of up to three dialysis patients when they are being transported for dialysis services. The attendant must remain with the patient(s) unless the provider of the dialysis treatment and the

nursing facility sign a release form stating that the presence of the attendant is not necessary during the dialysis treatment. The release must be faxed to the SoonerRide broker's business office prior to the date of the dialysis service.

(1) In instances when an attendant does not remain with the member(s) during dialysis treatment, SoonerRide is not responsible for transporting the attendant back to the nursing facility.

(2) In instances when an attendant does not remain with the member(s) during dialysis treatment, the nursing facility is responsible for providing an attendant to accompany the member(s) on the return trip from the dialysis center. The nursing facility is also responsible for transporting that attendant to the dialysis center in order to accompany the member(s) on the return trip.

(c) In the event that a member is voluntarily moving from one nursing facility to another, SoonerRide will provide NET to the new facility. The nursing facility that the member is moving from will be responsible for scheduling the transportation and providing an attendant for the member.

(d) In the event that a nursing facility's license is terminated, SoonerRide will provide NET to a new nursing facility. The nursing facility that the member is moving from will be responsible for scheduling the NET through SoonerRide and providing an attendant to accompany the member.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
SUBCHAPTER 3. COVERAGE AND EXCLUSIONS

317:35-3-2. SoonerCare transportation and subsistence

(a) The Oklahoma Health Care Authority (OHCA) is responsible for assuring that necessary transportation is available to all eligible SoonerCare members who are in need of SoonerCare medical services in accordance with 42 CFR 431.53. The agency contracts with a broker to provide statewide curb to curb coverage for non-emergency transportation under the SoonerRide program. The broker provides the most appropriate and least costly mode of transportation necessary to meet the individual needs of SoonerCare members. As the Medicaid Agency, OHCA is the payer of last resort, with few exceptions. When other resources are available, those resources must first be utilized. Exceptions to this policy are those receiving medical treatment through Indian Health Services and those eligible for the Crime Victims Compensation Act. The agency contracts directly with ambulance and air providers for all other transportation needs for eligible members not provided by SoonerRide. SoonerRide excludes those individuals who are categorized as:

(1) Qualified Medicare Beneficiaries(QMB)when SoonerCare pays only the Medicare premium, deductible, and co-pay;
(2) Specified Low Income Medicare Beneficiaries (SLMB)only;
(3) Qualifying Individuals-1;
(4) individuals who are in an institution for mental disease (IMD);
(5) inpatient;
(6) institutionalized~~(i.e. long-term care facility)~~;
(7) Home and Community Based Waiver members with the exception of the In-home Supports Waiver for Children, the ADvantage Waiver, the Living Choice demonstration, ~~the Sooner Seniors Waiver, the My Life; My Choice Waiver~~ and the Medically Fragile Waiver.

(b) Members seeking medically necessary non-emergency transportation will be required to contact the SoonerRide reservation center. Contact will be made via a toll-free phone number which is answered Monday through Saturday, 8 a.m. to 6 p.m. Whenever possible, the member is required to notify SoonerRide at least 72 hours prior to the appointment. The member is asked to furnish the SoonerRide reservation center their SoonerCare member number, home address, the time and date of the medical appointment, the address and phone number of the medical provider, and any physical/mental limitations which will impact the type of transportation needed. SoonerRide makes arrangements for the most appropriate, least costly

transportation. SoonerRide verifies appointments when appropriate. If the member disagrees with the transportation arranged or denied by SoonerRide, an appeal must be filed with OHCA according to OAC 317:2-1-2. The appropriateness of transportation may be appealed only to the extent that the transportation does not meet the medical needs of the member. Dissatisfaction with the use of public transportation, shared rides, type of vehicle, etc., is not appropriate grounds for appeal. The Oklahoma Health Care Authority's decision is final.

(1) **Authorization for transportation by private vehicle or bus.** Transportation by private vehicle or bus is administered through the broker when it is necessary for an eligible member to receive medical services.

(2) **Authorization for transportation by taxi.** Taxi service may be authorized at the discretion of the broker.

(3) **Transportation by ambulance (ground, air ambulance or helicopter).** Transportation by ambulance is compensable for individuals eligible for SoonerCare benefits when other available transportation does not meet the medical needs of the individual. Payment is made for ambulance transportation to and/or from a medical facility for medical care compensable under SoonerCare.

(4) **Transportation by airplane.** When an individual's medical condition is such that transportation out-of-state by a commercial airline is required, approval for airfare must be secured by telephoning the OHCA who will make the necessary flight arrangements.

(5) **Subsistence (lodging and meals).** Payment for lodging and/or meals assistance for an eligible member and/or an approved medical escort is provided only when medically necessary in connection with transportation to and from SoonerCare compensable services. The member and/or medical escort must make a reasonable effort to secure lodging at a hospital or non-profit organization. The Oklahoma Health Care Authority (OHCA) has discretion and final authority to approve or deny any lodging and/or meal services.

(A) Lodging and/or meals are reimbursable when prior approved. Payment for lodging and/or meals is limited to a period of up to 24 hours prior to the start of the member's medical services and up to 24 hours after the services end. Lodging is approved for the member and/or one approved medical escort. The following factors may be considered by OHCA when approving reimbursement for a member and/or one medical escort:

(i) travel is to obtain specialty care; and

(ii) the trip cannot be completed during SoonerRide operating hours;

(iii) the trip is 100 miles or more from the member's

residence, as listed in the OHCA system, to the medical facility; and/or

(iv) the member's medical treatment requires an overnight stay, or the condition of the member discourages traveling.

(B) When a member is not required to have a PCP or when a PCP referral is not required to obtain a SoonerCare covered service, a member may go to any provider they choose but SoonerCare will not reimburse for transportation, lodging, or meals if the distance is beyond what is considered the nearest appropriate facility.

(C) ~~Meals will be reimbursed only if an overnight stay occurs and the stay meets the lodging criteria is met.~~Meals will be reimbursed if lodging criteria is met, and duration of trip is or exceeds 18 hours.

(D) Reimbursement for meals is based on a daily per diem and may be used for breakfast, lunch or dinner, or all three meals, whichever is required.

(E) During inpatient or outpatient medical stays, lodging and/or meals services are reimbursed for a period of up to 14 days without prior approval; stays exceeding the 14 day period must be prior approved. A member may not receive reimbursement for lodging and/or meals services for days the member is an inpatient in a hospital or medical facility.

(F) For eligible members in the Neonatal Intensive Care Unit (NICU) a minimum visitation of 6 hours per day for the medical escort is required for reimbursement of lodging and/or meals services. Non-emergency transportation services for medically necessary visitation may be provided for eligible medical escorts.

(G) Lodging must be with a SoonerCare contracted Room and Board provider, when available, before direct reimbursement to a member and/or medical escort can be approved. If the lodging provider provides meals the member and/or medical escort is not eligible for separate reimbursement and may not seek assistance for meals obtained outside of the contracted Room and Board provider facility. If lodging and/or meal assistance with contracted Room and Board providers is not available, the member and/or medical escort may request reimbursement assistance by submitting the appropriate travel reimbursement forms. The travel reimbursement forms may be obtained by contacting SoonerCare Care Management division. Any lodging and/or meal expenses claimed on the travel reimbursement forms must be documented with the required receipts and medical records to document the

lodging and/or meals criteria have been met. Reimbursement will not exceed established state per diem amounts. The OHCA has discretion and the final authority to approve or deny lodging and/or meals reimbursement.

(6) **Escort assistance required.** Payment for transportation and lodging and/or meals of one medical escort may be approved if the service is required. If the Oklahoma Department of Human Services (OKDHS) removes a child from his/her home, a court must appoint a temporary guardian. During this time the temporary guardian is eligible for escort related lodging and/or meals services. ~~The custodial parent, if under investigation, is not eligible.~~ It is the responsibility of the OHCA to determine this necessity. The decision should be based on the following circumstances:

(A) when the individual's health or disability does not permit traveling alone; and

(B) when the individual seeking medical services is a minor child.

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

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

All providers must comply with the requirements as set forth in this Section.

(1) **Screening.**

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

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

(C) **Target population and limitations.** ~~This service is compensable only on behalf of a member who is under a PACT program.~~Screening is compensable on behalf of a member who is seeking services for the first time from the contracted agency. This service is not compensable if the member has previously received or is currently receiving services from the agency, unless there has been a gap in service of more than six months. To qualify for reimbursement, the screening tools used must be evidence based or otherwise approved by OHCA and ODMHSAS and appropriate for the age and/or developmental stage of the member.

(2) **Assessment.**

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

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

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

(D) **Target population and limitations.** The Behavioral Health Assessment by a Non-Physician, moderate complexity, is compensable on behalf of a member who is seeking

services for the first time from the contracted agency. This service is not compensable if the member has previously received or is currently receiving services from the agency, unless there has been a gap in service of more than six months and it has been more than one year since the previous assessment.

(E) **Documentation requirements.** The assessment must include all elements and tools required by the OHCA. In the case of children under the age of 18, it is performed with the direct, active face-to-face participation of the parent or guardian. The child's level of participation is based on age, developmental and clinical appropriateness. The assessment must include at least one DSM diagnosis from the most recent DSM edition. The assessment must contain but is not limited to the following:

- (i) Date, to include month, day and year of the assessment session(s);
- (ii) Source of information;
- (iii) Member's first name, middle initial and last name;
- (iv) Gender;
- (v) Birth Date;
- (vi) Home address;
- (vii) Telephone number;
- (viii) Referral source;
- (ix) Reason for referral;
- (x) Person to be notified in case of emergency;
- (xi) Presenting reason for seeking services;
- (xii) Start and stop time for each unit billed;
- (xiii) Signature of parent ~~of~~or guardian participating in face-to-face assessment. Signature required for members over the age of 14;
- (xiv) Bio-Psychosocial information which must include:
  - (I) Identification of the member's strengths, needs, abilities and preferences;
  - (II) History of the presenting problem;
  - (III) Previous psychiatric treatment history, include treatment for psychiatric; substance abuse; drug and alcohol addiction; and other addictions;
  - (IV) Health history and current biomedical conditions and complications;
  - (V) Alcohol, Drug, and/or other addictions history;
  - (VI) Trauma, abuse, neglect, violence, and/or sexual assault history of self and/or others, include Department of Human Services involvement;

(VII) Family and social history, include MH, SA, Addictions, Trauma/Abuse/Neglect;
(VIII) Educational attainment, difficulties and history;
(IX) Cultural and religious orientation;
(X) Vocational, occupational and military history;
(XI) Sexual history, including HIV, AIDS, and STD at-risk behaviors;
(XII) Marital or significant other relationship history;
(XIII) Recreation and leisure history;
(XIV) Legal or criminal record, including the identification of key contacts, (e.g., attorneys, probation officers, etc.);
(XV) Present living arrangements;
(XVI) Economic resources;
(XVII) Current support system including peer and other recovery supports.

(xv) Mental status and Level of Functioning information, including questions regarding:
(I) Physical presentation, such as general appearance, motor activity, attention and alertness, etc.;
(II) Affective process, such as mood, affect, manner and attitude, etc.;
(III) Cognitive process, such as intellectual ability, social-adaptive behavior, thought processes, thought content, and memory, etc.; and
(IV) Full DSM diagnosis.

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

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

(xviii) Signature and credentials of ~~LBHP~~the practitioner who performed the face-to-face behavioral assessment;

(xix) Client Data Core Elements reported into designated OHCA representative.

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

(A) **Definition.** The Behavioral Health Service Plan is developed based on information obtained in the assessment

and includes the evaluation of all pertinent information by the practitioners and the member. It includes a discharge plan. It is a process whereby an individualized plan is developed that addresses the member's strengths, functional assets, weaknesses or liabilities, treatment goals, objectives and methodologies that are specific and time limited, and defines the services to be performed by the practitioners and others who comprise the treatment team. Behavioral Health Service Plan Development is performed with the direct active participation of the member and a member support person or advocate if requested by the member. In the case of children under the age of 18, it is performed with the participation of the parent or guardian and the child as age and developmentally appropriate, and must address school and educational concerns and assisting the family in caring for the child in the least restrictive level of care. For adults, it is focused on recovery and achieving maximum community interaction and involvement including goals for employment, independent living, volunteer work, or training. A Service Plan Development, Low Complexity is required every 6 months and must include an update to the bio-psychosocial assessment and re-evaluation of diagnosis.

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

(C) **Time requirements**. Service Plan updates must be conducted face-to-face and are required every six months during active treatment. Updates can be conducted whenever it is clinically needed as determined by the ~~LBHP~~qualified practitioner and member.

(D) **Documentation requirements**. Comprehensive and integrated service plan content must address the following:

(i) member strengths, needs, abilities, and preferences(SNAP);

(ii) identified presenting challenges, problems, needs and diagnosis;

(iii) specific goals for the member;

(iv) objectives that are specific, attainable, realistic, and time-limited;

(v) each type of service and estimated frequency to be received;

(vi) the practitioner(s) name and credentials that will be providing and responsible for each service;

(vii) any needed referrals for service;
(viii) specific discharge criteria;
(ix) description of the member's involvement in, and responses to, the service plan, and his/her signature and date;
(x) service plans are not valid until all signatures are present (signatures are required from the member, ~~(~~if 14 or over), the parent/guardian (if younger than 18 or otherwise applicable), and the primary LBHP or Licensure Candidate; and
(xi) all changes in service plan must be documented in a service plan update (low complexity) or within the service plan until time for the update (low complexity). Any changes to the existing service plan must be signed and dated by the member (if 14 or over), the parent/guardian (if younger than 18 or otherwise applicable), and the lead LBHP or Licensure Candidate.
(xii) Updates to goals, objectives, service provider, services, and service frequency, must be documented within the service plan until the six month review/update is due.
(xiii) Service plan updates must address the following:

(I) update to the bio-psychosocial assessment, re-evaluation of diagnosis service plan goals and/ or objectives;
(II) progress, or lack of, on previous service plan goals and/or objectives;
(III) a statement documenting a review of the current service plan and an explanation if no changes are to be made to the service plan;
(IV) change in goals and/or objectives (including target dates) based upon member's progress or identification of new need, challenges and problems;
(V) change in frequency and/or type of services provided;
(VI) change in practitioner(s) who will be responsible for providing services on the plan;
(VII) change in discharge criteria;
(VIII) description of the member's involvement in, and responses to, the service plan, and his/her signature and date; and
(IX) service plans are not valid until all signatures are present. The required signatures are: from the member (if 14 or over), the parent/guardian (if younger than 18 or otherwise applicable), and

the primary LBHP or Licensure Candidate.

(E) **Service limitations:**

(i) Behavioral Health Service Plan Development, Moderate complexity (i.e., pre-admission procedure code group) are limited to 1 per member, per provider, unless more than a year has passed between services, then another one can be requested and may be authorized by OHCA or its designated agent.

(ii) Behavioral Health Service Plan Development, Low Complexity: Service Plan updates are required every six months during active treatment. Updates can be conducted whenever needed as determined by the provider and member. The date of service is when the service plan is complete and the date the last required signature is obtained. Services should always be age, developmentally, and clinically appropriate.

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

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

(B) **Qualified ~~professionals~~practitioners.** Assessment/Evaluation testing will be provided by a psychologist, certified psychometrist, psychological technician of a psychologist ~~or a LBHP.~~, an LBHP or Licensure Candidate. For assessments conducted in a school setting, the Oklahoma State Department of Education requires that a licensed supervisor sign the assessment. Each qualified professional must have a current contract with the Oklahoma Health Care Authority.

(C) **Documentation requirements.** All psychological services must be reflected by documentation in the member's record. All assessment, testing, and treatment services/units billed must include the following:

(i) date;

(ii) start and stop time for each session/unit billed and physical location where service was provided;

(iii) signature of the provider;

(iv) credentials of provider;

(v) specific problem(s), goals and/or objectives addressed;

(vi) methods used to address problem(s), goals and objectives;

(vii) progress made toward goals and objectives;
(viii) patient response to the session or intervention; and
(ix) any new problem(s), goals and/or objectives identified during the session.

(D) **Service Limitations**. Testing for a child younger than three must be medically necessary and meet established Child (0-36 months of Age) criteria as set forth in the Behavioral Health Provider Manual. Evaluation and testing is clinically appropriate and allowable when an accurate diagnosis and determination of treatment needs is needed. Eight hours/units of testing per patient over the age of ~~two~~<u>three</u>, per provider is allowed every 12 months. There may be instances when further testing is appropriate based on established medical necessity criteria found in the Behavioral Health Provider Manual. Justification for additional testing beyond allowed amount as specified in this section must be clearly explained and documented in the medical record. Testing units must be billed on the date the actual testing, interpretation, scoring, and reporting are performed. A maximum of 12 hours of therapy and testing, per day per rendering provider are allowed. A child who is being treated in an acute inpatient setting can receive separate psychological services by a physician or psychologist as the inpatient per diem is for "non-physician" services only. A child receiving Residential level treatment in either a therapeutic foster care home, or group home may not receive additional individual, group or family counseling or psychological testing unless allowed by the OHCA or its designated agent. Psychologists employed in State and Federal Agencies, who are not permitted to engage in private practice, cannot be reimbursed for services as an individually contracted provider. For assessment conducted in a school setting the Oklahoma State Department of Education requires that a licensed supervisor sign the assessment. Individuals who qualify for Part B of Medicare: Payment is made utilizing the SoonerCare allowable for comparable services. Payment is made to physicians, LBHPs or psychologists with a license to practice in the state where the services is performed or to practitioners who have completed education requirements and are under current board approved supervision to become licensed.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 6. INPATIENT PSYCHIATRIC HOSPITALS

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

An interdisciplinary team of a physician, ~~mental~~licensed behavioral health professional(s) (LBHP), registered nurse, and other staff who provide services to adult members age 21 to 64 in the facility oversee all components of the active treatment and provide services appropriate to their respective discipline. The team developing the individual plan of care must include, at a minimum, the following:

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

(2) ~~a mental health professional~~An LBHP licensed to practice by one of the ~~following~~ boards in (A) through (F):

(A) Psychology (health service specialty only);

(B) Social Work (clinical specialty only);

(C) Licensed Professional Counselor;

(D) Licensed Behavioral Practitioner;

(E) Licensed Marital and Family Therapist;

(F) Licensed Alcohol and Drug Counselor; or

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

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

~~(3)~~(4) a registered nurse with a minimum of two years of experience in a mental health treatment setting.

317:30-5-95.19. Therapeutic services for persons over 65 years of age receiving inpatient acute psychiatric services

An interdisciplinary team of a physician, licensed behavioral health professional(s) (LBHP)~~LBHPs~~, registered nurse, and other staff who provide services to members over 65 years of age who are receiving inpatient acute psychiatric services in the facility oversee all components of the active treatment and provide services appropriate to their respective discipline.

The team developing the individual plan of care must include, at a minimum, the following:

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

(2) ~~a~~an LBHP licensed to practice by one of the ~~following~~ boards in (A) through (F):

(A) Psychology (health service specialty only);

(B) Social Work (clinical specialty only);

(C) Licensed Professional Counselor;

(D) Licensed Behavioral Practitioner;

(E) Licensed Marital and Family Therapist;

(F) Licensed Alcohol and Drug Counselor; or

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

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

~~(3)~~(4) a registered nurse with a minimum of two years of experience in a mental health treatment setting.

317:30-5-95.36. Treatment team for inpatient children's services

An interdisciplinary team of a physician, ~~mental health professionals,~~licensed behavioral health professionals, registered nurse, member, parent/legal guardian for members under the age of 18, and other personnel who provide services to members in the facility must develop the individual plan of care, oversee all components of the active treatment and provide the services appropriate to their respective discipline. Based on education and experience, preferably including competence in child psychiatry, the teams must be:

(1) capable of assessing the member's immediate and long range therapeutic needs, developmental priorities and personal strengths and liabilities;

(2) capable of assessing the potential resources of the member's family, and actively involving the family of members under the age of 18 in the ongoing plan of care;

(3) capable of setting treatment objectives;

(4) capable of prescribing therapeutic modalities to achieve the plan objectives;

(5) capable of developing appropriate discharge criteria and plans; and

(6) trained in a recognized behavioral/management intervention program such as MANDT System, Controlling Aggressive Patient Environment (CAPE), SATORI, Professional Assault Crisis Training (PRO-ACT), or a trauma informed methodology with the utmost focus on the minimization of seclusion and restraints.

317:30-5-95.39. Seclusion, restraint, and serious incident reporting requirements for children

(a) Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the member, a staff member or others from harm and may only be imposed to ensure the immediate physical safety of the member, a staff member or others. The use of restraint or seclusion must be in accordance with a written modification to the member's individual plan of care. The type or technique of restraint or seclusion used must be the least restrictive intervention that will be effective to protect the member or others from harm. Restraint or seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order. Mechanical restraints will not be used on children under age 18.

(1) Each facility must have policies and procedure to describe the conditions, in which seclusion and restraint would be utilized, the behavioral/management intervention program followed by the facility and the documentation required. Each order by a physician or Licensed Independent Practitioner (LIP) may authorize the RN to continue or terminate the restraint or seclusion based on the member's face to face evaluation. Each order for restraint or seclusion may only be renewed in accordance with the following limits for up to a total of 24 hours:

(A) four hours for children 18 to 20 years of age;

(B) two hours for children and adolescents nine to 17 years of age; or

(C) one hour for children under nine years of age.

(2) The documentation required to ensure that seclusion and restraint was appropriately implemented and monitored will include at a minimum:

(A) documentation of events leading to intervention used to manage the violent or self-destructive behaviors that jeopardize the immediate physical safety of the member or others;

(B) documentation of alternatives or less restrictive interventions attempted;

(C) an order for seclusion/restraint including the name of the LIP, date and time of order;

(D) orders for the use of seclusion/restraint must never be written as a standing order or on an as needed basis;

(E) documentation that the member continually was monitored face to face by an assigned, trained staff member, or continually monitored by trained staff using both video and audio equipment during the seclusion/restraint;

(F) the results of a face to face assessment completed within one hour by a LIP or RN who has been trained in accordance with the requirements specified at OAC 317:30-5-95.35 to include the:

(i) member's immediate situation;

(ii) member's reaction to intervention;

(iii) member's medical and behavioral conditions; and

(iv) need to continue or terminate the restraint or seclusion.

(G) in events the face to face was completed by a trained RN, documentation that the trained RN consulted the attending physician or other LIP responsible for the care of the member as soon as possible after the completion of the one-hour face to face evaluation;

(H) debriefing of the child within 24 hours by ~~a~~an LBHP or licensure candidate;

(I) debriefing of staff within 48 hours; and

(J) notification of the parent/guardian.

(b) Staff must be trained and able to demonstrate competency in the application of restraints, implementation of seclusion, monitoring, assessment, and providing care for a member in restraint or seclusion before performing any of these actions and subsequently on an annual basis. The PRTF must require appropriate staff to have education, training, and demonstrated knowledge based on the specific needs of the member population in at least the following:

(1) techniques to identify staff and member behaviors, events, and environmental factors that may trigger circumstances that require the use of restraint or seclusion;

(2) the use of nonphysical intervention skills;

(3) choosing the least restrictive intervention based on an individualized assessment of the member's medical behavior status or condition;

(4) the safe application and use of all types of restraint or seclusion used in the PRTF, including training in how to recognize and respond to signs of physical and psychological distress;

(5) clinical identification of specific behavioral changes

that indicate that restraint or seclusion is no longer necessary;

(6) monitoring the physical and psychological well-being of the member who is restrained or secluded, including but not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by the policy of the PRTF associated with the one hour face to face evaluation; and

(7) the use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including annual re-certification.

(c) Individuals providing staff training must be qualified as evidence by education, training and experience in techniques used to address members' behaviors. The PRTF must document in staff personnel records that the training and demonstration of competency were successfully completed.

(d) The process by which a facility is required to inform the OHCA of a death, serious injury, or suicide attempt is as follows:

(1) The hospital administrator, executive director, or designee is required to contact the OHCA Behavioral Health Unit by phone no later than 5:00 p.m. on the business day following the incident.

(2) Information regarding the SoonerCare member involved, the basic facts of the incident, and follow-up to date must be reported. The agency will be asked to supply, at a minimum, follow-up information with regard to member outcome, staff debriefing and programmatic changes implemented (if applicable).

(3) Within three days, the OHCA Behavioral Health Unit must receive the above information in writing (example: Facility Critical Incident Report).

(4) Member death must be reported to the OHCA Behavioral Health Services Unit as well as to the Centers for Medicare and Medicaid Regional office in Dallas, Texas.

(5) Compliance with seclusion and restraint reporting requirements will be verified during the onsite inspection of care see OAC 317:30-5-95.42, or using other methodologies.

317:30-5-95.41. Documentation of records for children's inpatient services

(a) All documentation for services provided under active treatment must be documented in an individual note and reflect the content of each session provided. Individual, Family, Process Group, Expressive Group, Individual Rehabilitative and Group Rehabilitative Services documentation must include, at a minimum, the following:

(1) date;
(2) start and stop time for each session;
(3) dated signature of the therapist and/or staff that provided the service;
(4) credentials of the therapist;
(5) specific problem(s) addressed (problems must be identified on the plan of care);
(6) method(s) used to address problems;
(7) progress made towards goals;
(8) member's response to the session or intervention; and
(9) any new problem(s) identified during the session.

(b) Signatures of the member, parent/guardian for members under the age of 18, doctor, Licensed Behavioral Health Professional (LBHP), and RN are required on the individual plan of care and all plan of care reviews. The individual plan of care and plan of care review are not valid until signed and separately dated by the member, parent/legal guardian for members under the age of 18, doctor, RN, LBHP, and all other requirements are met. All treatment team staff providing individual therapy, family therapy and process group therapy must sign the individual plan of care and all plan of care reviews.

PART 21. OUTPATIENT BEHAVIORAL HEALTH AGENCY SERVICES

317:30-5-240.2. Provider participation standards

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

(1) Private, Community-based Organizations must be accredited as a provider of outpatient behavioral health services from one of the accrediting bodies and be an incorporated organization governed by a board of directors or be certified by the certifying agency in accordance with Section(s) 3-317, 3-323A, 3-306.1, or 3-415 of Title 43A of the Oklahoma Statutes;
(2) State-operated programs under the direction of ODMHSAS must be accredited by one of the accrediting bodies or be certified by the certifying agency in accordance with Section(s) 3-317, 3-323A, 3-306.1 or 3-415 of Title 43A of the Oklahoma Statues;
(3) Freestanding Psychiatric Hospitals must be licensed and certified by the State Survey Agency as meeting Medicare psychiatric hospital standards and JCAHO accreditation;
(4) General Medical Surgical Hospitals must be appropriately licensed and certified by the State Survey Agency as meeting Medicare standards, including a JCAHO or AOA accreditation;

(5) Federally Qualified Health Centers/Community Health Centers facilities that qualify under OAC 317:30-5-660;
(6) Indian Health Services/Tribal Clinics/Urban Tribal Clinics facilities that qualify under Federal regulation;
(7) Rural Health Clinics facilities that qualify under OAC 317:30-5-355;
(8) Public Health Clinics and County Health Departments;
(9) Public School Systems.

(b) **Certifications.** In addition to the accreditation in paragraph (a) above or ODMHSAS certification in accordance with Section(s) 3-317, 3-323A, 3-306.1 or 3-415 of Title 43A of the Oklahoma Statutes, provider specific credentials are required for the following:

(1) Substance Abuse agencies (OAC 450:18-1-1);
(2) Evidence Based Best Practices but not limited to:
(A) Assertive Community Treatment (OAC 450:55-1-1);
(B) Multi-Systemic Therapy (Office of Juvenile Affairs); and
(C) Peer Support/Community Recovery Support;
(3) Systems of Care (OAC 340:75-16-46);
(4) Mobile and Facility-based Crisis Intervention (OAC 450:23-1-1);
(5) Case Management (OAC 450:50-1-1);
(6) RBMS in group homes (OAC 377:10-7) or therapeutic foster care settings (OAC 340:75-8-4);
(7) Day Treatment - CARF, JCAHO, or COA ~~will be required as of December 31, 2009~~for Day Treatment Services; and
(8) Partial Hospitalization/Intensive Outpatient CARF, JCAHO, or COA ~~will be required as of December 31, 2009~~for Partial Hospitalization services.

(c) **Provider enrollment and contracting.**

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

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

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

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

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

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

(A) One of the LBHPs;

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

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

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

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

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

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

(A) Assessments and Service Plans;

(B) Psychotherapies;

(C) Behavioral Health Rehabilitation services;

(D) Crisis Intervention services;
(E) Support Services; and
(F) Day Treatment/Intensive Outpatient.

(4) Be available 24 hours a day, seven days a week, for Crisis Intervention services.

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

(6) Comply with all applicable Federal and State Regulations.

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

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

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

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

317:30-5-240.3. Staff Credentials

(a) **Licensed Behavioral Health Professional (LBHPs).** LBHPs are defined as follows:

(1) Allopathic or Osteopathic Physicians with a current license and board certification in psychiatry or board eligible in the state in which services are provided, or a current resident in psychiatry practicing as described in OAC 317:30-5-2.

(2) Practitioners with a license to practice in the state in which services are provided, issued by one of the licensing boards listed in (A) through (F). The exemptions from licensure under 59 § 1353(4) (Supp. 2000) and (5), 59 § 1903(C) and (D) (Supp. 2000), 59 § 1925.3(B) (Supp. 2000) and (C), and 59 § 1932(C) (Supp. 2000) and (D) do not apply to Outpatient Behavioral Health Services.

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

(3) Advanced Practice Nurse (certified in a psychiatric mental health specialty), licensed as a registered nurse with a current certification of recognition from the board of

nursing in the state in which services are provided.

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

~~(5) Licensure candidates~~(b) **Licensure Candidates.** Licensure candidates are practitioners actively and regularly receiving board approved supervision, and extended supervision by a fully licensed clinician if board's supervision requirement is met but the individual is not yet licensed, to become licensed by one of the licensing boards listed in (2)(A) through (F) above. The supervising ~~licensed professional~~LBHP responsible for the member's care must:

~~(A)~~(1) staff the member's case with the candidate,

~~(B)~~(2) be personally available, or ensure the availability of ~~a fully licensed~~ an LBHP to the candidate for consultation while they are providing services,

~~(C)~~(3) agree with the current plan for the member, and

~~(D)~~(4) confirm that the service provided by the candidate was appropriate; and

~~(E)~~(5) The member's medical record must show that the requirements for reimbursement were met and the ~~licensed professional~~LBHP responsible for the member's care has reviewed, countersigned, and dated the service plan and any updates thereto so that it is documented that the licensed professional is responsible for the member's care.

~~(b)~~(c) **Certified Alcohol and Drug Counselors ~~(CADC's)~~(CADCs).** ~~CADC's~~CADCs are defined as having a current certification as a CADC in the state in which services are provided.

~~(c)~~(d) **Multi-Systemic Therapy (MST) Provider**. Masters level therapist who ~~work~~works on a team established by OJA which may include Bachelor level staff.

~~(d)~~(e) **Peer Recovery Support Specialist (PRSS).** The Peer Recovery Support Specialist must be certified by ODMHSAS pursuant to requirements found in OAC 450:53.

~~(e)~~(f) **Family Support and Training Provider (FSP).** FSPs are defined as follows:

(1) Have a high school diploma or equivalent;

(2) be 21 years of age and have successful experience as a family member of a child or youth with serious emotional disturbance, or a minimum of 2 years experience working with children with serious emotional disturbance or be equivalently qualified by education in the human services field or a combination of work experience and education with one year of education substituting for one year of experience (preference is given to parents or care givers of child with SED);

(3) successful completion of ODMHSAS Family Support Training;
(4) pass background checks; and
(5) service plans must be overseen and approved by ~~a~~an LBHP or Licensure Candidate; and
(6) must function under the general direction of ~~a~~an LBHP, or Licensure Candidate or systems of care team, with ~~a~~an LBHP or Licensure Candidate available at all times to provide back up, support, and/or consultation.

~~(f)~~(g) **Behavioral Health Aide (BHA)**. BHAs are defined as follows:

(1) Behavioral Health Aides must have completed 60 hours or equivalent of college credit; or
(2) may substitute one year of relevant employment and/or responsibility in the care of children with complex emotional needs for up to two years of college experience; and
(3) must have successfully completed the specialized training and education curriculum provided by the ODMHSAS; and
(4) must be supervised by a bachelor's level individual with a minimum of two years case management or care coordination experience; and
(5) service plans must be overseen and approved by ~~a~~an LBHP or Licensure Candidate; and
(6) must function under the general direction of ~~a~~an LBHP, or Licensure Candidate and/or systems of care team, with ~~a~~an LBHP or Licensure Candidate available at all times to provide back up, support, and/or consultation.

317:30-5-241.4 Crisis Intervention

(a) **Onsite and Mobile Crisis Intervention Services (CIS).**

(1) **Definition**. Crisis Intervention Services are face-to-face services for the purpose of responding to acute behavioral or emotional dysfunction as evidenced by psychotic, suicidal, homicidal severe psychiatric distress, and/or danger of AOD relapse. The crisis situation including the symptoms exhibited and the resulting intervention or recommendations must be clearly documented.

(2) **Limitations.** Crisis Intervention Services are not compensable for SoonerCare members who reside in ~~ICF/MR~~ICF/IID facilities, or who receive RBMS in a group home or Therapeutic Foster Home. CIS is also not compensable for members who experience acute behavioral or emotional dysfunction while in attendance for other behavioral health services, unless there is a documented attempt of placement in a higher level of care. The maximum is eight units per month; established mobile crisis response teams can bill a maximum of ~~sixteen units~~four hours per month, and ~~40 units~~ten hours each 12 months per member.

(3) **Qualified professionals**. Services must be provided by ~~a~~an LBHP or Licensure Candidate.

(b) **Facility Based Crisis Stabilization (FBCS).** FBCS services are emergency psychiatric and substance abuse services aimed at resolving crisis situations. The services provided are emergency stabilization, which includes a protected environment, chemotherapy, detoxification, individual and group treatment, and medical assessment.

(1) **Qualified ~~professionals~~practitioners**. FBCS services are provided under the supervision of a physician aided by a licensed nurse, and also include LBHPs and Licensure Candidates for the provision of group and individual treatments. A physician must be available. This service is limited to providers who contract with or are operated by the ODMHSAS to provide this service within the overall behavioral health service delivery system.

(2) **Limitations**. The unit of service is per hour. Providers of this service must meet the requirements delineated in the OAC 450:23. Documentation of records must comply with OAC 317:30-5-248.

317:30-5-241.5 Support services

(a) **Program of Assertive Community Treatment (PACT) Services.**

(1) **Definition**. PACT is provided by an interdisciplinary team that ensures service availability 24 hours a day, seven days a week and is prepared to carry out a full range of treatment functions wherever and whenever needed. An individual is referred to the PACT team service when it has been determined that his/her needs are so pervasive and/or unpredictable that it is unlikely that they can be met effectively by other combinations of available community services, or in circumstances where other levels of outpatient care have not been successful to sustain stability in the community.

(2) **Target population**. Individuals 18 years of age or older with serious and persistent mental illness and co-occurring disorders. PACT services are those services delivered within an assertive community-based approach to provide treatment, rehabilitation, and essential behavioral health supports on a continuous basis to individuals 18 years of age or older with serious mental illness with a self-contained multi-disciplinary team. The team must use an integrated service approach to merge essential clinical and rehabilitative functions and staff expertise. This level of service is to be provided only for persons most clearly in need of intensive ongoing services.

(3) **Qualified ~~professionals~~practitioners**. Providers of PACT services are specific teams within an established

organization and must be operated by or contracted with and certified by the ODMHSAS in accordance with 43A O.S. 319 and OAC 450:55. The team leader must be an LBHP or Licensure Candidate.

(4) **Limitations**. PACT services are billable in 15 minute units. A maximum of 105 hours per member per year in the aggregate is allowed. All PACT compensable SoonerCare services are required to be face-to-face. The following services are separately billable: Case management, facility-based crisis stabilization, physician and medical services.

(5) **Service requirements**. PACT services must include the following:

(A) PACT assessments (initial and comprehensive);

(i) **Initial assessment**- is the initial evaluation of the member based upon available information, including self-reports, reports of family members and other significant parties, and written summaries from other agencies, including police, court, and outpatient and inpatient facilities, where applicable, culminating in a comprehensive initial assessment. Member assessment information for admitted members shall be completed on the day of admission to the PACT. The start and stop times for this service should be recorded in the chart.

(ii) **Comprehensive assessment**- is the organized process of gathering and analyzing current and past information with each member and the family and/or support system and other significant people to evaluate: 1) mental and functional status; 2) effectiveness of past treatment; 3) current treatment, rehabilitation and support needs to achieve individual goals and support recovery; and 4) the range of individual strengths (e.g., knowledge gained from dealing with adversity or personal/professional roles, talents, personal traits) that can act as resources to the member and his/her recovery planning team in pursuing goals. Providers must bill only the face-to-face service time with the member. Non-face to face time is not compensable. The start and stop times for this service should be recorded in the chart.

(B) Behavioral health service plan (moderate and low complexity by a non-physician treatment planning and review) is a process by which the information obtained in the comprehensive assessment, course of treatment, the member, and/or treatment team meetings is evaluated and used to develop a service plan that has individualized goals, objectives, activities and services that will enable a member to improve. The initial assessment serves

as a guide until the comprehensive assessment is completed. It is to focus on recovery and must include a discharge plan. It is performed with the direct active participation by the member. SoonerCare compensation for this service includes only the face to face time with the member. The start and stop times for this service should be recorded in the chart.

(C) Treatment team meetings (team conferences with the member present) is a billable service. This service is conducted by the treatment team, which includes the member and all involved practitioners. For a complete description of this service, see OAC 450:55-5-6 Treatment Team Meetings. This service can be billed to SoonerCare only when the member is present and participating in the treatment team meeting. The conference starts at the beginning of the review of an individual member and ends at the conclusion of the review. Time related to record keeping and report generation is not reported. The start and stop times should be recorded in the member's chart. The participating psychiatrist/physician should bill the appropriate CPT code; and the agency is allowed to bill one treatment team meeting per member as medically necessary.

(D) Individual and family psychotherapy;

(E) Individual rehabilitation;

(F) Recovery support services;

(G) Group rehabilitation;

(H) Group psychotherapy;

(I) Crisis Intervention;

(J) Medication training and support services;

(K) Blood draws and /or other lab sample collection services performed by the nurse.

(b) **~~Behavioral Health Aide Services.~~Therapeutic Behavioral Services.**

(1) **Definition**. ~~Behavioral Health Aides provide~~Therapeutic behavioral services include behavior management and redirection and behavioral and life skills remedial training provided by qualified behavioral health aides. The behavioral health aide also provides monitoring and observation of the child's emotional/behavioral status and responses, providing interventions, support and social skills redirection when needed. Training is generally focused on behavioral, interpersonal, communication, self help, safety and daily living skills.

(2) **Target population**. This service is limited to children with serious emotional disturbance who are in an ODMHSAS contracted systems of care community based treatment program,

or are under OKDHS or OJA custody residing within a RBMS level of care, who need intervention and support in their living environment to achieve or maintain stable successful treatment outcomes.

(3) **Qualified ~~professionals~~practitioners.** Behavioral Health Aides must be trained/credentialed through ODMHSAS.

(4) **Limitations.** The Behavioral Health Aide cannot bill for more than one individual during the same time period. Therapeutic behavioral services by a BHA, Treatment Parent Specialist (TPS) or Behavioral Health School Aide (BHSA) cannot be delivered during the same clock time.

(5) **Documentation requirements.** Providers must follow requirements listed in OAC 317:30-5-248.

(c) **Family Support and Training.**

(1) **Definition.** This service provides the training and support necessary to ensure engagement and active participation of the family in the service plan development process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process. Child Training is provided to family members to increase their ability to provide a safe and supportive environment in the home and community for the child. Parent Support ensures the engagement and active participation of the family in the service plan development process and guides families toward taking a proactive role in their child's treatment. Parent Training is assisting the family with the acquisition of the skills and knowledge necessary to facilitate an awareness of their child's needs and the development and enhancement of the family's specific problem-solving skills, coping mechanisms, and strategies for the child's symptom/behavior management.

(2) **Target population.** Family Support and Training is designed to benefit the SoonerCare eligible child experiencing a serious emotional disturbance who is in an ODMHSAS contracted systems of care community based treatment program, are diagnosed with a pervasive developmental disorder, or are under OKDHS or OJA custody, are residing within a RBMS level of care or are at risk for out of home placement, and who without these services would require psychiatric hospitalization.

(3) **Qualified ~~professionals~~practitioners.** Family Support Providers ~~(FSP)~~(FSPs) must be trained/credentialed through ODMHSAS.

(4) **Limitations.** The FSP cannot bill for more than one individual during the same time period.

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

(d) **Peer Recovery Support Services (PRSS).**

(1) **Definition.** Peer recovery support services are an EBP model of care which consists of a qualified peer recovery support specialist provider ~~PRSS~~(PRSS) who assists individuals with their recovery from behavioral health disorders. Recovery Support is a service delivery role in the ODMHSAS public and contracted provider system throughout the behavioral health care system where the provider understands what creates recovery and how to support environments conducive of recovery. The role is not interchangeable with traditional staff members who usually work from the perspective of their training and/or their status as a licensed behavioral health provider; rather, this provider works from the perspective of their experimental expertise and specialized credential training. They lend unique insight into mental illness and what makes recovery possible because they are in recovery.

(2) **Target population.** Children 16 and over with SED and/or substance use disorders and adults 18 and over with SMI and/or substance use disorder(s).

(3) **Qualified professionals.** Peer Recovery Support Specialists ~~PRSS~~(PRSS) must be certified through ODMHSAS pursuant to OAC 450:53.

(4) **Limitations.** The PRSS cannot bill for more than one individual during the same time period. This service can be an individual or group service. Groups have no restriction on size.

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

(6) **Service requirements.**

(A) PRSS staff utilizing their knowledge, skills and abilities will:

(i) teach and mentor the value of every individual's recovery experience;

(ii) model effective coping techniques and self-help strategies;

(iii) assist members in articulating personal goals for recovery; and

(iv) assist members in determining the objectives needed to reach his/her recovery goals.

(B) PRSS staff utilizing ongoing training must:

(i) proactively engage members and possess communication skills/ability to transfer new concepts, ideas, and insight to others;

(ii) facilitate peer support groups;

(iii)assist in setting up and sustaining self-help (mutual support) groups;

(iv) support members in using a Wellness Recovery Action Plan (WRAP);
(v) assist in creating a crisis plan/Psychiatric Advanced Directive;
(vi) utilize and teach problem solving techniques with members;
(vii) teach members how to identify and combat negative self-talk and fears;
(viii) support the vocational choices of members and assist him/her in overcoming job-related anxiety;
(ix) assist in building social skills in the community that will enhance quality of life. Support the development of natural support systems;
(x) assist other staff in identifying program and service environments that are conducive to recovery; and
(xi) attend treatment team and program development meetings to ensure the presence of the member's voice and to promote the use of self-directed recovery tools.

PART 83. RESIDENTIAL BEHAVIOR MANAGEMENT SERVICES

317:30-5-740.1. Provider qualifications and requirements

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

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

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

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

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

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

(2) **Licensed Behavioral Health Professional (LBHP).** A masters level professional that provides treatment and supervision for the treatment staff to maintain clinical standards of care and provide direct clinical services. In addition to the requirements at OAC 317:30-5-240.3(a)and (b), the LBHP or Licensure Candidate in a TFC setting must demonstrate a general ~~processional~~professional or educational background in the following areas:

(A) case management, assessment and treatment planning;

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

(C) treatment of children with attachment disorders;

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

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

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

(G) anger management;

(H) crisis intervention; and

(I) trauma informed methodology.

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

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

(A) have a high school diploma or equivalent;

(B) be employed by the foster care agency as a foster parent complete with OSBI and OKDHS background screening;

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

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

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

(F) complete required annual trainings.

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

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

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

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

(3) treatment of children with attachment disorders;

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

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

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

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

(8) anger management;

(9) inpatient authorization procedures;

(10) crisis intervention;

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

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

(13) trauma informed methodology.

317:30-5-741. Coverage by category

(a) **Adults.** Outpatient Behavioral Health Services in Therapeutic Foster settings are not covered for adults.

(b) **Children.** Outpatient behavioral health services are allowed in therapeutic foster care settings for certain children and youth as medically necessary. The children and youth receiving

services in this setting have special psychological, social and emotional needs, requiring more intensive, therapeutic care than can be found in the traditional foster care setting. The designated children and youth must continually meet medical necessity criteria to be eligible for coverage in this setting.

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

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

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

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

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

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

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

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 1. PHYSICIANS

317:30-5-22. Obstetrical care

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

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

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

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

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

(B) One ultrasound after the first trimester will be covered. This ultrasound must be performed by a board certified Obstetrician-Gynecologist (OB-GYN), Radiologist, or a Maternal-Fetal Medicine specialist. In addition,

this ultrasound may be performed by a Nurse Midwife, Family Practice Physician or Advance Practice Nurse Practitioner in Obstetrics with certification in obstetrical ultrasonography.

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

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

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

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

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

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

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

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

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

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

(2) Standby at C-Section is not compensable when billed by a physician participating in delivery.
(3) Payment is not made for an assistant surgeon for obstetrical procedures that include prenatal or post partum care.
(4) An additional allowance is not made for induction of labor, double set-up examinations, fetal stress tests, or pudendal anesthetic. Providers must not bill separately for these procedures.
(5) Fetal scalp blood sampling is considered part of the total OB care.

(e) Obstetrical coverage for children is the same as for adults with additional procedures being covered due to EPSDT provisions if determined to be medically necessary.
(1) Services deemed medically necessary and allowable under federal Medicaid regulations are covered by the EPSDT/OHCA Child Health Program even though those services may not be part of the Oklahoma Health Care Authority SoonerCare program. Such services must be prior authorized.
(2) Federal Medicaid regulations also require the State to make the determination as to whether the service is medically necessary and do not require the provision of any items or services that the State determines are not safe and effective or which are considered experimental.

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

(a) **Enhanced services.** Enhanced services are available for pregnant women eligible for SoonerCare and are in addition to services for uncomplicated maternity cases. Women deemed high risk based on criteria established by the OHCA may receive prior authorization for medically necessary enhanced benefits which include:
(1) prenatal at risk ante partum management;
(2) a combined maximum of 12 fetal non stress test(s) and biophysical profiles (additional units can be prior authorized for multiple fetuses); and
(3) a maximum of 6 repeat ultrasounds not covered under OAC 317:30-5-22(b)(2).

(b) **Prior authorization.** To receive enhanced services, the following documentation must be received by the OHCA Medical Authorizations Unit for review and approval:
(1) ACOG or other comparable comprehensive prenatal assessment;
(2) chart note identifying and detailing the qualifying high risk condition; and

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

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

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

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

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

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.

Recommendation 1: Prior Authorize Viekira Pak™ (Ombitasvir/Paritaprevir/Ritonavir/Dasabuvir)

The Drug Utilization Review Board recommends the prior authorization of Viekira Pak™ (ombitasvir/paritaprevir/ritonavir/dasabuvir) with the following criteria:

Viekira Pak™ (Ombitasvir/Paritaprevir/Ritonavir/Dasabuvir) Approval Criteria:

1. Member must be 18 years of age or older; and
2. An FDA approved diagnosis of Chronic Hepatitis C (CHC) **genotype-1** with a METAVIR fibrosis score of **F2** or greater; and
3. Viekira Pak™ must be prescribed by a gastroenterologist, infectious disease specialist, or transplant specialist or the member must have been evaluated by a gastroenterologist, infectious disease specialist, or transplant specialist for hepatitis C therapy within the last three months; and
4. Hepatitis C Virus (HCV) genotype/subtype testing must be confirmed and indicated on prior authorization request; and
5. Pre-treatment viral load (HCV-RNA) must be confirmed and indicated on the petition. Viral load should have been taken within the last three months; and
6. The following regimens and requirements based on prior treatment experience, genotypic subtype, and cirrhosis will apply:
    a. **Genotype 1a, without cirrhosis:**
        i. Viekira Pak™ with weight-based ribavirin for 12 weeks
    b. **Genotype 1a, with cirrhosis:**
        i. Viekira Pak™ with weight-based ribavirin for 24 weeks
        ii. Viekira Pak™ with weight-based ribavirin for 12 weeks may be considered for some patients based on prior treatment history.
    c. **Genotype 1b, without cirrhosis:**
        i. Viekira Pak™ for 12 weeks
    d. **Genotype 1b, with cirrhosis:**
        i. Viekira Pak™ with weight-based ribavirin for 12 weeks
    e. New regimens will apply as approved by the FDA
7. Member must not have previously failed treatment with a hepatitis C protease inhibitor (non-responder or relapsed); and
8. Member must sign and submit the Hepatitis C Intent to Treat contract; and
9. Member's pharmacy must submit the Hepatitis C Therapy Pharmacy Agreement for each member on therapy; and
10. The prescriber must verify that they will provide SoonerCare with all necessary labs to evaluate hepatitis C therapy efficacy including Sustained Viral Response (SVR-12); and
11. Member must have no illicit IV drug use or alcohol abuse in the last six months and member must agree to no illicit IV drug use or alcohol use while on treatment and post-therapy; and
12. Must have documentation of initiation of immunization with the hepatitis A and B vaccines; and
13. Member must not have decompensated cirrhosis; and

14. Female members must not be pregnant and must have a pregnancy test immediately prior to therapy initiation. Female partners of male patients should also be checked for pregnancy for informational purposes. Male and female members must be willing to use two forms of non-hormonal birth control while on therapy and for six months after therapy completion; and
15. The prescriber must verify that the member's ALT levels will be monitored during the first four weeks of starting treatment and as clinically indicated thereafter; and
16. Member must not be taking the following medications: alfuzosin, carbamazepine, phenytoin, phenobarbital, gemfibrozil, rifampin, ergotamine, dihydroergotamine, ergonovine, methylergonovine, ethinyl estradiol, St. John's wort, lovastatin, simvastatin, pimozide, efavirenz, sildenafil, triazolam, oral midazolam; and
17. All other clinically significant issues must be addressed prior to starting therapy including but not limited to the following: neutropenia, anemia, thrombocytopenia, surgery, depression, psychosis, epilepsy, obesity, weight management, severe concurrent medical diseases, such as but not limited to, retinal disease or autoimmune thyroid disease; and
18. Prescribing physician must verify that they will work with the member to ensure the member remains adherent to hepatitis C therapies; and
19. Members must be adherent for continued approval. Treatment gaps of therapy longer than 3 days/month will result in denial of subsequent requests for continued therapy.
20. Approvals for treatment regimen initiation for 12 weeks of therapy will not be granted prior to the 10th of a month, and for 24 weeks of therapy prior to the 15th of a month in order to prevent prescription limit issues from affecting the member's compliance.

Recommendation 2: Prior Authorize Northera™ (Droxidopa)

The Drug Utilization Review Board recommends prior authorization of Northera™ (droxidopa) with the following criteria:

Northera™ (Droxidopa) Approval Criteria:

1. An FDA approved diagnosis of symptomatic neurogenic orthostatic hypotension caused by primary autonomic failure (Parkinson's disease, multiple system atrophy, and pure autonomic failure), dopamine beta-hydroxylase deficiency, or non-diabetic autonomic neuropathy; and
2. Member must be 18 years of age or older; and
3. Member must have tried and failed two of the following medications at recommended dosing within the last 90 days:
    a. Midodrine; or
    b. Fludrocortisone; or
    c. Pyridostigmine; or
    d. Have a contraindication to all preferred medications.
4. Initial approval will be for the duration of two weeks of treatment only.
5. Continued approval will require the prescriber to provide information regarding improved member response/effectiveness of this medication to determine whether Northera™ is continuing to provide a benefit.

6. Continued approval will be for the duration of three months. Each approval will require prescriber documentation of member response/effectiveness to Northera™.

Recommendation 3: Prior Authorize Akynzeo® (Netupitant/Palonosetron)

The Drug Utilization Review Board recommends the prior authorization of Akynzeo® (netupitant/palonosetron) with the following criteria:

Akynzeo® (Netupitant/Palonosetron) Approval Criteria:

1. An FDA approved diagnosis for the prevention of acute and delayed nausea and vomiting associated with initial and repeat courses of cancer chemotherapy; and
2. A recent trial of ondansetron (within the past six months) used for at least three days or one cycle that resulted in inadequate response.
3. Approval length based on duration of need.
4. A quantity limit of one capsule per chemotherapy cycle will apply.

Recommendation 4: Prior Authorize Lemtrada™ (Alemtuzumab) and Plegridy™ (Peginterferon β-1a)

The Drug Utilization Review Board recommends the prior authorization of Lemtrada™ (alemtuzumab) with the following criteria:

Lemtrada™ (Alemtuzumab) Approval Criteria:

1. An FDA approved diagnosis of relapsing forms of Multiple Sclerosis; and
2. Member must have had an inadequate response to two or more drugs indicated for the treatment of Multiple Sclerosis; and
3. Lemtrada™ must be administered in a setting with appropriate equipment and personnel to manage anaphylaxis or serious infusion reactions. The prescriber must agree that the member will be monitored for two hours after each infusion; and
4. The prescriber must agree to monitor complete blood counts with differential, serum creatinine levels, and urinalysis with urine counts at periodic intervals for 48 months after the last dose of Lemtrada™; and
5. The prescriber must agree that baseline and yearly skin examinations will be performed while the member is utilizing Lemtrada™ therapy; and
6. Member, prescriber, pharmacy, and healthcare facility must all enroll in the Lemtrada™ REMS Program and maintain enrollment throughout therapy.

Additionally the DUR Board recommends placement of Plegridy™ (peginterferon β-1a) into Tier-2 of the Multiple Sclerosis Interferon Prior Authorization category. Current criteria for this category will apply.

Multiple Sclerosis Interferon Approval Criteria:

1. An FDA approved diagnosis of relapsing remitting Multiple Sclerosis; and

2. Authorization of Tier-2 medications requires previous failure of the preferred Tier-1 product defined as:
   a. Occurrence of an exacerbation after six months; or
   b. Significant increase in MRI lesions after six months; or
   c. Adverse reactions or intolerable side effects; and
3. Approvals will not be granted for concurrent use with other disease modifying therapies; and
4. Compliance will be checked for continued approval every six months.

Multiple Sclerosis Interferon Medications*	
Tier-1	**Tier-2**
interferon β – 1a (Avonex®)	interferon β – 1a (Rebif®)
interferon β – 1b (Betaseron®)	interferon β – 1b (Extavia®)
	peginterferon β – 1a (Plegridy™)

*Tier structure based on supplemental rebate participation.

Recommendation 5: Prior Authorize Brisdelle® (Paroxetine Mesylate)

The Drug Utilization Review Board recommends the prior authorization of Brisdelle® (paroxetine mesylate) with the following criteria:

Brisdelle® (Paroxetine Mesylate) Approval Criteria:

1. An FDA approved diagnosis of moderate to severe vasomotor symptoms associated with menopause; and
2. Approvals for Brisdelle® will not be granted for psychiatric indications; and
3. Member must not have any of the contraindications for use of Brisdelle®; and
4. Two previous trials with either a selective serotonin reuptake inhibitor (SSRI) or a selective serotonin norepinephrine reuptake inhibitor (SNRI) or both, or a patient-specific, clinically significant reasoning why a SSRI or SNRI is not appropriate for the member; and
5. Authorization requires a patient-specific, clinically significant reason why paroxetine 10mg is not appropriate for the member; and
6. A quantity limit of 30 capsules per 30 days will apply.

Recommendation 6: Prior Authorize Orenitram™ (Treprostinil) and Revatio® (Sildenafil Oral Suspension)

The Drug Utilization Review Board recommends the prior authorization of Orenitram™ (treprostinil) and Revatio® (sildenafil) suspension with the following criteria:

Orenitram™ (Treprostinil) Approval Criteria:

1. An FDA approved diagnosis of pulmonary arterial hypertension; and
2. Previous failed trials of at least one of each of the following categories:
   a. Revatio® (sildenafil) or Adcirca® (tadalafil); and
   b. Letairis® (ambrisentan) or Tracleer® (bosentan); and

3. Medical supervision by a pulmonary specialist and/or cardiologist; and
4. A quantity limit of 90 tablets per 30 days will apply.

Revatio® (Sildenafil Suspension) Approval Criteria:

1. An FDA approved diagnosis of pulmonary arterial hypertension; and
2. Medical supervision by a pulmonary specialist and/or cardiologist; and
3. An age restriction will apply. The oral suspension formulation may be approvable for ages six years and younger. Members seven years and older must have a patient-specific, clinically significant reason why the member is not able to use the oral tablet formulation.
4. A quantity limit of 224mL per 30 days (two bottles) will apply.

Recommendation 7: Prior Authorize Myalept™ (Metreleptin)

The Drug Utilization Review Board recommends the prior authorization of Myalept™ (metreleptin) with the following criteria:

Myalept™ (Metreleptin) Approval Criteria:

2. An FDA approved diagnosis of leptin deficiency in patients with congenital or acquired generalized lipodystrophy; and
3. Approvals will not be granted for the following diagnoses:
    a. Metabolic disease without current evidence of generalized lipodystrophy
    b. HIV-related lipodystrophy
    c. General obesity not associated with congenital leptin deficiency
4. Myalept™ must be prescribed by an endocrinologist; and
5. Prescriber must agree to test for neutralizing antibodies in patients who experience severe infections or if they suspect Myalept™ is no longer effective.
    a. Baseline HbA1c, fasting glucose, and fasting triglycerides must be stated on prior authorization request
    b. Re-approvals will require recent lab values (HbA1c, fasting glucose, and fasting triglycerides) to ensure neutralizing antibodies have not developed; and
6. Prescriber and pharmacy must be enrolled in the Myalept™ REMS program; and
7. Approvals will be for the duration of three months to evaluate compliance and ensure the prescriber is assessing continued efficacy; and
8. A quantity limit of one vial per day will apply.