OKLAHOMA HEALTH CARE AUTHORITY
REGULARLY SCHEDULED BOARD MEETING
March 23, 2017 at 1:00 P.M.
Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
OKC, OK

A G E N D A

Items to be presented by Ed McFall, Chairman

1. Call to Order / Determination of Quorum

2. Action Item – Approval of the February 9, 2017 OHCA Board Meeting Minutes

Item to be presented by Becky Pasternik-Ikard, Chief Executive Officer

3. Discussion Item – Chief Executive Officer's Report; Employee Recognition

   a) All-Star Introduction
      - January All-Star – Efren Herrera, Member Services Manager (Melody Anthony)
      - February All-Star – Bryan Younger, Senior Technical Support Specialist (Lisa Gifford)

   b) Financial Update – Carrie Evans, Chief Financial Officer
      1. State Fiscal Year Budget Scenarios – Carrie Evans, Tywanda Cox

   c) Medicaid Director's Update – Garth Splinter, Deputy Chief Executive Officer

   d) Legislative Update – Emily Shipley, Director of Government Relations

Item to be presented by Derek Lieser, Data Integrity Director

4. Discussion Item – Enrollment & Eligibility Process Presentation

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

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

Item to be presented by Nancy Nesser, Pharmacy Director

6. 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 **Syndros™ (Dronabinol), Sustol® (Granisetron), and Bonjesta® (Doxylamine/Pyridoxine)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

b) Consideration and vote to add **Viekira XR™ (Dasabuvir/ Ombitasvir/Paritaprevir/Ritonavir) and Epclusa® (Sofosbuvir/Velpatasvir)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

c) Consideration and vote to add **Exondys 51™ (Eteplirsen)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

d) Consideration and vote to add **Cinqair® (Reslizumab)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

e) Consideration and vote to add **Fosrenol® (Lanthanum Carbonate), Velphoro® (Sucroferric Oxyhydroxide), and Auryxia™ (Ferric Citrate)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

f) Consideration and vote to add **Defitelio® (Defibrotide Sodium)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

g) Consideration and vote to add **Nuplazid™ (Pimavanserin)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

h) Consideration and vote to add **Veltassa® (Patiromer)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

i) Consideration and vote to add **Kanuma® (Sebelipase Alfa)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

j) Consideration and vote to add **Picato® (Ingenol Mebutate Gel)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

k) Consideration and vote to add **Briviact® (Brivaracetam), Fycompa™ (Perampanel Oral Suspension), and Carnexiv™ (Carbamazepine Injection)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

Item to be presented by Tiffany Lyon, Procurement & Contracts Development Director

7. Action Item – Consideration and Vote of Authority for Expenditure of Fund for the Lead Screening Campaign

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

8. 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. These rules HAVE NOT been revised for PERMANENT rulemaking.

OHCA Initiated

a) AMENDING Agency rules at OAC 317:30-5-72.1, 317:30-5-78, and 317:30-5-87 to modify the reimbursement structure to comply with federal regulation for Indian Health Services, Tribal Programs, Urban Indian Clinics (I/T/U), and non-I/T/U pharmacies. Revisions align reimbursement for covered outpatient drugs with Actual Acquisition Cost and create new pricing terms for specialty pharmaceutical products. Revisions also modify the current dispensing fee to a professional dispensing fee. In addition, revisions amend the reimbursement structure for I/T/U pharmacies; these pharmacies will be reimbursed at the Federal Office of Management and Budget encounter rate. I/T/U pharmacies will receive one rate per member per facility per day regardless of the number of prescriptions dispensed to the member on that day. Revisions also remove limitations for cessation benefits to align with current practice.
Budget Impact: Budget neutral

(Reference APA WF # 16-13)

b) ADDING Agency rules at OAC 317:2-1-16 to establish grievance procedures and processes for the supplemental payment program for nursing facilities owned and as applicable operated by non-state government owned entities.
Budget Impact: Budget neutral

(Reference APA WF # 16-16A)

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.

ODMHSAS Initiated

c) AMENDING Agency rules at OAC 317:30-5-11, 317:30-5-241, 317:30-5-241.1, and 317:30-5-241.6 to reduce the number of SoonerCare compensable service plan updates to two in one year. Outpatient behavioral health agencies will now be reimbursed for one initial comprehensive treatment plan and one update thereto bi-annually. **The aforementioned changes were reviewed and approved during promulgation of the emergency rule.**

Additional revisions remove outdated references to Axis diagnosis and align the changes to the Diagnostic and Statistical Manual of Mental Disorders. Revisions also clarify clinical outpatient behavioral health agency provider documentation requirements for service plan modifications made prior to the scheduled six month review or update. Rules are also revised to clarify that behavioral health case management is not reimbursable for members who are enrolled in a Health Home. Revisions also clarify that, unless otherwise specified in rule, reimbursement is not allowed for outpatient behavioral health services provided to members who are considered to be in "inpatient status." **The aforementioned "permanent rule-making" revisions have not been reviewed or approved.**
ODMHSAS Budget Impact: Budget neutral

(Reference APA WF # 16-35)

OHCA Initiated

d) ADDING Agency rules at OAC 317:30-5-136 to establish a supplemental payment program for nursing facilities owned and as applicable operated by non-state government owned (NSGO) entities. The proposed revisions establish requirements and criteria for supplemental payments to be made to participating NSGOs up to the allowable Medicare upper payment limit. In addition, proposed revisions define terms related to the program and set forth criteria and eligibility requirements. Rules are also added to outline cost reporting, change in ownership, and disbursement of payment. Additionally, revisions clarify eligibility requirements and care criteria for nursing facilities. Finally, references for appeal requirements are added. **The aforementioned changes were reviewed and approved during promulgation of the emergency rule.**

Additional revisions require the Agreement of Participation application be submitted at minimum 30 days prior to the start of the program. Further revisions require the submission of supporting documentation for care criteria metrics and the submission of said documentation and forms within five business days after the quarter end. **The aforementioned "permanent rule-making" revisions have not been reviewed or approved.**
Budget Impact: Budget neutral

(Reference APA WF # 16-16B)

e) AMENDING Agency rules at OAC 317:30-3-27, 317:30-5-47, 317:30-5-361 and 317:30-5-664.10 to update language to reflect the repeal of The Oklahoma Telemedicine Act, which eliminates the informed consent requirement from Oklahoma statutes. **The aforementioned changes were reviewed and approved during promulgation of the emergency rule.**

Additional revisions replace telemedicine with telehealth which allow flexibility for the use of telehealth technologies. In addition, new revisions define telehealth and specific telehealth technologies. **The aforementioned "permanent rule-making" revisions have not been reviewed or approved.**
Budget Impact: Budget neutral

(Reference APA WF # 16-18)

f) AMENDING Agency rules at OAC 317:2-1-2 to outline grievance procedures and processes for the Nursing Facility Supplemental Payment Program. **The aforementioned changes were reviewed and approved during promulgation of the emergency rule.**

Additional revisions remove the reference to administrative sanctions rules, which are being revoked. **The aforementioned "permanent rule-making" revisions have not been reviewed or approved.**
Budget Impact: Budget neutral

(Reference APA WF # 16-28B)

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

DHS Initiated

g) AMENDING Agency rules at OAC 317:30-5-518 to cleanup language, which adds the acronym for agency companion services and replaces the Oklahoma Department of Human Services acronym from "OKDHS" to "DHS." In addition, revisions change the name of the OKDHS Children and Family Services Division to DHS Child Welfare Services. Finally, revisions add the correct reference for agency companion services limits.
DHS Budget Impact: Budget neutral

(Reference APA WF # 16-24A)

h) AMENDING Agency rules at OAC 317:40-1-1, 317:40-5-103, 317:40-5-112, 317:40-7-2, 317:40-7-6, 317:40-7-12, 317:40-7-13, and 317:40-9-1 to implement changes recommended during the annual Oklahoma Department of Human Services Developmental Disabilities Services (DDS) rule review process. The proposed revisions add language to outline the standards for transportation providers and requirements for a Self-Directed Habilitation Training Specialist. Revisions update commonly used terms and specify that Home and Community-Based Waiver services require an annual eligibility review. Further language is added to define competitive integrated employment. In addition, the proposed revisions remove the treatment plan pre-approval requirements that exceed $1,000 by the DDS area medical director or designee for members of the Homeward Bound Waiver. Finally, language that requires the provider agency Human Rights Committees to review the member's protective intervention protocols are removed.
DHS Budget Impact: Budget neutral

(Reference APA WF # 16-24B)

i) AMENDING Agency rules at OAC 317:30-5-761 through 317:30-5-764 to add language to comply with new Centers for Medicare & Medicaid Services rules regarding Adult Day Health providers in Home and Community Based settings. Revisions clarify the required processes for case

management monitoring and reporting activities for all waiver services. Revisions update commonly used terms and replace "plan of care" with the term "person-centered service plan." Additional revisions clarify that the Consumer-Directed Personal Assistance Services and Supports (CD-PASS) option is available in every Oklahoma County. Further language is added that is consistent with the Physical Therapy Act. The proposed amendments specify maximum billing units per day for skilled nursing services. Revisions also clarify that the minimum of eight units is equivalent to two hours and that the 28 maximum billing units is equivalent to seven hours. Revisions update services that are provided by the ADvantage waiver program and remove those services no longer available. Revisions clarify the provider contract processes and those providers that are required to have annual audits. In addition, Adult Day Health and Assisted Living are added to the list of providers and are included in the periodic programmatic audit. Further revisions remove reference for the CD-PASS and Advanced Person Services Assistants to be documented through the Electronic Visit Verification System solely for reimbursement. Finally, language regarding speech and language therapy services is revoked as it is no longer offered in the ADvantage waiver.
DHS Budget Impact: Budget neutral

(Reference APA WF # 16-25A)

j) AMENDING Agency rules at OAC 317:35-15-2, 317:35-15-4, 317:35-15-8, 317:35-15-8.1, 317:35-15-10, 317:35-15-13.1, 317:35-15-13.2, 317:35-15-14, 317:35-17-1, 317:35-17-3, 317:35-17-5, 317:35-17-14, 317:35-17-18, 317:35-17-22 and 317:35-19-2 to update the ADvantage program and related services. The revisions add language regarding the personal care services process provided by the personal care provider agency nurse. Additional language outlines individuals who are not qualified to provide services as an Individual Personal Care Assistant. Language is added to clarify technical services that are provided by the State Plan Personal Care services program. Additional guidance is provided on the Oklahoma Department of Human Services (DHS) forms that are to be used in the eligibility process for personal care service authorization. Further revisions provide clarification on payment for personal care services if the client lives in the personal care assistant's home without DHS approval. Proposed revisions provide clarification on the timeframe in which nurses are to complete the Service Authorization Model visit and outline the steps to be taken if it is determined that there have been no changes in health or service needs. Language regarding the current practices and form numbers of Nursing Home Level of Care assessments has been updated. Additional revisions reflect changes due to the Interactive Voice Response Authentication (IVRA) system to the Electronic Visit Verification (EVV) system. Processes for documentation through the EVV system have been defined. Language is added that would identify what members would not be able to receive ADvantage waiver services due to illegal drug activity in the home. Additional updates are made to clarify mental impairment language. References made to the Supplemental Process for Expedited Eligibility Determination are removed as this process is no longer part of the ADvantage waiver. In addition, services that are no longer provided by the ADvantage waiver have been removed.
DHS Budget Impact: Budget neutral

(Reference APA WF # 16-25B)

OHCA Initiated

k) AMENDING Agency rules at OAC 317:30-3-5 to mirror federal regulation for cost sharing. Per current policy, the aggregate cost sharing liabilities in a given calendar year may not exceed five percent of the *member's* gross annual income. Per federal regulation, the aggregate limit on premiums and cost sharing incurred by *all members* in the Medicaid household should not exceed five percent of the *family's income* applied on a monthly basis.
Budget Impact: Budget neutral

(Reference APA WF # 16-03)

l) AMENDING Agency rules at OAC 317:35-9-48.1 to allow additional providers to evaluate Tax Equity and Fiscal Responsibility Act applicants under the age of three for the measurement of developmental milestones to determine Intermediate Care Facilities for Individuals with Intellectual Disabilities institutional level of care. Current rules only allow for an evaluation by providers within the SoonerStart Early Intervention Program. This policy revision allows for flexibility when determining level of care as there are other appropriate providers and evaluation tools that can be utilized to evaluate developmental milestones. Please note that other criteria for severe dysfunctional deficiencies in at least two total domain areas remain in effect.
Budget Impact: Budget neutral

(Reference APA WF # 16-19)

m) REVOKING Agency rules at OAC 317:30-3-19 and 317:30-3-19.1. ADDING Agency rules at OAC 317:30-3-19.3, 317:30-3-19.4, and 317:30-3-19.5. Revisions revoke administrative sanction policy as the language is obsolete and does not accord with current agency practices. Proposed revisions also revoke other agency rules which have been substantively revised to clarify what the agency may consider when deciding whether to terminate a contract with a particular enrolled provider.

Also, proposed revisions add a new rule which explains what factors the Oklahoma Health Care Authority may take into consideration when deciding whether to approve an application for a new or renewing provider enrollment contract. In addition, proposed revisions add a new rule which modifies and replaces the Emergency Rule which will expire on September 14, 2017. The new rule fulfills a federal requirement for all state Medicaid agencies to institute fingerprint-based criminal background checks for certain "high categorical risk" providers who want to contract with the state. Proposed revisions also add a new rule which streamlines, clarifies, and provides examples of the kinds of conduct that may serve as a basis for a for-cause termination of a provider contract.
Budget Impact: Budget neutral

(Reference APA WF # 16-28A)

n) AMENDING Agency rules at OAC 317:30-3-17, 317:30-3-44, 317:30-5-95.24, 317:30-5-96.5, 317:30-5-355.1, 317:30-5-375, 317:30-5-546, 317:30-5-661.1, and 317:30-5-1076 to update references to the physical address of the Oklahoma Health Care Authority, and correct formatting errors and misspelled words. Revisions also include replacing the words "recipient" and "patient" with the word "member." In addition, revisions add the term "certified" to nurse midwife to mirror terminology used by the Oklahoma Nursing Board.
Budget Impact: Budget neutral

(Reference APA WF # 16-29)

o) AMENDING Agency rules at OAC 317:45-1-2, 317:45-1-3, 317:45-7-2, 317:45-9-1, 317:45-11-10, 317:45-11-11, 317:45-11-20, and 317:45-11-23 to update the Insure Oklahoma policy. The proposed revisions add language to the definitions of "Full-time Employment" and "Full-time Employer." Definitions also clarify dependent and independent college student's enrollment requirements. Revisions remove references to annual and lifetime maximums to mirror current waiver authority. In addition, references to prosthetic devices, continuous positive airway pressure devices, and perinatal dental coverage are removed to mirror current SoonerCare coverage. Revisions also remove references to individuals under supervision and update the therapy limits for behavioral health services to mirror current SoonerCare coverage.
Budget Impact: Budget neutral

(Reference APA WF # 16-30)

p) AMENDING Agency rules at OAC 317:30-3-21, 317:30-3-43, 317:30-5-63, 317:30-5-120 through

317:30-5-125, 317:30-5-127, 317:30-5-129, 317:30-5-131.2, 317:30-5-132, 317:30-5-133, 317:30-5-133.1 and REVOKING Agency rules at OAC 317:30-5-128. Revisions update requirements for the State Survey Agency when they are certifying facilities with deficiencies. Revisions also amend the change of ownership process for facilities. Both revisions are necessary to comply with recent changes to federal and state regulation. Revisions also clarify that nursing facilities will be afforded a hearing pursuant to federal regulation. For nursing homes that handle trust accounts, the Department of Human Services allows facilities to use electronic ledgers and bank statements as source documents for inspections, accounting, and tracking purposes. Proposed revisions update rules to align with this practice. Further revisions amend rules governing quality of care fund requirements to accurately reflect how these funds are calculated and assessed as authorized by Oklahoma statutes. Proposed revisions also strike partial federal regulation language that is used in rules. Other revisions update the payment methodology for private nursing facilities to mirror language found in the State Plan, and adds influenza and pneumococcal vaccines as a covered routine service since they are not separately reimbursable. Additionally, revisions throughout amend terminology to correctly identify individuals residing in long term care facilities as those with intellectual disabilities and replaces the term "patient" with "member" as appropriate. Other general cleanup of terms include: replacing "agreement" with the term "contract," updating form names, revising the name of divisions, and striking references to policy that have been revoked.

In addition, revisions for trust funds revoke language that implies unclaimed funds escheats to the State. Additional changes revoke rules outlining the necessary requirements for members to obtain a private room. Nursing facilities receive a set reimbursement for room and board regardless of the privacy level so prescriptive rules are not required.
Budget Impact: Budget neutral

(Reference APA WF # 16-31A)

q) AMENDING Agency rules at OAC 317:35-9-4, 317:35-9-45, 317:35-19-8, and 317:35-19-9 to correctly identify individuals residing in Long-term Care facilities as those with intellectual disabilities and replaces the term "patient" with "member" as appropriate.
Budget Impact: Budget neutral

(Reference APA WF # 16-31B)

r) AMENDING Agency rules at OAC 317:30-5-40, 317:30-5-49, 317:30-5-260, 317:30-5-305, 317:30-5-430, and 317:30-5-890 to mirror to the Oklahoma Health Care Authority (OHCA) contracting requirements for Optometrists, Renal Dialysis Facilities, and Podiatrists. Birthing Center policy is also amended to add language that clarifies a contract with the OHCA is required to be reimbursed for services. The proposed change will align Birthing Centers policy with all other provider types. In addition, proposed revisions update Hospital policy to mirror the OHCA contracting requirements, revise outdated statutes for reporting abuse, and amend abuse reporting requirements.
Budget Impact: Budget neutral

(Reference APA WF # 16-32)

s) AMENDING Agency rules at OAC 317:30-5-742 to Therapeutic Foster Care policy to remove the minimum time requirements for behavioral health assessment services. These revisions will allow providers more flexibility in completing biopsychosocial assessments. Revisions also add frequency limitations to clarify limits on how often an assessment can be completed within a single agency. In addition, revisions clarify if an assessment is performed by a licensure candidate, it must be countersigned by the licensed behavioral health professional that is responsible for the member's care. This change will clarify oversight requirements for licensure candidates and ensure quality of care. Rules are also revised to clarify specific clinical documentation requirements when changes need to be made to the service plan prior to the scheduled three month review or update. Revisions also update numerical references and add taglines to align with current Administrative

Procedures Act guidelines.
Budget Impact: Budget neutral

(Reference APA WF # 16-33)

t) AMENDING Agency rules at OAC 317:30-5-696, 317:30-5-698 and 317:30-5-700.1 to add language allowing dental providers to submit the diagnostic cast or photographic images as evidence of medical necessity for dental services. The procedure is a necessary part of many dental practices, including orthodontics, and the change allows providers to bill for a necessary service. In addition, revisions add the term "certified" to nurse midwife to mirror terminology used by the Oklahoma Nursing Board.
Budget Impact: Agency staff has determined that the proposed rule may result in a cost savings of $14,395 total dollars; $4,375 state share; $10,560 federal share.

(Reference APA WF # 16-34)

u) AMENDING Agency rules at OAC 317:30-3-2.1, 317:30-3-4.1 and 317:30-3-30 to the Program Integrity Audits/Reviews policy. Revisions clarify the Oklahoma Health Care Authority (OHCA) audit process by: explaining that the scope of audits may include examination for fraud, waste, and/or abuse of the SoonerCare program; establishing a clearly defined response due date for providers who want to request an informal reconsideration and/or formal appeal of audit findings; and by informing providers that overpayments identified through the audit process may be withheld from future payments if the provider fails to timely contest the underlying audit findings. Also, proposed revisions in Uniform Electronic Transaction Act set a consistent timeframe in which medical records must be authenticated, including those instances in which transcription occurs. In addition, the rules have been revised to improve reader comprehension, and make the language consistent with other OHCA administrative rules.
Budget Impact: Budget neutral

(Reference APA WF # 16-36)

9. New Business

10. ADJOURNMENT

NEXT BOARD MEETING
May 25, 2017
Oklahoma Health Care Authority
Oklahoma City, OK

MINUTES OF A REGULARLY SCHEDULED BOARD MEETING
OF THE HEALTH CARE AUTHORITY BOARD
February 9, 2017
Oklahoma Health Care Authority Boardroom
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 8, 2017 at 11:00 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 3, 2017 at 8:00 a.m.

Pursuant to a roll call of the members, a quorum was declared to be present, and Vice-Chairman Armstrong called the meeting to order at 1:07 p.m.

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

DISCUSSION AND POSSIBLE VOTE ON APPROVAL OF BOARD MINUTES OF THE REGULARY SCHEDULED BOARD MEETING HELD JANUARY 12, 2017.

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 Case moved for approval of the January 12, 2017 board meeting minutes as published. The motion was seconded by Member Robison.

FOR THE MOTION: Chairman McFall, Vice Chairman Armstrong,

ABSTAINED: Member McVay, Member Nuttle

BECKY PASTERNIK-IKARD, CHIEF EXECUTIVE OFFICER'S REPORT

ITEM 3a / ALL-STAR INTRODUCTION

The following OHCA All-Star was recognized.

- October 2016 All-Star – Canielle Preston, Health Promotion Specialist (Lisa Gifford presented)
- November 2016 All-Star – Nelson Solomon, Public Information Specialist (Lisa Gifford presented)
- December 2016 All-Star – Fred Mensah, Financial Manager III (Carrie Evans presented)

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

Ms. Evans reported on the financial transactions through the month of December. OHCA has a positive variance of $4.8 million state dollars and are running under budget by $7.3 million in program spending and $1.7 million in administration. She reported that we are over budget in drug rebates and under budget in medical refunds and stated that we will continue to monitor those. Ms. Evans predicted that we will run slightly under budget for January. For more detailed information, see Item 3b in the board packet.

ITEM 3c / MEDICAID DIRECTOR'S UPDATE
Garth Splinter, Deputy Chief Executive Officer

Dr. Splinter provided an update for December 2016 data that included a report on the number of SoonerCare enrollees in different areas of the Medicaid program including total in-state providers. Dr. Splinter discussed charts provided for per

member per month cost by group. He also discussed the HEDIS Quality Measures for children and adolescent's access to primary care physicians. For more detailed information, see Item 3c in the board packet.

ITEM 3d / LEGISLATIVE UPDATE
Emily Shipley, Director of Government Relations

Ms. Shipley reported on HB 2962, which directs OHCA and partnering state agencies to study and prepare a report concentrating on the use of applied behavior analysis therapy treatment for children with ASD within the state's Medicaid program. Ms. Shipley reported on the future deadlines for this legislative session and the OHCA requested bills. For more detailed information, see item 3d in the board packet.

ITEM 4 / PROVIDER ENROLLMENT UPDATE
Amy Bradt, Director of Provider Enrollment

Ms. Bradt gave a provider enrollment report which included information on what the department does, categorical risk levels, low, moderate, and high risk provider screenings, providers moved to high risk, and additional screenings. For more detailed information, see item 4 in the board packet.

ITEM 5 / ANNOUNCEMENTS OF CONFLICTS OF INTEREST PANEL RECOMMENDATIONS FOR ALL ACTION ITEMS
Nicole Nantois, Chief of Legal Services

There were no recommendations regarding conflicts.

ITEM 6A-M / 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

ODMHSAS Initiated

A. AMENDING Agency rules at OAC 317:30-5-241.2 to continue coverage for the daily and weekly limits for individual, group and family psychotherapy services. The current daily limits were reduced to four units, six units and four units respectively. In addition, weekly limits were imposed that limit the total amount of group therapy in a week to three hours and individual and family therapy will cumulatively be limited to two hours per week. Revisions also include language that excludes therapy limitations to outpatient behavioral health services provided in a foster care setting.
ODMHSAS Budget Impact: Savings were 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 # 16-04)

B. AMENDING Agency rules at OAC 317:30-5-281 to decrease the monthly limits of psychotherapy reimbursable by SoonerCare for independently practicing Licensed Behavioral Health Professionals. The limits were reduced to four units/sessions per month.
ODMHSAS Budget Impact: Savings were 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 # 16-05)

OHCA Initiated

C. AMENDING Agency rules at OAC 317:30-5-42.17 and 317:30-5-432.1 to continue allowing SoonerCare contracted providers of vision services to be reimbursed separately for refraction in an eye exam. Previously approved revisions also specified that all non-high-index lenses must be polycarbonate. In addition, the revisions allow SoonerCare contracted suppliers of eyeglasses to be paid a fitting fee if the requirements of a fitting fee are met.
Budget Impact: Savings were 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 # 16-02)

D. AMENDING Agency rules at OAC 317:35-5-2 and 317:35-22-2 to continue the use of the global care current procedural terminology (CPT) codes for routine obstetrical care billing, which can be used if the provider had provided care for a member for greater than one trimester.
Budget Impact: Budget neutral

(Reference APA WF # 16-15B)

MOTION: Member Robison moved for approval of Items 6A-D as published. The motion was seconded by Member Bryant.

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

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.

OHCA Initiated

E. AMENDING Agency rules at OAC 317:30-5-2 clarified licensing provisions and contracting requirements for medical residents and clarified direct physician care visit limits. Proposed revisions removed language specific to non-licensed physicians in a training program. The revisions to the medical licensure requirements were necessary to comply with federal regulations that require all ordering or referring physicians be enrolled as participating providers. Rules regarding reimbursement for obstetrical care were amended to continue the use of the global current procedural terminology (CPT) codes for routine obstetrical care billing. The proposed revisions regarding direct physician care visit limits clarified that SoonerCare Choice members are exempt from primary care office visits limits. This proposed revision was necessary to comply with current Waiver parameters and to ensure the access to care for Choice members was not impacted. **The aforementioned changes were approved during promulgation of the emergency rule.**

The following are proposed changes not previously reviewed: Amendments to General Coverage policy clarify medical necessity requirements for molecular pathology services and identify the appropriate provider types that are allowed to order testing. The current rules outline requirements for genetic testing and proposed amendments clarify that these rules apply to all molecular pathology services. Molecular pathology and genetic testing are terms that are often used interchangeably, although molecular pathology can include a broader array of laboratory services.

Budget Impact: The proposed rules requiring medical residents to contract directly with OHCA and the reinstatement of the global CPT care codes are budget neutral.

Limiting molecular pathology services to one code per one test will result in savings to the agency which has been identified in WF #16-26.

(Reference APA WF # 16-12)

F. AMENDING Agency rules at OAC 317:30-5-22, 317:30-5-22.1, 317:30-5-226, 317:30-5-229, 317:30-5-356, and 317:30-5-664.8 to continue the use of the global care Current Procedural Terminology (CPT) codes for routine obstetrical care billing, which can be used if the provider had provided care for a member for greater than one trimester. **The aforementioned changes were approved during promulgation of the emergency rule.**

The following are proposed changes not previously reviewed: Amendments to Obstetrical policy add the term certified to the title nurse midwives to align rules with terminology used by the Oklahoma Board of Nursing. Revisions remove the requirement for providers to submit the paper form CH-17 to the OHCA as part of the prior authorization process for obtaining high risk obstetrical services. The prior authorization process is online and the form is duplicative of documentation that is now required to be submitted for approval.
Budget Impact: Budget neutral

(Reference APA WF # 16-15A)

MOTION: Member McVay moved for approval of items 6E & 6Fas published. The motion was seconded by Member Nuttle.

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

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

ODMHSAS Initiated

G. AMENDING Agency rules at OAC 317:30-5-95.26, 317:30-5-95.33, 317:30-5-95.34 and 317:30-5-96.3 to revise existing language to accurately reflect the total number of core active treatment hours for individuals in a Community Based Transitional (CBT) setting from four to four and a half hours. In addition, revisions clarify information regarding active treatment requirements for process group therapy if a child is admitted to the facility on a day other than the beginning of a treatment week. For example, in acute, by day three, one hour of treatment is required. By day five, two hours of treatment are required. Beginning on day seven, three hours of treatment are required each week. In residential treatment (including Psychiatric Residential Treatment Facilities (PRTF) and CBT), by day five, one hour of treatment is required. Beginning on day seven, two hours of treatment is required each week. In addition, policy amends medical necessity criteria for continued stay in an acute psychiatric setting for children to include requirements for 24 hour nursing/medical supervision. This change will help ensure appropriate level of care is being provided. Rules are also revised to update the time between treatment plan reviews. Revisions clarify that time between treatment plan reviews are at a minimum every five to nine calendar days when in acute care, 14 calendar days when in a regular PRTF, 21 calendar days in the OHCA approved longer term treatment programs or specialty PRTFs and 30 calendar days in CBT treatment programs. The extension of treatment plan reviews will allow inpatient providers additional time for response to treatment as well as ease the administrative burden without compromising quality of care. Further, rules are added to clarify that payment for Health Home transitioning services provided with an inpatient provider will be directly reimbursed to the Health Home outside of the inpatient facility's per diem or DRG rate.
ODMHSAS Budget Impact: The rule change to add health home transitioning services has a projected total savings of $937,128 with a state share savings of $132,008 attributable to the Oklahoma Department of Mental Health and Substance Abuse Services.

(Reference APA WF # 16-14)

OHCA Initiated

H. AMENDING Agency rules at OAC 317:30-5-1027 and 317:30-5-1033 to correct the number of units authorized for personal care services. The rules currently allow for 32 units yearly; however the 32 units which are in 10 minute increments have a daily limit rather than a yearly limit. In addition, rules are updated to reflect that claims must be received within six months from the date of service. This change was inadvertently missed during a previous change to the timely filing requirements.
Budget Impact: Budget neutral

(Reference APA WF # 16-11)

I. AMENDING Agency rules at OAC 317:1-3-4 to revise the State Plan Amendment and Rate Committee (SPARC) policy. Revisions increase the SPARC officials from five persons to seven persons and allows for appointed alternates. The changes to the membership enhances our coordinated efforts with sister agencies.
Budget Impact: Budget neutral

(Reference APA WF # 16-21)

J. AMENDING Agency rules at OAC 317:10-1-1, 317:10-1-3, 317:10-1-4, 317:10-1-12, and 317:10-1-16 to replace outdated references to the Oklahoma Department of Central Services with the Office of Management and Enterprise Services. The Oklahoma Department of Central Services was consolidated under the Office of Management and Enterprise Services in 2011. Revisions also clarify that supply and non-professional services acquisitions over $5,000 must be approved by the Chief Executive Officer, Executive Staff, or designee; current

rules allow for the CEO or designated associate director.
Budget Impact: Budget neutral

(Reference APA WF # 16-22)

K. AMENDING Agency rules at OAC 317:30-5-660.3, 317:30-5-661.4, 317:30-5-664.1, 317:30-5-1087, 317:30-5-1090, 317:30-5-1094, and 317:30-5-1098 to Indian Health Services, Tribal Program and Urban Indian Clinics (I/T/Us) and Federally Qualified Health Centers policy that removes the minimum 45-50 minute time requirement for outpatient behavioral health encounters. Rules are also added to indicate that behavioral health services must be billed on an appropriate claim form using appropriate Current Procedural Code (CPT) and guidelines. In addition, rules clarify that prescription drugs are now billed pursuant to the changes made to our Chapter 30 rules that adhere with federal guidelines. Those changes modified the pharmacy pricing methodology and now allow the I/T/U pharmacies to be reimbursed at the Federal Office of Management and Budget (OMB) encounter rate. Further, revisions reference a section of policy related to home health services that were changed to now require a face to face encounter prior to the ordering of services. In addition, rules are revised to replace the term telemedicine with telehealth to be more inclusive of an array of telehealth technologies that could potentially be used to deliver healthcare services to SoonerCare members.
Budget Impact: Agency staff has determined that the proposed rule may result in a budget impact for the aforementioned services when provided in a Federally Qualified Health Center. The budget impact is approximately $412,130 total dollars, $165,099 state share.

(Reference APA WF # 16-23)

L. AMENDING Agency rules at OAC 317:30-5-20 to clarify medical necessity criteria for molecular pathology services and specify which provider types can order testing. In addition, proposed Laboratory Services policy clarifies reimbursement requirements for molecular pathology tests that examine multiple genes in a single test panel. Providers must utilize a one code for one test approach to billing molecular pathology tests. If an appropriate code is not available, providers are permitted to bill one unit of an unlisted molecular pathology procedure code.
Budget Impact: A one year proposed budget savings is estimated at $50,000 total dollars; State share $20,715; Federal share $29,285.

(Reference APA WF # 16-26)

M. AMENDING Agency rules at OAC 317:30-5-42.16 and 317:30-5-546 to add language in accordance with Federal regulation that directs the ordering physician and/or qualified provider to conduct and document a face-to-face encounter with a member for the initiation of home health services. The revisions are applicable to home health services that are billed by home health agencies under Title XIX program.
Budget Impact: Budget neutral

(Reference APA WF # 16-27)

MOTION: Member Case moved for approval of items 6G-M as published. The motion was seconded by Member Bryant.

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

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

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

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

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

ITEM 8 / NEW BUSINESS

There was no new business.

ITEM 9 / ADJOURNMENT

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

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

Meeting adjourned at 2:37 p.m., 02/09/2017

NEXT BOARD MEETING
March 23, 2017
Oklahoma Health Care Authority
Oklahoma City, OK

Lindsey Bateman
Board Secretary

Minutes Approved: _____

Initials: _____

FINANCIAL REPORT

For the Seven Months Ended January 31,2017
Submitted to the CEO & Board

- Revenues for OHCA through January, accounting for receivables, were **$2,498,702,031** or **.4% under** budget.
- Expenditures for OHCA, accounting for encumbrances, were **$2,349,801,605 or .6% under** budget.
- The state dollar budget variance through January is a **positive $5,082,547.**
- The budget variance is primarily attributable to the following (in millions):

Expenditures:		
Medicaid Program Variance		4.73
Administration		1.6
Revenues:		
Drug Rebate		.1
Taxes and Fees		(1.3)
Overpayments/Settlements		(.03)
Total FY 17 Variance	**$**	**5.1**

ATTACHMENTS

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

REVENUES	FY17 Budget YTD	FY17 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 718,393,389	$ 718,393,389	$ -	0.0%
Federal Funds	1,342,489,822	1,334,724,024	(7,765,797)	(0.6)%
Tobacco Tax Collections	29,534,859	28,589,726	(945,133)	(3.2)%
Quality of Care Collections	45,666,521	45,465,752	(200,769)	(0.4)%
Prior Year Carryover	27,584,042	27,584,042	-	0.0%
Federal Deferral - Interest	55,372	55,372	-	0.0%
Drug Rebates	151,717,256	151,979,983	262,727	0.2%
Medical Refunds	20,547,524	20,467,831	(79,693)	(0.4)%
Supplemental Hospital Offset Payment Program	159,416,854	159,416,854	-	0.0%
Other Revenues	12,133,141	12,025,059	(108,082)	(0.9)%
TOTAL REVENUES	**$ 2,507,538,779**	**$ 2,498,702,031**	**$ (8,836,748)**	**(0.4)%**

EXPENDITURES	FY17 Budget YTD	FY17 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 32,594,778**	**$ 29,300,684**	**$ 3,294,094**	**10.1%**
ADMINISTRATION - CONTRACTS	**$ 49,904,180**	**$ 49,056,578**	**$ 847,602**	**1.7%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	23,903,429	23,423,540	479,889	2.0%
Acute Fee for Service Payments:				
Hospital Services	523,477,605	520,521,923	2,955,682	0.6%
Behavioral Health	11,493,595	11,411,024	82,571	0.7%
Physicians	232,836,418	231,981,767	854,651	0.4%
Dentists	73,861,831	72,974,416	887,415	1.2%
Other Practitioners	31,453,635	30,741,791	711,844	2.3%
Home Health Care	10,290,899	9,930,384	360,515	3.5%
Lab & Radiology	19,480,092	18,414,971	1,065,121	5.5%
Medical Supplies	27,117,746	27,044,788	72,958	0.3%
Ambulatory/Clinics	101,961,748	101,595,835	365,913	0.4%
Prescription Drugs	306,443,953	305,377,058	1,066,895	0.3%
OHCA Therapeutic Foster Care	(1)	(83,082)	83,081	0.0%
Other Payments:				
Nursing Facilities	324,857,380	324,889,635	(32,255)	(0.0)%
Intermediate Care Facilities for Individuals with Intellectual Disabilities Private	36,076,673	35,673,767	402,906	1.1%
Medicare Buy-In	96,421,283	96,411,833	9,450	0.0%
Transportation	37,894,730	37,675,357	219,373	0.6%
Money Follows the Person-OHCA	203,867	106,755	97,112	0.0%
Electonic Health Records-Incentive Payments	8,790,920	8,790,920	-	0.0%
Part D Phase-In Contribution	54,809,938	54,804,842	5,096	0.0%
Supplemental Hospital Offset Payment Program	353,179,907	353,179,907	-	0.0%
Telligen	6,576,912	6,576,912	-	0.0%
Total OHCA Medical Programs	**2,281,132,560**	**2,271,444,343**	**9,688,217**	**0.4%**
OHCA Non-Title XIX Medical Payments	89,382	-	89,382	0.0%
TOTAL OHCA	**$ 2,363,720,899**	**$ 2,349,801,605**	**$ 13,919,294**	**0.6%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ 143,817,879**	**$ 148,900,426**	**$ 5,082,547**	

OKLAHOMA HEALTH CARE AUTHORITY

Total Medicaid Program Expenditures
by Source of State Funds
SFY 2017, For the Seven Month Period Ending January 31, 2017

Category of Service	Total	Health Care Authority	Quality of Care Fund	HEEIA	SHOPP Fund	BCC Revolving Fund	Other State Agencies
SoonerCare Choice	$ 23,495,255	$ 23,416,919	$ -	$ 71,715	$ -	$ 6,621	$ -
Inpatient Acute Care	736,440,153	346,600,294	283,901	2,031,786	249,343,314	906,747	137,274,111
Outpatient Acute Care	254,936,605	170,514,994	24,269	2,464,326	79,741,297	2,191,720	
Behavioral Health - Inpatient	37,797,332	6,734,047	-	161,677	23,257,946	-	7,643,662
Behavioral Health - Psychiatrist	5,514,326	4,676,977	-	-	837,349	-	-
Behavioral Health - Outpatient	9,798,434	-	-	-	-	-	9,798,434
Behaviorial Health-Health Home	21,249,201	-	-	-	-	-	21,249,201
Behavioral Health Facility- Rehab	136,505,983	-	-	-	-	35,063	136,505,983
Behavioral Health - Case Management	10,539,268	-	-	-	-	-	10,539,268
Behavioral Health - PRTF	38,809,854	-	-	-	-	-	38,809,854
Residential Behavioral Management	10,905,394	-	-	-	-	-	10,905,394
Targeted Case Management	42,167,664	-	-	-	-	-	42,167,664
Therapeutic Foster Care	(83,082)	(83,082)	-	-	-	-	-
Physicians	267,127,195	229,514,264	33,892	(201,510)	-	2,433,611	35,346,938
Dentists	72,990,937	72,967,803	-	16,521	-	6,613	-
Mid Level Practitioners	1,549,377	1,533,836	-	14,182	-	1,359	-
Other Practitioners	29,438,073	28,894,217	260,379	231,477	-	52,000	-
Home Health Care	9,937,726	9,923,648	-	7,341	-	6,736	-
Lab & Radiology	18,841,086	18,286,165	-	426,115	-	128,805	-
Medical Supplies	27,205,836	25,446,411	1,581,727	161,048	-	16,650	-
Clinic Services	100,478,991	97,365,740	-	517,430	-	88,640	2,507,181
Ambulatory Surgery Centers	4,201,482	4,135,206	-	60,027	-	6,248	-
Personal Care Services	6,999,044	-	-	-	-	-	6,999,044
Nursing Facilities	324,889,635	199,259,735	125,629,900	-	-	-	-
Transportation	37,582,777	36,111,348	1,445,570	-	-	25,860	-
GME/IME/DME	88,748,342	-	-	-	-	-	88,748,342
ICF/IID Private	35,673,767	29,161,736	6,512,031	-	-	-	-
ICF/IID Public	8,960,079	-	-	-	-	-	8,960,079
CMS Payments	151,216,675	150,746,295	470,380	-	-	-	-
Prescription Drugs	312,879,553	304,049,869	-	7,502,495	-	1,327,189	-
Miscellaneous Medical Payments	92,580	92,580	-	-	-	-	-
Home and Community Based Waiver	117,911,394	-	-	-	-	-	117,911,394
Homeward Bound Waiver	47,909,486	-	-	-	-	-	47,909,486
Money Follows the Person	150,194	106,755	-	-	-	-	43,439
In-Home Support Waiver	14,678,692	-	-	-	-	-	14,678,692
ADvantage Waiver	107,696,830	-	-	-	-	-	107,696,830
Family Planning/Family Planning Waiver	2,268,111	-	-	-	-	-	2,268,111
Premium Assistance*	34,723,125	-	-	34,723,125	-	-	-
Telligen	6,576,912	6,576,912	-	-	-	-	-
Electronic Health Records Incentive Payments	8,790,920	8,790,920	-	-	-	-	-
Total Medicaid Expenditures	**$ 3,167,595,204**	**$ 1,774,823,590**	**$ 136,242,048**	**$ 48,187,756**	**$ 353,179,906**	**$ 7,233,861**	**$ 847,963,105**

* Includes $34,496,747 paid out of Fund 245

OKLAHOMA HEALTH CARE AUTHORITY

Summary of Revenues & Expenditures:

Other State Agencies

SFY 2017, For the Seven Month Period Ending January 31, 2017

		FY17 Actual YTD
REVENUE		
Revenues from Other State Agencies	$	363,788,002
Federal Funds		526,992,091
TOTAL REVENUES	**$**	**890,780,093**
EXPENDITURES		**Actual YTD**
Department of Human Services		
Home and Community Based Waiver	$	117,911,394
Money Follows the Person		43,439
Homeward Bound Waiver		47,909,486
In-Home Support Waivers		14,678,692
ADvantage Waiver		107,696,830
Intermediate Care Facilities for Individuals with Intellectual Disabilities Public		8,960,079
Personal Care		6,999,044
Residential Behavioral Management		8,085,669
Targeted Case Management		37,145,980
Total Department of Human Services		**349,430,612**
State Employees Physician Payment		
Physician Payments		35,346,938
Total State Employees Physician Payment		**35,346,938**
Education Payments		
Graduate Medical Education		50,325,402
Graduate Medical Education - Physicians Manpower Training Commission		3,652,219
Indirect Medical Education		33,086,772
Direct Medical Education		1,683,949
Total Education Payments		**88,748,342**
Office of Juvenile Affairs		
Targeted Case Management		1,489,415
Residential Behavioral Management		2,819,725
Total Office of Juvenile Affairs		**4,309,140**
Department of Mental Health		
Case Management		10,539,268
Inpatient Psychiatric Free-standing		7,643,662
Outpatient		9,798,434
Health Homes		21,249,201
Psychiatric Residential Treatment Facility		38,809,854
Rehabilitation Centers		136,505,983
Total Department of Mental Health		**224,546,402**
State Department of Health		
Children's First		1,038,644
Sooner Start		642,582
Early Intervention		2,231,381
Early and Periodic Screening, Diagnosis, and Treatment Clinic		370,656
Family Planning		75,730
Family Planning Waiver		2,180,936
Maternity Clinic		2,709
Total Department of Health		**6,542,638**
County Health Departments		
EPSDT Clinic		428,495
Family Planning Waiver		11,445
Total County Health Departments		**439,940**
State Department of Education		**101,242**
Public Schools		**161,002**
Medicare DRG Limit		**130,345,215**
Native American Tribal Agreements		**1,062,739**
Department of Corrections		**729,651**
JD McCarty		**6,199,245**
Total OSA Medicaid Programs	**$**	**847,963,105**
OSA Non-Medicaid Programs	**$**	**39,550,037**
Accounts Receivable from OSA	**$**	**(3,266,950)**

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

Fund 205: Supplemental Hospital Offset Payment Program Fund

SFY 2017, For the Seven Month Period Ending January 31, 2017

REVENUES	FY 17 Revenue
SHOPP Assessment Fee	$ 159,255,868
Federal Draws	212,855,062
Interest	58,176
Penalties	102,810
State Appropriations	(22,650,000)
TOTAL REVENUES	$ 349,621,916

EXPENDITURES	Quarter	Quarter	Quarter	FY 17 Expenditures
Program Costs:	7/1/16 - 9/30/16	10/1/16 - 12/31/16	1/1/17 - 3/31/17	
Hospital - Inpatient Care	76,250,540	79,873,814	93,218,960	$ 249,343,314
Hospital -Outpatient Care	27,213,505	28,255,818	24,271,974	79,741,297
Psychiatric Facilities-Inpatient	6,661,677	6,897,421	9,698,849	23,257,946
Rehabilitation Facilities-Inpatient	257,683	269,198	310,468	837,349
Total OHCA Program Costs	110,383,405	115,296,250	127,500,252	$ 353,179,907
Total Expenditures				$ 353,179,907

CASH BALANCE	$ (3,557,991)

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

Fund 230: Nursing Facility Quality of Care Fund

SFY 2017, For the Seven Month Period Ending January 31, 2017

REVENUES	Total Revenue	State Share
Quality of Care Assessment	$ 45,443,654	$ 45,443,654
Interest Earned	22,098	22,098
TOTAL REVENUES	**$ 45,465,752**	**$ 45,465,752**

EXPENDITURES	FY 17 Total $ YTD	FY 17 State $ YTD	Total State $ Cost
Program Costs			
Nursing Facility Rate Adjustment	$ 123,490,464	$ 48,914,573	
Eyeglasses and Dentures	160,576	63,604	
Personal Allowance Increase	1,978,860	783,826	
Coverage for Durable Medical Equipment and Supplies	1,581,727	626,522	
Coverage of Qualified Medicare Beneficiary	602,441	238,627	
Part D Phase-In	470,380	186,318	
ICF/IID Rate Adjustment	3,015,792	1,194,555	
Acute Services ICF/IID	3,496,239	1,384,860	
Non-emergency Transportation - Soonerride	1,445,570	572,590	
Total Program Costs	**$ 136,242,048**	**$ 53,965,475**	**$ 53,965,475**
Administration			
OHCA Administration Costs	$ 310,152	$ 155,076	
DHS-Ombudsmen	79,036	79,036	
OSDH-Nursing Facility Inspectors	-	-	
Mike Fine, CPA	-	-	
Total Administration Costs	**$ 389,188**	**$ 234,112**	**$ 234,112**
Total Quality of Care Fee Costs	**$ 136,631,236**	**$ 54,199,587**	
TOTAL STATE SHARE OF COSTS			**$ 54,199,587**

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

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

Fund 245: Health Employee and Economy Improvement Act Revolving Fund

SFY 2017, For the Seven Month Period Ending January 31, 2017

REVENUES	FY 16 Carryover	FY 17 Revenue	Total Revenue
Prior Year Balance	$ 5,199,281	$ -	$ 3,102,480
State Appropriations	(2,000,000)	-	-
Tobacco Tax Collections	-	23,514,830	23,514,830
Interest Income	-	71,893	71,893
Federal Draws	246,145	21,633,855	21,633,855
TOTAL REVENUES	**$ 3,445,426**	**$ 45,220,578**	**$ 48,323,058**

EXPENDITURES		FY 16 Expenditures	FY 17 Expenditures	Total $ YTD
Program Costs:				
	Employer Sponsored Insurance		$ 34,496,747	$ 34,496,747
	College Students/ESI Dental		226,379	89,669
Individual Plan				
	SoonerCare Choice		$ 69,123	$ 27,380
	Inpatient Hospital		2,026,701	802,776
	Outpatient Hospital		2,430,198	960,900
	BH - Inpatient Services-DRG		154,041	60,908
	BH -Psychiatrist		-	-
	Physicians		(168,562)	(66,650)
	Dentists		16,411	6,489
	Mid Level Practitioner		14,182	5,608
	Other Practitioners		227,686	90,027
	Home Health		5,500	2,175
	Lab and Radiology		415,346	164,228
	Medical Supplies		153,008	60,499
	Clinic Services		506,185	200,146
	Ambulatory Surgery Center		57,355	22,678
	Prescription Drugs		7,366,945	2,912,890
	Miscellaneous Medical		-	-
	Premiums Collected		-	(318,419)
Total Individual Plan			**$ 13,274,118**	**$ 4,931,635**
	College Students-Service Costs		**$ 190,512**	**$ 75,462**
Total OHCA Program Costs			**$ 48,187,756**	**$ 39,593,512**
Administrative Costs				
	Salaries	$ 32,930	$ 1,186,205	$ 1,219,135
	Operating Costs	15,971	95,033	111,004
	Health Dept-Postponing	-	-	-
	Contract - HP	294,045	1,410,374	1,704,419
Total Administrative Costs		**$ 342,946**	**$ 2,691,612**	**$ 3,034,558**
Total Expenditures				**$ 42,628,070**
NET CASH BALANCE		**$ 3,102,480**		**$ 5,694,988**

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

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

SFY 2017, For the Seven Month Period Ending January 31, 2017

REVENUES	FY 17 Revenue	State Share
Tobacco Tax Collections	$ 469,162	$ 469,162
TOTAL REVENUES	**$ 469,162**	**$ 469,162**

EXPENDITURES	FY 17 Total $ YTD	FY 17 State $ YTD	Total State $ Cost
Program Costs			
SoonerCare Choice	$ 6,621	$ 313	
Inpatient Hospital	906,747	42,889	
Outpatient Hospital	2,191,720	103,668	
Inpatient Services-DRG	-	-	
Psychiatrist	-	-	
TFC-OHCA	-	-	
Nursing Facility	-	-	
Physicians	2,433,611	115,110	
Dentists	6,613	313	
Mid-level Practitioner	1,359	64	
Other Practitioners	52,000	2,460	
Home Health	6,736	319	
Lab & Radiology	128,805	6,092	
Medical Supplies	16,650	788	
Clinic Services	88,640	4,193	
Ambulatory Surgery Center	6,248	296	
Prescription Drugs	1,327,189	62,776	
Transportation	23,107	1,093	
Miscellaneous Medical	2,753	130	
Total OHCA Program Costs	**$ 7,198,799**	**$ 340,503**	
OSA DMHSAS Rehab	$ 35,063	$ 1,658	
Total Medicaid Program Costs	**$ 7,233,861**	**$ 342,162**	
TOTAL STATE SHARE OF COSTS			**$ 342,162**

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.

SFY 2018
Appropriations Scenarios

Presentation to the OHCA Board of Directors

March 23, 2017

Oklahoma HealthCare Authority

CUTS TO PROGRAM IN LAST 6 SFYs

- **2010 – 3.25% provider rate cut**
- **2015 – 7.75% provider rate cut**
- **2016 – 3% provider rate cut**

  Today's reimbursement rate is 86.57% of the Medicare physician fee schedule.

- **More than $400 million has been cut from the program since SFY 2010**

Oklahoma HealthCare Authority

REGIONAL PHYSICIAN PROVIDER RATES

2016 Medicaid to Medicare Physician Fee Schedule

Arkansas = .80

Colorado = .72

Kansas = .78

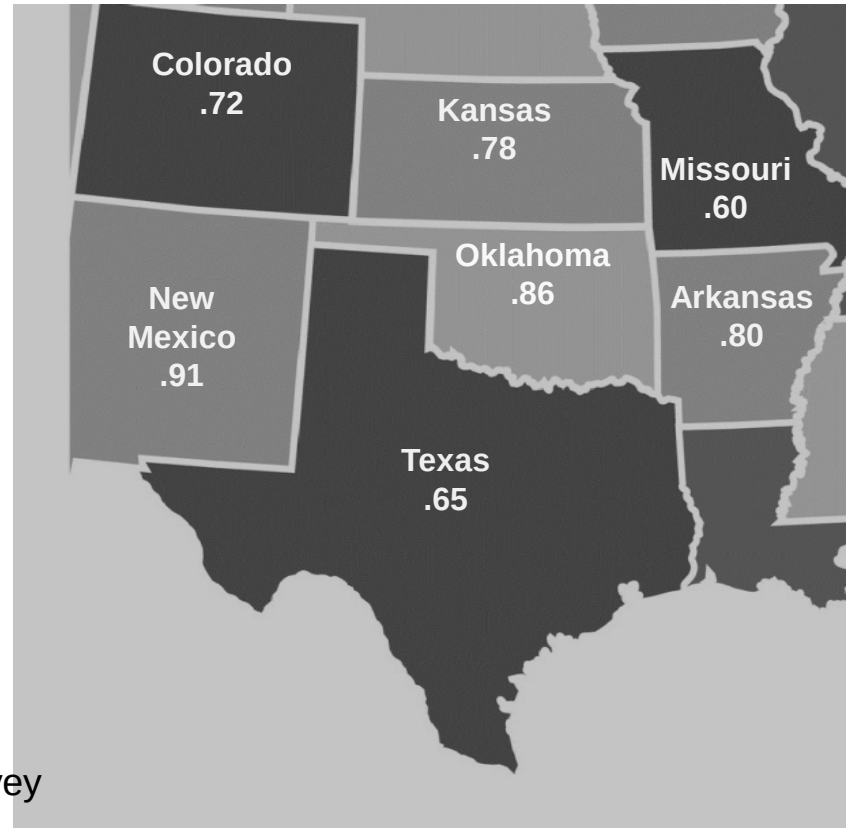
Louisiana = .71

Missouri = .60

New Mexico = .91

Oklahoma = .86

Texas = .65



Source: Urban Institute 2014 Medicaid Physician Survey

Oklahoma HealthCare Authority

SFY 2018 Appropriation Scenarios

SFY 2017 Appropriation base revised (after March 2017 revenue failure) **$986.4M**

State savings from 1% provider rate reduction **$8.6M**

If Congress extends ACA-CHIP funding (94%)

% Cut	Appropriation reduction (state only)	SFY18 Appropriation need	Total State Reduction	Total Reduction (state & federal)	Provider rate reduction equivalent
0% (Flat)	**-**	**$69M**	**$69M**	**$167M**	**8.0%**
5%	**$50M**	**$69M**	**$118M**	**$288M**	**13.7%**
10%	**$99M**	**$69M**	**$168M**	**$408M**	**19.5%**
14.5%	**$143M**	**$69M**	**$212M**	**$515M**	**24.6%**
15%	**$148M**	**$69M**	**$217M**	**$527M**	**25.2%**

*The ACA-CHIP funding will expire on 9/30/2017. If Congress reauthorizes the ACA funding match, OHCA will need **$69M** to maintain today's program and rates.*

If Congress does not extend CHIP funding

% Cut	Appropriation reduction (state only)	SFY18 Appropriation need	Total State Reduction	Total Reduction (state & federal)	Provider rate reduction equivalent
0% (Flat)	**-**	**$118M**	**$118M**	**$288M**	**13.7%**
5%	**$50M**	**$118M**	**$168M**	**$408M**	**19.5%**
10%	**$99M**	**$118M**	**$217M**	**$529M**	**25.3%**
14.5%	**$143M**	**$118M**	**$261M**	**$636M**	**30.4%**
15%	**$148M**	**$118M**	**$266M**	**$648M**	**30.9%**

*If Congress does not reauthorize the ACA CHIP funding match, OHCA will need **$118M** to maintain today's program and rates.*

Access Monitoring Review Plan Timeline

- OHCA submitted the initial Access Monitoring Review Plan (AMRP) to CMS on September 28, 2016 and received verbal approval on December 15, 2016.

- OHCA will review and update the federally required categories of services within the AMRP annually as well as post for public review on the public website.

- An updated AMRP will be submitted to CMS every three years.

Oklahoma HealthCare Authority

Access Monitoring Review Plan Service Categories

- Primary care services (including those provided by a physician, federally-qualified health center, clinic, or dental provider)
- Physician specialist services (e.g., cardiology)
- Behavioral health services (including mental health and substance use disorder)
- Pre- and post-natal obstetric services, including labor and delivery
- Home health services

Oklahoma HealthCare Authority

Access to Care Analysis

- Proposed reductions of provider payment rates must demonstrate sufficient access to care by comparing the following:
  - total number of providers/provider specialties;
  - total number of Medicaid eligible beneficiaries; and
  - increase/decrease of a services rendered.
- Effect on Access to Care
  - Monitoring will be informed by public review and will be conducted no less than annually.
  - If access deficiencies arise, the state must submit a corrective action plan to remediate diminished access within 12 months.

Oklahoma HealthCare Authority

OHCA Board Meeting
March 23, 2017
(January 2017 Data)

SOONERCARE ENROLLMENT/EXPENDITURES

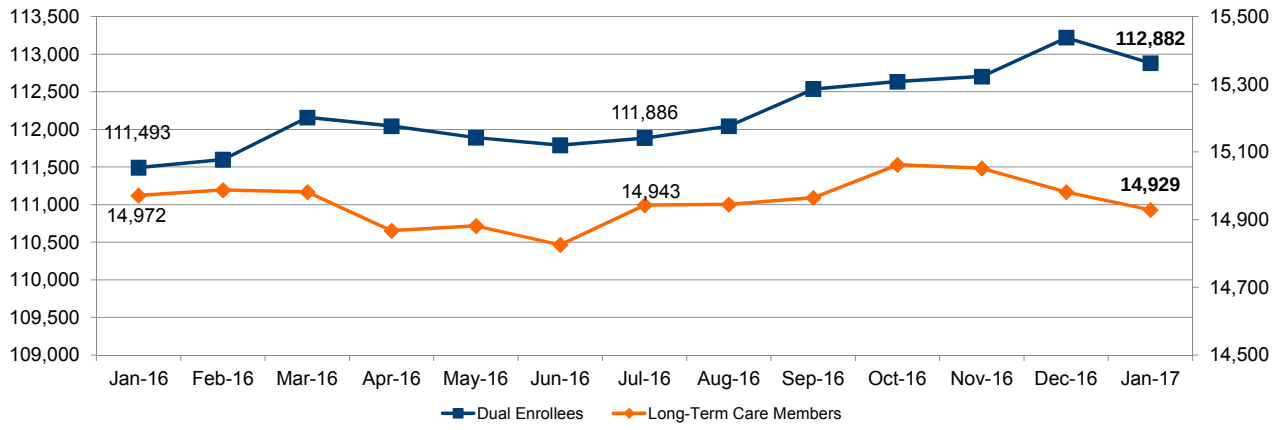
Delivery System			Enrollment January 2017	Children January 2017	Adults January 2017	Enrollment Change	Total Expenditures January 2017	PMPM January 2017	Forecasted Jan 2017 Trend PMPM
SoonerCare Choice Patient-Centered Medical Home			**549,075**	**453,577**	**95,498**	**-109**	**$132,132,353**		
	Lower Cost	*(Children/Parents; Other)*	505,836	439,933	65,903	-55	$95,469,547	$189	$201
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC)*	43,239	13,644	29,595	-54	$36,662,806	$848	$877
SoonerCare Traditional			**235,955**	**89,973**	**145,982**	**4,727**	**$155,843,212**		
	Lower Cost	*(Children/Parents; Other)*	122,841	84,852	37,989	4,466	$34,291,917	$279	$395
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC & HCBS Waiver)*	113,114	5,121	107,993	261	$121,551,295	$1,075	$1,224
SoonerPlan			**34,380**	**2,753**	**31,627**	**322**	**$222,865**	$6	$7
Insure Oklahoma			**20,132**	**551**	**19,581**	**7**	**$5,542,170**		
	Employer-Sponsored Insurance		15,259	360	14,899	-1	$3,928,932	$257	$319
	Individual Plan		4,873	191	4,682	8	$1,613,238	$331	$392
TOTAL			**839,542**	**546,854**	**292,688**	**4,947**	**$293,740,600**		

Enrollment totals include all members enrolled during the report month. Members may not have expenditure data. Children are members aged 0 - 20 or for Insure Oklahoma enrolled as Students or Dependents.

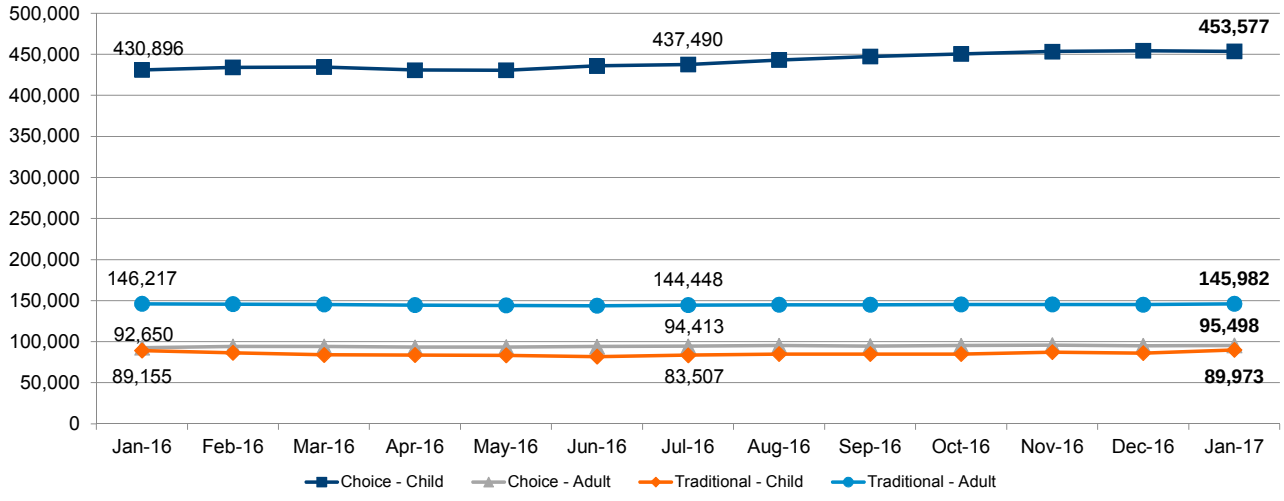
Total In-State Providers: 33,656 (+286) (In-State Providers counted multiple times due to multiple locations, programs, types, and specialties)

Physician	Pharmacy	Dentist	Hospital	Mental Health	Optometrist	Extended Care	Total PCPs	PCMH
9,080	972	1,295	202	6,289	676	225	6,435	2,601

DUAL ENROLLEES & LONG-TERM CARE MEMBERS



CHILDREN & ADULTS ENROLLMENT



OHCA BOARD OF DIRECTORS MEETING
LEGISLATIVE UPDATE, MARCH 23, 2017

As of March 16, 2017, following the March 2nd deadline, the Oklahoma State Legislature is considering 833 active bills. Over 1,400 bills that were introduced at the beginning of session have fallen dormant for the remainder of the 2017 session. OHCA is currently tracking 85 bills, of which five are OHCA request bills.

OHCA REQUEST BILLS

- HB 1579 – Rep. Chad Caldwell and Sen. Stephanie Bice – Data exchange with DPS to verify member identify;
  - Passed from House floor (87-5)
- SB 773 – Sen. Kim David and Rep. Glen Mulready – Foster children care coordination model;
  - Amended in committee to require RFI, rather than RFP
  - Passed from the Senate floor (33-9)
- SB 798 – Sen. Rob Standridge and Rep. Chris Kannady – OHCA provider audit appeals;
  - Passed unanimously in Senate committee (HHS)
- SB 819 – Sen. Frank Simpson and Rep. Pat Ownbey – Property liens;
  - Passed from Senate floor (43-4)
  - Introduced in the House 2-27-17
- SB 828 – Sen. A.J. Griffin and Rep. Chad Caldwell – Creation of nursing home UPL revolving fund;
  - Passed unanimously in Senate committees (Sub Appropriations, Health and Appropriations)
- *SB 729 – Sen. Frank Simpson and Rep. Pat Ownbey – Medicaid super lien;*
  - *Failed Deadline*

UPCOMING DEADLINES FOR THE 2017 LEGISLATIVE SESSION

April 13, 2017	House Measures to be Reported from Senate Committees
April 27, 2017	Third Reading of House and Senate Measures in Opposite Chamber
May 26, 2017	**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.

ELIGIBILITY AND ENROLLMENT

Board Presentation
March 23, 2017

Oklahoma HealthCare Authority

Online Enrollment Fast Facts

- Provides real-time eligibility decision AND enrollment
- Used for 70 percent of state's Medicaid applicants
- Handles 30K – 35K applications monthly, with an average of four persons per application
- Verifies as much as possible through data exchanges
- Central call center also handles paper documentation

Oklahoma HealthCare Authority

Application Process

- Required fields ensure applicants provide all necessary information.
- Real-time verifications occur throughout application: Social Security number, citizenship, alienage and income.
- If the system is unable to verify real-time, members must then provide necessary documentation.

Oklahoma HealthCare Authority

Application Methods

- Requires home users to create an account and go through an email registration process. This helps authenticate applicants and reduce duplicate applications.
- Those without a computer have access to an extensive partner network to assist with the application process.

Oklahoma HealthCare Authority

Data Exchanges

Preventing Fraud

Oklahoma HealthCare Authority

Data Exchanges Conducted on Member

- Social Security Administration
- Oklahoma Employment Service Commission (OESC)
- Department of Homeland Security
- Federally Facilitated Marketplace (FFM)
- Public Assistance Recipient Information Systems (PARIS)

Oklahoma HealthCare Authority

Data Exchanges Conducted on Member, cont.

- Office of Juvenile Affairs
- Child support cooperation
- Third-party liability (TPL)
- Suspicious pregnancy
- Oklahoma Tax Commission (OTC)

Oklahoma HealthCare Authority

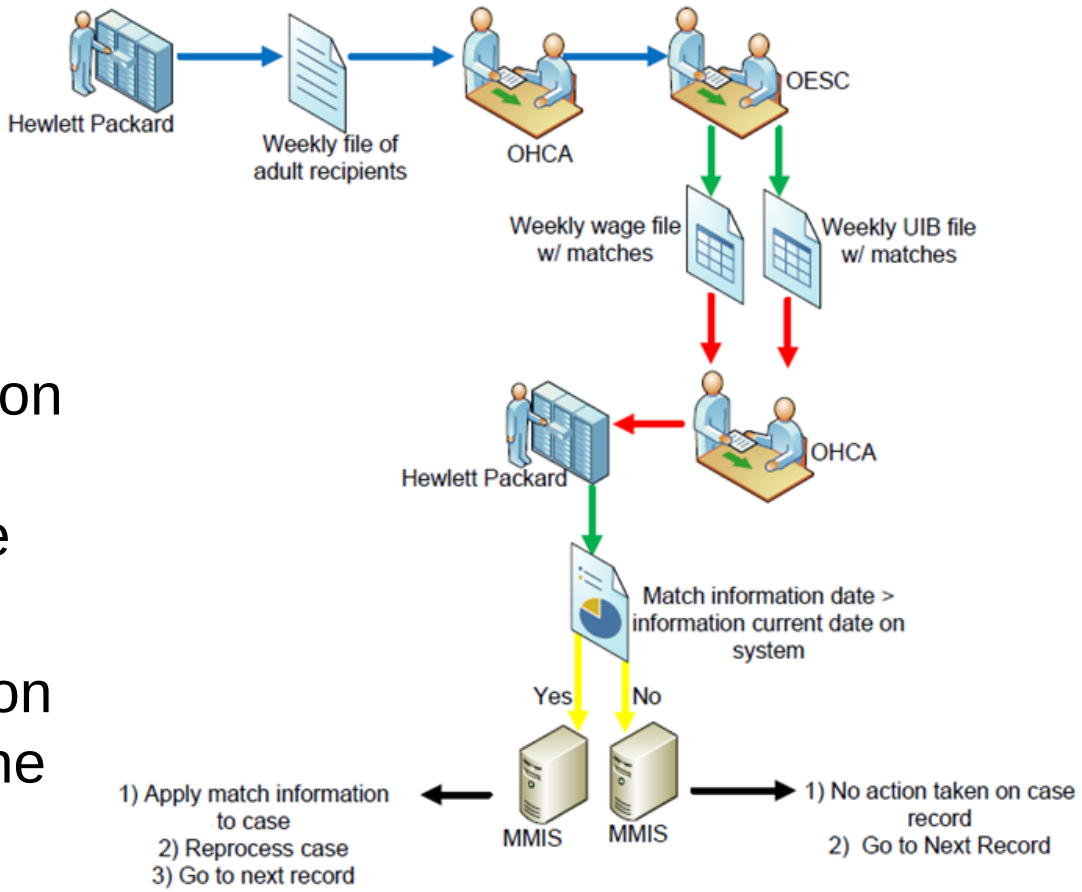
Discrepancies are Sworn Enemies of Automation

- Data-driven systems – Good, bad and Ugly
- Opportunity to rethink and redesign Policy
- Discrepancies and exceptions must be minimized to achieve automation
- Action is taken to stop something from happening, not to make it happen

Oklahoma HealthCare Authority

Employment Securities Commission

- Oklahoma uses an algorithm to verify earned income via a weekly data feed from OESC
- Earned income is based on quarterly wage data provided directly from the business
- Unemployment information is received weekly with the data source directly from OESC as the issuer



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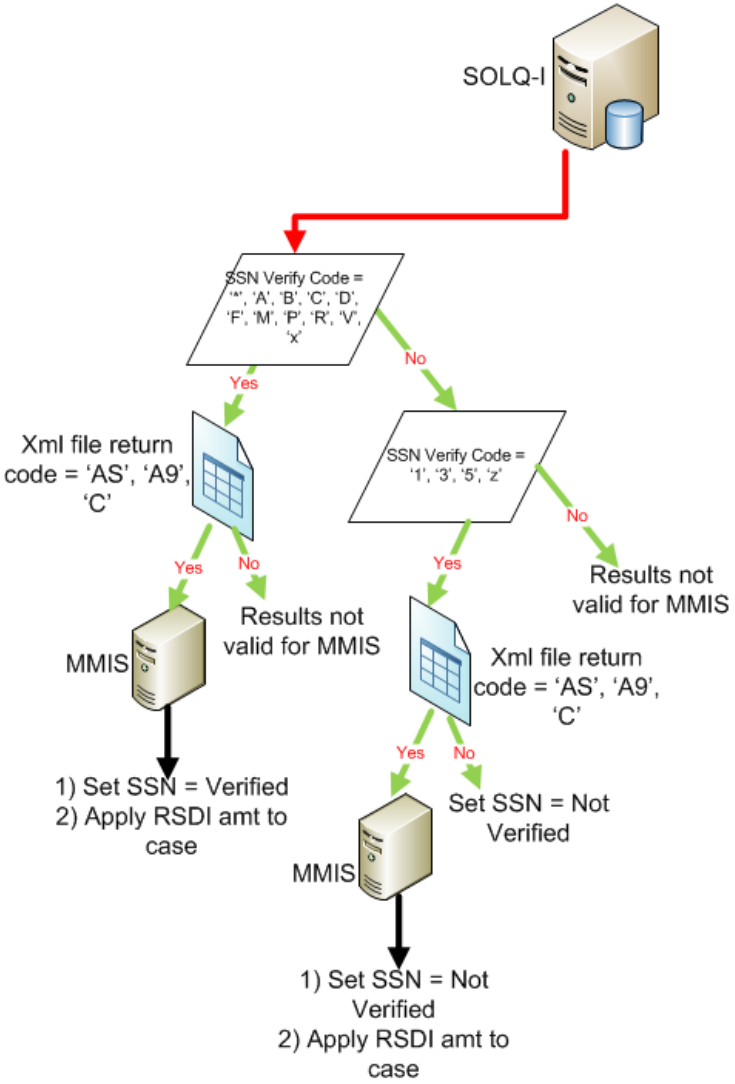
Social Security Administration

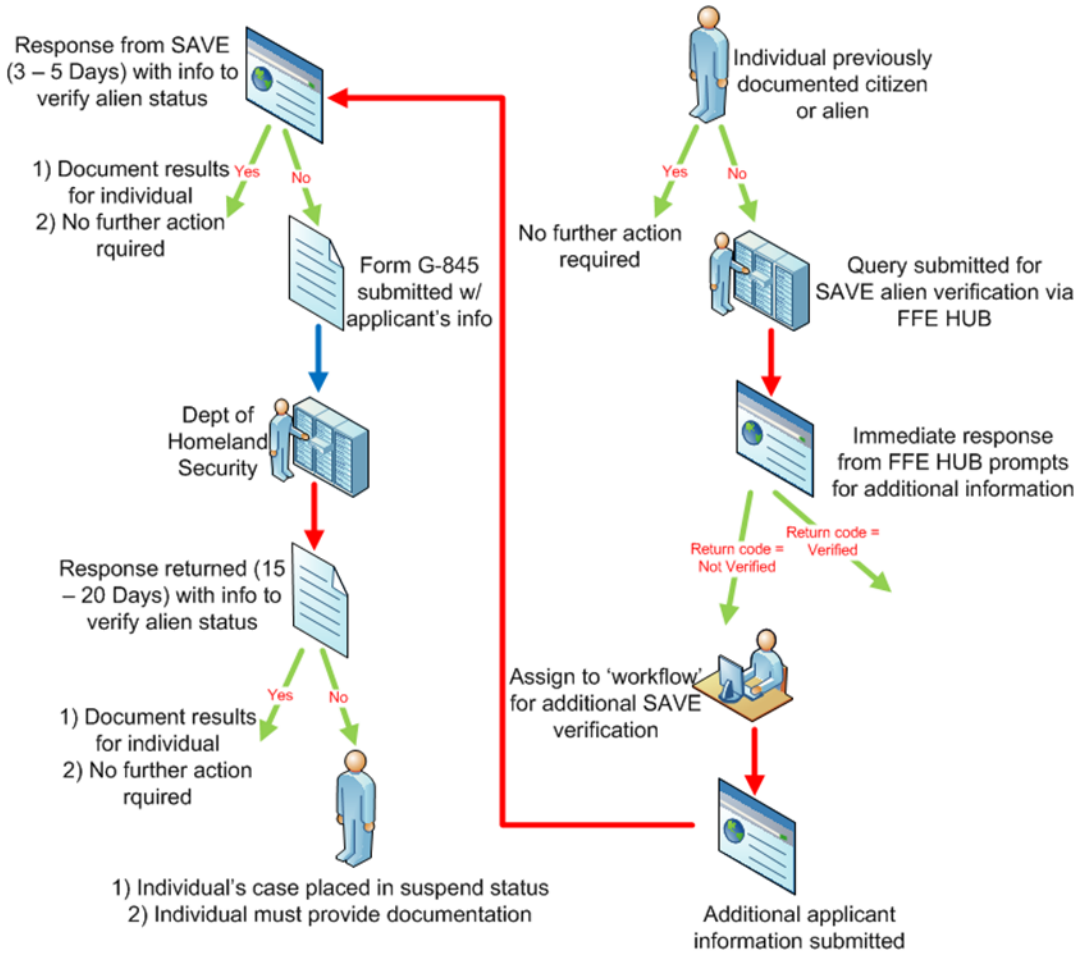
- Real-time verification of individual's Social Security Number and Citizenship
- Daily information related to Social Security Income and other benefits received via the SSA.
- Information is applied and process based on our business rules engine.



Oklahoma HealthCare Authority

Homeland Security

- Verifies individual citizenship status of
  - National or
  - Lawful presence
- Determines if an individual's eligibility for enrollment falls into one of our health plans
- There are three tiers that include both real-time and workflow within Member Services



Oklahoma HealthCare Authority

More About Data Exchanges

Other data exchanges (DX):

- **PARIS** - Ensures our members do not receive public assistance from other states. Occurs 2x/year, as well as ad hoc with neighboring states
- **FFM** - Oklahoma receives nightly and ad hoc information on Oklahomans who are deemed eligible for Medicaid coverage via healthcare.gov
- **Office of Juvenile Affairs -** Provides monthly and ad hoc files related to juveniles who are in the custody of the state more than 30 days
- **Child support cooperation -** Sends nightly files that ensure parents are cooperating with Oklahoma Child Support offices

Oklahoma HealthCare Authority

More About DXs, cont.

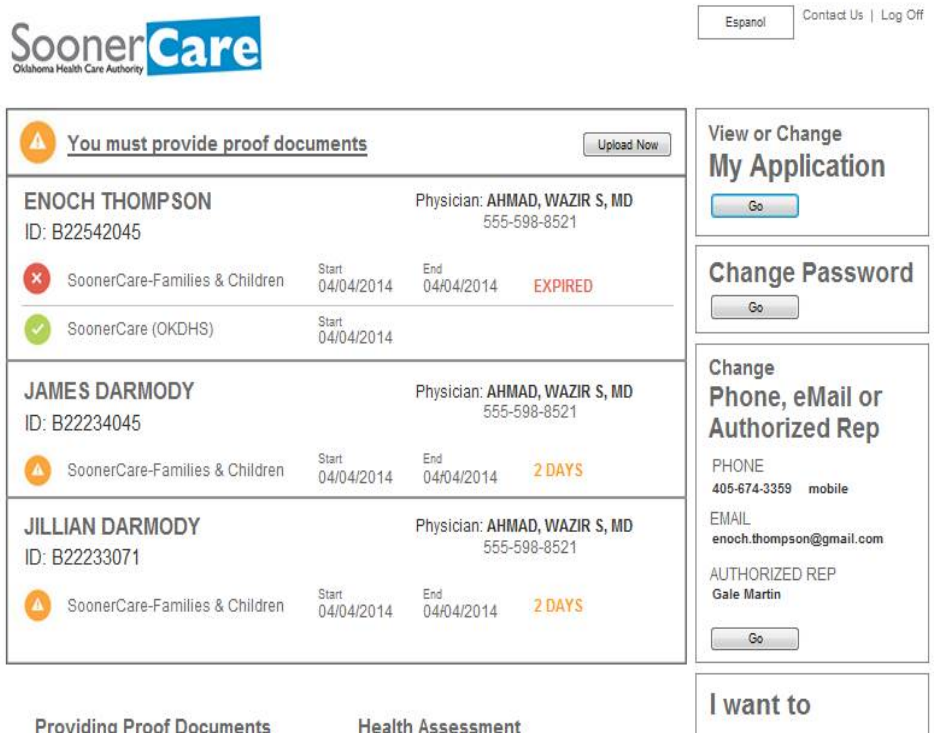
Checks and balances:

- Conducted by request and is accomplished by Member Services through workflow
- Information is self-declared for application purposes and follows the letter of the law
- Continues to have the best PERM rate in the nation
- Procedures to ensure maximum customer experience

Oklahoma HealthCare Authority

Next Steps for Online Enrollment

- Integration of new populations within online enrollment
  - The aged, blind and disabled (ABD) population
  - Tax Equity and Fiscal Responsibility Act (TEFRA)
  - Breast and cervical cancer
- Single “No Wrong Door” portal



- Working with the Health and Human Services (HHS) cabinet secretary and members of HHS agencies for increased integration

Oklahoma HealthCare Authority

Next Steps for Online Enrollment, cont.

Checks and balances:

- Work to improve DX services with the federal HUB and explore new exchanges
- Work with Oklahoma State Department of Health to enhance the state Enterprise Master Person (Patient) Index (eMPI)
- Department of Public Safety data exchange (HB1579)
- Identity proofing upon account setup

Oklahoma HealthCare Authority

www.mySoonerCare.org

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Oklahoma HealthCare Authority

Drug	Used for	Cost	Notes
Syndros	Nausea	not yet available	
Sustol	Nausea	$500 per chemo cycle	Generic less than $20/cycle
Bonjesta	Nausea	not yet available	
Viekira EX	Hepatitis C	$83,000/treatment	
Epclusa	Hepatitis C	$74,760/treatment	
Exondys 51	Muscular Dystrophy	$32,000-$160,000/month	orphan drug
Cinqair	Severe asthma	$1,670/month	
Fosrenol	Chronic kidney disease	$950/month	Several choices less than
Velphoro	Chronic kidney disease	$950/month	$100 per month
Auryxia	Chronic kidney disease	$875/month	
Defitelio	Rare complication	$138,600 - $396,000	orphan drug
Nuplazid	Parkinsons Psychosis	$1,950/month	
Veltassa	High potassium	$665/month	other available for $50-200
Kanuma	Rare genetic liver disease	$10,000/vial	orphan drug
Picato	Skin lesions	$875/treatment	
Briviact	Seizure disorders	$1,000/month	
Fycompa	Seizure disorders	$1,350/month	
Carnexiv	Seizure disorders	not yet available	orphan drug

Recommendation 1: Prior Authorize Syndros™ (Dronabinol), Sustol® (Granisetron), and Bonjesta® (Doxylamine/Pyridoxine)

The Drug Utilization Review Board recommends the prior authorization of Syndros™ (dronabinol oral solution), Sustol® (granisetron subcutaneous injection), and Bonjesta® (doxylamine/pyridoxine 20mg/20mg oral tablets) with the following criteria:

Marinol® and Syndros™ (Dronabinol) and Cesamet® (Nabilone) Approval Criteria:

1. Approval can be granted for six months for the diagnosis of HIV related loss of appetite.
2. The diagnosis of chemotherapy induced nausea and vomiting requires the following:
    a. 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 will be based on duration of need.
4. For Marinol® (dronabinol) and Cesamet® (nabilone), a quantity limit of 60 capsules per 30 days will apply.
5. For Syndros™ (dronabinol) oral solution, the quantity approved will be patient-specific depending on patient diagnosis, maximum recommended dosage, and manufacturer packaging.
6. For Syndros™ (dronabinol) oral solution, an age restriction of six years and younger will apply. Members older than six years of age will require a patient-specific, clinically significant reason why dronabinol oral capsules cannot be used.

Sustol® (Granisetron Subcutaneous Injection) Approval Criteria:

1. An FDA approved indication for use in the prevention of acute and delayed nausea and vomiting associated with initial and repeat courses of moderately emetogenic chemotherapy (MEC) or anthracycline and cyclophosphamide (AC) combination chemotherapy regimens; and
2. Chemotherapy regimen must be listed on the prior authorization request; and
3. A recent trial of ondansetron (within the past six months) used for at least three days or one cycle that resulted in inadequate response is required for authorization in members receiving MEC; and
4. No ondansetron trial is required for authorization of granisetron in members receiving AC combination chemotherapy regimens; and
5. A patient-specific, clinically significant reason why the member cannot use Kytril® (granisetron hydrochloride injection); and
6. A quantity limit of one injection every seven days will apply.

Diclegis® and Bonjesta® (Doxylamine/Pyridoxine) Approval Criteria:

1. An FDA approved diagnosis of nausea and vomiting associated with pregnancy that is not responsive to conservative management; and
2. Trials with at least two non-pharmacological therapies that have failed to relieve nausea and vomiting; and
3. A patient-specific, clinically significant reason why member cannot use over-the-counter (OTC) doxylamine and OTC Vitamin B_6 (pyridoxine).

4. If the daily net cost of Bonjesta® (doxylamine/pyridoxine 20mg/20mg) is greater than the daily net cost of Diclegis® (doxylamine/pyridoxine 10mg/10mg), authorization of Bonjesta® would also require a patient-specific, clinically significant reason why member cannot use Diclegis®.

Recommendation 2: Prior Authorize Viekira XR™ (Dasabuvir/ Ombitasvir/Paritaprevir/Ritonavir) and Epclusa® (Sofosbuvir/Velpatasvir)

The Drug Utilization Review Board recommends the following:

1. The prior authorization of Viekira XR™ (ombitasvir/paritaprevir/ritonavir/dasabuvir) and Epclusa® (sofosbuvir/velpatasvir) with criteria similar to the other prior authorized hepatitis C medications.
2. The removal of the minimum METAVIR fibrosis score of F2. The removal of the fibrosis score requirement will be phased in as follows: Members with a fibrosis score of F1 will be eligible for approval July 1, 2017 and members with a fibrosis score of F0 will be eligible for approval January 1, 2018.
3. Updating the criteria regarding alcohol and illicit IV drug use for all direct-acting antivirals (DAAs) to the following: Prescriber must agree to counsel members on potential harms of illicit IV drug use or alcohol use and member must agree to no illicit IV drug use or alcohol use while on treatment and post-therapy.

Viekira Pak™ and Viekira XR™ (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; and
3. Member must have a METAVIR fibrosis score of F2 or greater or equivalent scoring with an alternative test. Fibrosis testing type and scoring must be indicated on prior authorization request (members with a fibrosis score of F1 will be eligible for approval July 1, 2017 and members with a fibrosis score of F0 will be eligible for approval January 1, 2018); and
4. Viekira Pak™ or Viekira XR™ 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
5. Hepatitis C Virus (HCV) genotype/subtype testing must be confirmed and indicated on prior authorization request; and
6. 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
7. The following regimens and requirements based on prior treatment experience, genotypic subtype, and cirrhosis will apply:
    a. **Genotype 1a, without cirrhosis:**
        i. Viekira Pak™ or Viekira XR™ with weight-based ribavirin for 12 weeks
    b. **Genotype 1a, with compensated cirrhosis:**
        i. Viekira Pak™ or Viekira XR™ with weight-based ribavirin for 24 weeks
        ii. Viekira Pak™ or Viekira XR™ with weight-based ribavirin for 12 weeks may be considered for some patients based on prior treatment history.
    c. **Genotype 1b, without cirrhosis or with compensated cirrhosis:**

i. Viekira Pak™ or Viekira XR™ for 12 weeks

d. New regimens will apply as approved by the FDA

8. Member must not have previously failed treatment with a hepatitis C protease inhibitor (non-responder or relapsed); and
9. Member must sign and submit the Hepatitis C Intent to Treat contract; and
10. Member's pharmacy must submit the Hepatitis C Therapy Pharmacy Agreement for each member on therapy; and
11. 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
12. Prescriber must agree to counsel members on potential harms of illicit IV drug use or alcohol use and member must agree to no illicit IV drug use or alcohol use while on treatment and post-therapy; and
13. Must have documentation of initiation of immunization with the hepatitis A and B vaccines; and
14. Member must not have decompensated cirrhosis or moderate-to-severe hepatic impairment (Child-Pugh B and C); and
15. Female members must not be pregnant and must have a pregnancy test immediately prior to therapy initiation. 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 for those on ribavirin); and
16. 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
17. Member must not be taking the following medications: alfuzosin, ranolazine, dronedarone, carbamazepine, phenytoin, phenobarbital, colchicine, gemfibrozil, rifampin, lurasidone, pimozide, ergotamine, dihydroergotamine, methylergonovine, ethinyl estradiol, cisapride, St. John's wort, lovastatin, simvastatin, efavirenz, sildenafil, triazolam, oral midazolam, darunavir/ritonavir, lopinavir/ritonavir, rilpivirine, and salmeterol; and
18. 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
19. Prescribing physician must verify that they will work with the member to ensure the member remains adherent to hepatitis C therapies; and
20. 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.
21. 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.

Epclusa® (Sofosbuvir/Velpatasvir) 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, genotype-2, genotype-3, genotype-4, genotype-5, or genotype-6; and
3. Member must have a METAVIR fibrosis score of F2 or greater or equivalent scoring with an alternative test. Fibrosis testing type and scoring must be indicated on prior authorization request (members with a fibrosis score of F1 will be eligible for approval July 1, 2017 and members with a fibrosis score of F0 will be eligible for approval January 1, 2018); and

4. Epclusa® must be prescribed by a gastroenterologist, infectious disease specialist, or transplant specialist or the member must have been evaluated for hepatitis C treatment by a gastroenterologist, infectious disease specialist, or transplant specialist within the last three months; and
5. Hepatitis C Virus (HCV) genotype testing must be confirmed and indicated on prior authorization request; and
6. 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
7. The following regimens and requirements based on cirrhosis status will apply:
    a. **Genotype-1, -2, -3, -4, -5, -6:**
        i. **Treatment-naïve or treatment-experienced without cirrhosis or with compensated cirrhosis (Child-Pugh A):**
            1. Epclusa® for 12 weeks
        ii. **Treatment-naïve or treatment-experienced with decompensated cirrhosis (Child-Pugh B and C):**
            1. Epclusa® + weight-based ribavirin for 12 weeks
    b. New regimens will apply as approved by the FDA
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 Virologic Response (SVR-12); and
11. Prescriber must agree to counsel members on potential harms of illicit IV drug use or alcohol use 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 severe renal impairment (estimated Glomerular Filtration Rate [eGFR] <30mL/min/1.73m^2); and
14. Female members must not be pregnant and must have a pregnancy test immediately prior to therapy initiation. 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 for ribavirin users); and
15. Member must not be taking the following medications: H2-receptor antagonists at doses greater than 40mg famotidine equivalent, amiodarone, omeprazole or other proton pump inhibitors, topotecan, rifampin, rifabutin, rifapentine, carbamazepine, eslicarbazepine, phenytoin, phenobarbital, oxcarbazepine, efavirenz, tenofovir disoproxil fumarate, tipranavir/ritonavir, St. John's wort, and rosuvastatin doses exceeding 10mg; and
16. If member is using antacids they must agree to separate antacid and Epclusa® administration by four hours; 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.
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 in order to prevent prescription limit issues from affecting the member's compliance.

Recommendation 3: Prior Authorize Exondys 51™ (Eteplirsen)

The Drug Utilization Review Board recommends the prior authorization of Exondys 51™ (eteplirsen) with the following criteria:

Exondys 51™ (Eteplirsen) Approval Criteria:

1. An FDA approved diagnosis of Duchenne muscular dystrophy (DMD) in patients who have a confirmed mutation of the DMD gene that is amenable to exon 51 skipping; and
2. The member's recent weight must be provided on the prior authorization request in order to authorize the appropriate amount of drug required according to package labeling.

Recommendation 4: Prior Authorize Cinqair® (Reslizumab)

The Drug Utilization Review Board recommends the prior authorization of Cinqair® (reslizumab) with the following criteria:

Cinqair® (Reslizumab) Approval Criteria:

1. An FDA approved indication of add-on maintenance treatment of patients with severe asthma with an eosinophilic phenotype; and
2. Member must be 18 years of age or older; and
3. Member must have a blood eosinophil count of at least 400/mcL (within three to four weeks of dosing); and
4. Member must have had at least two asthma exacerbations requiring systemic corticosteroids within the last 12 months or require daily systemic corticosteroids despite compliant use of high-dose inhaled corticosteroid (ICS) plus at least one additional controller medication; and
5. Member must have failed a high-dose ICS used compliantly for at least the past 12 months (for ICS/LABA combination medications, the highest approved dose meets this criteria); and
6. Member must have failed at least one other asthma controller medication used in addition to the high-dose ICS compliantly for at least the past three months; and
7. Cinqair® must be administered in a healthcare setting by a healthcare professional prepared to manage anaphylaxis; and
8. Cinqair® must be prescribed by an allergist, pulmonologist, or pulmonary specialist or the member must have been evaluated by an allergist, pulmonologist, or pulmonary specialist within the last twelve months (or be an advanced care practitioner with a supervising physician who is an allergist, pulmonologist, or pulmonary specialist); and
9. Initial approvals will be for the duration of six months after which time compliance will be evaluated for continued approval.
10. Member's weight should be provided on prior authorization requests. Weights should have been taken within the last four weeks to provide accurate weight-based dosing.

Recommendation 5: Prior Authorize Fosrenol® (Lanthanum Carbonate), Velphoro® (Sucroferric Oxyhydroxide), and Auryxia™ (Ferric Citrate)

The Drug Utilization Review Board recommends the prior authorization of Velphoro® (sucroferric oxyhydroxide) and Auryxia™ (ferric citrate) with the following criteria:

Velphoro® (Sucroferric Oxyhydroxide) and Auryxia™ (Ferric Citrate) Approval Criteria:

1. A diagnosis of hyperphosphatemia in patients with chronic kidney disease (CKD) on dialysis; and
2. Documented trials of inadequate response to at least two of the phosphate binders available without a prior authorization or a patient-specific, clinically significant reason why the member cannot use a phosphate binder available without a prior authorization.
3. For Auryxia™, a quantity limit of 12 tablets per day will apply based on maximum recommended dose.

Fosrenol® (Lanthanum Carbonate) 1,000mg Chewable Tablets, 750mg Oral Powder, and 1,000mg Oral Powder Approval Criteria:

1. A diagnosis of hyperphosphatemia in patients with end stage renal disease (ESRD); and
2. Documented trials of inadequate response to at least two of the phosphate binders available without a prior authorization or a patient-specific, clinically significant reason why the member cannot use a phosphate binder available without a prior authorization; and
3. For the approval of Fosrenol® oral powder, a patient-specific, clinically significant reason why a special formulation is needed over a phosphate binder available without a prior authorization, such as Fosrenol® 500mg or 750mg chewable tablets which can be crushed, must be provided; and
4. For the approval of Fosrenol® 1,000mg chewable tablets, a patient-specific, clinically significant reason why the member cannot use a phosphate binder available without a prior authorization, such as Fosrenol® 500mg or 750mg chewable tablets, must be provided.

Recommendation 6: Prior Authorize Defitelio® (Defibrotide Sodium)

The Drug Utilization Review Board recommends the prior authorization of Defitelio® (defibrotide sodium) with the following criteria:

Defitelio® (Defibrotide Sodium) Approval Criteria:

1. An FDA approved diagnosis of hepatic veno-occlusive disease (VOD), also known as sinusoidal obstruction syndrome (SOS), with renal or pulmonary dysfunction following hematopoietic stem-cell transplantation.
2. Initial approvals will be for one month of therapy. An additional month of therapy (maximum of 60 days) may be granted if the physician documents the continued need for therapy.

Recommendation 7: Prior Authorize Nuplazid™ (Pimavanserin)

The DUR Board recommends the prior authorization of Nuplazid™ (pimavanserin) with the following criteria:

Nuplazid™ (Pimavanserin) Approval Criteria:

1. An FDA approved diagnosis of hallucinations and delusions associated with Parkinson's disease psychosis; and
2. Member must have concomitant diagnosis of Parkinson's disease; and
3. Nuplazid™ will not be approved for the treatment of patients with dementia-related psychosis unrelated to the hallucinations and delusions associated with Parkinson's disease psychosis; and
4. Initial approvals will be for the duration of three months. For continuation, the prescriber must include information regarding improved response/effectiveness of this medication.
5. A quantity limit of two tablets daily will apply.

Recommendation 8: Prior Authorize Veltassa® (Patiromer)

The DUR Board recommends the prior authorization of Veltassa® (patiromer) with the following criteria:

Veltassa® (Patiromer) Approval Criteria:

1. An FDA approved diagnosis of hyperkalemia; and
2. A trial of a potassium-eliminating diuretic or documentation why a diuretic is not appropriate for the member; and
3. Documentation of a low potassium diet; and
4. A patient-specific, clinically significant reason why member cannot use sodium polystyrene sulfonate powder which is available without a prior authorization; and
5. A quantity limit of 30 packets per month will apply.

Recommendation 9: Prior Authorize Kanuma® (Sebelipase Alfa)

The DUR Board recommends the prior authorization of Kanuma® (sebelipase alfa) with the following criteria:

Kanuma® (Sebelipase Alfa) Approval Criteria:

3. An FDA approved diagnosis of Lysosomal Acid Lipase (LAL) deficiency; and
4. Kanuma® (sebelipase alfa) must be administered in a healthcare setting by a healthcare professional prepared to manage anaphylaxis; and
5. The member's recent weight must be provided on the prior authorization request in order to authorize the appropriate amount of drug required according to package labeling.

Recommendation 10: Prior Authorize Picato® (Ingenol Mebutate 0.015% and 0.05% Gel)

The DUR Board recommends the prior authorization of Picato® (ingenol mebutate gel) with the following criteria:

Picato® (Ingenol Mebutate Gel) Approval Criteria:

1. An FDA approved diagnosis of actinic keratosis (AK); and
2. Member must be 18 years of age or older; and
3. Patient-specific information must be documented on the prior authorization form, including all of the following:
    a. Number of AK lesions being treated; and
    b. Size of each lesion being treated; and
    c. Location of lesions being treated; and
4. Approval quantity and length will be based on patient-specific information provided, in accordance with Picato® prescribing information and FDA approved dosing regimen.

Recommendation 11: Prior Authorize Briviact® (Brivaracetam), Fycompa™ (Perampanel Oral Suspension), and Carnexiv™ (Carbamazepine Injection)

The DUR Board recommends recommends the prior authorization of Briviact® (brivaracetam), Fycompa™ (perampanel oral suspension), and Carnexiv™ (carbamazepine injection) with the following criteria:

Briviact® (Brivaracetam) Approval Criteria:

1. An FDA approved indication of adjunctive therapy in the treatment of partial-onset seizures; and
2. Initial prescription must be written by a neurologist; and
3. Member must have failed therapy with at least three other medications commonly used for seizures.
4. Members currently stable on Briviact® and who have a seizure diagnosis will be grandfathered.
5. Approval length for Briviact® injection will be for a maximum of seven days of therapy. Further approval may be granted if prescriber documents an ongoing need for Briviact® intravenous (IV) therapy over oral Briviact® formulations.

Fycompa™ (Perampanel) Approval Criteria:

1. An FDA approved indication of adjunctive therapy in the treatment of partial-onset seizures with or without secondarily generalized seizures or primary generalized tonic-clonic (PGTC) seizures; and
2. Initial prescription must be written by a neurologist; and
3. Member must have failed therapy with at least three* other medications commonly used for seizures. (*Fycompa™ has currently provided a supplemental rebate to require a trial with one other medication; however, Fycompa™ will follow the original criteria and require trials with three other medications if the manufacturer chooses not to participate in supplemental rebates.)
4. For Fycompa™ oral suspension, a patient-specific, clinically significant reason why Fycompa™ oral tablets cannot be used.
5. Members currently stable on Fycompa™ and who have a seizure diagnosis will be grandfathered.

Carnexiv™ (Carbamazepine Injection) Approval Criteria:

1. An FDA approved indication; and
2. Initial prescription must be written by a neurologist; and
3. Member must currently be stable on oral carbamazepine; and
4. Member must have a current condition in which oral administration is temporarily not feasible and needing Carnexiv™ for replacement therapy; and
5. Approval length will be for a maximum of seven days of therapy. Further approval may be granted if prescriber documents an ongoing need for Carnexiv™ intravenous (IV) therapy over oral carbamazepine formulations.

Submitted to the C.E.O. and Board on March 23, 2017

AUTHORITY FOR EXPENDITURE OF FUNDS
Lead Screening Campaign

BACKGROUND

In November 2016, CMS issued a bulletin regarding the coverage of blood lead screening tests and encouraged states to take action, specifically mentioning utilizing an HSI project to do so. The bulletin mentioned an approved HSI project in Missouri that has an outreach and education piece.

OHCA is seeking a Contractor to conduct target market research, develop campaign materials, and purchase media buys to promote general awareness. In addition to these efforts, conduct a focused educational campaign with providers. Design a comprehensive media and promotional campaign for increasing blood lead screening tests for children in Oklahoma.

SCOPE OF WORK

- Research existing blood lead screening test materials and campaigns, both locally through the Oklahoma State Department of Health (OSDH) and nationally.
- Conduct stakeholder interviews to determine audience, needs, etc.
- Develop creative concepts and media plan based on existing materials and needs.
- Create materials for use on Broadcast TV, radio, billboards, bus benches, print, and digital.
- Ensure all materials meet OSDH and OHCA branding standards.
- Upon OHCA approval of the media plan, the Contractor's Media Director shall negotiate contracts with media vendors, including defining specific deliverable deadlines and on-air dates.
- Upon delivery of final piece, transfer of all data in a useable format to OHCA, to include all native production files, edited revisions, and updates after the final approved versions.

CONTRACT PERIOD

Date of award through June 30, 2018 with one (1) annual option to renew through June 30, 2019.

CONTRACT AMOUNT AND PROCUREMENT METHOD

- Will be awarded through Non-Mandatory statewide contract available through OMES
- Federal matching percentage is 95%+
- Estimated contract amounts

	SFY18	SFY19	Total
Federal $	$949,600	$949,600	$1,899,200
State $	$50,400	$50,400	$100,800
Total	$1,000,000	$1,000,000	$2,000,000

RECOMMENDATION

- Board approval to procure the services discussed above.

March Board
Proposed Rule Changes

These rules were posted for comment on January 18, 2017 through February 17, 2017.

Face to face tribal consultations regarding the proposed changes were held Tuesday, November 3, 2015; Tuesday, September 6, 2016; Tuesday, November 1, 2016; and Tuesday, January 3, 2017. The proposed rules were presented to the Medical Advisory Committee on Thursday, November 17, 2016 and/or on Thursday, March 9, 2017. The proposed rules were also presented at a public hearing on Tuesday, February 21, 2017 at 1:00 p.m. in the Oklahoma Health Care Authority Board Room.

The following permanent rules HAVE previously been approved by the Board and the Governor under EMERGENCY rulemaking. These rules HAVE NOT been revised for PERMANENT rulemaking.

OHCA Initiated

a) AMENDING Agency rules at OAC 317:30-5-72.1, 317:30-5-78, and 317:30-5-87 to modify the reimbursement structure to comply with federal regulation for Indian Health Services, Tribal Programs, Urban Indian Clinics (I/T/U), and non-I/T/U pharmacies. Revisions align reimbursement for covered outpatient drugs with Actual Acquisition Cost and create new pricing terms for specialty pharmaceutical products. Revisions also modify the current dispensing fee to a professional dispensing fee. In addition, revisions amend the reimbursement structure for I/T/U pharmacies; these pharmacies will be reimbursed at the Federal Office of Management and Budget encounter rate. I/T/U pharmacies will receive one rate per member per facility per day regardless of the number of prescriptions dispensed to the member on that day. Revisions also remove limitations for cessation benefits to align with current practice.
Budget Impact: Budget neutral

(Reference APA WF # 16-13)

b) ADDING Agency rules at OAC 317:2-1-16 to establish grievance procedures and processes for the supplemental payment program for nursing facilities owned and as applicable operated by non-state government owned entities.
Budget Impact: Budget neutral

(Reference APA WF # 16-16A)

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.

ODMHSAS Initiated

c) AMENDING Agency rules at OAC 317:30-5-11, 317:30-5-241, 317:30-5-241.1, and 317:30-5-241.6 to reduce the number of SoonerCare compensable service plan updates to two in one year. Outpatient behavioral health agencies will now be reimbursed for one initial comprehensive treatment plan and one update thereto bi-annually. **The aforementioned changes were reviewed and approved during promulgation of the emergency rule.**

Additional revisions remove outdated references to Axis diagnosis and align the changes to the Diagnostic and Statistical Manual of Mental Disorders. Revisions also clarify clinical outpatient behavioral health agency provider documentation requirements for service plan modifications made prior to the scheduled six month review or update. Rules are also revised to clarify that behavioral health case management is not reimbursable for members who are enrolled in a Health Home. Revisions also clarify that, unless otherwise specified in rule, reimbursement is not allowed for outpatient behavioral health services provided to members who are considered to be in "inpatient status." **The aforementioned "permanent rule-making" revisions have not been reviewed or approved.**
ODMHSAS Budget Impact: Budget neutral

(Reference APA WF # 16-35)

OHCA Initiated

d) ADDING Agency rules at OAC 317:30-5-136 to establish a supplemental payment program for nursing facilities owned and as applicable operated by non-state government owned (NSGO) entities. The proposed revisions establish requirements and criteria for supplemental payments to be made to participating NSGOs up to the allowable Medicare upper payment limit. In addition, proposed revisions define terms related to the program and set forth criteria and eligibility requirements. Rules are also added to outline cost reporting, change in ownership, and disbursement of payment. Additionally, revisions clarify eligibility requirements and care criteria for nursing facilities. Finally, references for appeal requirements are added. **The aforementioned changes were reviewed and approved during promulgation of the emergency rule.**

Additional revisions require the Agreement of Participation application be submitted at minimum 30 days prior to the start of the program. Further revisions require the submission of supporting documentation for care criteria metrics and the submission of said documentation and forms within five business days after the quarter end. **The aforementioned "permanent rule-making" revisions have not been reviewed or approved.**
Budget Impact: Budget neutral

(Reference APA WF # 16-16B)

e) AMENDING Agency rules at OAC 317:30-3-27, 317:30-5-47, 317:30-5-361 and 317:30-5-664.10 to update language to reflect the repeal of The Oklahoma Telemedicine Act, which eliminates the informed consent requirement from Oklahoma statutes. **The aforementioned changes were reviewed and approved during promulgation of the emergency rule.**

Additional revisions replace telemedicine with telehealth which allow flexibility for the use of telehealth technologies. In addition, new revisions define telehealth and specific telehealth technologies. **The aforementioned "permanent rule-making" revisions have not been reviewed or approved.**
Budget Impact: Budget neutral

(Reference APA WF # 16-18)

f) AMENDING Agency rules at OAC 317:2-1-2 to outline grievance procedures and processes for the Nursing Facility Supplemental Payment Program. **The**

aforementioned changes were reviewed and approved during promulgation of the emergency rule.

Additional revisions remove the reference to administrative sanctions rules, which are being revoked. **The aforementioned "permanent rule-making" revisions have not been reviewed or approved.**
Budget Impact: Budget neutral

(Reference APA WF # 16-28B)

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

DHS Initiated

g) AMENDING Agency rules at OAC 317:30-5-518 to cleanup language, which adds the acronym for agency companion services and replaces the Oklahoma Department of Human Services acronym from "OKDHS" to "DHS." In addition, revisions change the name of the OKDHS Children and Family Services Division to DHS Child Welfare Services. Finally, revisions add the correct reference for agency companion services limits.
DHS Budget Impact: Budget neutral

(Reference APA WF # 16-24A)

h) AMENDING Agency rules at OAC 317:40-1-1, 317:40-5-103, 317:40-5-112, 317:40-7-2, 317:40-7-6, 317:40-7-12, 317:40-7-13, and 317:40-9-1 to implement changes recommended during the annual Oklahoma Department of Human Services Developmental Disabilities Services (DDS) rule review process. The proposed revisions add language to outline the standards for transportation providers and requirements for a Self-Directed Habilitation Training Specialist. Revisions update commonly used terms and specify that Home and Community-Based Waiver services require an annual eligibility review. Further language is added to define competitive integrated employment. In addition, the proposed revisions remove the treatment plan pre-approval requirements that exceed $1,000 by the DDS area medical director or designee for members of the Homeward Bound Waiver. Finally, language that requires the provider agency Human Rights Committees to review the member's protective intervention protocols are removed.
DHS Budget Impact: Budget neutral

(Reference APA WF # 16-24B)

i) AMENDING Agency rules at OAC 317:30-5-761 through 317:30-5-764 to add language to comply with new Centers for Medicare & Medicaid Services rules regarding Adult Day Health providers in Home and Community Based settings. Revisions clarify the required processes for case management monitoring and reporting activities for all waiver services. Revisions update commonly used terms and replace "plan of care" with the term "person-centered service plan." Additional revisions clarify that the Consumer-Directed Personal Assistance Services and Supports (CD-PASS) option is available in every Oklahoma County. Further language is added that is consistent with the Physical Therapy Act. The proposed amendments specify maximum billing units per day for skilled nursing services. Revisions also clarify that the minimum of eight units is equivalent to two hours and that the 28 maximum billing units is equivalent to seven hours. Revisions update services that are provided by the ADvantage waiver program

and remove those services no longer available. Revisions clarify the provider contract processes and those providers that are required to have annual audits. In addition, Adult Day Health and Assisted Living are added to the list of providers and are included in the periodic programmatic audit. Further revisions remove reference for the CD-PASS and Advanced Person Services Assistants to be documented through the Electronic Visit Verification System solely for reimbursement. Finally, language regarding speech and language therapy services is revoked as it is no longer offered in the ADvantage waiver.
DHS Budget Impact: Budget neutral

(Reference APA WF # 16-25A)

j) AMENDING Agency rules at OAC 317:35-15-2, 317:35-15-4, 317:35-15-8, 317:35-15-8.1, 317:35-15-10, 317:35-15-13.1, 317:35-15-13.2, 317:35-15-14, 317:35-17-1, 317:35-17-3, 317:35-17-5, 317:35-17-14, 317:35-17-18, 317:35-17-22 and 317:35-19-2 to update the ADvantage program and related services. The revisions add language regarding the personal care services process provided by the personal care provider agency nurse. Additional language outlines individuals who are not qualified to provide services as an Individual Personal Care Assistant. Language is added to clarify technical services that are provided by the State Plan Personal Care services program. Additional guidance is provided on the Oklahoma Department of Human Services (DHS) forms that are to be used in the eligibility process for personal care service authorization. Further revisions provide clarification on payment for personal care services if the client lives in the personal care assistant's home without DHS approval. Proposed revisions provide clarification on the timeframe in which nurses are to complete the Service Authorization Model visit and outline the steps to be taken if it is determined that there have been no changes in health or service needs. Language regarding the current practices and form numbers of Nursing Home Level of Care assessments has been updated. Additional revisions reflect changes due to the Interactive Voice Response Authentication (IVRA) system to the Electronic Visit Verification (EVV) system. Processes for documentation through the EVV system have been defined. Language is added that would identify what members would not be able to receive ADvantage waiver services due to illegal drug activity in the home. Additional updates are made to clarify mental impairment language. References made to the Supplemental Process for Expedited Eligibility Determination are removed as this process is no longer part of the ADvantage waiver. In addition, services that are no longer provided by the ADvantage waiver have been removed.
DHS Budget Impact: Budget neutral

(Reference APA WF # 16-25B)

OHCA Initiated

k) AMENDING Agency rules at OAC 317:30-3-5 to mirror federal regulation for cost sharing. Per current policy, the aggregate cost sharing liabilities in a given calendar year may not exceed five percent of the *member's* gross annual income. Per federal regulation, the aggregate limit on premiums and cost sharing incurred by *all members* in the Medicaid household should not exceed five percent of the *family's income* applied on a monthly basis.
Budget Impact: Budget neutral

(Reference APA WF # 16-03)

l) AMENDING Agency rules at OAC 317:35-9-48.1 to allow additional providers to evaluate Tax Equity and Fiscal Responsibility Act applicants under the age of three for

the measurement of developmental milestones to determine Intermediate Care Facilities for Individuals with Intellectual Disabilities institutional level of care. Current rules only allow for an evaluation by providers within the SoonerStart Early Intervention Program. This policy revision allows for flexibility when determining level of care as there are other appropriate providers and evaluation tools that can be utilized to evaluate developmental milestones. Please note that other criteria for severe dysfunctional deficiencies in at least two total domain areas remain in effect.
Budget Impact: Budget neutral

(Reference APA WF # 16-19)

m) REVOKING Agency rules at OAC 317:30-3-19 and 317:30-3-19.1. ADDING Agency rules at OAC 317:30-3-19.3, 317:30-3-19.4, and 317:30-3-19.5. Revisions revoke administrative sanction policy as the language is obsolete and does not accord with current agency practices. Proposed revisions also revoke other agency rules which have been substantively revised to clarify what the agency may consider when deciding whether to terminate a contract with a particular enrolled provider.

Also, proposed revisions add a new rule which explains what factors the Oklahoma Health Care Authority may take into consideration when deciding whether to approve an application for a new or renewing provider enrollment contract. In addition, proposed revisions add a new rule which modifies and replaces the Emergency Rule which will expire on September 14, 2017. The new rule fulfills a federal requirement for all state Medicaid agencies to institute fingerprint-based criminal background checks for certain "high categorical risk" providers who want to contract with the state. Proposed revisions also add a new rule which streamlines, clarifies, and provides examples of the kinds of conduct that may serve as a basis for a for-cause termination of a provider contract.
Budget Impact: Budget neutral

(Reference APA WF # 16-28A)

n) AMENDING Agency rules at OAC 317:30-3-17, 317:30-3-44, 317:30-5-95.24, 317:30-5-96.5, 317:30-5-355.1, 317:30-5-375, 317:30-5-546, 317:30-5-661.1, and 317:30-5-1076 to update references to the physical address of the Oklahoma Health Care Authority, and correct formatting errors and misspelled words. Revisions also include replacing the words "recipient" and "patient" with the word "member." In addition, revisions add the term "certified" to nurse midwife to mirror terminology used by the Oklahoma Nursing Board.
Budget Impact: Budget neutral

(Reference APA WF # 16-29)

o) AMENDING Agency rules at OAC 317:45-1-2, 317:45-1-3, 317:45-7-2, 317:45-9-1, 317:45-11-10, 317:45-11-11, 317:45-11-20, and 317:45-11-23 to update the Insure Oklahoma policy. The proposed revisions add language to the definitions of "Full-time Employment" and "Full-time Employer." Definitions also clarify dependent and independent college student's enrollment requirements. Revisions remove references to annual and lifetime maximums to mirror current waiver authority. In addition, references to prosthetic devices, continuous positive airway pressure devices, and perinatal dental coverage are removed to mirror current SoonerCare coverage. Revisions also remove references to individuals under supervision and update the therapy limits for behavioral health services to mirror current SoonerCare coverage.
Budget Impact: Budget neutral

(Reference APA WF # 16-30)

p) AMENDING Agency rules at OAC 317:30-3-21, 317:30-3-43, 317:30-5-63, 317:30-5-120 through 317:30-5-125, 317:30-5-127, 317:30-5-129, 317:30-5-131.2, 317:30-5-132, 317:30-5-133, 317:30-5-133.1 and REVOKING Agency rules at OAC 317:30-5-128. Revisions update requirements for the State Survey Agency when they are certifying facilities with deficiencies. Revisions also amend the change of ownership process for facilities. Both revisions are necessary to comply with recent changes to federal and state regulation. Revisions also clarify that nursing facilities will be afforded a hearing pursuant to federal regulation. For nursing homes that handle trust accounts, the Department of Human Services allows facilities to use electronic ledgers and bank statements as source documents for inspections, accounting, and tracking purposes. Proposed revisions update rules to align with this practice. Further revisions amend rules governing quality of care fund requirements to accurately reflect how these funds are calculated and assessed as authorized by Oklahoma statutes. Proposed revisions also strike partial federal regulation language that is used in rules. Other revisions update the payment methodology for private nursing facilities to mirror language found in the State Plan, and adds influenza and pneumococcal vaccines as a covered routine service since they are not separately reimbursable. Additionally, revisions throughout amend terminology to correctly identify individuals residing in long term care facilities as those with intellectual disabilities and replaces the term "patient" with "member" as appropriate. Other general cleanup of terms include: replacing "agreement" with the term "contract," updating form names, revising the name of divisions, and striking references to policy that have been revoked.

In addition, revisions for trust funds revoke language that implies unclaimed funds revert to the State. Additional changes revoke rules outlining the necessary requirements for members to obtain a private room. Nursing facilities receive a set reimbursement for room and board regardless of the privacy level so prescriptive rules are not required.
Budget Impact: Budget neutral

(Reference APA WF # 16-31A)

q) AMENDING Agency rules at OAC 317:35-9-4, 317:35-9-45, 317:35-19-8, and 317:35-19-9 to correctly identify individuals residing in Long-term Care facilities as those with intellectual disabilities and replaces the term "patient" with "member" as appropriate.
Budget Impact: Budget neutral

(Reference APA WF # 16-31B)

r) AMENDING Agency rules at OAC 317:30-5-40, 317:30-5-49, 317:30-5-260, 317:30-5-305, 317:30-5-430, and 317:30-5-890 to mirror the Oklahoma Health Care Authority (OHCA) contracting requirements for Optometrists, Renal Dialysis Facilities, and Podiatrists. Birthing Center policy is also amended to add language that clarifies a contract with the OHCA is required to be reimbursed for services. The proposed change will align Birthing Centers policy with all other provider types. In addition, proposed revisions update Hospital policy to mirror the OHCA contracting requirements, revise outdated statutes for reporting abuse, and amend abuse reporting requirements.
Budget Impact: Budget neutral

(Reference APA WF # 16-32)

s) AMENDING Agency rules at OAC 317:30-5-742.2 to Therapeutic Foster Care policy to remove the minimum time requirements for behavioral health assessment services. These revisions will allow providers more flexibility in completing biopsychosocial assessments. Revisions also add frequency limitations to clarify limits on how often an assessment can be completed within a single agency. In addition, revisions clarify if an assessment is performed by a licensure candidate, it must be countersigned by the licensed behavioral health professional that is responsible for the member's care. This change will clarify oversight requirements for licensure candidates and ensure quality of care. Rules are also revised to clarify specific clinical documentation requirements when changes need to be made to the service plan prior to the scheduled three month review or update. Revisions also update numerical references and add taglines to align with current Administrative Procedures Act guidelines.
Budget Impact: Budget neutral

(Reference APA WF # 16-33)

t) AMENDING Agency rules at OAC 317:30-5-696, 317:30-5-698 and 317:30-5-700.1 to add language allowing dental providers to submit the diagnostic cast or photographic images as evidence of medical necessity for dental services. The procedure is a necessary part of many dental practices, including orthodontics, and the change allows providers to bill for a necessary service. In addition, revisions add the term "certified" to nurse midwife to mirror terminology used by the Oklahoma Nursing Board.
Budget Impact: Agency staff has determined that the proposed rule may result in a cost savings of $14,395 total dollars; $4,375 state share; $10,560 federal share.

(Reference APA WF # 16-34)

u) AMENDING Agency rules at OAC 317:30-3-2.1, 317:30-3-4.1 and 317:30-3-30 to the Program Integrity Audits/Reviews policy. Revisions clarify the Oklahoma Health Care Authority (OHCA) audit process by: explaining that the scope of audits may include examination for fraud, waste, and/or abuse of the SoonerCare program; establishing a clearly defined response due date for providers who want to request an informal reconsideration and/or formal appeal of audit findings; and by informing providers that overpayments identified through the audit process may be withheld from future payments if the provider fails to timely contest the underlying audit findings. Also, proposed revisions in Uniform Electronic Transaction Act set a consistent timeframe in which medical records must be authenticated, including those instances in which transcription occurs. In addition, the rules have been revised to improve reader comprehension, and make the language consistent with other OHCA administrative rules.
Budget Impact: Budget neutral

(Reference APA WF # 16-36)

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 5. PHARMACIES

317:30-5-72.1. Drug benefit

OHCA administers and maintains an Open Formulary subject to the provisions of Title 42, United States Code (U.S.C.), Section 1396r-8. The OHCA covers a drug that has been approved by the Food and Drug Administration (FDA) and whose manufacturers have entered into a drug rebate agreement with the Centers for Medicare and Medicaid Services (CMS), subject to the following exclusions and limitations.

(1) The following drugs, classes of drugs, or their medical uses are excluded from coverage:

(A) Agents used to promote fertility.

(B) Agents primarily used to promote hair growth.

(C) Agents used for cosmetic purposes.

(D) Agents used primarily for the treatment of anorexia or weight gain. Drugs used primarily for the treatment of obesity, such as appetite suppressants are not covered. Drugs used primarily to increase weight are not covered unless otherwise specified.

(E) Agents that are investigational, experimental or whose side effects make usage controversial.

(F) Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or designee.

(G) Agents when used for the treatment of sexual or erectile dysfunction, unless such agents are used to treat a condition, other than sexual or erectile dysfunction, for which the agents have been approved by the Food and Drug Administration.

(2) The drug categories listed in (A) through ~~(E)~~(D) of this paragraph are covered at the option of the state and are subject to restrictions and limitations. An updated list of products in each of these drug categories is included on the OHCA's public website.

(A) Agents used for the systematic relief of cough and colds. Antihistamines for allergies or antihistamine use associated with asthmatic conditions may be covered when medically necessary and prior authorized.

(B) Vitamins and Minerals. Vitamins and minerals are not covered except under the following conditions:

(i) prenatal vitamins are covered for pregnant women up to age 50;
(ii) fluoride preparations are covered for persons under 16 years of age or pregnant;
(iii) vitamin D, metabolites, and analogs when used to treat end stage renal disease are covered;
(iv) iron supplements may be covered for pregnant women if determined to be medically necessary;
(v) vitamin preparations may be covered for children less than 21 years of age when medically necessary and furnished pursuant to EPSDT protocol; and
(vi) some vitamins are covered for a specific diagnosis when the FDA has approved the use of that vitamin for a specific indication.

~~(C) Agents used for smoking cessation. A limited smoking cessation benefit is available.~~

~~(D)~~(C) Coverage of non-prescription or over the counter drugs is limited to:

(i) Insulin, PKU formula and amino acid bars, other certain nutritional formulas and bars for children diagnosed with certain rare metabolic conditions;
(ii) certain smoking cessation products;
(iii) family planning products;
(iv) OTC products may be covered if the particular product is both cost-effective and clinically appropriate; and
(v) prescription and non-prescription products which do not meet the definition of outpatient covered drugs, but are determined to be medically necessary.

~~(E)~~(D) Coverage of food supplements is limited to PKU formula and amino acid bars for members diagnosed with PKU, other certain nutritional formulas and bars for children diagnosed with certain rare metabolic conditions when medically necessary and prior authorized.

(3) All covered outpatient drugs are subject to prior authorization as provided in OAC ~~317-30-5-77.2~~317:30-5-77.2 and 317:30-5-77.3.

(4) All covered drugs may be excluded or coverage limited if:

(A) the prescribed use is not for a medically accepted indication as provided under 42 U.S.C. § 1396r-8; or
(B) the drug is subject to such restriction pursuant to the rebate agreement between the manufacturer and CMS.

317:30-5-78. Reimbursement

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

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

~~(1) **Maximum Allowable Cost.**~~

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

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

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

~~(2) **The Estimated Acquisition Cost.** The Estimated Acquisition Cost (EAC) means the agency's best estimate of the price generally and currently paid by providers for a drug marketed or sold by a particular manufacturer or labeler. EAC is typically based on a benchmark published price plus or minus a percentage. The current benchmark price is the Average Wholesale Price (AWP) as provided by the OHCA's pricing resource. EAC is calculated as AWP minus 12%. The Wholesale Acquisition Cost (WAC) means the price paid by the wholesaler for drugs purchased from the wholesaler's supplier, typically the manufacturer of the drug. Should the AWP no longer be published by the agency's pricing vendor then the agency will use WAC as the benchmark price whereas the EAC will be calculated as WAC + 5.6%.~~

(a) **Reimbursement.** Reimbursement for pharmacy claims is based on the sum of the ingredient cost plus a professional dispensing fee for brand and generic drugs dispensed by a retail community pharmacy or for a member residing in a long term care facility.

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

(1) **Maximum Allowable Cost.** The State Maximum Allowable Cost (SMAC) is established for certain products which have a Food and Drug Administration (FDA) approved generic equivalent. The SMAC will be calculated using prices from pharmaceutical wholesalers who supply these products to pharmacy providers in Oklahoma. Pharmacies may challenge a specific product's SMAC price by providing information from their wholesaler(s)

to certify a net cost higher than the calculated SMAC price and that there is not another product available to them which is generically equivalent to the higher priced product.

(2) **Actual Acquisition Cost.** The Actual Acquisition Cost (AAC) means the cost of a particular drug product to the pharmacy based on a review of invoices or the Wholesale Acquisition Cost (WAC), whichever is lower. The National Average Drug Acquisition Cost (NADAC) is based on a review of invoices and published by Centers for Medicare and Medicaid Services (CMS) and will be used in the determination of AAC.

(3) **Specialty Pharmaceutical Allowable Cost.** Reimbursement for specialty drugs not typically dispensed by a retail community pharmacy and dispensed primarily by delivery, including clotting factor for hemophilia, shall be set as a Specialty Pharmaceutical Allowable Cost (SPAC). The Medicare Part B allowed charge, defined as Average Sales Price (ASP) plus 6%, WAC, and NADAC when available, will be considered in setting the SPAC rate. For the purpose of this section, a drug may be classified as a specialty drug when it has one or more of the following characteristics:

(A) Covered by Medicare Part B;

(B) "5i drug" – Injected, infused, instilled, inhaled, or implanted;

(C) Cost greater than $1,000.00 per claim;

(D) Licensed by the FDA under a Biological License Application;

(E) Special storage, shipping, or handling requirements;

(F) Available only through a limited distribution network; and/or

(G) Does not have a NADAC price from CMS.

(4) **Exceptions.**

(A) Physician administered drugs shall be priced based on a formula equivalent to the Medicare Part B allowed charge, defined as ASP plus 6%. If a price equivalent to the Medicare Part B allowed charge cannot be determined, a purchase invoice may be supplied by the provider and will be considered in setting the reimbursement.

(B) I/T/U pharmacies shall be reimbursed at the OMB encounter rate as a per member per facility per day fee regardless of the number of prescriptions filled on that day. I/T/U pharmacies should not split prescriptions into quantities less than a one month supply for maintenance medications. For this purpose a maintenance medication is one that the member uses consistently month to month.

(C) Pharmacies other than I/T/U facilities that acquire drugs via the Federal Supply Schedule (FSS) or at nominal price outside the 340B program or FSS shall notify OHCA and submit

claims at their actual invoice price plus a professional dispensing fee.

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

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

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

(1) the lower of Actual Acquisition Cost (AAC), State Maximum Allowable Cost (SMAC), or Specialty Pharmaceutical Allowable Cost (SPAC) plus a professional dispensing fee, or

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

OHCA will provide the pharmacy notice of its intent to conduct a review of usual and customary charges at least ten days in advance of its planned date of review.

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

(1) have an existing provider agreement with OHCA,

(2) submit the claim in a format acceptable to OHCA,

(3) have a prior authorization before filling the prescription, if a prior authorization is necessary,

(4) have a proper brand name certification for the drug, if necessary, and

(5) include the usual and customary charges to the general public as well as the ~~estimated~~ actual acquisition cost and professional dispensing fee.

(f) **Claims.** Prescription reimbursement may be made only for individuals who are eligible for coverage at the time a prescription is filled. Member eligibility information may be accessed by swiping a SoonerCare identification card through a commercial card swipe machine which is connected to the eligibility database or via the Point of Sale (POS) system when a prescription claim is submitted for payment. Persons who do not contract with commercial vendors can use the Member Eligibility Verification System (EVS) at no additional cost.

317:30-5-87. 340B Drug Discount Program

(a) The purpose of this Section is to provide special provisions for providers participating in the 340B Drug Discount program. The 340B Drug Discount program special provisions apply to a provider that has asserted it is a "covered entity" or a contract pharmacy for a covered entity under the provisions of 42 U.S.C. § 256b of the United States Code (otherwise known as the 340B Drug Discount Program).

(b) Covered Entities.

(1) The covered entity must notify OHCA in writing within 30 days of any changes in 340B participation, as well as any changes in name, address, NPI number, etc.

(2) The covered entity must maintain their status on the HRSA Medicaid exclusion file and report any changes to OHCA within 30 days.

(3) The covered entity must execute a contract addendum with OHCA in addition to their provider contract.

(4) To prevent a duplicate discount, quarterly adjustments will be made to all pharmacy or medical claims for drugs submitted by the covered entity. OHCA will adjust each claim by subtracting the ~~Unit Rebate Amount~~340B Ceiling Price from the amount reimbursed and ~~multiplied~~ multiplying the difference by the quantity submitted. All drugs shall be

adjusted by the ~~URA~~ 340B Ceiling Price whether purchased through the 340B program or otherwise when billed using the registered SoonerCare NPI number on the HRSA Medicaid Exclusion File. OHCA will use the ~~Unit Rebate Amount~~ 340B Ceiling Price applicable to the quarter in which the claim is ~~submitted to OHCA for payment~~ paid.

(c) Contract pharmacies for covered entities may be permitted to bill drug products purchased under the 340B Drug Discount Program to the Oklahoma Medicaid Program when certain conditions are met and an agreement is in place between OHCA, the contract pharmacy and the covered entity. These pharmacies will be subject to the recovery process stated above.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 2. GRIEVANCE PROCEDURES AND PROCESS

317:2-1-16. Nursing Facility Supplemental Payment Program Appeals

In accordance with OAC 317:30-5-136, OHCA is authorized to promulgate rules for appeals of the Nursing Facility Supplemental Payment Program (NFSPP). The rules in this Section describe those appeal rights.

(1) The following are appealable issues of the program: program eligibility determination, the assessed amount for each component of the Intergovernmental transfer, the Upper Payment Limit (UPL) payment, the Upper Payment Limit Gap payment, and penalties for the providers. This is the final and only process for appeals regarding NFSPP. Suspensions or terminations from the program are not appealable in the administrative process.

(2) Appeals are heard by the OHCA Administrative Law Judge (ALJ).

(3) To file an appeal, the provider (Appellant is the provider who files an appeal) shall file an LD-2 form within twenty (20) days from the date of the OHCA letter which advises the provider of the program eligibility determination, component of intergovernmental transfer (IGT), UPL payment, UPL GAP and/or a penalty. An IGT that is not received by the date specified by OHCA, or that is not the total indicated on the NPR shall be subject to penalty and suspension from the program. Any applicable penalties must also be deducted from the UPL payment regardless of any appeal action requested by the facility. Any change in the payment amount resulting from an appeals decision in which a recoupment or additional allocation is necessary will be adjusted in the future from any Medicaid payments.

(4) Consistent with Oklahoma rules of practice, the non-state government owned (NSGO) entity must be represented by an attorney licensed to practice within the State of Oklahoma. Attorneys not licensed to practice in Oklahoma must comply with 5 O.S. Art II, Sec. 5, and rules of the Oklahoma Bar Association.

(5) The hearing will be conducted in an informal manner, without formal rules of evidence or procedure. However parties who fail to appear at a hearing, after notification of said hearing date, will have their cases dismissed for failure to prosecute.

(6) The provider has the burden of proof by the preponderance of the evidence standard as defined by the Oklahoma Supreme Court.
(7) The docket clerk will send the Appellant and any other necessary party a notice which states the hearing location, date, and time.
(8) The ALJ may:
(A) Identify and rule on issues being appealed which will be determined at the administrative hearing;
(B) Require the parties to state their positions concerning appeal issue(s);
(C) Require the parties to produce for examination those relevant witnesses and documents under their control;
(D) Rule on whether witnesses have knowledge of the facts at issue;
(E) Establish time limits for the submission of motions or memoranda;
(F) Rule on relevant motions, requests and other procedural items, limiting all decisions to procedure matters and issues directly related to the contested determination resulting from OAC 317:30-5-136;
(G) Rule on whether discovery requests are relevant;
(H) Strike or deny witnesses, documents, exhibits, discovery requests, and other requests or motions which are cumulative, not relevant, not material, used as a means of harassment, unduly burdensome, or not timely filed;
(I) Schedule pre-hearing conferences to settle, simplify, or identify issues in a proceeding or to consider other matters that may end the appeal;
(J) Impose appropriate sanctions against any party failing to obey an order of the ALJ;
(K) Rule on any requests for extension of time;
(L) Dismiss an issue or appeal if:
(i) it is not timely filed or is not within the OHCA's jurisdiction or authority;
(ii) it is moot or there is insufficient evidence to support the allegations;
(iii) the appellant fails or refuses to appear for a scheduled meeting; or
(iv) the appellant refuses to accept a settlement offer which affords the relief the party could reasonably expect if the party prevailed in the appeal;
(M) Set and/or limit the time frame for the hearing.
(9) After the hearing:
(A) The ALJ should attempt to make the final hearing decision within ninety (90) days from the date of the

hearing and send a copy of the ALJ's decision to both parties outlining their rights to appeal the decision. Any appeal of the final order pursuant to 12 O.S. § 951 must be filed with the District Court of Oklahoma County within 30 days.

(B) It shall be the duty of the Appellant in any District Court appeal to order a written transcript of proceedings to be used on appeal. The transcript must be ordered within thirty (30) days of the filing of an appeal in the District Court and any costs associated with the preparation of the transcript shall be borne by the Appellant.

(10) All orders and settlements are non-precedential decisions.

(11) The hearing shall be digitally recorded and closed to the public.

(12) The case file and any audio recordings shall remain confidential.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 1. PHYSICIANS

317:30-5-11. Psychiatric services

(a) Payment is made for procedure codes listed in the Psychiatry section of the most recent edition of the American Medical Association Current Procedural Terminology codebook. The codes in this service range are accepted services within the SoonerCare program for children and adults with the following exceptions:

(1) Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes.

(2) Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist the patient.

(3) Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purposes) for other physicians, agencies, or insurance carriers.

(4) Unlisted psychiatric service or procedure.

(b) All services must be medically necessary and appropriate and include ~~a Diagnostic and Statistical Manual (DSM) multi axial diagnosis completed for all five axes~~at least one Diagnostic and Statistical Manual (DSM) diagnosis from the most recent version of the DSM.

(c) Services in the psychiatry section of the CPT manual must be provided by a board eligible or board certified psychiatrist or a physician, physician assistant, or nurse practitioner with additional training that demonstrates the knowledge to conduct the service performed.

(d) Psychiatric services performed via telemedicine are subject to the requirements found in OAC 317:30-3-27.

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~~Prior Authorization 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~~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.

(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) Services to members during an inpatient stay. Unless otherwise specified in rules, reimbursement is not allowed for outpatient behavioral health services provided to members who are considered to be in "inpatient status" as defined in OAC 317:30-5-41.

(g) 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.

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.** Screening is compensable on behalf of a member who is seeking services for the first time from the contracted agency. This service is not compensable if the member has previously received or is currently receiving services from the agency, unless there has been a gap in service of more than six (6) months. To qualify for reimbursement, the screening tools used must be ~~evidence based~~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~~person(s) resulting in a written summary report, diagnosis and recommendations. All agencies must assess the medical necessity of each individual to determine the appropriate level of care.

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

(C) **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 (6) months and it has been more than one (1) year since the previous assessment.

(D) **Documentation requirements**. The assessment must include all elements and tools required by the OHCA. In the case of children under the age of ~~18~~eighteen (18), it

is performed with the direct, active face-to-face participation of the parent or guardian. The child's level of participation is based on age, developmental and clinical appropriateness. The assessment must include at least one DSM diagnosis from the most recent DSM edition. The information in the assessment must contain but is not limited to the following:

(i) Behavioral, including substance use, abuse, and dependence;

(ii) Emotional, including issues related to past or current trauma;

(iii) Physical;

(iv) Social and recreational;

(v) Vocational;

(vi) Date of the assessment sessions as well as start and stop times;

(vii) Signature of parent or guardian participating in face-to-face assessment. ~~Signature~~Signatures are required for members over the age of ~~14~~fourteen (14); and

(viii) Signature and credentials of the practitioner who performed the face-to-face behavioral assessment

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

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

volunteer work, or training. A Service Plan Development, Low Complexity is required every ~~6~~six (6) months and must include an update to the bio-psychosocial assessment and re-evaluation of diagnosis.

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

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

(D) **Documentation requirements**. Comprehensive and integrated service plan content must address the following:

(i) member strengths, needs, abilities, and preferences~~(SNAP)~~ (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 a service plan must be documented in either a scheduled six (6) month service plan update (low complexity) or within the existing service plan through an amendment until time for the update (low complexity). Any changes to the existing service plan must, prior to implementation, be signed and dated by the member (if 14 or over), 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.~~

(xii) Amendment of an existing service plan to revise or add goals, objectives, service provider, service type, and service frequency, may be completed prior to the scheduled six (6) month review/update. A plan amendment must be documented through an addendum to the service plan, dated and signed prior to the implementation, by the member (if 14 or over), the parent/guardian (if younger than 18 or otherwise applicable), and the lead LBHP or Licensure Candidate.

(xiii) Behavioral health service plan development, low complexity, must address the following:

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

(II) progress, or lack of, on previous service plan goals and/or objectives;

(III) a statement documenting a review of the current service plan and an explanation if no changes are to be made to the service plan;
(IV) change in goals and/or objectives (including target dates) based upon member's progress or identification of new need, challenges and problems;
(V) change in frequency and/or type of services provided;
(VI) change in practitioner(s) who will be responsible for providing services on the plan;
(VII) change in discharge criteria;
(VIII) description of the member's involvement in, and responses to, the service plan, and his/her signature and date; and
(IX) service plan updates (low complexity) are not valid until all signatures are present. The required signatures are: from the member (if 14 or over), 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~~Complexity (i.e., pre-admission procedure code group) ~~are~~is limited to ~~1~~one (1) per member, per provider, unless more than ~~a~~one (1) year has passed between services, ~~then another one~~in which case, one can be requested and ~~may be~~performed, if authorized by OHCA or its designated agent.

(ii) Behavioral Health Service Plan Development, Low Complexity: Service Plan updates are required every six (6) months during active treatment. Updates, however, can be conducted whenever clinically needed as determined by the provider and member, but are only reimbursable twice in one (1) year. The date of service is when the service plan is complete and the date the last required signature is obtained. Services should always be age, developmentally, and clinically appropriate.

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

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

(B) **Qualified practitioners**. Assessment/Evaluation testing will be provided by a psychologist, certified psychometrist, psychological technician of a psychologist, an LBHP or Licensure Candidate. For assessments conducted in a school setting, the Oklahoma State Department of Education (OSDE) requires that a licensed supervisor sign the assessment. Each qualified professional must have a current contract with the ~~Oklahoma Health Care Authority~~OHCA.

(C) **Documentation requirements**. All psychological services must be ~~reflected by documentation~~documented in the member's record. All assessment, testing, and treatment services/units billed must include the following:

(i) date;

(ii) start and stop time for each session/unit billed and physical location where service was provided;

(iii) signature of the provider;

(iv) credentials of provider;

(v) specific problem(s), goals and/or objectives addressed;

(vi) methods used to address problem(s), goals and objectives;

(vii) progress made toward goals and objectives;

(viii) patient response to the session or intervention; and

(ix) any new problem(s), goals and/or objectives identified during the session.

(D) **Service Limitations**. Testing for a child younger than three (3) must be medically necessary and meet established Child (0-36 months of ~~Age~~age) criteria as set forth in the ~~Behavioral Health Provider Manual~~Prior Authorization Manual. Evaluation and testing is clinically appropriate and allowable when an accurate diagnosis and determination of treatment needs is needed. Eight (8) hours/units of testing per patient over the age of three (3), per provider is allowed every ~~12~~twelve (12) months. There may be instances when further testing is appropriate based on established medical necessity criteria found in the ~~Behavioral Health Provider Manual~~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 actual testing, interpretation, scoring, and reporting are performed. A maximum of ~~12~~twelve (12) hours of therapy and

testing, per day per rendering provider are allowed. A child who is being treated in an acute inpatient setting can receive separate psychological services by a physician or psychologist as the inpatient per diem is for "non-physician" services only. A child receiving ~~Residential~~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~~OSDE requires that a licensed supervisor sign the assessment. ~~Individuals~~For individuals who qualify for Part B of Medicare~~: Payment~~, payment is made utilizing the SoonerCare allowable for comparable services. Payment is made to physicians, LBHPs or psychologists with a license to practice in the state where the services is performed or to practitioners who have completed education requirements and are under current board approved supervision to become licensed.

317:30-5-241.6 Behavioral Health Case Management

Payment is made for behavioral health case management services as set forth in this Section.

(1) **Description of behavioral health case management services**. Services under behavioral health case management are not comparable in amount, duration and scope. The target group for behavioral health case management services are persons under age ~~21~~twenty-one (21) who are in imminent risk of out-of-home placement for psychiatric or substance abuse reasons or are in out-of-home placement due to psychiatric or substance abuse reasons and chronically and/or severely mentally ill adults who are institutionalized or are at risk of institutionalization. All behavioral health case management services will be subject to medical necessity criteria.

(A) Behavioral health case management services are provided to assist eligible individuals in gaining access to needed medical, social, educational and other services essential to meeting basic human needs. The behavioral health case manager provides assessment of case management needs, development of a case management care plan,

referral, linkage, monitoring and advocacy on behalf of the member to gain access to appropriate community resources. The behavioral health case manager must monitor the progress in gaining access to services and continued appropriate utilization of necessary community resources. Behavioral case management is designed to promote recovery, maintain community tenure, and to assist individuals in accessing services for themselves following the case management guidelines established by ODMHSAS. In order to be compensable, the service must be performed utilizing the Strengths Based model of case management. This model of case management assists individuals in identifying and securing the range of resources, both environmental and personal, needed to live in a normally interdependent way in the community. The focus for the helping process is on strengths, interests, abilities, knowledge and capacities of each person, not on their diagnosis, weakness or deficits. The relationship between the service member and the behavioral health case manager is characterized by mutuality, collaboration, and partnership. Assistive activities are designed to occur primarily in the community, but may take place in the behavioral health case manager's office, if more appropriate. The provider will coordinate with the member and family (if applicable) by phone or face-to-face, to identify immediate needs for return to home/community no more than ~~72~~seventy-two (72) hours after notification that the member/family requests case management services. For members discharging from a higher level of care than outpatient, the higher level of care facility is responsible for scheduling an appointment with a case management agency for transition and post discharge services. The case manager will make contact with the member and family (if applicable) for transition from the higher level of care than outpatient back to the community, within ~~72~~seventy-two (72) hours of discharge, and then conduct a follow-up appointment/contact within seven days. The case manager will provide linkage/referral to physicians/medication services, psychotherapy services, rehabilitation and/or support services as described in the case management service plan. Case Managers may also provide crisis diversion (unanticipated, unscheduled situation requiring supportive assistance, face-to-face or telephone, to resolve immediate problems before they become overwhelming and severely impair the individual's

ability to function or maintain in the community) to assist member(s) from progression to a higher level of care. During the follow-up phase of these referrals or links, the behavioral health case manager will provide aggressive outreach if appointments or contacts are missed within two business days of the missed appointments. Community/home based case management to assess the needs for services will be scheduled as reflected in the case management service plan, but not less than one time per month. The member/parent/guardian has the right to refuse behavioral health case management and cannot be restricted from other services because of a refusal of behavioral health case management services.

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

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

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

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

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

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

(iii) Face-to-face meetings with treatment or service providers, necessary for the implementation of activities delineated in the individual plan of care.

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

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

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

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

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

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

(A) Resource coordination services are targeted to adults with serious mental illness and children and adolescents with mental illness or serious emotional disturbance, and their families, who need assistance in accessing, coordination, and monitoring of resources and services. Services are provided to assess an individual's strengths and meet needs in order to achieve stability in the community. Standard managers have caseloads of 30 - 35 members. Basic case management/resource coordination is limited to ~~25~~twenty-five (25) units per member per month.

(B) Intensive Case Management (ICM) is targeted to adults with serious and persistent mental illness (including

members in PACT programs) and Wraparound Facilitation Case Management (WFCM) is targeted to children with serious mental illness and emotional disorders (including members in a System of Care Network) 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~~eight (8) and ~~10~~ten (10) families. To ensure that these intense needs are met, case manager caseloads are limited between 10-15 caseloads. The ICM shall be a Certified Behavioral Health Case Manager, have a minimum of ~~2~~two (2) years Behavioral Health Case Management experience, crisis diversion experience, must have attended the ODMHSAS ~~6~~six (6) hours ICM training, and ~~24~~twenty-four (24) hour availability is required. ICM/WFCM is limited to ~~54~~fifty-four (54) units per member per month.

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

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

(B) managing finances; ~~or~~

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

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

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

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

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

(H) mentoring or tutoring;

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

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

(K) monitoring financial goals;

(L) services to nursing home residents;

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

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

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

(A) children/families for whom behavioral health case management services are available through OKDHS/OJA staff without special arrangements with OKDHS, OJA, and OHCA;

(B) members receiving Residential Behavior Management Services (RBMS) in a foster care or group home setting unless transitioning into the community;

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

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

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

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

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

(A) date;

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

(C) start and stop times for each service;

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

(E) credentials of the service provider;

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

(G) specific activities performed by the behavioral health case manager on behalf of the child related to advocacy, linkage, referral, or monitoring used to address needs, goals and/or objectives;

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

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

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

(K) member satisfaction with staff intervention.

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

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 9. LONG TERM CARE FACILITIES

317:30-5-136. Nursing Facility Supplemental Payment Program

(a) **Purpose.** The nursing facility supplemental payment program is a supplemental payment, up to the Medicare upper payment limit, made to a non-state government owned entity that owns and as applicable has operating responsibility for a nursing facility(ies).

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

(1) **"Funds"** means a sum of money or other resources, as outlined in 42 Code of Federal Regulations 433.51, appropriated directly to the State or local Medicaid agency, or funds that are transferred from other public agencies (including Indian tribes) to the State or local agency and under its administrative control, or funds certified by the contributing public agency as representing expenditures eligible for Federal Financial Participation (FFP).

(2) **"Intergovernmental transfer (IGT)"** means a transfer of state share funds from a non-state government owned entity to the Oklahoma Health Care Authority.

(3) **"Non-state government-owned (NSGO)"** means an entity owned and as applicable operated by a unit of government other than the state and approved by OHCA as a qualified NSGO. Pursuant to federal and OHCA approval an NSGO may include public trusts pursuant to the Trust Authorities established under Oklahoma Statute Title 60.

(4) **"Resource Utilization Groups (RUGs)"** means the system used to set Medicare per diem payments for skilled nursing facilities, as the basis to demonstrate a Medicare payment estimate for use in the upper payment limit calculation.

(5) **"Supplemental payment calculation period"** means the calendar quarter for which supplemental payment amounts are calculated based on adjudicated claims for days of service provided in the qualifying quarter. Note, in the event there are no paid days in the quarter as a result of the time in which the claims are adjudicated, the supplemental payment will be calculated on days billed in a subsequent quarter.

(6) **"Upper payment limit (UPL)"** refers to a reasonable estimate of the amount that would be paid for the services

furnished by a facility under Medicare payment principles.

(c) **Eligible nursing facilities.** A nursing facility that is owned and as applicable under the operational responsibility of an NSGO is eligible for participation when the following conditions are met:

(1) the nursing facility is licensed and certified by the Oklahoma State Department of Health;

(2) the participating NSGO has provided proof that it holds the facility's license and has complete operational responsibility for the facility;

(3) the participating NSGO has completed and submitted the Agreement of Participation application at minimum thirty (30) days prior to the start of the participation quarter and received approval from OHCA for participation;

(4) the NSGO has signed an attestation that a plan towards the reduction and mitigation of unnecessary Return to Acute Admissions (RTA) will be implemented within six months of program participation start date;

(5) the facility is an active participant in the Focus on Excellence program; and

(6) the facility and NSGO comply with care criteria requirements. All facilities must provide supporting documentation (e.g., baselines, written plan, improvement summary, data sources) for the care criteria metrics.

(d) **NSGO participation requirements.** The following conditions are required of the NSGO:

(1) must execute a nursing facility provider contract as well as an agreement of participation with the OHCA;

(2) must provide and identify the state share dollars' source of the IGT;

(3) must pay the calculated IGT to OHCA by the required deadline;

(4) must provide proof of ownership, if applicable (i.e. Change of Ownership) as Licensed Operator of the nursing facility;

(5) must provide OHCA with an executed Management Agreement between the NSGO and the facility Manager;

(6) must provide proof of district authority for nursing facility participants which include proximity requirements of no greater than one hundred fifty (150) miles of NSGO. Exceptions may be made at the sole discretion of OHCA; and

(7) must provide per facility, the per patient per Medicaid day (PPMD) IGT within specified timeframe of receipt of the Notice of Program Reimbursement (NPR) as indicated below:

(A) For the first year-$6.50 PPMD.

(B) For the second year-$7.50 PPMD.

(C) For the third year-$8.50 PPMD, or the equivalent of

10% of nursing facility budget of the current fiscal year, whichever is less. This amount excludes any IGT for actual administration cost associated with the nursing home UPL supplemental program. Any remaining IGT after administration cost will be distributed through the rate setting methodology process. Distribution will occur once escrowed funds reach an amount sufficient to distribute as determined by OHCA.

(e) **Care Criteria.**

(1) Each facility will be required to meet or exceed at minimum two of the five established care criteria metrics contained in paragraphs (A) through (E) of this section. The facility will be required to develop and implement a plan and identify the current baseline for each criterion. Each facility must demonstrate ongoing progress through baseline outcomes, performance summary and goals. Care criteria data and forms must be completed and submitted within five (5) business day after quarter end.

(A) Facilities must develop and implement a written plan for the mitigation of unnecessary Return to Acute Admissions (RTA) within six (6) months of participation. The plan will include the RTA for the trailing twelve (12) month period. The resulting outcome is to improve the efficiency and care avoidance cost to the overall SoonerCare program. A written plan must be developed and must include the following:

(i) the RTA management tool which identifies those residents at high risk for the potential return to acute;

(ii) the RTA management tools to support effective communications;

(iii) advance directive planning and implementation; and

(iv) application of Quality Assurance/Program Integrity (QA/PI) methodology in review of RTAs for the root cause analysis and teaching needs.

(B) Facilities are required to implement a pro-active Pneumonia/Flu Vaccination program which will result in improved vaccination scores above the facility specific baseline at or above the national average, as measured using the CMS Quality Metrics. The resulting outcome is to improve efficiency and care avoidance costs to the overall SoonerCare program. A written plan must be developed and must include the following:

(i) the latest available three quarter average of CMS measure code 411 (% of long-stay residents assessed and appropriately given the seasonal influenza vaccine) and

415 (% of long-stay residents assessed and appropriately given the pneumococcal vaccine) to establish baseline;

(ii) the current measure code 411 and 415 score; and

(iii) the written plan for flu and pneumonia vaccination program to address new admissions and current residents.

(C) Facilities are required to participate in the Oklahoma Healthy Aging Initiative. The resulting outcome is to improve the quality of care and health of members. Facilities must attest to elevate healthy aging in Oklahoma by implementing a plan that accomplishes at least one of the following strategies:

(i) preventing and reducing of falls;

(ii) improving of nutrition;

(iii) increasing physical activity; or

(iv) reducing depression.

(D) Facilities are required to actively take part in an OHCA approved satisfaction survey. The resulting outcome is to improve the quality of care being delivered to members. A written plan must be developed and implemented and must include the following:

(i) the satisfaction survey results;

(ii) analysis of satisfaction survey with identification of, at minimum, one area for improvement; and

(iii) plan of action towards identified areas of improvement.

(E) Facilities are required to demonstrate improvement above the facility specific baseline in the five (5) Star Quality Measures Composite scoring. Metrics will be determined based upon CMS Nursing Home Compare composite score over the trailing twelve (12) month period. Facilities with Quality Measures star rating of three (3) or better for the most recent quarter or showing improvement in composite scoring with no two (2) quarters consistently below three (3), will be recognized as meeting the care criteria. The resulting outcome is to improve the quality of care being provided.

(i) Facilities must provide the most recent three (3) quarter average of the CMS quality measure star rating to establish baseline.

(ii) Facilities are required to have a star rating of (3) or better or must demonstrate improvement over previous quarter with no two (2) quarters below three (3) stars.

(2) The care criteria measures may be evaluated at the

discretion of OHCA on an annual basis after each fiscal year, following implementation of the program. However, OHCA reserves the right to conduct intermittent evaluations within any given year based on the quality, care and safety of SoonerCare members. The evaluation may be conducted by an independent evaluator. In addition, care criteria metrics may be internally evaluated after each fiscal year at the discretion of OHCA, in collaboration with an advisory committee composed of OHCA agency staff and provider representatives. The OHCA may make adjustments to the care criteria measures based on findings and recommendations as a result of the independent or internal evaluation.

(f) **Supplemental Payments.**

(1) The nursing facility supplemental payments to a NSGO under this program shall not exceed Medicare payment principles pursuant to 42 CFR 447.272. Payments are made in accordance with the following criteria:

(A) The methodology utilized to calculate the upper payment limit is the RUGs.

(B) The eligible supplemental amount is the difference/gap between the SoonerCare payment and the Medicare upper payment limit as determined based on compliance with the Care Criteria metrics.

(2) The amount of the eligible supplemental payment is associated with improvement of care of SoonerCare nursing facility residents as demonstrated through the care criteria. NSGO participants receive payment under the program based on earned percentages related to the care criteria. The NSGO must meet or exceed at least two (2) of the five (5) established care criteria metrics to be eligible for UPL payment for each quarter. After at least two (2) of the five (5) metrics have been met, the NSGO is eligible for eighty-five percent (85%) of the total eligible UPL amount for participating nursing facilities. The NSGO may qualify for the remaining fifteen percent (15%) of the total UPL by attribution in five percent (5%) increments for each additional care criterion that is met resulting in the full one hundred percent (100%) of the eligible UPL amount.

(g) **Change in ownership.**

(1) A nursing facility participating in the supplemental payment program must notify the OHCA of changes in ownership (CHOW) that may affect the nursing facility's continued eligibility within thirty (30) days after such change.

(2) For a nursing facility that changes ownership on or after the first day of the SoonerCare supplemental payment limit calculation period, the data used for the calculations will include data from the facility for the entire upper payment

limit calculation period relating to payments for days of service provided under the prior owner, pro-rated to reflect only the number of calendar days during the calculation period that the facility is owned by the new owner.

(h) **Disbursement of payment to facilities.** Facilities must secure allowable Intergovernmental Transfer funds (IGT) from a NSGO to fund the non-federal share amount. The method is as follows:

(1) The OHCA or its designee will notify the NSGO of the non-federal share amount to be transferred by an IGT, via a designated portal and NPR, for purposes of seeking federal financial participation (FFP) for the UPL supplemental payment, within twenty-five (25) business days after the end of the quarter. This amount will take into account the percentage of metrics achieved under the care criteria requirement. The NSGO will have five (5) business days to sign the participant agreement and make payment of the state share in the form of an IGT either in person or via mail. In addition, the NSGO will be responsible to also remit, upon receipt of the NPR, the applicable PPMD IGT in full, pursuant to (d)(7) above.

(2) If the total transfer and PPMD IGT are received within five (5) business days, the UPL payment will then be disbursed to the NSGO by OHCA within ten (10) business days in accordance with established payment cycles. An IGT that is not received by the date specified by OHCA, or that is not the total indicated on the NPR shall be subject to penalty and suspension from the program.

(i) **Penalties/Adjustments.** Failure by an NSGO to remit the full IGT indicated on the NPR by OHCA or its designee within the defined timeframes below indicates the NSGO has voluntarily elected to withdraw participation for that current quarter and may reapply for participation in the program in subsequent quarter(s).

(1) The total IGT must be received within five (5) business days from receipt of the NPR uploaded by OHCA or its designee in the program portal.

(A) Receipt of the total IGT within five (5) business days is not subject to penalty.

(B) The date the NPR is uploaded to the portal is the official date the clock starts to measure the five (5) business days.

(2) Any IGT received after the fifth business day but with an OHCA date stamp or mailing postal mark on or prior to five (5) business days from the official date of the uploaded NPR in the portal will not be subject to penalty; however, payment will be disbursed during the next available OHCA

payment cycle.

(3) Any IGT with an OHCA date stamp or mailing postal mark received with a date after five (5) business days of receipt of the NPR, but not exceeding eight (8) business days of receipt of the NPR will be deemed late and subject to a penalty in accordance with (3)(B) below.

(A) Any NSGO that remits payment of the total IGT under the above circumstances will receive payment during the next available OHCA payment cycle including an assessed penalty as described below.

(B) A five percent (5%) penalty will be assessed for total IGT payments received after five (5) business days but within eight business days of receipt of the NPR of assessed amount. The five percent (5%) penalty will be assessed on the total eligible supplemental payment for the quarter in which the IGT is late and assessed to the specific NSGO as applicable.

(C) The OHCA will notify the NSGO of the assessed penalty via invoice. If the provider fails to pay the OHCA the assessed penalty within the time frame noted on the invoice to the NSGO, the assessed penalty will be deducted from the nursing facility's Medicaid payment. The penalty must be paid regardless of any appeals action requested by the NSGO. Should an appeals decision result in a disallowance of a portion or the entire assessed penalty, reimbursement to the NSGO will be made to future nursing facility Medicaid payments.

(4) If a nursing facility fails to achieve at a minimum, two (2) of the care criteria metrics for two (2) consecutive quarters, the facility will be suspended for two (2) subsequent quarters and will not be eligible to participate in the program during suspended quarters. A facility that has been suspended for a total of four (4) quarters within a two (2) year period due to non-compliance with the Care Criteria will be terminated from the program, and if the facility wishes to participate again, it will be required to reapply. Reentry into the program is at the sole discretion of the OHCA, taking into consideration input from the advisory committee and/or stakeholders. If the facility is readmitted to the program, terms of participation may include a probationary period with defined requirements as it relates to care.

(j) **Appeals.** Applicant and participant appeals may be filed in accordance with grievance procedures found at OAC 317:2-1-2(b) and 317:2-1-16.

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

SUBCHAPTER 3. GENERAL PROVIDER SERVICES

PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-27. ~~Telemedicine~~Telehealth

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

"Remote patient monitoring" means the use of digital technologies to collect medical and other forms of health data (e.g. vital signs, weight, blood pressure, blood sugar) from individuals in one location and electronically transmit that information securely to health care providers in a different location for assessment and recommendations.

"Store and forward" means the acquisition (storing) of clinical information (e.g. data, document, image, sound, video) that is then electronically transmitted (forwarded to or retrieved by) to another site for clinical evaluation.

"Telehealth" means the mode of delivering healthcare services via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of patients, at a distance from health care providers.

~~(a)~~(b) **Applicability and scope.** The purpose of this Section is to implement ~~telemedicine~~telehealth policy that improves access to health care services, while complying with all applicable ~~federal~~Federal and ~~state~~State ~~statutes~~laws and regulations. ~~Telemedicine~~Telehealth services are not an expansion of SoonerCare covered services but an option for the delivery of certain covered services. However, if there are technological difficulties in performing an objective thorough medical assessment or problems in the member's understanding of ~~telemedicine~~telehealth, hands-on-assessment and/or in person care must be provided for the member. Any service delivered using telehealth technology must be appropriate for ~~telemedicine~~telehealth delivery and be of the same quality and otherwise on par with the same service delivered in person. A ~~telemedicine~~telehealth encounter must comply with the Health Information Portability and Accountability Act (HIPAA). For purposes of SoonerCare reimbursement ~~telemedicine~~telehealth 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~~Telehealth 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)~~(c) **Conditions.** The following conditions apply to all services rendered via ~~telemedicine~~telehealth.

(1) Interactive audio and video telecommunications must be used, permitting encrypted real-time communication between the physician or practitioner and the SoonerCare member. The telecommunication service must be secure and adequate to protect the confidentiality and integrity of the ~~telemedicine~~telehealth information transmitted. As a condition of payment the member must actively participate in the ~~telemedicine~~telehealth visit.

(2) The ~~telemedicine~~telehealth 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~~telehealth visit need to be trained in the use of the ~~telemedicine~~telehealth equipment and competent in its operation.

(3) The medical or behavioral health related service must be provided at an appropriate site for the delivery of ~~telemedicine~~telehealth services. An appropriate ~~telemedicine~~ telehealth site is one that has the proper security measures in place; the appropriate administrative, physical and technical safeguards should be in place that ~~ensure~~ensures the confidentiality, integrity~~,~~ and security of electronic protected health information. 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. Appropriate ~~telemedicine~~telehealth 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~~telehealth 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~~telehealth

requirements.

~~(5) The health care practitioner must obtain written consent from the SoonerCare member that states 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.~~

~~(6)~~(5) If the member is a minor child, a parent/guardian must present the minor child for ~~telemedicine~~telehealth services unless otherwise exempted by State or Federal law. The parent/guardian need not attend the ~~telemedicine~~telehealth session unless attendance is therapeutically appropriate.

~~(7)~~(6) The member retains the right to withdraw at any time.

~~(8)~~(7) All ~~telemedicine~~telehealth activities must comply with the HIPAA Security Standards, OHCA policy, and all other applicable ~~state~~State and ~~federal~~Federal laws and regulations.

~~(9)~~(8) 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.

~~(10)~~(9) There will be no dissemination of any member images or information to other entities without written consent from the member.

~~(c)~~(d) **Reimbursement.**

(1) Health care services delivered by telehealth such as Remote Patient Monitoring, Store and Forward, or any other telehealth technology, must be compensable by OHCA in order to be reimbursed.

~~(1)~~(2) Services provided by ~~telemedicine~~telehealth must be billed with the appropriate modifier.

~~(2)~~(3) If the technical component of an X-ray, ultrasound or electrocardiogram is performed during a ~~telemedicine~~ telehealth transmission, the technical component can be billed by the provider that provided that service. The professional component of the procedure and the appropriate visit code should be billed by the provider that rendered that service.

~~(3)~~(4) The cost of ~~telemedicine~~telehealth equipment and transmission is not reimbursable by SoonerCare.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 3. HOSPITALS

317:30-5-47. Reimbursement for inpatient hospital services

Reimbursement will be made for inpatient hospital services in the following manner:

(1) Covered inpatient services provided to eligible SoonerCare members admitted to in-state acute care and critical access hospitals will be reimbursed the lesser of the billed charges or the Diagnosis Related Group (DRG) amount. In addition to the billed charges or DRG payment, whichever is less, an outlier payment may be made to the hospital for very high cost stays. Additional outlier payment is applicable if either the amount billed by the hospital or DRG payment, whichever applies, is less than a threshold amount of the hospital cost. Each inpatient hospital claim is tested to determine whether the claim qualified for a cost outlier payment. Payment is equal to a percentage of the cost after the threshold is met.

(2) The lesser of the billed charges or DRG amount and outlier, if applicable, represent full reimbursement for all non-physician services provided during the inpatient stay. Payment includes but is not limited to:

(A) laboratory services;

(B) prosthetic devices, including pacemakers, lenses, artificial joints, cochlear implants, implantable pumps;

(C) technical component on radiology services;

(D) transportation, including ambulance, to and from another facility to receive specialized diagnostic and therapeutic services;

(E) pre-admission diagnostic testing performed within 72 hours of admission; and

(F) organ transplants.

(3) Hospitals may submit a claim for payment only upon the final discharge of the patient or upon completion of a transfer of the patient to another hospital.

(4) Covered inpatient services provided to eligible members of the Oklahoma SoonerCare program, when treated in out-of-state hospitals will be reimbursed in the same manner as in-state hospitals.

(5) Cases which indicate transfer from one acute care hospital to another will be monitored under a retrospective utilization review policy to help ensure that payment is not made for inappropriate transfers.

(6) The transferring hospital will be paid the lesser of the calculated transfer fee or the DRG base payment amount for a non-transfer.

(7) If the transferring or discharge hospital or unit is exempt from the DRG, that hospital or unit will be reimbursed according to the method of payment applicable to the particular facility or units.

(8) Covered inpatient services provided in out-of-state specialty hospitals may be reimbursed at a negotiated rate

not to exceed 100% of the cost to provide the service. Negotiation of rates will only be allowed when the OHCA determines that the specialty hospital or specialty unit provides a unique (non-experimental) service required by SoonerCare members and the provider will not accept the DRG payment rate. Prior authorization is required.

(9) New providers entering the SoonerCare program will be assigned a peer group and will be reimbursed at the peer group base rate for the DRG payment methodology or the statewide median rate for per diem methods.

~~(10) When services are delivered via telemedicine to hospital inpatients, the originating site facility fee will be paid outside the DRG payment.~~

~~(11)~~(10) All inpatient services are reimbursed per the methodology described in this section and/or as approved under the Oklahoma State Medicaid Plan.

PART 35. RURAL HEALTH CLINICS

317:30-5-361. Billing

(a) **Encounters.** 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. 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~~Eyeglasses.** ~~Glasses~~Eyeglasses prescribed by a licensed optometrist are billed using the appropriate revenue code and HCPCS code. Payment is limited to two ~~glasses~~eyeglasses per year. Any ~~glasses~~eyeglasses 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

317:30-5-664.10. Health Center reimbursement

(a) In accordance with Section 702 of the Medicare, Medicaid and

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

(b) As claims/encounters are filed, reimbursement for SoonerCare Choice members is made for all medically necessary covered primary care and other approved health services at the PPS rate.

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

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

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

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 2. GRIEVANCE PROCEDURES AND PROCESS

317:2-1-2. Appeals

(a) **Member Process Overview.**

(1) The appeals process allows a member to appeal a decision which adversely affects their rights. Examples are decisions involving medical services, prior authorizations for medical services, or discrimination complaints.

(2) In order to file an appeal, the member files a LD-1 form within 20 days of the triggering event. The triggering event occurs at the time when the Appellant (Appellant is the person who files a grievance) knew or should have known of such condition or circumstance for appeal.

(3) If the LD-1 form is not received within 20 days of the triggering event, OHCA sends the Appellant a letter stating the appeal will not be heard because it is untimely. In the case of tax warrant intercept appeals, if the LD-1 form is not received by OHCA within the timeframe pursuant to Title 68 O.S. § 205.2, OHCA sends the Appellant a letter stating the appeal will not be heard because it is untimely.

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

(5) The staff advises the Appellant that if there is a need for assistance in reading or completing the grievance form that arrangements will be made.

(6) Upon receipt of the member's appeal, a fair hearing before the Administrative Law Judge (ALJ) will be scheduled. The member will be notified in writing of the date and time for this procedure. The member must appear at this hearing and it is conducted according to OAC 317:2-1-5. The ALJ's decision may be appealed to the Chief Executive Officer of the OHCA, which is a record review at which the parties do not appear (OAC 317:2-1-13).

(7) Member appeals are ordinarily decided within 90 days from the date OHCA receives the member's timely request for a fair hearing unless the member waives this requirement. [Title 42 CFR 431.244(f)]

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

(b) **Provider Process Overview.**

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

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

(A) The Appellant (Appellant is the provider who files an appeal) files an LD form requesting an appeal hearing within 20 days of the triggering event. The triggering event occurs at the time when the Appellant knew or should have known of such condition or circumstance for appeal. (LD-2 forms are for provider appeals and LD-3 forms are for nursing home wage enhancement grievances.)

(B) If the LD form is not received within 20 days of the triggering event, OHCA sends the Appellant a letter stating the appeal will not be heard because it is untimely.

(C) A decision will be rendered by the ALJ ordinarily within 45 days of the close of all evidence in the case.

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

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

(1) Member Appeals:

(A) Discrimination complaints regarding the SoonerCare program;

(B) Appeals which relate to the scope of services, covered services, complaints regarding service or care, enrollment, disenrollment, and reenrollment in the SoonerCare Program;

(C) Fee for Service appeals regarding the furnishing of services, including prior authorizations;

(D) Appeals which relate to the tax warrant intercept system through the Oklahoma Health Care Authority. Tax warrant intercept appeals will be heard directly by the ALJ. A decision will be rendered by the Administrative Law Judge within 20 days of the hearing before the ALJ;

(E) Proposed administrative sanction appeals pursuant to OAC 317:35-13-7. Proposed administrative sanction appeals will be heard directly by the ALJ. A decision by the ALJ will ordinarily be rendered within 20 days of the hearing before the ALJ. This is the final and only appeals process for proposed administrative sanctions;

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

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

(2) Provider Appeals:

(A) Whether Pre-admission Screening and Resident Review (PASRR) was completed as required by law;

(B) Denial of request to disenroll member from provider's SoonerCare Choice panel;

(C) Appeals by Long Term Care facilities for nonpayment of wage enhancements, determinations of overpayment or

underpayment of wage enhancements, and administrative penalty determinations as a result of findings made under OAC 317:30-5-131.2(b)(5), (e)(8), and (e)(12);
(D) Appeals of Professional Service Contract awards and other matters related to the Central Purchasing Act pursuant to Title 74 O. S. § 85.1;
(E) Drug rebate appeals;
~~(F) Proposed administrative sanction appeals pursuant to 317:30-3-19. Proposed administrative sanction appeals will be heard directly by the ALJ. A decision will normally be rendered by the ALJ within 20 days of the hearing before the ALJ. This is the final and only appeals process for proposed administrative sanctions;~~
~~(G)~~(F) Provider appeals of OHCA audit findings pursuant to OAC 317:2-1-7. This is the final and only appeals process for appeals of OHCA audits; and
~~(H)~~(G) Oklahoma Electronic Health Records Incentive program appeals related only to incentive payments, incentive payment amounts, provider eligibility determinations, and demonstration of adopting, implementing, upgrading, and meaningful use eligibility for incentives.
~~(I)~~(H) Supplemental Hospital Offset Payment Program (SHOPP) annual assessment, Supplemental Payment, fees or penalties as specifically provided in OAC 317:2-1-15.
(I) Nursing Facility Supplemental Payment Program (NFSPP) eligibility determinations, the assessed amount for each component of the Intergovernmental transfer, Upper Payment Limit payments, the Upper Payment Limit Gap, and penalties specifically provided in OAC 317:30-5-136. This is the final and only process for appeals regarding NFSPP.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 55. RESPITE CARE

317:30-5-518. Coverage limitations

(a) Payment is not made for daily respite care and specialized foster care or agency companion services (ACS) for the same member on the same date of service.

(b) Respite care:

(1) is not available to members in ~~the~~Oklahoma Department of Human Services (DHS) custody ~~of the Oklahoma Department of Human Services (OKDHS) and~~or in out-of-home placement funded by ~~the OKDHS Children and Family Services Division;~~DHS Child Welfare Services; and

(2) for members not receiving ACS, is limited to 30 days or 720 hours annually per member, except as approved by the DHS Developmental Disabilities Services ~~Division~~ director and authorized in the member's Plan of Care; or

(3) for members receiving ACS, is limited ~~in accordance with OAC 317:40-5-8.~~per Oklahoma Administrative Code 317:40-5-3.

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~~This Section ~~apply~~applies to services funded through Medicaid HCBS Waivers per Oklahoma Administrative Code (OAC) 317:35-9-5 and~~ per~~ Section 1915(c) of the Social Security Act. ~~The specific~~Specific Waivers are the In-Home Supports Waiver (IHSW) for Adults, ~~the In-Home Supports Waiver (IHSW)~~IHSW for Children,~~ the~~ Community Waiver, and~~ the~~ Homeward Bound Waiver.

(b) **Program provisions.** Each individual requesting services provided through an HCBS Waiver and his or her family or guardian, are responsible for:

(1) accessing, with~~ the assistance of the~~ Oklahoma Department of Human Services (DHS) staff~~,~~ assistance, all benefits available under Oklahoma's Medicaid State Plan or other payment sources prior to accessing funding for those same services under ~~a~~an HCBS Waiver program;

(2) cooperating in the determination of medical and financial eligibility~~,~~ including prompt reporting of changes in income or resources;

(3) choosing between services provided through an HCBS Waiver ~~and~~or institutional care; and

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

(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 (1)~~(A),(B), or (C)~~(2) through (8) of this Subsection.

(1) **HCBS Waiver services.** Services provided through 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 (a) of this Section, ~~a person~~an applicant must meet conditions per OAC 317:35-9-5. The applicant: ~~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 per Section 1-819 of Title 63 of the Oklahoma Statutes (63 O.S. § 1-819), or Intermediate Care facility for individuals with intellectual disabilities (ICF/IID). The individual may not be receiving 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(IHSW).** To be eligible for services funded through the IHSW, a person must:~~

~~(i) meet all criteria listed in (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 Oklahoma Health Care Authority (OHCA) Level of Care Evaluation Unit (LOCEU);~~

~~(iv) be 3 years of age or older;~~

~~(v) be determined by the OHCA/LOCEU to meet the 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) a DHS Child Welfare Services (CWS) foster home; or~~

~~(IV) a 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 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 listed in (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 DDS and 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 3 years of age or older; and~~

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

(A) must be determined financially eligible for SoonerCare per OAC 317:35-9-68;

(B) 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, or residential care home per Section 1-820 of Title 63 of the Oklahoma Statutes (O.S. 63-1-820), or Intermediate Care facility for individuals with intellectual disabilities (ICF/IID);

(C) may not be receiving 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 OAC 340:100-5-22.2; and

(D) must also meet other Waiver-specific eligibility

criteria.

(2) **In-Home Supports Waivers (IHSW).** To be eligible for services funded through the IHSW, an applicant must:

(A) meet all criteria listed in (c) of this Section; and

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

(C) 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 Oklahoma Health Care Authority (OHCA) Level of Care Evaluation Unit (LOCEU);

(D) be 3 years of age or older;

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

(F) reside in:

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

(ii) his or her own home;

(iii) a DHS Child Welfare Services (CWS) foster home; or

(iv) a 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 HCBS Waiver resources within the annual per capita Waiver limit agreed on between the State of Oklahoma and the Centers for Medicare and Medicaid Services (CMS).

(3) **Community Waiver.** To be eligible for services funded through the Community Waiver, the applicant must:

(A) meet all criteria listed in (c) of this Section;

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

(C) have an intellectual disability as defined in the Diagnostic and Statistical Manual of Mental Disorders or a related condition by DDS and be covered under the State's alternative disposition plan adopted under Section 1919(e)(7)(E) of the Social Security Act; or

(D) 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

(E) be 3 years of age or older; and

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

(G) have critical support needs that can be met by the Community Waiver and cannot be met by IHSW services or

other service alternatives, as determined by the DDS director or designee.

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

(A) 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;

(B) meet all criteria for HCBS Waiver services listed in (c) of this Section; and

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

(D) 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 as determined by DDS, and to be covered under the State's alternative disposition plan adopted under Section 1919(e)(7)(E) of the Social Security Act; or

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

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

~~(2)~~(5) **Evaluations and information.** ~~The person~~Applicants desiring services through any of the Waivers listed in (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 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~~and 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~~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 the requested approval date~~,~~ that includes a developmental history; and

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

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

(E) proof of disability ~~according to~~per SSA guidelines. When a disability determination is not made by SSA, ~~OHCA/LOCEU~~OHCA LOCEU may make a disability determination using ~~the same guidelines as SSA.~~SSA guidelines.

~~(3)~~(6) **Eligibility determination.** OHCA reviews the diagnostic reports listed in (2) of this subsection and makes ~~a~~an eligibility determination ~~of eligibility~~ for DDS HCBS Waivers.

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

~~(5)~~(8) **Member's choice.** A determination of need for 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 DDS resources are unavailable~~ for new persons to be added~~to add individuals to services funded through 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. Active United States Armed Forces personnel, who have a pending HCBS Waiver application in another state for an immediate family member, may be placed on the list~~ in accordance~~ with the date they applied in the other state. The person's name is added to the list when ~~they provide~~he or she provides proof of application date from the other state.

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

(3) An individual applicant is removed from the Request for Waiver Services List when ~~the individual:~~he or she:

(A) is found to be ineligible for services;

(B) cannot be located by DHS;

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

(D) is not ~~a~~an Oklahoma 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~~applicant removed from the Request for Waiver Services List, ~~due to the inability to locate the individual by DHS, may later submit to DDS~~because he or she could not be located, may submit a written request to be ~~returned to the Request for Waiver Services List.~~reinstated to the list. The ~~individual~~applicant is returned ~~at~~to the same chronological place on the Request for Waiver Services List ~~that the individual had prior to removal~~, provided ~~the individual~~he or she was on the list prior to January 1, 2015.

(e) **Applications.** When resources are sufficient for initiation of HCBS Waiver services, DDS ensures action regarding a request for services occurs within 45-calendar days. When action is not taken within the required 45-calendar days, the applicant may seek resolution per OAC ~~340:2-5.~~340:2-5-61.

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

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

(f) **Admission protocol.** Initiation of services funded through an HCBS Waiver occurs in chronological order from the Request for Waiver Services List per (d) of this Section based on the date of DDS receipt of a completed request for services, as a result of the informed choice of the person requesting services or the individual acting on the member's behalf, and upon determination of eligibility, per (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, per 43A O.S. § 10-103:

~~(I) is hospitalized;~~

~~(II) has moved into a nursing facility;~~

~~(III) is permanently incapacitated; or~~

~~(IV) has died; and~~

(I) is hospitalized;

(II) moved into a nursing facility;

(III) is permanently incapacitated; or

(IV) 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) DHS finds 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 appropriated special funds with which to serve a specific group or a specific class of individuals ~~under the provisions of an~~per HCBS Waiver~~;~~ provisions;

(3) Waiver services ~~are~~may be required for people who transition to the community from a public ICF/IID or~~ who are~~ children in ~~the State's~~DHS custody receiving services from 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/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 are determined by Preadmission Screening and Resident Review (PASRR) evaluation conducted per Title 42 Section 483.100 of the Federal Code of Regulations 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, and choose to receive services funded through the Community or Homeward Bound Waiver.

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

(1) When a member receiving services funded through the IHSW for children becomes 18 years of age, services through the IHSW for adults ~~become~~becomes 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 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 was within the IHSW per capita allowance.

(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~~OHCA LOCEU when a determination of disability was not made by the Social Security Administration. The ~~OHCA/LOCEU~~OHCA LOCEU determines categorical relationship to the SoonerCare disabled category according to Social Security Administration guidelines. ~~OHCA/LOCEU~~OHCA LOCEU also approves the level of care per OAC 317:30-5-122 and confirms a diagnosis of intellectual disability per the Diagnostic and Statistical Manual of Mental Disorders. ~~DDS may require a new psychological evaluation and re-determination of eligibility at any time when a significant change of condition, disability, or psychological status is noted.~~

(1) DDS may require a new psychological evaluation and re-determination of eligibility at any time when a significant change of condition, disability, or psychological status is noted.

(2) Annual review of eligibility requires a medical evaluation that is current within one year of the requested approval date. The medical evaluation must be submitted by the member or the individual acting on his or her behalf 30-calendar days prior to the Plan of Care expiration.

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

(1) a member or the individual ~~action~~acting on the member's behalf chooses to no longer receive Waiver services;

(2) a member is incarcerated;

(3) a member is financially ineligible to receive Waiver services;

(4) a member is determined by ~~the Social Security Administration~~SSA to no longer have a disability qualifying the individual for services under these Waivers;

(5) a member is determined by the ~~OHCA/LOCEU~~OHCA LOCEU to no longer be eligible;
(6) a member moves out of state~~,~~ or the custodial parent or guardian of a member who is a minor moves out of state;
(7) a member is admitted to a nursing facility, ICF/IID, residential care facility, hospital, rehabilitation facility, or mental health facility for more than ~~30 consecutive~~30-consecutive calendar days;
(8) the guardian of a member who is a minor or adjudicated adult fails to cooperate during the annual review process per OAC 340:100-5-50 through 340:100-5-58;
(9) the guardian of a member who is a minor or adjudicated adult fails to cooperate in the implementation of 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 were not effective;
(10) the member is determined to no longer be SoonerCare eligible;
(11) there is sufficient evidence the member or the individual acting on the member's behalf 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) the member or the individual acting on the member's behalf either cannot be located, did not respond~~ to~~, or did not allow case management to complete plan development or monitoring activities as required ~~by policy~~per OAC 340:100-3-27 and the member or the individual acting on the member's behalf:
   (A) does not respond to the notice of intent to terminate; or
   (B) the response prohibits the case manager from being able to complete plan development or monitoring activities as required ~~by policy;~~per OAC 340:100-3-27;
(13) the member or the individual acting on the member's behalf fails to cooperate with the case manager to implement a Fair Hearing decision;
(14) it is determined services provided through an HCBS Waiver are no longer necessary to meet the member's needs and professional documentation provides assurance the member's health, safety, and welfare can be maintained without Waiver supports;
(15) the member or the individual acting on the member's behalf fails to cooperate with service delivery;
(16) a family member, 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; or

(17) a member no longer receives a minimum of one Waiver service per month and DDS is unable to monitor the 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/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 SoonerCare ineligibility date.

SUBCHAPTER 5. MEMBER SERVICES

PART 9. SERVICE PROVISIONS

317:40-5-103. Transportation

(a) **Applicability.** The rules in this Section apply to transportation services provided through the Oklahoma Department of Human Services ~~DHS,~~(DHS), Developmental Disabilities Services ~~DDS~~(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.

(B) Public transportation may be provided up to a maximum of $5,000 per Plan of Care year. The 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~~Oklahoma Administrative Code (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, 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 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) The provider ensures all members wear safety belts during transport.

(4) Regular vehicle 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) 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; or trip mileage calculation from Global Positioning System(GPS) software;

(C) name of the member transported; and

(D) purpose of the trip.

(6) 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 to the DDS area office 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 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 DDS area manager or designee;

(11) services 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~~when 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 only considers the ~~needs of the member only.~~member's needs. 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.~~transportation.** Adapted transportation may be transportation provided in modified vehicles with wheelchair or ~~stretcher safe~~stretcher-safe travel systems or lifts that meet the member's 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 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 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 requirements are met.

(6) The transportation provider ensures all staff assisting with transportation ~~has been~~is 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 only the units authorized for the identified residential setting.

(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 identified specific needs that require additional transportation for a limited period; or

(B) any combination of public transportation services with adapted or non-adapted~~; or~~ transportation; or

(C) public transportation services in excess of $5,000, when it is the most cost effective service option for necessary transportation.

317:40-5-112. Dental services

(a) **Applicability.** ~~OAC 317:40-5-112~~Coverage applies to members:

(1) receiving dental services through the Homeward Bound Waiver; and

(2) 21 years of age ~~or~~and older receiving dental services through the Community Waiver or In-Home Supports Waiver for adults.

(b) **Description of services.** Dental services include services per OAC 317:30-5-482. Preventative, restorative, replacement, and repair services to achieve or restore functionality are provided after appropriate review, ~~if~~when required per OAC 317:40-5-112(e).

(c) **Standard of care.** Comprehensive diagnostic and treatment services are authorized for each member eligible to receive such services from qualified personnel~~,~~ including licensed dentists and dental hygienists ~~in accordance with the~~per applicable Home and Community-Based Services (HCBS) Waiver limits. Part 79 of OAC 317:30-5 and dental guidelines published by the Oklahoma Health Care Authority (OHCA) must be followed.

(d) **Providers.** Providers of dental services must have a non-restrictive license to practice dentistry in Oklahoma or the state where treatment is rendered.

(e) **Treatment plan.** A proposed dental treatment plan must be

submitted to the member and Personal Support Team (Team) for review.

(1) All arrangements for services must be made with the Developmental Disabilities Services ~~Division (DDSD)~~(DDS) case manager and be specified in the member's Individual Plan (IP).

~~(2) The DDSD area medical director or designee must pre-approve treatment plans for members in the Homeward Bound Waiver exceeding $1,000.00.~~

~~(3)~~(2) Requests for pre-authorization must propose services that are the most cost effective to restore dental health ~~in accordance with~~per OHCA published dental guidelines ~~published by the OHCA~~.

(f) **Frequency of examination.** The dentist and Team determine frequency of ~~examination~~examinations on an individual basis.

(g) **Documentation of dental services.** The dental provider summarizes dental services ~~provided~~ on the Oklahoma Department of Human Services ~~(OKDHS)~~(DHS) Form 06HM005E, Referral Form for Examination or Treatment, or comparable form for members who receive residential services.

(h) **Prevention.** The member's IP must address the prevention of dental disease and promotion of dental health. Independence in oral hygiene care is promoted. ~~If~~When the member is unable to maintain adequate oral hygiene as determined by the dentist and Team, direct assistance and responsibility must be assigned to appropriate Team members in the IP.

SUBCHAPTER 7. EMPLOYMENT SERVICES THROUGH HOME AND COMMUNITY-BASED SERVICES WAIVERS

317:40-7-2. Definitions

The following words and terms, when used in this Subchapter shall have the following meaning, unless the context clearly ~~indicate~~indicates otherwise.

"Commensurate ~~Wage"~~wage" means wages paid to a worker with a disability based on the worker's productivity in proportion to the wages and productivity of workers without a disability performing essentially the same work in the same geographic area. Commensurate wages must be based on the prevailing wage paid to experienced workers without disabilities doing the same job.

"Competitive integrated employment" means work in the competitive labor market performed on a full-time or part-time basis in integrated community settings. The individual is compensated at or above minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Competitive employment is an individual placement.

"Employment ~~Assessment"~~assessment" means the evaluation that identifies the unique preferences, strengths, and needs of ~~the service recipient~~members in relation to work. The assessment determines work skills and work behaviors, is supplemented by personal interviews and behavioral observations, and incorporates information that addresses the ~~service recipient's~~member's desired medical, physical, psychological, social, cultural, and educational outcomes, as well as present and future employment options. The assessment~~, which~~ is updated annually or more frequently as needed, and includes support needs, environmental preferences, and possible accommodations.

"Enhanced ~~Rate"~~rate" means a differential rate established to provide an incentive to provider agencies to provide community employment services to ~~service recipients~~members with significant needs.

"Group ~~Placement"~~placement" means ~~two to eight service recipients~~two-to-eight workers with disabilities abilities situated close together, who are provided continuous, long-term training and support in an integrated job site. ~~Service recipients~~Members may be employed by the company or by the provider agency. The terms "work crew" and "enclave" also describe a group placement.

"Individual placement in community-based services" means the ~~service recipient~~member is provided supports that enable him or her to participate in approved community-based activities~~, as described in OAC 317:40-7-5,~~ per Oklahoma Administrative Code 317:40-7-5, individually and not as part of a group placement.

"Individual placement in job coaching services" means one ~~service recipient~~member receiving job ~~coach~~coaching services, who:

(A) works in an integrated job setting;

(B) receives minimum wage or more;

(C) does not receive services from a job coach who is simultaneously responsible for continuous job coaching for a group;

(D) is employed by a community employer or the provider agency; and

(E) has a job description that is specific to his or her work.

"Integrated ~~Employment Site"~~employment site" means an activity or job that provides regular interaction with people without disabilities, excluding service providers, to the same extent that a worker without disabilities in a comparable position interacts with others.

"Job ~~Coach"~~coach" means an individual who holds a ~~DDSD-approved~~DDS-approved training job coach certification and provides ongoing support services to eligible persons in supported employment placements. Services directly support the ~~service recipient's~~member's work activity including

marketing and job development, job and work site assessment, training and worker assessment, job matching procedures, development of co-worker natural and paid supports, and teaching job skills.

"Job ~~Sampling"~~sampling" means a paid situational assessment whereby a ~~service recipient~~member performs a job at a prospective employer's integrated job site~~,~~ in order to determine the ~~service recipient's~~member's interests and abilities. Situational assessments adhere to the Department of Labor (DOL) regulations regarding wages. The Personal Support Team determines the appropriate type and number of situational assessments for each ~~service recipient.~~member.

~~"On-Site Supports"~~"On-site supports" means a situation in which the job coach is physically at the job site providing job training to a ~~service recipient.~~member.

"Situational assessment" means a comprehensive community-based evaluation of the ~~service recipient's~~member's functioning in relation to the supported job~~,~~ including the job site, ~~the~~ community through which the ~~service recipient~~member must travel to and from the job, and ~~the people~~those at the job site, such as the job coach, co-workers, and ~~supervisor.~~supervisors.

~~"Sub-Contract With Industry"~~"Sub-contract with industry" means the provider agency enters into a sub-contract with an industry or business to pay industry employees to provide supports to ~~service recipients.~~members. ~~If~~When the industry agrees, the provider agency may contract directly with an industry employee(s) ~~of the industry directly~~ to provide the services. The state continues to pay the provider agency and the agency provides all pertinent information ~~that is~~ required for persons served by the agency. The Team determines what, if any, training is required for the employees of the industry providing services.

"Supported ~~Employment"~~employment" means competitive work in an integrated work setting with ongoing support services for ~~service recipients~~members for whom competitive employment has not traditionally occurred or ~~has been~~was interrupted or intermittent as a result of the member's disabilities.

"Unpaid ~~Training"~~training" means unpaid experience in integrated employment sites ~~in accordance~~per with DOL regulations. ~~Service recipients~~Members do a variety of tasks~~,~~ ~~which~~that do not equal the full job description of a regular worker.

"Volunteer ~~Job"~~job" means an unpaid activity in which a ~~service recipient~~member freely participates.

317:40-7-6. ~~Center-Based Services~~Center-based services

(a) ~~Center-Based Services~~Center-based services are ~~provided in segregated settings, where the majority of people served have a disability. Any employment service provided where a majority of~~

~~the people at the site are persons with a disability is billed as Center-Based Services.~~any employment service provided where a majority of the people at the site are persons with a disability. These settings facilitate opportunities to seek employment in competitive settings and support access to the greater community.

(b) ~~Center-Based Services~~Center-based services are pre-planned~~,~~ documented activities that relate to the member's identified employment outcomes.

(c) Examples of ~~Center-Based Services~~Center-based services are active participation in:

(1) ~~paid contract work which occurs in a workshop or other center-based setting.~~learning and work experiences where the individual can develop general, non-job-task specific strengths and skills that contribute to employability in paid employment in integrated community settings;

(2) ~~Team-prescribed~~team-prescribed therapy programs, such as speech, physical therapy, or switch activation ~~which are~~ implemented by employment provider staff in the workshop or other center-based setting~~.~~; and

~~(3) unpaid training or paid work experience which occurs in a setting without opportunities for regular daily interactions with co-workers without disabilities or the general public.~~

~~(4)~~(3) computer classes, ~~GED~~General Education Development preparation, job club, interviewing skills, or other classes whose participants all have disabilities, even ~~if~~when the location is in the community.

(d) Paid contract work is usually subcontracted, and the persons receiving services earn commensurate wage according to Department of Labor regulations.

~~(e) For SoonerCare reimbursement in Center-Based Services, a member's pay cannot exceed 50% of minimum wage.~~

~~(f)~~(e) Participation in Center-Based Services is limited to 15 hours per week for persons receiving services through the Homeward Bound Waiver, unless approved through the exception process explained in ~~OAC~~(OAC) 317:40-7-21.

~~(g)~~(f) ~~Agency~~The provider agency must meet physical plant expectations of ~~OAC~~(OAC) 340:100-17-13.

~~(h)~~(g) During periods in which no paid work is available for members, despite the provider's documented good faith efforts ~~of the provider~~ to secure~~ such~~ work, the ~~employment provider~~employment-provider agency ensures~~ that~~ each member participates in training activities that are age appropriate, work related, and consistent with the ~~IP.~~Individual Plan. Such activities may include, but are not limited to:

(1) resume development and application writing;

(2) work attire selection;

(3) job interview training and practice;

(4) job safety and evacuation training;

(5) personal or social skills training; and
(6) stamina and wellness classes.

317:40-7-12. Enhanced rates

An ~~Enhanced Rate~~enhanced rate is available for both ~~Community-Based Group Services~~community-based group services and ~~Group Job Coaching Services~~group job-coaching services when necessary to meet a member's intensive personal needs in the employment setting(s). The need for the enhanced rate is identified through the Personal Support Team process and is supported by documentation in the Individual Plan (Plan) with consideration of risk assessment per ~~OAC~~Oklahoma Administrative Code(OAC) 340:100-5-56 and assessment of medical, nutritional, ~~and~~ mobility needs, ~~and:~~and the:

(1) Team assessment of the member's needs per OAC 340:100-5-51, OAC 340:100-5-56, OAC 340:100-5-57, and OAC 340:100-5-26; ~~of the member's needs.~~

(2) ~~the~~ member must:

(A) have a protective intervention ~~plan~~protocol (PIP) that:

(i) contains a restrictive or intrusive procedure ~~as defined in~~per OAC 340:100-1-2 implemented in the employment setting; and

(ii) ~~has been~~is approved by the State Behavior Review Committee ~~(SBRC)~~(SHRBRC) ~~in accordance with~~per OAC 340:100-3-14 or by the Developmental Disabilities Services ~~Division (DDSD)~~(DDS) staff per OAC 340:100-5-57; ~~and~~

~~(iii) has been reviewed by the Human Rights Committee (HRC) per OAC 340:100-3-6;~~

(B) have procedures included in the ~~Individual~~ Plan ~~which~~that address dangerous behavior that places the member or others at risk of serious physical harm but are neither restrictive or intrusive procedures ~~as defined in~~per OAC 340:100-1-2. The Team submits documentation of this risk and the procedures to the positive support field specialist to ~~assure that~~ensure positive approaches are being used to manage dangerous behavior;

(C) have a visual impairment that requires assistance for mobility or safety;

(D) have nutritional needs requiring tube feeding or other dependency for food intake ~~which~~that must occur in the employment setting~~.~~;

(E) have mobility needs, such that he or she requires two or more people for lifts, transfers, and personal care. Use of a mechanical lift or other assistive technology ~~has been~~is evaluated for the current employment program and determined not feasible by the ~~DDSD~~DDS division director or designee; or

(F) reside in alternative group home ~~as described in~~per OAC 317:40-5-152~~.~~; and

(3) ~~The~~ enhanced rate can be claimed only ~~if~~when the person providing services fulfills all applicable training criteria specified in OAC 340:100-3-38. There are no exceptions for the enhanced rate other than as allowed in this Section.

~~(4) There are no exceptions for the enhanced rate other than as allowed in this Section.~~

317:40-7-13. Supplemental ~~Supports for Center-Based Services~~supports for center-based services

(a) ~~In those instances when~~When a member receiving ~~Center-Based Services~~center-based services needs additional supports, the provider assigns staff in patterns that most effectively meet the needs of each member as indicated by a personal care and/or a risk assessment and defined in the Individual Plan (IP) or Protective Intervention ~~Plan.~~Protocol (PIP).

(b) ~~If~~When re-arranging staff patterns is not sufficient to meet the member's needs, the provider may file a request and plan for Supplemental Supports utilizing Vocational Habilitation Training Specialist Services. Supplemental ~~Supports can be~~supports are claimed only ~~if~~when provided by a staff member who ~~has~~ completed all specialized training and individual-specific training prescribed by the Team ~~in accordance with OAC~~per Oklahoma Administrative Code(OAC) 340:100-3-38.

(c) Supplemental ~~Supports for Center-Based Services~~supports for center-based services include two types of services, behavioral continuous support, and personal care intermittent support.

(1) **Continuous ~~Supplemental Supports.~~supplemental supports.** Continuous ~~Supplemental Supports~~supplemental supports cannot exceed 15 hours per week for persons receiving services through the Homeward Bound ~~waiver~~Waiver unless specifically approved through the exception process ~~described in~~per OAC 317:40-7-21.

(A) To be eligible for continuous supplemental supports, the member must have:

(i) a ~~protective intervention plan~~behavioral PIP that:

(I) contains a restrictive or intrusive procedure ~~as defined in~~per OAC 340:100-1-2 implemented in the employment setting;

~~(II) has been submitted to the Human Rights Committee (HRC) per OAC 340:100-3-6; and~~

~~(III)~~(II) ~~has been~~is approved by the State Human Rights and Behavior Review Committee ~~(SBRC)~~(SHRBRC) per OAC 340:100-3-14 or by the Developmental Disabilities Services ~~Division (DDSD)~~(DDS) staff per OAC 340:100-5-57; or

(ii) procedures included in the ~~protective intervention plan which~~PIP that address dangerous behavior that

places the member or others at risk of serious physical harm. The Team submits documentation of this risk and the procedures to the ~~DDSD~~DDS positive support field specialist to ~~assure that~~ensure positive approaches are being used to manage dangerous behavior.

(B) The Team documents discussion of the need for continuous ~~Supplemental Supports.~~supplemental supports.

(2) **Intermittent Supplemental Supports.** To receive personal care intermittent support, a member must have a personal care need that requires staffing of at least one-to-one during ~~that~~the time frame when the support is needed.

(A) ~~If~~When a member needs intermittent personal care support during ~~Center-Based Services,~~center-based services, the Team documents discussion ~~of:~~of the:

(i) ~~the~~ specific support need(s) of the member, such as staff-assisted repositioning, lifting, transferring, individualized bathroom assistance, or nutritional support; and

(ii) ~~the~~ calculations that combine the time increments of support to determine the total number of units needed on the Plan of Care.

(B) The case manager sends the documentation to the case management supervisor for approval.

(C) The case management supervisor signs and forwards a copy of the approval, denial, or recommended modifications to the case manager within two ~~working~~business days of receipt~~.~~ of the documentation.

(D) A member may receive ~~Center-Based Services~~center-based services and ~~Intermittent Supplemental Supports~~intermittent supplemental supports at the same time.

(d) Supplemental ~~Support for Center-Based Services~~support for center-based services described in this Section cannot be accessed in ~~Community-Based Services.~~community-based services.

(e) Sufficient staff must be available in the center-based facility to provide the supplemental support in order for a provider to claim the units.

SUBCHAPTER 9. SELF-DIRECTED SERVICES

317:40-9-1. ~~Self-Directed Services~~Self-directed services (SDS)

(a) **Applicability.** ~~The rules in this section apply~~This Section applies to ~~self-directed services~~SDS provided through ~~Home and Community Based Service~~Home and Community-Based Services (HCBS) Waivers operated by the Oklahoma Department of Human Services ~~(OKDHS)~~(DHS) Developmental Disabilities Services ~~Division (DDSD).~~(DDS).

(b) **Member ~~Option.~~option.** Traditional service delivery methods are available for eligible members who do not elect to self-

direct ~~their~~ services.

(c) **General ~~Information.~~information.** ~~Self-Direction is~~SDS are an option for members receiving ~~Home and Community Based Services (HCBS)~~HCBS through the In-Home Supports Waiver for Adults (IHSW-A), ~~or the~~ In-Home Supports Waiver for Children (IHSW-C)~~.~~ when the adult member lives in a non-residential setting. ~~Self-Direction~~SDS provides a member the opportunity ~~for a member~~ to exercise choice and control in identifying, accessing, and managing specific ~~waiver~~Waiver services and supports in accordance with ~~their~~his or her needs needs and personal preferences. ~~Self-Directed Services (SDS)~~SDS are Waiver services ~~that the Oklahoma Department of Human Services (OKDHS)~~DHS ~~Developmental Disabilities Services Division (DDSD)~~DDS specifies may be directed by the member or representative using ~~both~~ employer and budget authority.

(1) ~~Services~~SDS may be directed by:

(A) an adult member, ~~if~~when the member has the ability to self-direct; ~~or~~

(B) a member's legal representative ~~of the member,~~ including a parent, spouse or legal guardian; or

(C) a non-legal representative freely chosen by the member or ~~their~~his or her legal representative.

(2) The person directing services must:

(A) be 18 years of age or older;

(B) comply with ~~OKDHS/DDSD~~DDS and Oklahoma Health Care Authority (OHCA) rules and regulations;

(C) complete required ~~OKDHS/DDSD~~DDS training for self-direction;

(D) sign an agreement with ~~OKDHS/DDSD;~~DDS;

(E) be approved by the member or ~~their~~his or her legal representative to act in the capacity of a representative; ~~and~~

(F) demonstrate knowledge and understanding of the member's needs and preferences~~.~~; and

(G) not serve as the SDS-HTS for the member her or she is directing services

(d) **~~SDS program includes:~~The SDS program includes:**

(1) The SDS ~~Budget.~~budget. A plan of care is developed to meet the member's needs without SDS consideration ~~of SDS~~. The member may elect to self-direct part or ~~all of~~ the entire amount identified for traditional Habilitation Training Specialist (HTS) services. This amount is under the control and discretion of the member in accordance with this policy and the approved ~~IHSW,~~plan of care, and is the allocated amount ~~which~~that may be used to develop the SDS budget. The SDS budget details the specific plan for spending.

(A) ~~A~~The SDS budget is developed annually at the time of the annual plan development and updated as necessary by the member, case manager, parent, legal guardian, and

others the member invites to participate in the development of the budget.

(B) Payment may only be authorized for goods and services not covered by SoonerCare or other generic funding sources~~,~~ and ~~meets the~~meet criteria of service necessity per OAC 340:100-3-33.1.

(C) The member's SDS budget includes the actual cost of administrative activities including fees for services performed by a ~~Financial Management Services~~financial management services (FMS) subagent, background checks, ~~workers~~workers' compensation insurance, and the amount identified for SD-HTS and SD-GS.

(D) The SDS budget is added to the plan of care to replace any portion of traditional HTS services to be self-directed.

(2) The SD-Habilitation Training Specialist (SD-HTS) supports the member's self-care, daily living and leisure skills needed to reside successfully in the community. Services are provided in community-based settings in a manner that contributes to the member's independence, self-sufficiency, community inclusion, and well-being. SD-HTS services must be included in the approved SDS budget. Payment ~~will~~is not ~~be~~ made for routine care and supervision that is normally provided by a family member or the member's spouse. SD-HTS services are provided only during periods when staff is engaged in purposeful activity that directly or indirectly benefits the member. At no time are SD-HTS services authorized for periods during which the staff are allowed to sleep. Legally responsible persons may not provide services per OAC 340:100-3-33.2. Other family members providing services must be employed by provider agencies per OAC 340:100-3-33.2. For the purpose of this policy, family members include parents and siblings including ~~step and half~~step- and half-siblings and anyone living in the same home as the member. Payment does not include room and board, maintenance, or upkeep or improvements to the member's or family's residence. A SD-HTS must:

(A) be 18 years of age;

(B) pass a background check per OAC 340:100-3-39;

(C) demonstrate competency to perform required tasks;

(D) complete required training per OAC ~~340:100-3-38.5;~~340:100-3-38 et seq.;

(E) sign an agreement with ~~OKDHS/DDSD~~DDS and the member;

(F) be physically able and mentally alert to carry out the duties of the job;

(G) not work more than 40 hours in any week in the capacity of a SD-HTS; ~~and~~

(H) not implement restrictive or intrusive procedures per OAC 340:100-5-57~~.~~;

(I) provide 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; and

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

(3) ~~Self-Directed Goods and Services~~Self-directed goods and services (SD-GS). SD-GS are incidental, non-routine goods and services that promote the member's self-care, daily living, adaptive functioning, general household activity, meal preparation and leisure skills needed to reside successfully in the community and do not duplicate other services authorized in the member's plan of care. These goods and services must be included in the individual plan and approved SDS budget. SD-GS must meet the~~ following~~ requirements~~:~~ listed in (A) through (F).

(A) The item or service is justified by a recommendation from a licensed professional.

(B) The item or service is not prohibited by Federal ~~and~~or State statutes and regulations.

(C) One or more of the following additional criteria are met~~:~~. The item or service would:

(i)~~ the item or service would~~ increase the member's functioning related to the disability;

(ii)~~ the item or service would~~ increase the member's safety in the home environment; or

(iii)~~ the item or service would~~ decrease dependence on other SoonerCare funded services.

(D) SD-GS may include, but are not limited to:

(i) fitness items that can be purchased at~~ most~~ retail stores;

(ii) personal emergency monitoring systems;

(iii) a food catcher;

(iv) a specialized swing set;

(v) toothettes or an electric toothbrush;

(vi) a seat lift;

(vii) weight loss ~~program;~~programs; or

(viii) gym memberships when:

(I) there is an identified need for weight loss or increased physical activity;

(II) justified by outcomes related to weight loss, increased physical activity or stamina; and

(III) in subsequent plan of care year requests, documentation is provided that supports the member's progress toward weight loss or increased physical activity or stamina.

(E) SD-GS may not be used for:

(i) co-payments for medical services;

(ii) over-the-counter medications;
(iii) items or treatments ~~that have~~ not ~~been~~ approved by the Food and Drug Administration;
(iv) homeopathic services;
(v) services available through any other funding source, such as SoonerCare, Medicare, private insurance, public school system, ~~Rehabilitation Services~~rehabilitation services, or natural supports;
(vi) room and board~~,~~ including deposits, rent, and mortgage payments;
(vii) personal items and services not directly related to the member's disability;
(viii) vacation expenses;
(ix) insurance;
(x) vehicle maintenance or ~~any~~ other transportation related expense;
(xi) costs related to internet access;
(xii) clothing;
(xiii) tickets and related costs to attend recreational events;
(xiv) services, goods, or supports provided to, or benefiting persons other than the member; ~~or~~
(xv) experimental goods or services~~.~~;
(xvi) personal trainers;
(xvii) spa treatments; or
(xviii) goods or services with costs that significantly exceed community norms for the same or similar ~~good~~goods or ~~service.~~services.

(F) SD-GS are reviewed and approved by ~~DDSD division~~the DDS director or designee.

(e) **Member Responsibilities**. When the member chooses the SDS option, the member or member's representative is the employer of record and must:

(1) enroll and complete the ~~OKDHS/DDSD sanctioned~~DDS-sanctioned training course in self-direction. The training must be completed prior to the implementation of self-direction and ~~will cover the following areas:~~covers:

(A) staff recruitment;
(B) hiring of staff as an employer of record;
(C) ~~orientation and instruction of staff in duties consistent with approved specifications;~~staff orientation and instruction;
(D) supervision of staff including scheduling and service provisions;
(E) ~~evaluation of staff;~~staff evaluation;
(F) ~~discharge of staff;~~staff discharge;
(G) philosophy of self-direction;
(H) OHCA policy on self-direction;
(I) individual budgeting;

(J) development of a self-directed support plan;
(K) cultural diversity; and
(L) rights, risks, and responsibilities~~.~~;
(2) sign an agreement with ~~OKDHS/DDSD;~~DDS;
(3) agree to utilize the services of a FMS subagent;
(4) agree to pay administrative costs for background checks, FMS subagent fee, and ~~worker's~~workers' compensation insurance from ~~their~~his or her SDS budget;
(5) comply with federal and state employment laws and ensure no employee works more than 40 hours per week in the capacity of an SD-HTS;
(6) ensure that each employee is qualified to provide the services for which ~~he/she~~he or she is employed and that all billed services are actually provided;
(7) ensure that each employee complies with all ~~OKDHS/DDSD~~DDS training requirements~~ for In-Home Support Waivers~~ per OAC ~~340:100-3-38.5;~~340:100-3-38 et seq.;
(8) recruit, hire, supervise, and discharge ~~when necessary~~ all employees providing self-directed services~~;~~, when necessary;
(9) verify employee qualifications;
(10) obtain ~~a~~ background ~~screening~~screenings on all employees providing SD-HTS services per OAC 340:100-3-39;
(11) send progress reports per OAC 340:100-5-52.
(12) participate in the Individual Plan and SDS budget process;
(13) immediately notify the case manager of any changes in circumstances or emergencies~~, which~~ that may require modification of the type or amount of services provided for in the member's Individual Plan or SDS budget;
(14) wait for approval of budget modifications before implementing changes;
(15) comply with ~~OKDHS/DDSD~~DDS and OHCA administrative rules;
(16) cooperate with ~~OKDHS/DDSD~~DDS monitoring requirements per OAC 340:100-3-27;
(17) cooperate with~~ all requirements of the~~ FMS subagent requirements to ensure accurate records and prompt payroll processing including:
(A) reviewing and signing employee time cards;
(B) verifying the accuracy of hours worked; and
(C) ensuring the appropriate expenditure of funds~~.~~;
(18) complete all required documents within established timeframes;
(19) pay for services incurred in excess of the budget amount;
(20) pay for services not identified and approved in the member's SDS budget;
(21) pay for services provided by an unqualified provider;

(22) determine staff duties, qualifications, and specify service delivery practices consistent with SD-HTS ~~waiver~~Waiver service specifications;
(23) orient and instruct staff in duties;
(24) evaluate staff performance;
(25) identify and train back-up staff, when required;
(26) determine amount paid for services within Plan limits;
(27) schedule staff and the provision of services;
(28) ensure SD-HTS do not implement restrictive or intrusive procedures per OAC 340:100-5-57; and
(29) sign an agreement with ~~OKDHS/DDSD~~DDS and the SD-HTS.

(f) **Financial ~~Management Services~~management services (FMS) subagent responsibilities**. The FMS subagent is an entity designated as an agent by ~~OKDHS/DDSD~~DDS to act on behalf of members who have employer and budget authority for the purpose of managing payroll tasks for the member's employee(s) and for making payment of SD-GS as authorized in the member's Plan. FMS subagent duties include, but are not limited to:
(1) compliance with all ~~OKDHS/DDSD~~DDS and OHCA administrative rules and contract requirements;
(2) compliance with random and targeted audits conducted by ~~OKDHS/DDSD~~DDS or the OHCA;
(3) provision of financial management support to the member by tracking individual expenditures and monitoring SDS budgets;
(4) processing the member's employee payroll, withholding, filing and paying of applicable federal, state and local employment-related taxes and insurance;
(5) collection and process of employee's time sheets and making payment to member's employees;
(6) processing and payment of invoices for SD-GS as authorized in the member's SDS budget;
(7) providing each member with information that ~~will assist with managing the~~assists with the SDS budget~~;~~ management;
(8) providing reports to members/representatives, as well as ~~OKDHS/DDSD~~ monthly to DDS and to OHCA upon request;
(9) providing ~~OKDHS/DDSD~~DDS and OHCA authorities access to individual member's accounts through a web-based program;
(10) assisting members in verifying employee citizenship status;
(11) maintaining separate accounts for each member's SDS budget;
(12) tracking and reporting member funds, balances, and disbursements; ~~and the balance of member funds;~~
(13) receiving and disbursing funds for ~~the~~SDS payment ~~of SDS under an~~per OHCA agreement ~~with the OHCA~~; and
(14) executing and maintaining a contractual agreement between ~~OKDHS/DDSD~~DDS and the SD-HTS (employee).

(g) **~~OKDHS/DDSD Case Management~~DDS case management responsibilities in support of SDS**.

(1) The case manager develops the member's Plan per OAC 340:100-5-50 through ~~58;~~340:100-5-58;

(2) The ~~DDSD~~DDS case manager meets with the member, ~~and/or the~~ member's representative, or legal guardian to discuss the following service delivery options in the HCBS Waiver:

(A) traditional Waiver services; and

(B) self-directed services including information regarding scope of choices, options, rights, risks, and responsibilities associated with self-direction.

(3) ~~If~~When the member chooses self-direction, the case manager ~~will~~:

(A) ~~discuss~~discusses with member or representative the available amount ~~available~~ in the budget;

(B) ~~assist~~assist the member or representative with the development and modification of the SDS budget;

(C) ~~submit~~submits request for SD-GS to the ~~DDSD division~~DDS director or designee for review and approval prior to the case manager's approval of the SDS budget;

(D) ~~approve~~approves the SDS budget and modifications;

(E) ~~assist~~assists the member or representative ~~with developing~~develop or ~~revising~~revise an emergency back-up plan;

(F) ~~provide~~provides the FMS subagent a copy of the member's authorized SDS budget and any modifications;

(G) ~~monitor~~monitors implementation of the Plan per OAC 340:100-3-27~~.~~;

(H) ~~ensure that~~ensures services are initiated within required time frames;

(I) ~~conduct~~conducts ongoing monitoring of ~~the~~Plan implementation ~~of the Plan~~ and the member's health and welfare;

(J) ~~specify~~specifies additional employee qualifications in the Plan based on the member's needs and preferences ~~so long as~~when such qualifications are consistent with approved ~~waiver~~Waiver qualifications;

(K) ~~specify~~specifies in the Plan how services are provided;

(L) ~~refer~~refers potential SD-HTS providers to the FMS subagent for enrollment;

(M) ~~assist~~assists in locating and securing services and other community resources that promote community integration~~, community membership~~ and independence~~,~~ as provided in the member's Plan; and

(N) ~~ensure any~~ensures restrictive or intrusive procedures per OAC 340:100-5-57 are not implemented by the SD-HTS. If the Team determines restrictive or intrusive procedures are necessary, SD-HTS is not appropriate to meet the

member's needs ~~of the member~~ and traditional services must be used.

(h) **Government ~~Fiscal/Employer Agent Model.~~fiscal/employer agent model.** ~~OKDHS/DDSD~~DDS serves as the Organized Health Care Delivery System (OHCDS) ~~as well as the~~and FMS provider in a Centers for Medicare and Medicaid Services (CMS) approved ~~Government Fiscal/Employer Agent~~government fiscal/employer agent model. ~~OKDHS/DDSD~~DDS has an interagency agreement with OHCA.

(i) **Voluntary ~~Termination of Self-Directed Services.~~termination of self-directed services.** Members may discontinue self-directing services without disruption at any time, provided traditional ~~waiver~~Waiver services are in place. Members or representatives may not choose the self-directed option again until the next annual planning meeting, with services resuming no earlier than the beginning of the next plan of care. ~~Any~~A member desiring to file a complaint must follow ~~the~~ procedures ~~set forth~~per ~~by OKDHS at~~ OAC 340:2-5-61.

(j) **Involuntary ~~Termination of Self-Directed Services.~~termination of self-directed services.**

(1) Members may be ~~terminated~~ involuntarily terminated from self-direction and offered traditional ~~waiver~~Waiver services when it has been determined by ~~OKDHS/DDSD Director~~ the DDS director or designee that any of the following exist:

(A) immediate health and safety risks associated with self-direction, such as, imminent risk of death or irreversible or serious bodily injury related to ~~waiver~~Waiver services;

(B) intentional misuse of funds following notification, assistance and support from ~~OKDHS/DDSD;~~DDS;

(C) failure to follow and implement policies of self-direction after receiving DDS technical assistance and guidance ~~from OKDHS/DDSD~~;

(D) fraud; ~~or~~

(E) it is determined that restrictive or intrusive procedures are essential for safety~~.~~; or

(F) reliable information shows the employer of record or SD-HTS engaged in illegal activity.

(2) When action is taken to involuntarily terminate the member from self-directed services ~~involuntarily~~, the case manager assists the member ~~in accessing~~access needed and appropriate services through the traditional ~~waiver~~Waiver services option, ensuring that no lapse in necessary services occurs for which the member is eligible.

(3) The Fair Hearing process ~~as described in~~per OAC 340:100-3-13 applies.

(k) **Reporting requirements**. While operating as an Organized Health Care Delivery System, ~~OKDHS/DDSD will provide to the~~DDS

provides OHCA reports detailing provider activity in the format and at ~~such~~ times ~~as required by the~~ OHCA~~.~~ requires.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 85. ADVANTAGE PROGRAM WAIVER SERVICES

317:30-5-761. Eligible providers

ADvantage Program service providers, except pharmacy providers, must be certified by the ADvantage Program ADvantage Administration (AA) and all providers must have a current signed SoonerCare contract on file with ~~the Medicaid Agency (Oklahoma Health Care Authority).~~the Oklahoma Health Care Authority (OHCA), the State Medicaid Agency.

(1) The provider programmatic certification process must verify~~ that~~ the provider meets licensure, certification and training standards as specified in the ~~waiver~~Waiver document and agrees to ADvantage Program Conditions of Participation. Providers must obtain programmatic certification to be ADvantage Program certified.

(2) The provider financial certification process must verify that the provider uses sound business management practices and has a financially stable business. All providers, except for ~~NF~~nursing facility (NF) ~~Respite,~~respite, ~~Medical Equipment~~medical equipment and ~~Supplies,~~supplies, and ~~Environmental Modification~~environmental modification providers, must obtain financial certification to be ADvantage Program certified.

(3) Providers may fail to gain or may lose ADvantage Program certification due to failure to meet~~ either~~ programmatic or financial standards.

(4) At a minimum, provider financial certification is reevaluated annually.

(5) The Oklahoma Department of Human Services ~~(OKDHS)/Aging Services Division (ASD)~~(DHS) Aging Services (AS) evaluates ~~Adult Day Care~~adult day health and ~~Home Delivered Meal~~home-delivered meal providers for compliance with ADvantage programmatic certification requirements. When an adult day health or home-delivered meal provider does not have a contract with AS the provider must obtain programmatic certification to be ADvantage program certified. For ~~Assisted Living Services~~assisted living services provider programmatic certification, the ADvantage program relies in part upon the Oklahoma State Department of ~~Health/Protective~~Health Protective Health Services for review and verification of provider compliance with ADvantage standards for ~~Assisted Living Services~~assisted living services providers. Providers of ~~Medical Equipment and Supplies, Environmental Modifications, Personal Emergency~~

~~Response Systems, Hospice, CD-PASS, and NF Respite~~medical equipment and supplies, environmental modification, personal emergency response systems, hospice, Consumer-Directed personal Assistance Services and Supports (CD-PASS), and NF respite services do not have a programmatic evaluation after the initial certification.

(6) ~~OKDHS/ASD will~~DHS AS does not authorize a legal guardian for a member or an active ~~Power of Attorney~~power of attorney for a member to be that ~~member's Consumer-Directed Personal Assistance Services and Supports (CD-PASS)~~CD-PASS member's services provider ~~of services~~.

(7) ~~OKDHS/ASD will~~DHS AS may authorize a ~~legally responsible spouse of a member~~member's legally-responsible spouse to be SoonerCare reimbursed ~~under the~~per 1915(c) ADvantage Program as a service provider.

(8) ~~OKDHS/ASD~~DHS AS may authorize a member's legal guardian ~~of a member~~ to be SoonerCare reimbursed ~~under the~~per 1915(c) ADvantage Program as a service provider except as a provider of CD-PASS services. Authorization for ~~either~~a spouse or legal guardian as a provider requires the ~~following~~ criteria in (A) through (D) and monitoring provisions to be met~~:~~.

(A) Authorization for a spouse or legal guardian to be the care provider for a member may occur only ~~if~~when 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 member's needs ~~of the member~~ are so extensive that the spouse or legal guardian ~~who provides~~providing the care is prohibited from working outside of 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~~federally-approved Waiver document;

(ii) be necessary to avoid institutionalization;

(iii) be a service/support ~~that is~~ specified in the ~~individual~~person-centered service plan;

(iv) be provided by a person who meets the provider qualifications and training standards specified in the ~~waiver~~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 State Medicaid Agency~~OHCA for the payment of personal care or personal assistance services; and

(vi) not be an activity~~ that~~ the spouse or legal guardian would ordinarily perform or is responsible to perform. ~~If~~When any of the following criteria are met, assistance or care provided by the spouse or guardian ~~will be~~is determined to exceed the extent and/or nature of the assistance ~~they would be~~he or she is expected to ordinarily provide~~ in their role~~ as spouse or guardian~~:~~. The spouse or guardian:

(I) ~~spouse or guardian has~~ resigned from ~~full-time/part-time~~part-time or full-time employment to provide care for the member; or

(II) ~~spouse or guardian~~ has reduced employment from ~~full-time to part-time~~part-time or full-time to provide care for the member; or

(III) ~~spouse or guardian has taken~~took a leave of absence without pay to provide care for the member; or

(IV)~~ spouse or guardian~~ provides ~~assistance/care~~assistance and/or care for the member 35 or more hours per week without pay and the member has remaining unmet needs because ~~no other~~another provider is ~~available~~unavailable due to the nature of the ~~assistance/care,~~assistance and/or care, special language or ~~communication,~~communication needs, or the member's intermittent hours of care requirements~~ of the member~~.

(C) The spouse or legal guardian~~ who is a~~ service provider ~~will comply~~complies with~~ the following~~:

(i) not ~~provide~~providing more than 40 hours of services in a ~~seven day~~seven-day period;

(ii) planned work schedules that must be available in advance ~~to~~for the member's ~~Case Manager,~~case manager and variations to the schedule must be noted and supplied to the case manager two weeks in advance ~~to the Case Manager~~ unless the change is due to an emergency;

(iii) ~~maintain~~maintaining and ~~submit~~submitting time sheets and other required documentation for hours paid; and

(iv) ~~be~~is documented in the person-centered service plan as the member's care provider.

(D) In addition to case management, monitoring, and reporting activities required for all ~~waiver~~Waiver services, the state is obligated to additional monitoring requirements when members elect to use a spouse or legal guardian as a paid service provider. The AA ~~will monitor~~monitors through documentation submitted by the ~~Case Manager the following:~~case manager, at least

quarterly: expenditures, monthly home visits with member, and the health safety, and welfare status of the individual member.

~~(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.~~

(9) Providers of durable medical equipment and supplies must comply with ~~OAC~~Oklahoma Administrative Code 317:30-5-210(2) regarding proof of delivery for items shipped to the member's residence.

(10) ~~The OKDHS Aging Service Division (OKDHS/ASD)~~DHS AS ~~—~~periodically performs a programmatic audit of adult day health, assisted living, ~~Case Management,~~case management, ~~Home Care~~home care ~~(providers of Skilled Nursing, State Plan Personal Care, In-Home Respite, Advanced Supportive/Restorative Assistance and Therapy Services)~~(providers of skilled nursing, personal care, in-home respite and advanced supportive/restorative assistance and therapy services) and CD-PASS providers. If due to a programmatic audit, a provider Plan of Correction is required, the AA ~~stops~~may stop new ~~case~~cases and referrals to the provider until the Plan of Correction ~~has been~~is approved, ~~and~~ implemented~~.~~ and follow-up review occurs. Depending on the nature and severity of problems discovered during a programmatic audit, at the discretion of the ~~OKDHS/ASD,~~DHS AS, members determined to be at risk for health or safety may be transferred from a provider requiring a Plan of Correction to another provider.

317:30-5-762. Coverage

Individuals receiving ADvantage Program services must ~~have been~~be determined ~~to be~~ eligible for the program and must have an approved ~~plan of care.~~person-centered service plan. Any ADvantage Program service provided must be listed on the approved ~~plan of care and must be necessary~~person-centered service plan to prevent institutionalization of the member. Waiver services ~~which~~that 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~~ Consumer-Directed Personal Assistance Services and Supports (CD-PASS), ~~availability of CD-PASS is limited to ADvantage Program members that reside in counties that have sufficient provider capacity to offer the CD-PASS service option as determined by OKDHS/ASD.~~services are available to ADvantage Program members in every county.

(2) ADvantage ~~Case Managers within the CD-PASS approved area will~~case managers provide information and materials that explain the CD-PASS service option to~~ their~~ members. The ~~AA~~ ADvantage Administration (AA) provides information and material on CD-PASS to ~~Case Managers~~case managers for distribution to members.

(3) The member may request CD-PASS services from ~~their Case Manager~~his or her case manager or call an ~~AA maintained~~AA-maintained toll-free number to request CD-PASS services.

(4) The AA uses the following criteria to determine an ADvantage member's service eligibility to participate in CD-PASS~~:~~, the:

~~(A) residence in the CD-PASS approved area;~~

~~(B)~~(A) member's health and safety with CD-PASS services can reasonably be assured based on a review of service history records and~~ a~~ review of ~~member~~a member's capacity and readiness to assume ~~Employer~~employer responsibilities under CD-PASS with any one of the following findings as basis to deny a request for CD-PASS due to inability to assure member health and safety~~;~~, when the member:

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

(ii) ~~the member is not willing~~is unwilling to assume responsibility, or to enlist an ~~"authorized representative"~~authorized representative to assume responsibility, in one or more areas of CD-PASS, such as in service planning~~, or in~~ assuming the role of employer of the ~~PSA~~personal services assistant (PSA) or ~~APSA~~advanced personal services assistant (APSA) provider,~~ or~~ in monitoring and managing health or in preparation for emergency backup~~,~~; or

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

~~(C)~~(B) member voluntarily makes an informed choice to receive CD-PASS services. As part of the informed choice decision-making process for CD-PASS, the AA staff or ~~the Case Manager~~case manager provides consultation and assistance as the member completes a self-assessment of preparedness to assume the role of ~~Employer of their Personal Services Assistant.~~employer of his or her PSA or APSA. The orientation and enrollment process ~~will provide~~provides the member with a basic understanding of

what ~~will be~~is expected of them under CD-PASS, the supports available to assist them to successfully perform ~~Employer~~employer responsibilities and an overview of the potential risks involved.

(5) The AA uses the following criteria to determine that based upon documentation, a person is no longer allowed to participate in CD-PASS:

(A) the member does not have the ability to make decisions about ~~his/her~~his or her care or service planning and the member's ~~"authorized representative"~~authorized representative is ~~not willing~~unwilling to assume CD-PASS responsibilities; ~~or~~

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

(C) 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"~~authorized representative with capacity to assist with CD-PASS responsibilities; ~~or~~

(D) the member abuses or exploits ~~their~~the employee; ~~or~~

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

(F) the member, even with CM/CDA and Financial Management Services assistance, is unable to operate within ~~their~~his or her Individual Budget Allocation; or

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

317:30-5-763. Description of services

Services included in the ADvantage Program are:

(1) **Case management.**

(A) Case management services, regardless of payment source assist a member ~~in gaining~~to gain access to medical, social, educational, or other services~~, regardless of payment source~~ that may benefit ~~the member in maintaining~~him or her to maintain 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 service plan, listing only services~~

~~necessary to prevent institutionalization of the member, as determined through the assessments. Case managers initiate the addition of necessary services or deletion of unnecessary services, as dictated by the member's condition and available support. Case managers monitor the member's condition to ensure delivery and appropriateness of services and initiate service plan reviews. Case managers submit an individualized Form 02CB014, Services Backup Plan, on all initial service plans, annually at reassessment, and on updates as appropriate throughout the year, reflecting risk factors and measures in place to minimize risks. When 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, helps the member transition from institution to home by updating the service plan, and preparing services to start on the date the member is discharged from the institution. Case managers must meet ADvantage Program minimum requirements for qualification and training prior to providing services to ADvantage members. Providers of ADvantage services for the member, or for those who have an interest in, or are employed by an ADvantage provider for the member must not provide case management or develop the person-centered service plan, except when the AA demonstrates the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area, also provides other ADvantage services. Prior to providing services to members receiving Consumer-Directed Personal Assistance Services and Supports (CD-PASS), case manager supervisors and case managers are required to receive training and demonstrate knowledge regarding the CD-PASS service delivery model, "Independent Living Philosophy," and demonstrate person-centered planning competency.~~

(i) initiate and oversee necessary assessments and reassessments to establish or reestablish Waiver program eligibility;

(ii) develop the member's comprehensive person-centered service plan, listing only the services necessary to prevent institutionalization of the member, as determined through the assessments;

(iii) initiate the addition of necessary services or deletion of unnecessary services, as dictated by the member's condition and available support;

(iv) monitor the member's condition to ensure delivery and appropriateness of services and initiate person-centered service plan reviews. Case managers submit an individualized Form 02CB014, Services Backup Plan, on

all initial service plans, annually at reassessment, and on updates as appropriate throughout the year, reflecting risk factors and measures in place to minimize risks. When a member requires hospital or nursing facility (NF) services, the case manager:

(I) assists the member in accessing institutional care and, as appropriate, periodically monitors the member's progress during the institutional stay;

(II) helps the member transition from institution to home by updating the person-centered service plan;

(III) prepares services to start on the date the member is discharged from the institution; and

(IV) must meet ADvantage Program minimum requirements for qualification and training prior to providing services to ADvantage members.

(B) Providers of ADvantage services for the member or for those who have an interest in or are employed by an ADvantage provider for the member must not provide case management or develop the person-centered service plan, except when the AA demonstrates the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area, also provides other ADvantage services. Prior to providing services to members receiving Consumer-Directed Personal Assistance Services and Supports (CD-PASS), case manager supervisors, and case managers are required to receive training and demonstrate knowledge regarding the CD-PASS service delivery model, "Independent Living Philosophy," and demonstrate competency person-centered planning.

~~(B)~~(C) Providers may only claim time for billable case management activities, described as:

(i) any task or function per Oklahoma Administrative Code (OAC) 317:30-5-763(1)(A) that only an ADvantage case manager because of skill, training, or authority can perform on behalf of a member; and

(ii) ancillary activities, such as clerical tasks including, but not limited to, mailing, copying, filing, faxing, driving time, or supervisory and administrative activities are not billable case management activities. The administrative cost of these activities and other normal and customary business overhead costs are included in the reimbursement rate for billable activities.

~~(C)~~(D) 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~~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 a population density greater than 25 persons per square mile.

(ii) Very rural/difficult service area rate: ~~Case~~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 a population density equal to, or less than 25 persons per square mile. Exceptions are services to members who reside in Oklahoma ~~Department of Human Services Aging Services(DHS AS)~~DHS AS identified ~~zip~~Zip codes in Osage County adjacent to the metropolitan areas of Tulsa and Washington Counties. Services to these members are prior authorized and billed using the standard rate.

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

(2) **Respite.**

(A) Respite services are provided to members who are unable to care for themselves. Services are provided on a short-term basis due to the primary caregiver's absence or need for relief. Payment for respite care does not include room and board costs unless more than seven hours are provided in a nursing facility. Respite care is only utilized when other sources of care and support are exhausted. Respite care is only listed on the service plan when it is necessary to prevent institutionalization of the member. Units of services are limited to the number of units approved on the service plan.

(B) In-home respite services are billed per 15-minute units of service. Within any one-day period, a minimum of eight units (2 hours) must be provided with a maximum of 28 units (7 hours) provided. The service is provided in the member's home.

(C) Facility-based extended respite is filed for a per diem rate when provided in a nursing facility. Extended respite must be at least eight hours in duration.

(D) In-home extended respite is filed for a per diem rate. A minimum of eight hours must be provided in the member's home.

(3) **Adult day health (ADH) care.**

(A) ~~Adult day health care~~ADH is furnished on a ~~regularly scheduled~~regularly-scheduled basis for one or more days per week in an outpatient setting. It provides both health

and social services necessary to ensure the member's optimal functioning. ~~Physical, occupational, and speech therapies are only provided as an enhancement to the basic adult day health care service when authorized by the service plan and are billed as a separate procedure. Meals provided as part of this service do not constitute a full nutritional regimen. Personal care service enhancement in adult day health care is assistance in bathing, hair care, or laundry service, authorized by the service plan and billed as separate procedures. Most assistance with activities of daily living (ADL), such as eating, mobility, toileting, and nail care are integral services to adult day health care service and are covered by the adult day health care basic reimbursement rate. Assistance with bathing, hair care, or laundry service is not a usual and customary adult day health care service. Enhanced personal care in adult day health care for assistance with bathing, hair care, or laundry service is authorized when an ADvantage Waiver member who uses adult day health care requires assistance with bathing, hair care, or laundry service to maintain his or her health and safety.~~Most assistance with activities of daily living (ADLs), such as eating, mobility, toileting, and nail care are integral services to ADH care service and are covered by the ADH care basic reimbursement rate.

(B) ~~Adult day health~~ADH care is a 15-minute unit of service. No more than eight hours, 32 units~~,~~ (eight hours) are authorized per day. The number of units of service a member may receive is limited to the number of units approved on the member's approved service plan.

(C) Physical, occupational, and speech therapies are only provided as an enhancement to the basic ADH care service when authorized by the service plan and are billed as a separate procedure. ~~Adult day health~~ADH care therapy enhancement is a maximum of one session unit per day of service.

(D) ~~Adult day health personal care enhancement is a maximum of one unit per day of bathing, hair care, or laundry service.~~Meals provided as part of this service do not constitute a full nutritional regimen. One meal, that contains at least one-third of the current daily dietary recommended intake (DRI) as established by the Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences, is provided to those participants who are in the center for four or more hours per day, and does not constitute a full nutritional regimen. Member's access to food at any time must also be available in addition to the required meal and is

consistent with an individual not receiving Medicaid-funded services and supports.

(E) Personal care service enhancement in ADH is assistance in bathing, hair care, or laundry service, authorized by the person-centered service plan and billed as separate procedures. This service is authorized when as ADvantage Waiver member who uses ADH requires assistance with bathing, hair care, or laundry to maintain health and safety. Assistance with bathing, hair care, or laundry service is not a usual and customary ADH care service. ADH personal care enhancement is a maximum of one unit per day of bathing, hair care, or laundry service.

(F) DHS Home and Community-Based Services (HCBS) Waiver settings have qualities defined in federal regulation per Section 441.301 (c)(4) of Title 42 of Code of Federal Regulations [42 CFR § 441.301 (c)(4)] based on the needs of the individual defined in the member's authorized service plan.

(i) The ADH center is integrated and supports full access of ADvantage members to the greater community, including opportunities to:

(I) seek employment and work in competitive integrated ADH Center, not a requirement for persons that are retirement age;

(II) engage in community life;

(III) control personal resources; and

(IV) receive services in the community, to the same degree as individuals not receiving ADvantage Program or other Medicaid HBCS Waiver services.

(ii) The ADH is selected by the member from all available service options and given the opportunity to visit and understand the options.

(iii) The ADH ensures the member's rights of privacy, dignity, respect, and freedom from coercion and restraint.

(iv) The ADH optimizes the member's 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.

(v) The ADH facilitates the member's choice regarding services and supports~~,~~ including the provider.

(vi) Each member has the freedom and support to control his or her own schedules, activities, and access to food at any time.

(vii) Each member may have visitors whenever he or she chooses.

(viii) The ADH center is physically accessible to the member.

(G) ADH centers that are presumed not to be Home and Community-Based settings per 42 CFR § 441.301(c)(5)(v) include:

(i) ADH centers in a publicly or privately-owned facility providing inpatient treatment;

(ii) ADH centers on the grounds of or adjacent to a public institution;

(iii) ADH centers with the effect of isolating individuals from the broader community of individuals not receiving ADvantage Program or another Medicaid HCBS;

(H) If the ADH is presumed not HCBS, according to 42 CFR § 441.301(c)(5)(v), it may be subject to heightened scrutiny by AA, OHCA, and CMS. The ADH must provide evidence that the ADH portion of the facility has clear administrative, financial, programmatic, and environmental distinctions from the institution and comply with additional monitoring by the AA.

(4) **Environmental modifications**.

(A) Environmental modifications are physical adaptations to the home, required by the member's person-centered service plan that are necessary to ensure the health, welfare, and safety of the member or enable the member to function with greater independence in the home, and that without such, the member would require institutionalization. Adaptations or improvements to the home 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 person-centered service plan that enable members to increase their abilities to perform ~~ADLs,~~Activities of Daily Living (ADLs), or to perceive, control, or communicate with the environment in which they live. Necessary items for life support, ancillary supplies, and equipment necessary for the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid state plan are also included. This service excludes any equipment and/or supply items 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 HealthCare Common Procedure Code (HCPC). Reoccurring supplies shipped and delivered 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 and delivering these items. Payment for medical supplies is limited to the SoonerCare rate ~~if~~when established, to the Medicare rate, or to actual acquisition cost, plus 30 percent. All services must have prior authorization.

(6) **Advanced supportive/restorative assistance**.

(A) Advanced supportive/restorative assistance services are maintenance services used to assist a member who has a chronic, yet stable~~,~~ condition. These services assist with ADLs that require devices and procedures related to altered body functions. These services are for maintenance only and are not utilized as treatment services.

(B) Advanced supportive/restorative assistance service is billed per 15-minute unit of service. The number of units of service a member may receive is limited to the number of units approved on the person-centered service plan.

(7) **Nursing.**

(A) Nursing services are services listed in the person-centered service plan that are within the scope of the Oklahoma Nursing Practice Act. These services are provided by a registered nurse (RN), a licensed practical nurse (LPN), or a licensed vocational nurse (LVN) under the supervision of an RN licensed to practice in the state. Nursing services may be provided on an intermittent or part-time basis or may be comprised of continuous care. The provision of the nursing service works to prevent or postpone the institutionalization of the member.

(B) Nursing services are services of a maintenance or preventative nature provided to members with stable, chronic conditions. These services are not intended to treat an acute health condition and may not include services reimbursable under either Medicaid or the Medicare 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 they meet the member's needs as specified in the person-centered service plan. A nursing assessment/evaluation, on-site visit is made to each member ~~for whom~~, with additional visits for members with advanced supportive/restorative assistance services ~~are~~ authorized to evaluate the condition of the member and medical appropriateness of services. An assessment/evaluation ~~visit~~ report is ~~made~~forwarded to the ADvantage Program case manager in accordance with review

schedule determined between the case manager and ~~nurse,~~outlined in the member's person-centered service plan, to report the member's condition or other significant information concerning each ~~advanced supportive/restorative care~~ADvantage member.

(i) The ADvantage Program case manager may recommend authorization of nursing services as part of the interdisciplinary team planning for the member's person-centered service plan and/or assessment/evaluation of the:

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

(II) 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 per rules and regulations for the delegation of nursing tasks established by the Oklahoma Board of Nursing.

(ii) In addition to assessment/evaluation, the ADvantage Program case manager may recommend authorization of nursing services to:

(I) prepare a one-week supply of insulin syringes for a person who is blind and has diabetes, who can safely self-inject the medication but cannot fill his or her own syringe. This service includes monitoring the member's continued ability to self-administer the insulin;

(II) prepare 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) monitor 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) provide nail care for the member with diabetes or member who has circulatory or neurological compromise; and

(V) provide consultation and education to the member, member's family, or other informal caregivers identified in the person-centered service plan, regarding the nature of the member's chronic condition. Skills training, including return skills demonstration to establish competency, to the member, family, or other informal caregivers as specified in the person-centered service plan for

preventive and rehabilitative care procedures are also provided.

(C) Nursing service includes interdisciplinary team planning and recommendations for the member's person-centered service plan development and/or assessment/evaluation~~,~~ 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 interdisciplinary team planning and recommendations for the member's person-centered service plan ~~and for performing assessment/evaluations, another~~other procedure ~~code is~~codes may be used to bill for all other authorized nursing services. A maximum of eight units, two hours, per day of nursing for service plan development and assessment evaluation are allowed. An agreement by a provider to perform a nurse evaluation is also an agreement to provide the Medicaid in-home care services for which the provider is certified and contracted. Reimbursement for a nurse evaluation is denied when 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) **Skilled nursing services.**

(A) Skilled nursing services listed in the person-centered service plan that are within the scope of the state's Nurse Practice Act and are ordered by a licensed physician, osteopathic physician, physician assistant, or an advanced practice nurse and are provided by an RN, ~~or an~~ LPN, or LVN under the supervision of a ~~registered nurse,~~an RN, licensed to practice in the state. Skilled nursing services provided in the member's home or other community setting are services requiring the specialized skills of a licensed nurse. The scope and nature of these services are intended for treatment of a disease or a medical condition and are beyond the scope of ADvantage nursing services. These intermittent nursing services are targeted toward a prescribed treatment or procedure that must be performed at a specific time or other predictable rate of occurrence. The RN contacts the member's physician to obtain necessary information or orders pertaining to the member's care. When the member has an ongoing need for service activities requiring more or less units than authorized, the RN must recommend, in writing, that the service plan be revised.

(B) Skilled nursing services are provided on an intermittent or part-time basis, and billed per 15-minute units of service. Skilled nursing services are provided

when nursing services are not available through Medicare or other sources or when SoonerCare plan nursing services limits are exhausted. Amount, frequency, and duration of services are prior-authorized in accordance with the member's person-centered service plan.

(9) **~~Home delivered~~Home-delivered meals.**

(A) ~~Home delivered~~Home-delivered meals provide one meal per day. A ~~home delivered~~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 dietary reference intakes as established by the Food and Nutrition Board of the National Academy of Sciences. ~~Meals~~Home-delivered meals are only provided to members who are unable to prepare meals and lack an informal provider to do meal preparation.

(B) ~~Home delivered~~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 in accordance with the member's person-centered service plan. The provider must obtain a signature from the member or the member's representative at the time the meal is delivered. In the event the member is temporarily unavailable, such as at a doctor's appointment and the meal is left at the member's home, the provider must document the reason a signature was not obtained. The signature logs must be available for review.

(10) **Occupational therapy services.**

(A) Occupational therapy services are 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 enabling him or her 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 limitations of his or her practice, working under the supervision of a licensed occupational therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services when appropriate. The occupational therapist ensures monitoring and documentation of the

member's rehabilitative progress and reports to the member's case manager and physician to coordinate the necessary addition 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.

(11) **Physical therapy services.**

(A) Physical therapy services are those services that maintain or improve 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 the use of physical therapeutic means, such as massage, manipulation, therapeutic exercise, cold and/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. Under the Physical Therapy Act, a physical therapist may evaluate a member's rehabilitation potential and develop and implement an appropriate, written, therapeutic regimen without a referral from a licensed health care practitioner for a period not to exceed 30-calendar days. Any treatment required after the 30-calendar day period requires a prescription from a physician or the physician's assistant of the licensee. The regimen utilizes paraprofessional physical therapy assistant services, within the limitations of his or her 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 when appropriate. The licensed physical therapist ensures monitoring and documentation of the member's rehabilitative progress and reports to the member's case manager and physician to coordinate the necessary addition 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.~~authorized as ADH care therapy enhancement and are a maximum of one session unit per day of service. Payment is not allowed solely for written reports or record documentation.

(12) **Speech and language therapy services.**

(A) Speech and language therapy services are those that maintain or improve speech and language communication ~~disability~~and swallowing disorders/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 the use of therapeutic means, such as evaluation, specialized treatment, or development~~,~~ and oversight of a therapeutic maintenance program. Under a physician's order, a licensed speech and language pathologist evaluates the member's rehabilitation potential and develops an appropriate, written, therapeutic regimen. The regimen utilizes ~~paraprofessional therapy assistant~~Speech Language Pathology Assistant services within the limitations of his or her practice, working under the supervision of the licensed ~~speech and language pathologist.~~Speech and Language Pathologist. The regimen includes education and training for informal caregivers to assist with, and/or maintain services when appropriate. The ~~speech and language pathologist~~Speech and Language Pathologist ensures monitoring and documentation of the member's rehabilitative progress and reports to the member's case manager and physician to coordinate the necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Speech and language therapy services are ~~billed per 15-minute unit of service.~~authorized as ADH care therapy enhancement and are a maximum of one session unit per day of service. Payment is not allowed solely for written reports or record documentation.

(13) **Hospice services.**

(A) Hospice services are palliative and comfort care provided to the member and his or her family when a physician certifies the member has a terminal illness, with a life expectancy of six months or less, and orders hospice care. ADvantage hospice care is authorized for a six-month period~~,~~ and requires physician certification of a terminal illness and orders of hospice care. When 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 30-calendar days prior to the initial hospice authorization end date, and re-certify that the member has a terminal illness, has six months or less to live, and orders additional hospice care. After the initial authorization period, additional periods of ADvantage hospice may be authorized for a maximum of 60-calendar day increments with physician certification that the member has a terminal illness and six months or less to live. A member's person-centered service plan that includes hospice care must comply with Waiver requirements

to be within total person-centered 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 experienced during the final stages of illness, through the end of life, and bereavement. The member signs a statement choosing hospice care instead of routine medical care with 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 illness in the home environment. Hospice care services include nursing care, physician services, medical equipment and supplies, drugs for symptom and pain relief, home health aide and personal care services, physical, occupational and speech therapies, medical social services, dietary counseling, and grief and bereavement counseling to the member and/or the member's family.

(C) A hospice ~~plan of care~~person-centered service plan must be developed by the hospice team in conjunction with the member's ADvantage case manager before hospice services are provided. The hospice services must be related to the palliation or management of the member's terminal illness, symptom control, or to enable the member to maintain ADL and basic functional skills. A member who is eligible for Medicare hospice provided as a Medicare Part A benefit, is not eligible to receive ADvantage hospice services.

(D) Hospice services are billed per diem of service for days covered by a hospice ~~plan of care~~person-centered service plan and while the hospice provider is responsible for providing hospice services as needed by the member or member's family. The maximum total annual reimbursement for a member's hospice care within a 12-month period is limited to an amount equivalent to 85 percent of the Medicare hospice cap payment, and must be authorized on the member's person-centered service plan.

(14) **ADvantage personal care.**

(A) ADvantage personal care is assistance to a member in carrying out ADLs, such as bathing, grooming, and toileting or in carrying out instrumental activities of daily living (IADLs), such as preparing meals and laundry service, to ensure the member's personal health and safety, or to prevent or minimize physical health regression or deterioration. Personal care services do not include service provision of a technical nature, such as tracheal suctioning, bladder catheterization, colostomy irrigation, or the operation and maintenance of equipment of a technical nature.

(B) ADvantage home care agency skilled nursing staff working in coordination with an ADvantage case manager ~~are~~is responsible for the development and monitoring of the member's personal care services.

(C) ADvantage personal care services are prior-authorized and billed per 15-minute unit of service, with units of service limited to the number of units on the ADvantage approved person-centered service plan.

(15) **Personal emergency response system.**

(A) Personal emergency response system (PERS) is an electronic device that enables members at high risk of institutionalization, to secure help in an emergency. Members may also wear a portable "help" button to allow for mobility. PERS is connected to the person's phone and programmed to signal, per member preference, a friend, relative, or a response center, once the "help" button is activated. For an ADvantage member to be eligible for PERS service, the member must meet all of the service criteria in (i) through (vi). The:

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

(ii) member lives alone and without a regular caregiver, paid or unpaid, and therefore is left alone for long periods of time;

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

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

(v) member 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~~PERS service avoids premature or unnecessary institutionalization of the member.

(B) PERS services are billed using the appropriate ~~HCPC~~Healthcare Common Procedure Coding (HCPC) procedure code for installation, monthly service, or PERS purchase. All services are prior authorized ~~in accordance with~~per the ADvantage approved service plan.

(16) ~~**Consumer-Directed Personal Assistance Services and Support (CD-PASS).**~~**CD-PASS.**

(A) CD-PASS are personal services assistance (PSA) and advanced personal services assistance (APSA) that enable a member in need of assistance to reside in ~~their~~his or her home and community of ~~their choosing~~choice, rather than in an institution; and to carry out functions of daily living, self-care, and mobility. CD-PASS services are

delivered as authorized on the person-centered service plan. The member becomes the employer of record and employs the PSA and the APSA. The member is responsible, with assistance from ADvantage Program Administrative Financial Management Services (FMS), for ensuring the employment complies with state and federal labor law requirements. The member/employer may designate an adult family member or friend, who is not a PSA or APSA to the member, as an "authorized representative" to assist in executing the employer functions. The member/employer:

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

(ii) is solely responsible to provide instruction and training to the PSA or APSA on tasks and works with the consumer directed agent/case manager (CDA) to obtain ADvantage skilled nursing services assistance with training, when necessary. Prior to performing an APSA 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.

(B) The services the PSA may provide include:

(i) assistance with mobility and transferring in and out of bed, wheelchair, or motor vehicle, or all;

(ii) assistance with routine bodily functions ~~that may include:~~, such as:

(I) bathing and personal hygiene;

(II) dressing and grooming; and

(III) eating, including meal preparation and cleanup;

(iii) assistance with home services ~~that may include~~, such as shopping, laundry ~~service~~, cleaning, and seasonal chores;

(iv) companion assistance, ~~that may include~~ such as letter writing, reading mail, and providing escort or transportation to participate in approved activities or events. "Approved activities or events," means community, civic participation guaranteed to all citizens including, but not limited to, exercise of religion, voting or participation in daily life activities in which exercise of choice and decision

making is important to the member, and may include shopping for food, clothing, or other necessities, or for participation in other activities or events specifically approved on the person-centered service plan.

(C) An APSA provides assistance with ADLs to a member with a stable, chronic condition, when such assistance requires devices and procedures related to altered body function if such activities, in the opinion of the attending physician or licensed nurse, may be performed if the member were physically capable, and the procedure may be safely performed in the home. Services provided by the APSA are maintenance services and are never used as therapeutic treatment. Members who develop medical complications requiring skilled nursing services while receiving APSA services are referred to his or her attending physician, who appropriate, order home health services. APSA includes assistance with health maintenance activities that may include:

(i) routine personal care for persons with ostomies, including tracheotomies, gastrostomies, and colostomies with well-healed stoma, external, indwelling, and suprapubic catheters that include changing bags and soap and water hygiene around the ostomy or catheter site;

(ii) removing external catheters, inspecting skin, and reapplication of same;

(iii) administering prescribed bowel program, including use of suppositories and sphincter stimulation, and enemas ~~(~~pre-packaged only without contraindicating rectal or intestinal conditions;

(iv) applying medicated ~~(prescription)~~prescription lotions or ointments and dry, non-sterile dressings to unbroken skin;

(v) using a lift for transfers;

(vi) manually assisting with oral medications;

(vii) providing passive range of motion (non-resistive flexion of joint) therapy, delivered in accordance with the person-centered service plan unless contraindicated by underlying joint pathology;

(viii) applying non-sterile dressings to superficial skin breaks or abrasions; and

(ix) using universal precautions as defined by the Centers for Disease Control and Prevention.

(D) FMS are program administrative services provided to participating CD-PASS members/employers by ~~DHS AS.~~AA. FMS are employer-related assistance that provides Internal Revenue Service (IRS) fiscal reporting agent and other

financial management tasks and functions including, but not limited to:

(i) processing employer payroll, after the member/employer has verified and approved the employee timesheet, 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/employer and in accordance with the member/employer's individual budget allocation;

(iii) responsibility for obtaining criminal and abuse registry background checks on prospective hires for ~~PSAs or APSAs~~PSA or APSA on the member/employer's behalf;

(iv) providing orientation and training regarding employer responsibilities, as well employer information and management guidelines, materials, tools, and staff consultant expertise to support and assist the member ~~in~~ successfully ~~performing~~perform employer-related functions; and

(v) making Hepatitis B vaccine and vaccination series available to PSA and APSA employees in compliance with Occupational Safety and Health Administration (OSHA) standards.

(E) The PSA service 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 person-centered service plan.

(F) The APSA service 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 person-centered service plan.

(17) **Institutional transition services.**

(A) Institutional transition services are those services necessary to enable a member to leave the institution and receive necessary support through ADvantage Waiver services in his or her home and community.

(B) Transitional case management services are services per ~~OAC~~Oklahoma Administrative Code (OAC) 317:30-5-763(1) required by the member and included on the member's person-centered service plan that 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. ~~Advantage~~ADvantage transitional case management services assist institutionalized members who are eligible to receive

ADvantage services in gaining access to needed Waiver and other State plan services, as well as needed medical, social, educational, and other services to assist in the transition, regardless of the funding source for the services to which access is gained. Transitional case management services may be authorized for periodic monitoring of an ADvantage member's progress during an institutional stay and for assisting the member transition from institution to home by updating the person-centered service plan, including necessary institutional transition services to prepare services and supports to be in place or to start on the date the member is discharged from the institution. Transitional case management services may be authorized to assist individuals that have not previously received ADvantage services, but were referred by DHS AS to the case management provider for assistance in transitioning from the institution to the community with ADvantage services support.

(i) Institutional transition case management services are prior authorized and billed per 15-minute unit of service using the appropriate ~~HCPC~~Healthcare Common Procedure Coding (HCPC) procedure code and modifier associated with the location of residence of the member served per OAC 317:30-5-763(1)(C).

(ii) A unique modifier code is used to distinguish transitional case management services from regular case management services.

(C) Institutional transition services may be authorized and reimbursed per the conditions in (i) through (iv).

(i) The service is necessary to enable the member to move from the institution to his or her home.

(ii) The member is eligible to receive ADvantage services outside of the institutional setting.

(iii) Institutional transition services are provided to the member within 180 calendar-days of discharge from the institution.

(iv) ~~services~~Services provided while the member is in the institution are claimed as delivered on the day of discharge from the institution.

(D) When the member receives institutional transition services but fails to enter the Waiver, any institutional transition services provided are not reimbursable.

(18) **Assisted living services~~.~~ (ALS).**

(A) ~~Assisted living services (ALS)~~ALS are personal care and supportive services furnished to Waiver members who reside in a homelike, non-institutional setting that includes 24-hour, on-site response capability to meet scheduled or unpredictable member needs and to provide supervision, safety, and security. Services also include

social and recreational programming and medication assistance, to the extent permitted under State law. The ALS provider is responsible for coordinating services provided by third parties to ADvantage members in the assisted living center. Nursing services are incidental rather than integral to the provision of ALS. ADvantage reimbursement for ALS includes services of personal care, housekeeping, laundry ~~service~~, meal preparation, periodic nursing evaluations, nursing supervision during nursing intervention, intermittent or unscheduled nursing care, medication administration, assistance with cognitive orientation, assistance with transfer and ambulation, planned programs for socialization, activities, and exercise, and for arranging or coordinating transportation to and from medical appointments. Services, except for planned programs for socialization, activities, and exercise are to meet the member's specific needs as determined through the individualized assessment and documented on the member's person-centered service plan.

(B) The ADvantage ALS philosophy of service delivery promotes member choice, and to the greatest extent possible, member control. A member has control over his or her living space and his or her choice of personal amenities, furnishings, and activities in the residence. The ADvantage member must have the freedom to control his or her schedule and activities. The ALS provider's documented operating philosophy, including policies and procedures, must reflect and support the principles and values associated with the ADvantage assisted living philosophy and approach to service delivery emphasizing member dignity, privacy, individuality, and independence.

(C) ADvantage ALS required policies for admission and termination of services and definitions.

(i) ADvantage-certified assisted living centers (ALC) are required to accept all eligible ADvantage members who choose to receive services through the ALC, subject only to issues relating to, one or more of the following:

(I) rental unit availability;

(II) the compatibility of the member with other residents;

(III) the center's ability to accommodate residents who have behavior problems, wander, or have needs that exceed the services the center provides; or

(IV) restrictions initiated by statutory limitations.

(ii) The ALC may specify the number of units the provider is making available to service ADvantage members. ~~The number of rental units available to~~

~~service the ADvantage participants may be altered based upon written request from the provider and acceptance by the ADvantage Administration (AA).~~At minimum, the ALC must designate 10 residential units for ADvantage members. Residential units designated for ADvantage may be used for other residents at the ALC if there are no pending ADvantage members for those units. Exceptions may be requested in writing subject to the approval of AA.

(iii) Mild or moderate, cognitive impairment of the applicant is not a justifiable reason to deny ALC admission. Centers are required to specify whether they are able to accommodate members who have behavior problems or wander. Denial of admission due to a determination of incompatibility must be approved by the case manager and the ADvantage Administration (AA). Appropriateness of placement is not a unilateral determination by the ALC. The ADvantage case manager, the member, or member's designated representative, and the ALC in consultation determine the appropriateness of placement.

(iv) The ALC is responsible for meeting the member's needs for privacy, dignity, respect, and freedom from coercion and restraint. The ALC must optimize the member's initiative, autonomy and independence in making life choices. The ALC must facilitate member choices regarding services and supports, and who provides them. Inability to meet those needs is not recognized as a reason for determining an ADvantage member's placement is inappropriate. The ALC agrees to provide or arrange and coordinate all of the services listed in the Oklahoma State Department of Health regulations per ~~(OAC 310:663-3-3),~~OAC 310:663-3-3, except for specialized services.

(v) In addition, the ADvantage participating ALC agrees to provide or coordinate the services listed in (I) through (III).

(I) Provide an emergency call system for each participating ADvantage member.

(II) Provide up to three meals per day plus snacks sufficient to meet nutritional requirements, including modified special diets, appropriate to the member's needs and choices; and provide members with 24-hour access to food by giving members control in the selection of the foods they eat, by allowing the member to store personal food in his or her room, by allowing the member to prepare and eat food in his or her room, and allowing him or her to decide when to eat.

(III) Arrange or coordinate transportation to and from medical appointments. The ALC must assist the member with accessing transportation for integration into the community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, and control his or her personal resources and receive services in the community to the same degree of access as residents not receiving ADvantage services.

(vi) The provider may offer any specialized service or rental unit for members with Alzheimer's disease and related dementias, physical disabilities, or other special needs the facility intends to market. Heightened scrutiny, through additional monitoring of the ALC by AA, will be utilized for those ALC's that also provide inpatient treatment; settings on the grounds of or adjacent to a public institution and/or other settings that tend to isolate individuals from the community. The ALC must include evidence that the ALC portion of the facility has clear administrative, financial, programmatic and environmental distinctions from the institution.

(vii) When the provider arranges and coordinates services for members, the provider is obligated to ~~assure~~ensure the provision of those services.

(viii) Per OAC 310:663-1-2, "personal care" is defined as "assistance with meals, dressing, movement, bathing or other personal needs or maintenance, or general supervision of the physical and mental well-being of a person, and includes assistance with toileting." For ADvantage ALS, assistance with "other personal needs" in this definition includes assistance with grooming and transferring. The term "assistance" is clarified to mean hands-on help, in addition to supervision.

(ix) The specific ALS assistance provided along with amount and duration of each type of assistance is based upon the member's assessed need for service assistance and is specified in the ALC's service plan that is incorporated as supplemental detail into the ADvantage comprehensive person-centered service plan. The ADvantage case manager in cooperation with ALC professional staff, develops the person-centered service plan to meet member needs. As member needs change, the person-centered service plan is amended consistent with the assessed, documented need for change in services.

(x) Placement, or continued placement of an ADvantage member in an ALC is inappropriate ~~if~~when any one or more of the conditions exist.

(I) The member's needs exceed the level of services the center provides. Documentation must support ALC efforts to provide or arrange for the required services to accommodate participant needs.

(II) The member exhibits behavior or actions that repeatedly and substantially ~~interfere~~interferes with the rights or well-being of other residents and the ALC ~~has~~ documented efforts to resolve behavior problems including medical, behavioral, and increased staffing interventions. Documentation must support the ALC attempted interventions to resolve behavior problems.

(III) The member has a complex, unstable, or unpredictable medical condition and treatment cannot be developed and implemented appropriately in the assisted living environment. Documentation must support the ALC attempts to obtain appropriate member care.

(IV) The member fails to pay room and board charges and/or DHS determined vendor payment obligation.

(xi) Termination of residence when inappropriately placed. Once a determination is made that a member is inappropriately placed, the ALC must inform the member and the member's representative, ~~if~~when any, the AA and the member's ADvantage case manager. The ALC must develop a discharge plan in consultation with the member, the member's representative, the ADvantage case manager, and the AA. The ALC and case manager must ensure the discharge plan includes strategies for providing increased services, when appropriate, to minimize risk and meet the higher care needs of members transitioning out of the ALC, when the reason for discharge is inability to meet member needs. ~~If~~When voluntary termination of residency is not arranged, the ALC must provide written notice to the member and to the member's representative, with a copy to the member's ADvantage case manager and the AA, giving the member ~~30 calendar days,~~30-calendar days written notice of the ALC's intent to terminate the residency agreement and move the member to an appropriate care provider. The ~~30 calendar day~~30-calendar day requirement must not apply when emergency termination of the residency agreement is mandated by the member's immediate health needs or when the termination of the residency agreement is necessary for the physical safety of the member or other ALC residents. The written notice of involuntary termination of residency for reasons of inappropriate placement must include:

(I) a full explanation of the reasons for the termination of residency;
(II) the notice date;
(III) the date notice was given to the member and the member's representative, the ADvantage Case Manager, and the AA;
(IV) the date the member must leave ALC; and
(V) notification of appeal rights and the process for submitting appeal of termination of Medicaid ALS to OHCA.

(D) ADvantage ALS provider standards in addition to licensure standards.

(i) Physical environment.

(I) The ALC must provide lockable doors on the entry door of each rental unit and an attached, lockable compartment within each member unit for valuables. Members must have exclusive rights to his or her unit with lockable doors at the entrance of the individual or shared rental unit. Keys to rooms may be held by only appropriate ALC staff as designated by the member's choice. Rental units may be shared only when a request to do so is initiated by the member. Members must be given the right to choose his or her roommate.

(II) The member has a legally enforceable agreement, ~~(lease)~~lease, with the ALC. The member must have the same responsibilities and protections from eviction as all tenants under the landlord tenant law of the state, county, city, or other designated entity.

(III) The ALC must provide each rental unit with a means for each member to control the temperature in the residential unit through the use of a damper, register, thermostat, or other reasonable means ~~that is~~ under the control of the member and that preserves privacy, independence, and safety, provided that the Oklahoma State Department of Health may approve an alternate means based on documentation that the design of the temperature control is appropriate to the special needs of each member who has an alternate temperature control.

(IV) For ALCs built prior to January 1, 2008, each ALC individual residential unit must have a minimum total living space, including closets and storage areas, of 250 square feet; for ALCs built after December 31, 2007, each ALC individual residential unit must have a minimum total living space, including closets and storage areas, of 360 square feet.

(V) The ALC must provide a private bathroom for each living unit that must be equipped with one lavatory, one toilet, and one bathtub or shower stall.

(VI) The ALC must provide at a minimum, a kitchenette, defined as a space containing a refrigerator, adequate storage space for utensils, and a cooking appliance, a microwave is acceptable.

(VII) The member is responsible for furnishing the rental unit. ~~If~~When a member is unable to supply basic furnishings defined as a bed, dresser, nightstand, chairs, table, trash can, and lamp, or if member supplied furnishings pose a health or safety risk, the member's ADvantage case manager in coordination with the ALC, must assist the member in obtaining basic furnishings for the rental unit. The member must have the freedom to furnish and decorate the rental unit within the scope of the lease or residency agreement.

(VIII) The ALC must meet the requirements of all applicable federal and state laws and regulations including, but not limited to, state and local sanitary codes, state building and fire safety codes, and laws and regulations governing use and access by persons with disabilities.

(IX) The ALC must ensure the design of common areas accommodates the special needs of the resident population and that the rental unit accommodates the special needs of the member in compliance with the Americans with Disabilities Act accessibility guidelines per 28 Code of Federal Regulations, Part 36, Appendix A, at no additional cost to the member.

(X) The ALC must provide adequate and appropriate social and recreational space for residents and the common space must be proportionate to the number of residents and appropriate for the resident population.

(XI) The ALC must provide appropriately monitored outdoor space for resident use.

(XII) The ALC must provide the member with the right to have visitors of his or her choosing at any time. Overnight visitation is allowed, but may be limited by the ALC to the extent to which a visitor may stay overnight.

(XIII) The ALC must be physically accessible to members.

(ii) Sanitation.

(I) The ALC must maintain the facility, including its individual rental units that are in a clean, safe, ~~sanitary,~~and sanitary manner, that are insect

and rodent free, odorless, and in good repair at all times.

(II) The ALC must maintain buildings and grounds in a good state of repair, in a safe and sanitary condition, and in compliance with the requirements of applicable regulations, bylaws, and codes.

(III) The ALC stores clean laundry in a manner that prevents contamination and changes linens at time intervals necessary to avoid health issues.

(IV) The ALC must provide housekeeping in member rental units to maintain a safe, clean, and sanitary environment.

(V) The ALC must have policies and procedures for members' pets.

(iii) Health and Safety.

(I) The ALC must provide building security that protects members from intruders with security measures appropriate to building design, environmental risk factors, and the resident population.

(II) The ALC must respond immediately and appropriately to missing members, accidents, medical emergencies, or deaths.

(III) The ALC must have a plan in place to prevent, contain, and report any diseases considered to be infectious or are listed as diseases that must be reported to the Oklahoma State Department of Health (OSDH).

(IV) The ALC must adopt policies for the prevention of abuse, neglect, and exploitation that include screening, training, prevention, investigation, protection during investigation, and reporting.

(V) The ALC must provide services and facilities that accommodate the needs of members to safely evacuate in the event of fires or other emergencies.

(VI) The ALC must ensure staff is trained to respond appropriately to emergencies.

(VII) The ALC must ensure that fire safety requirements are met.

(VIII) The ALC must offer meals that provide balanced and adequate nutrition for members.

(IX) The ALC must adopt safe practices for the preparation and delivery of meals.

(X) The ALC must provide a 24-hour response to personal emergencies that is appropriate to the needs of the resident population.

(XI) The ALC must provide safe transportation to and from ALC sponsored social or recreational outings.

(iv) Staff to resident ratios.

(I) The ALC must ensure a sufficient number of trained staff are on duty, awake, and present at all times, 24 hours a day, and seven days a week, to meet the needs of residents and to carry out all of the processes listed in the ALC's written emergency and disaster preparedness plan for fires and other disasters.

(II) The ALC must ensure staffing is sufficient to meet the needs of the ADvantage Program members in accordance with each member's ADvantage person-centered service plan.

(III) The ALC must have plans in place to address situations where there is a disruption to the ALC's regular work force.

(v) Staff training and qualifications.

(I) The ALC must ensure staff has qualifications consistent with their job responsibilities.

(II) All staff assisting in, or responsible for, food service must have attended a food service training program offered or approved by OSDH.

(III) The ALC must provide staff orientation and ongoing training to develop and maintain staff knowledge and skills. All direct care and activity staff receive at least eight hours of orientation and initial training within the first month of employment and at least four hours annually thereafter. Staff providing direct care on a dementia unit must receive four additional hours of dementia specific training. Annual first aid and cardiopulmonary resuscitation (CPR) certification do not count toward the four hours of annual training.

(vi) Staff supervision.

(I) The ALC must ensure delegation of tasks to non-licensed staff ~~must be~~is consistent and in compliance with all applicable state regulations including, but not limited to, the Oklahoma Nurse Practice Act and OSDH Nurse Aide Certification rules.

(II) The ALC must ensure that, where the monitoring of food intake or therapeutic diets is provided at the prescribed services level, a registered dietitian monitors member health and nutritional status.

(vii) Resident rights.

(I) The ALC must provide to each member and each member's representative, at the time of admission, a copy of the resident statutory rights listed in Section 1-1918 of Title 63 of the Oklahoma Statutes (O.S. 63-1-1918) amended to include additional

rights and the clarification of rights as listed in the ADvantage Member Assurances. A copy of resident rights must be posted in an easily accessible, conspicuous place in the facility. The facility must ensure that staff is familiar with and observes, the resident rights.

(II) The ALC must conspicuously post for display in an area accessible to residents, employees, and visitors, the assisted living center's complaint procedures and the name, address, and telephone number of a person authorized to receive complaints. A copy of the complaint procedure must also be given to each member, the member's representative, or the legal guardian. The ALC must ensure all employees comply with the ALC's complaint procedure.

(III) The ALC must provide to each member and member's representative, at the time of admission, information about Medicaid grievance and appeal rights, including a description of the process for submitting a grievance or appeal of any decision that decreases Medicaid services to the member.

(viii) Incident reporting.

(I) The ALC must maintain a record of incidents that occur and report incidents to the member's ADvantage case manager and to the AA, utilizing the AA Critical Incident Reporting form. Incident reports are also~~ to be~~ made to Adult Protective Services (APS) and to the ~~Oklahoma State Department of Health (OSDH),~~OSDH, as appropriate, ~~in accordance with the ALC's~~per ALC licensure rules, utilizing the specific reporting forms required.

(II) Incidents requiring report by licensed ALC are those defined by OSDH per OAC 310:663-19-1 and listed on the AA Critical Incident Reporting Form.

(III) Reports of incidents must be made to the member's ADvantage case manager and to the AA via ~~facsimile or mail~~electronic submission within one business day of the reportable incident's discovery utilizing the AA Critical Incident Reporting form. ~~If~~When required, a follow-up report of the incident must be submitted via ~~facsimile or mail~~electronic submission to the member's ADvantage case manager and to the AA. The ~~follow up~~follow-up report must be submitted within ~~five business~~5-business days of the incident. The final report must be filed with the member's ADvantage case manager and the AA when the investigation is complete, not to exceed ~~10 business~~10-business days after the incident.

(IV) Each ALC having reasonable cause to believe that a member is suffering from abuse, neglect, exploitation, or misappropriation of member property must make a report to ~~DHS Adult Protective Services (APS)~~APS as soon as the person is aware of the situation per O.S. 43A § 10-104.A. Reports are also made to OSDH, as appropriate, per ALC licensure rules.

(V) The preliminary incident report must at the minimum, include who, what, when, where, and the measures taken to protect the member and resident(s) during the investigation. The follow-up report must at the minimum, include preliminary information, the extent of the injury or damage, ~~if~~when any, and preliminary investigation findings. The final report at a minimum~~,~~ includes preliminary and follow-up information, a summary of investigative actions representing a thorough investigation, investigative findings and conclusions based on findings, and corrective measures to prevent future occurrences. When it is necessary to omit items, the final report must include why such items were omitted and when they will be provided.

(ix) Provision of or arrangement for necessary health services. The ALC must:

(I) ~~The ALC must~~ arrange or coordinate transportation for members to and from medical appointments.

(II) ~~The ALC must~~ provide or coordinate with the member and the member's ADvantage case manager for delivery of necessary health services. The ADvantage case manager is responsible for monitoring all health-related services required by the member as identified through assessment and documented on the person-centered service plan, are provided in an appropriate and timely manner. The member has the freedom to choose any available provider qualified by licensure or certification to provide necessary health services in the ALC.

(E) ALS are billed per diem of service for days covered by the ADvantage member's person-centered service plan and during which the ALS provider is responsible for providing ALS for the member. The per diem rate for ADvantage assisted living services for a member is one of three per diem rate levels based on a member's need for type of, intensity of, and frequency of service to address member ADLs, IADLs, and health care needs. The rate level is based on the Universal Comprehensive Assessment Tool (UCAT) assessment by the member's ADvantage case manager

employed by a case management agency independent of the ALS provider. The determination of the appropriate per diem rate is made by the AA clinical review staff.

(F) The ALC must notify AA 90-calendar days before terminating or not renewing the ALC's ADvantage contract.

(i) The ALC must give notice in writing to the member, the member's representative(s), the AA, and the member's ADvantage Case Manager 90-calendar days before:

(I) voluntary cessation of the ALC's ADvantage contract; or

(II) closure of all or part of the ALC.

(ii) The notice of closure must state:

(I) the proposed ADvantage contract termination date;

(II) the termination reason;

(III) an offer to assist the member secure an alternative placement;

(IV) advise the member or member's representative, and the member's ADvantage case manager on available housing alternatives;

(V) the facility must comply with all applicable laws and regulations until the closing date, including those related to resident transfer or discharge.

(iii) Following the last move of the last ADvantage member, the ALC must provide in writing to the AA:

(I) the effective date of closure based on the discharge date of the last resident;

(II) a list of members transferred or discharged and where they relocated,; and

(III) the plan for storage of resident records per OAC 310:663-19-3(g), relating to preservation of resident records and the name, address, and phone numbers of the person responsible for the records.

317:30-5-764. Reimbursement

(a) Rates for ~~waiver~~Waiver services are set in accordance with the ~~rate setting~~rate-setting process by the State Plan Amendment and Rate Committee (SPARC) and approved by the Oklahoma Health Care Authority Board.

(1) The rate for ~~NF Respite~~Nursing Facility (NF) respite is set equivalent to the rate for routine level of care ~~nursing facility~~NF services that require providers having equivalent qualifications;

(2) The rate for daily units for Adult Day Health ~~Care are~~is set equivalent to the rate established by the Oklahoma Department of Human Services (DHS) for ~~the~~ equivalent services provided for the ~~OKDHS~~(DHS) Adult Day Service

Program that ~~require~~requires providers ~~having~~have equivalent qualifications~~;~~.

(3) The rate for units of ~~Home-Delivered Meals~~home-delivered meals is are set equivalent to the rate established by the ~~Oklahoma Department of Human Services~~DHS for the equivalent services provided for the ~~OKDHS~~DHS Home-Delivered Meals Program that require providers having equivalent qualifications~~;~~.

(4) The rates for units of ADvantage Personal Care and In-Home Respite are set equivalent to State Plan Agency Personal Care unit rate ~~which require~~that requires providers ~~having~~have equivalent qualifications~~;~~.

(5) The rates for Advanced Supportive/Restorative Assistance is set equivalent to 1.077 of the State Plan Agency Personal Care unit rate;

(6) ~~CD-PASS~~Consumer-Directed Personal Assistance Services and Supports (CD-PASS) 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:~~the items listed in (A) – (C) of this paragraph.

(A) The Individual Budget Allocation (IBA) Expenditure Accounts Determination constrains total Medicaid reimbursement for CD-PASS services to be less than expenditures for equivalent services using agency providers.

(B) The PSA and APSA service unit rates are calculated by the ~~OKDHS/ASD~~DHS Aging Services (AS) during the CD-PASS service eligibility determination process. ~~The OKDHS/ASD~~DHS AS 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)~~(PSA) or Advanced Supportive/Restorative ~~(for APSA)~~(APSA)service ~~rate.~~rates. The allocation of portions of the PSA and/or APSA ~~rate~~rates to cover salary, mandatory taxes, and optional benefits ~~(including Worker's Compensation insurance, if available)~~including Worker's Compensation insurance, when available, is determined individually for each member using the CD-PASS Individualized Budget Allocation (IBA) Expenditure Accounts Determination Process.

(C) The IBA Expenditure Accounts Determination process defines the level of program financial resources required to meet the member's need for CD-PASS services. ~~If~~When 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 ~~Case Manager,~~case manager, based upon an updated

assessment, amends the person-centered service plan to increase CD-PASS service units appropriate to meet additional member need. ~~The OKDHS/ASD,~~DHS AS, upon favorable review, authorizes the amended person-centered service 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.

(7) Three per diem reimbursement rate levels for the ADvantage assisted living services are set. Different rate per diem levels are established to adequately reimburse the provider for the provision of different levels of service to accommodate different level of member need for services-type, intensity and frequency to address member ~~ADL/IADL~~Activities of Daily Living and Instrumental Activities of Daily Living (ADL/IADL) and health care needs. Rounded to the nearest cent, the lowest level Assisted Living Services per diem rate is set equivalent to 11.636 times the State Plan Agency Personal Care unit rate; the mid-level per diem rate is set equivalent to 15.702 times the State Plan Agency Personal Care unit rate; and the highest level Assisted Living Services per diem rate is set equivalent to 21.964 times the State Plan Agency Personal Care unit rate. The specific rate level appropriate to a particular member's service is determined by ~~UCAT~~Uniform Comprehensive Assessement Tool, Part III (UCAT III) assessment by the member's ADvantage ~~Case Manager~~case manager employed by a ~~Case Management~~case managment agency~~ that is~~ independent of the Assisted Living Services provider. ADvantage payment is not made for 24-hour skilled care in an ~~Assisted Living Center.~~assisted living center. Federal financial participation is not available for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement. Separate payment is not made for ADvantage services of personal care, advanced supportive/restorative assistance, skilled nursing, Personal Emergency Response System, home-delivered meals, adult day ~~care~~health or environmental modifications to a member while receiving ~~Assisted Living Services~~assisted living services since these services are integral to and inherent in the provision of ~~Assisted Living Service.~~assisted living service. However, separate payment may be made for Medicaid State Plan and/or Medicare Home Health benefits to members receiving ADvantage ~~Assisted Living.~~assisted living. Separate payment is not made for ADvantage respite to a member while receiving ~~Assisted Living Services~~assisted living services since by definition ~~Assisted Living Services~~assisted living services assume the responsibility

for 24-hour oversight/monitoring of the member, eliminating the need for informal support respite. The member is responsible for room and board costs; however, for an ADvantage member, the ADvantage ~~Assisted Living Services~~assisted living services provider is allowed to charge a maximum for room and board that is no more than ~~90%~~90 percent of the ~~SSI~~Supplemental Security Income (SSI) Federal Benefit Rate. ~~If in accordance with~~When, per OAC 317:35-17-1(b) and 317:35-17-11, the member has a vendor payment obligation, the provider is responsible for collecting the vendor payment from the member.

(7) The maximum total annual reimbursement for a ~~member=s Hospice~~member's hospice care within a ~~twelve month~~12-month period is limited to an amount equivalent to ~~85%~~85 percent of the Medicare Hospice Cap payment.

(b) The ~~OKDHS/ASD~~DHS AS approved ADvantage person-centered service plan is the basis for the ~~MMIS~~Medicaid Management Information Systems (MMIS) service prior authorization, ~~specifying:~~specifying the:

(1) service;

(2) service provider;

(3) units authorized; and

(4) begin and end dates of service authorization.

(c) Service time for ~~Personal Care, Case Management, Case Management services for Institution Transitioning, Nursing, Skilled Nursing, Advanced Supportive/Restorative Assistance, In-Home Respite, CD-PASS Personal Services Assistance, and Advanced Personal Services Assistance~~personal care, case management services for institution transitioning, nursing, skilled nursing, supportive/restorative assistance, and in-home respite, is documented solely through the use of the Electronic Visit Verification System (EVV), previously known as Interactive Voice Response Authentication ~~(IVRA)~~ system, when services are provided in the home. Providers are required to use the ~~IVRA~~EVV system after access to the system is made available by ~~OKDHS.~~DHS. The ~~IVRA~~EVV system provides alternate backup solutions should the automated system be unavailable. In the event of ~~IVRA~~EVV backup system failure, the provider ~~will document~~documents time in accordance with their agency backup plan. The agency's backup ~~procedures~~plans are only permitted when the ~~IVRA~~EVV system is unavailable.

(d) As part of ADvantage quality assurance, provider audits 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~~and documentation of service provisions ~~will be turned over~~are given to ~~the~~OHCA's Program Integrity Unit for follow-up investigation.

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

SUBCHAPTER 15. PERSONAL CARE SERVICES

317:35-15-2. Personal ~~Care~~care services

(a) Personal ~~Care~~care is assistance to an individual in carrying out ~~activities of daily living~~Activities of Daily Living (ADLs) or in carrying out ~~instrumental activities of daily living~~Instrumental Activities of Daily Living (IADLs) directly related to the member's personal care needs to prevent or minimize physical health regression or deterioration. ~~The Personal Care~~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~~of the care plan, when necessary~~, of the care plan~~. Personal ~~Care~~care services do not include technical services, such as~~ tracheal~~ suctioning, tracheal care, gastrostomy-tube feeding or care, specialized feeding due to choking risk, application of compression stockings, bladder catheterization, colostomy irrigation, wound care, application of prescription lotions or topical ointments, range of motion exercises, or the operation of equipment of a technical nature, such as a patient lift~.~ or oxygen equipment.

(b) Personal ~~Care~~care members may receive services in limited types of living arrangements. The specific living arrangements are set forth below.

(1) Personal ~~Care~~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. Personal care may not be approved when the client lives in the personal care assistant's home except with the approval of Oklahoma Department of Human Services (DHS) Aging Services.

(2) Additional living arrangements in which members may receive ~~Personal Care~~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~~personal care members who are full-time students, a dormitory room qualifies as an allowable living

arrangement in which to receive ~~Personal Care~~personal care services for the period during which the member is a student.

(4) With prior approval of the ~~OKDHS~~DHS area nurse, ~~Personal Care~~personal care services may be provided in an educational or employment setting to assist the member ~~in achieving~~achieve vocational goals identified in the care plan.

(c) Personal ~~Care~~care services may be provided by an individual employed by the member referred to as an ~~Individual Personal Care Assistant~~individual personal care assistant (IPCA) or by a ~~Personal Care Assistant~~personal care assistant (PCA) employed by a home care agency~~ that is~~ certified to provide ~~Personal Care~~personal care services and contracted with the ~~OHCA~~Oklahoma Health Care Authority (OHCA) to provide ~~Personal Care~~personal care services. ~~OKDHS~~DHS must determine an IPCA to be qualified to provide ~~Personal Care~~personal care services and not identified as formal/informal support for member before they can provide services. Persons eligible to serve as either IPCAs or PCAS must~~ meet the following criteria~~:

(1) ~~are~~be 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 be included in the ~~OKDHS~~DHS Community Services Worker Registry;

(4) ~~have~~ not ~~been~~be convicted of a crime or have any criminal background history or registry listings that prohibit employment ~~as defined in~~per O.S. Title 63, Section 1-1950.1;

(5) demonstrate the ability to understand and carry out assigned tasks;

(6) ~~are~~ not be 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);~~, exceptions may be made for a legal guardian to provide services only with prior approval from DHS Aging Services;

(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~~ADL or ~~Instrumental Activities of Daily Living~~IADL assessed needs.

317:35-15-4. Determination of medical eligibility for Personal Care

(a) **Eligibility.** The ~~OKDHS~~Oklahoma Department of Human Services (DHS) area nurse determines medical eligibility for ~~Personal Care~~personal care services based on the ~~UCAT~~Uniform Comprehensive Assessment Tool (UCAT) and the determination that the member has unmet care needs that require ~~Personal Care~~personal care services. Personal ~~Care~~care services are initiated to support the informal care~~ that is being~~ provided in the member's home. Personal ~~Care~~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~~personal care services are not furnished when they principally benefit the family unit. To be eligible for ~~Personal Care~~personal care services, the individual must:

(1) have adequate informal supports ~~that~~consisting of adult supervision that is present or available to contribute to care, or ~~decision making~~decision-making ability as documented on the UCAT, to remain in ~~his/her~~his or her home without risk to ~~his/her~~his or her health, safety, and well-being~~:~~, the individual:

(A) ~~the individual~~ must have the ~~decision making~~decision-making ability to respond appropriately to situations that jeopardize ~~his/her~~his or her health and safety or available supports that compensate for ~~his/her~~his or her lack of ability as documented on the UCAT~~,~~; or

(B) ~~the individual~~ who has ~~his/her~~his or her ~~decision making~~decision-making ability, but lacks the physical capacity to respond appropriately to situations that jeopardize health and safety and ~~has been~~was informed by the ~~OKDHS~~DHS 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 as documented on the UCAT. An individual who poses a threat to self or others as supported by professional documentation or other credible documentation may not be approved for Personal Care services~~;~~. An individual who is actively psychotic or believed to be in danger of potential harm to self or others 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~~,~~ or other credible 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, shall 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.),~~includes activities, such as getting in and out of a tub, or bed to chair;

(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) means the member's UCAT Consumer Support score is zero ~~which~~that indicates~~,~~ in the UCAT assessor's clinical judgment, formal and informal sources are sufficient for present level of member need in most functional areas.

(4) means the member's UCAT Consumer Support score is five ~~which~~that 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.

(5) means the UCAT Consumer score is 15 ~~which~~that 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~~ADLs 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

(6) means the member's UCAT Consumer score is 25 ~~which~~that 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.

(7) **"Community ~~Services Worker"~~services worker"** means any ~~person~~non-licensed health professional 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~~.

(8) **"Community Services Worker Registry"** means a registry established by the ~~OKDHS,~~DHS, ~~as required by~~per 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~~per 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~~was made by ~~OKDHS~~DHS or an administrative law judge, amended in 2002, to include the listing of SoonerCare ~~PCAs~~personal care assistants (PCAs) providing personal care services.

(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.

(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.

(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.

(12) **"MSQ"** means the mental status questionnaire.

(13) **"MSQ moderate risk range"** means a total ~~weighted score~~weighted-score of seven to ~~eleven which~~11 that indicates an orientation-memory-concentration impairment or memory impairment.

(14) **"Nutrition moderate risk"** means the total weighted UCAT Nutrition score is eight or more ~~which~~that indicates poor appetite or weight loss combined with special diet requirements, medications, or difficulties in eating.

(15) **"Social resources score is eight or more"** means the member lives alone or has no informal support when he or she is sick, ~~or~~ needs assistance, or has little or no contact with others.

(c) **Medical eligibility minimum criteria for ~~Personal Care.~~personal care.** The medical eligibility minimum criteria for ~~Personal Care~~personal care are the minimum UCAT score criteria ~~which~~that a member must meet for medical eligibility for personal care and are:

(1) 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) Consumer Support is 15 or more; or Consumer Support score is five and the Social Resources score is eight or more.

(d) **Medical eligibility determination.** Medical eligibility for ~~Personal Care~~personal care is determined by the ~~OKDHS.~~DHS. The medical decision for ~~Personal Care~~personal care is made by the ~~OKDHS~~DHS area nurse utilizing the UCAT.

(1) Categorical relationship must be established for determination of eligibility for ~~Personal Care.~~personal care. ~~If~~When categorical relationship to Aid to the Disabled ~~has~~was not ~~already been~~ established~~,~~ but there is an extremely emergent need for ~~Personal Care~~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~~Form 08MA016E, Authorization for Examination, ~~OKDHS form 08MA016E,~~ and ~~the~~Form 08MA02E, Report of Physician's Examination, ~~OKDHS form 08MA02E,~~ to a licensed medical or osteopathic ~~physician (refer to OAC 317:30-5-1).~~health care professional, refer to

Oklahoma Administrative Code OAC 317:30-5-1. The ~~physician~~licensed health care professional cannot be in a medical facility ~~intern,~~internship, residency, or fellowship program or in the full time employment of the Veterans Administration, United States Public Health Service, or other agency. The ~~OKDHS~~DHS 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 the categorical relationship using the Social Security Administration (SSA) ~~same~~ definition~~ used by SSA~~. A follow-up is required by the ~~OKDHS~~DHS county worker with ~~the Social Security Administration (SSA)~~(SSA) to ~~be sure that SSA's~~ensure the SSA disability decision ~~agrees with~~is also the LOCEU decision~~ of LOCEU~~.

(2) Approved contract agencies or the ~~AA~~ADvantage Administration (AA) may complete~~ the~~ UCAT Part I for intake and screening and forward the form to the county office.

(3) Upon receipt of the referral, ~~OKDHS~~DHS county staff may initiate the UCAT, Part I.

(4) The ~~OKDHS~~DHS nurse is responsible for completing the UCAT assessment visit within ~~10 working~~10-business days of the ~~Personal Care~~personal care referral for the applicant who is SoonerCare eligible at the time of the request. The ~~OKDHS~~DHS nurse completes the assessment visit within ~~20 working~~20-business days of the referral for the applicant not determined SoonerCare eligible at the time of the request. ~~If~~When 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)~~emergency situation, or to avoid institutional placement, the UCAT Part III assessment visit has ~~top priority for scheduling.~~top-scheduling priority.

(5) During the assessment visit, the ~~OKDHS~~DHS nurse completes the UCAT and reviews~~ with the member~~ rights to privacy, fair hearing, provider choice, and the pre-service acknowledgement agreement~~.~~ with the member. The ~~OKDHS~~DHS nurse informs the applicant of medical eligibility criteria and provides information about ~~OKDHS~~DHS long-term care service options. The ~~OKDHS~~DHS nurse documents ~~on the UCAT III whether~~if the member wants to be considered for nursing facility level of care services or if the member is applying for a specific service program~~.~~ on UCAT III. ~~If,~~When, based ~~upon~~on the information obtained during the assessment, the ~~OKDHS~~DHS nurse determines if the member may be at risk for health and safety, an immediate referral is made to Adult Protective Services (APS)~~.~~ or Child Protective Services, as applicable.

The referral is documented on the UCAT.

(A) ~~If~~When the applicant's needs cannot be met by ~~Personal Care~~personal care services alone, the ~~OKDHS~~DHS nurse informs the applicant of the other community long-term care service options. The ~~OKDHS~~DHS nurse assists the applicant in ~~accessing~~access service options selected by the applicant in addition to, or in place of, Personal Care services.

(B) ~~If~~When 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~~DHS nurse informs the applicant of the qualified agencies in ~~their~~his or her local area ~~available to~~that provide services and obtains the applicant's primary and secondary choice of agencies. ~~If~~When the applicant or family declines to choose a primary personal care service agency, the ~~OKDHS~~DHS nurse selects an agency from a list of all available agencies, using a round-robin system. The ~~OKDHS~~DHS nurse documents the name of the selected personal care provider agency.

(6) The ~~OKDHS~~DHS nurse completes the UCAT within ~~three working~~three-business days of the assessment visit and sends it to the ~~OKDHS~~DHS area nurse for medical eligibility determination. Personal ~~Care~~care service eligibility is established ~~as~~on the date~~ when~~ medical eligibility is approved and financial eligibility is established. This date serves as the certification date for services to be initiated.

(A) ~~If~~When the length of time from the~~ date the~~ initial assessment to the date of service eligibility determination exceeds ~~90 days,~~90-calendar days, a new UCAT and assessment visit is required.

(B) The ~~OKDHS~~DHS 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~~DHS nurse.

(7) The ~~OKDHS~~DHS area nurse notifies the ~~OKDHS~~DHS county worker via ELDERS of the ~~Personal Care~~personal care certification. The authorization line is open via automation from ELDERS~~ and five visits by a skilled nurse are automatically authorized~~.

(8) Upon establishment of ~~Personal Care~~personal care certification, the ~~OKDHS~~DHS 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~~one-business day of provider

agency acceptance, the ~~OKDHS~~DHS nurse forwards the referral information to the provider agency for SAM plan development. ~~(see OAC 317:35-15-8(a)).~~ Refer to OAC 317:35-15-8 (a).

(9) Following the SAM packet development by the provider agency, and within ~~three working~~three-business days of receipt of the packet from the provider agency, the ~~OKDHS~~DHS 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.

(10) Within ~~10 working~~10-business days of receipt of the SAM case from the ~~OKDHS~~DHS nurse, the ~~OKDHS~~DHS 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~~DHS nurse ~~for revision~~ for further justification.

(11) Within ~~one working~~one-business day of knowledge of the authorization, the ~~OKDHS~~DHS nurse forwards the service plan authorization to the provider agency.

317:35-15-8. Agency ~~Personal Care Service Authorization and Monitoring~~personal care service authorization and monitoring

(a) Within ~~ten working~~10-business days of receipt of the referral for ~~Personal Care~~personal care services, the ~~Personal Care~~personal care provider agency nurse completes a ~~SAM~~Service Authorization Model (SAM) visit in the home to assess the member's ~~Personal Care~~personal care service needs, completes a SAM packet based on the member's needs and submits the packet to the ~~OKDHS~~DHS nurse. The member's SAM packet includes~~:~~ DHS Forms:

(1) 02AG044E, Personal Care Progress Notes ~~(OKDHS form 02AG044E)~~;

(2) 02AG030E, Personal Care Planning Schedule/Service Plan ~~[OKDHS form 02AG030E (AG-5)/02AG031E (AG-6)]~~; and

(3) 02AG029E, Personal Care Plan ~~[OKDHS form 02AG029E (AG-4)]~~.

(b) ~~If~~When more than one person in the household ~~has been~~was referred to receive ~~Personal Care~~personal care or ADvantage services, all household members' SAM packets are discussed and developed with the eligible members so service delivery ~~can be~~is coordinated to achieve the most efficient use of resources. The number of units of ~~Personal Care~~personal care service authorized for each individual is distributed between all eligible family members to ~~assure~~ensure that the absence of one family member does not adversely affect the family member(s) remaining in the home. ~~If~~When one or more persons in the same household with a ~~Personal Care~~personal care member ~~have been~~were referred to or are receiving other formal services, such as ADvantage or

Developmental Disability Services, then those services are coordinated as well.

(c) The ~~Personal Care~~personal care provider agency receives documentation from ~~OKDHS~~DHS as authorization to begin services. The agency delivers a copy of the care plan ~~[OKDHS form 02AG029E(AG-4)]~~Form 02AG029E and the Personal Care Planning Schedule/Service Plan to the member upon initiating services.

(d) Prior to placing a ~~PCA~~personal care assistant (PCA) in the member's home or other service-delivery setting~~,~~ by the provider agency, an Oklahoma State Bureau of Investigation (OSBI) background check, an Oklahoma State Department of Health Registry check, and an ~~OKDHS~~DHS Community Services Worker Registry check must be completed ~~in accordance with~~per Sections 1-1944 through 1-1948 of Title 63 of the Oklahoma Statutes. Payment is made for PCAs who provide ~~Personal Care~~personal care services ~~who also~~and meet ~~the~~ criteria ~~as defined in~~ OAC ~~317:35-15-2(c)(1)(1 through 8).~~317:35-15-2(c)(1) 1 through 8).

(e) The provider agency nurse monitors ~~their~~the member's plan of care.

(1) The ~~Personal Care~~personal care provider agency contacts the member within ~~five working~~five-business days of receipt of the authorized document in order to ensure ~~that~~ services ~~have been~~were implemented ~~and the needs of the member are being met.~~according to the authorized plan of care.

(2) The provider agency nurse makes a SAM home visit at least every six months to assess the member's satisfaction with ~~their~~his or her care and to evaluate the SAM packet for adequacy of goals and authorized units. Whenever a home visit is made, the provider agency nurse documents ~~their~~ findings in the Personal Care Progress Notes. The provider agency forwards a copy of the Progress Notes to the ~~OKDHS~~DHS nurse for review within ~~5 business~~five-business days of the visit. The monitoring visit may be conducted by a Licensed Practical Nurse (LPN) only when the PCA is not performing hands-on personal care. A Registered Nurse (RN) must also co-sign the progress notes.

(3) Requests by the provider agency nurse to change the number of units authorized in the SAM packet are submitted to ~~OKDHS~~(DHS) and are approved or denied by the ~~OKDHS~~(DHS) area nurse~~,~~ or designee, prior to ~~implementation of the~~ changed number of units~~.~~ unit implementation.

(4) Annually, or more frequently ~~if~~when the member's needs change, the provider agency nurse re-assesses the member's ~~need~~need's and develops a new SAM packet to meet the member's needs. The provider agency nurse conducts a home visit and completes and submits the annual reassessment

documents to the ~~OKDHS~~DHS nurse no sooner than ~~60 days~~60-calendar days before the existing service plan end-date, ~~but sufficiently in advance of the end-date.~~and no later than 14-calendar days prior to service.

(5) ~~If~~When the member is unstaffed, the provider agency communicates with the member and makes efforts to re-staff. It is recommended the provider agency contacts unstaffed members weekly by ~~telephone~~phone to actively monitor the health and safety of the member and documents ongoing efforts to provide staff. ~~If~~When the member is unstaffed for ~~30 calendar~~30-calendar days, the provider agency notifies the ~~OKDHS~~DHS nurse on ~~an OKDHS form~~Form 02AG032E, Provider Communication Form. The ~~OKDHS~~DHS nurse contacts the member and ~~if~~when the member chooses, initiates a transfer of the member to another provider agency that can provide staff.

317:35-15-8.1. Agency Personal Care services; billing, and problem resolution

The ~~AA~~ADvantage Administration (AA) certifies qualified ~~Personal Care~~personal care provider agencies and facilitates the execution of the agencies' SoonerCare contracts on behalf of the ~~OHCA.~~Oklahoma Health Care Authority (OHCA). ~~The~~ OHCA ~~will check~~checks the list of providers ~~that have been~~ barred from Medicare/SoonerCare participation to ensure that the ~~Personal Care~~personal care services agency is not listed.

(1) **Payment for ~~Personal Care.~~personal care.** Payment for ~~Personal Care~~personal care services is made for care provided in the member's "own home" or in other ~~limited types~~limited types of living arrangements ~~in accordance with~~per OAC 317:35-15-2(b)(1 through 4).

(A) **Use of provider agency.** To provide ~~Personal Care~~personal care services, an agency must be licensed by the Oklahoma State Department of Health, meet certification standards identified by ~~OKDHS~~the Oklahoma Department of Human Services (DHS), and possess a current SoonerCare contract.

(B) **Reimbursement.** Personal ~~Care~~care services payment on behalf of a member is made according to the type of service and number of units of ~~Personal Care~~personal care services authorized in the ~~SAM~~Service Authorization Model (SAM) packet.

(i) The amount paid to 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 SAM packet are eligible for reimbursement. Provider

agencies serving more than one ~~Personal Care~~personal care service member residing in the same residence ~~will assure that~~ensure the members' 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~~personal care services is for tasks performed in accordance ~~with~~per OAC 317:30-5-951 only when listed on an authorized plan of care. Payment for ~~Personal Care~~personal care skilled nursing service is made on behalf of the member for assessment/evaluation and associated service planning per SAM nursing visit.

(iii) Service time for personal care services is documented through the use of the Electronic Visit Verification System (EVV), previously known as Interactive Voice Response Authentication (IVRA) system, when services are provided in the home.

(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~~When the member is dissatisfied with the Personal Care provider agency or the assigned PCA and has exhausted attempts to work with the Personal Care provider agency's grievance process without resolution, the member ~~may contact the~~is referred to the ~~OKDHS nurse~~DHS State Plan Care Unit to attempt to resolve the 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~~per with OAC 317:2-1-2.

(B) When a ~~problem with performance of the~~ PCA performance issue is identified, ~~the~~ provider agency staff ~~will conduct~~conducts a counseling conference with the member and/or the PCA as appropriate. ~~The~~ Provider agency staff ~~will counsel~~counsels the PCA regarding problems with his/her performance.

(3) **Persons ineligible to serve as PCAs.** Payment from SoonerCare funds for ~~Personal Care~~personal care services may not be made to an individual who is a legally responsible family member of the member, such as a spouse, legal guardian, or parent of minor child, to whom he/she is providing personal care services~~.~~ (exceptions may be made for legal guardians with prior approval from the Department of

Human Services/Aging Services (DHS/AS).

317:35-15-10. Redetermination of medical eligibility for ~~Personal Care~~personal care services

(a) **Medical eligibility redetermination.** The ~~OKDHS~~Oklahoma Department of Human Services (DHS) area nurse must complete a redetermination of medical eligibility before the end of the long-term care medical certification period.

(b) **Recertification.** The ~~OKDHS~~DHS nurse re-assesses the ~~Personal Care~~personal care services member for medical re-certification based on the member's needs and level of caregiver support required, using the ~~UCAT~~Uniform Comprehensive Assessment Tool (UCAT) at least every 36 months. During this re-certification assessment, the ~~OKDHS~~DHS nurse informs the member of the state's other SoonerCare long-term care options. The ~~OKDHS~~DHS nurse submits the re-assessment to the ~~OKDHS~~DHS area nurse for recertification. Documentation is sent to the ~~OKDHS~~DHS area nurse no later than the ~~tenth~~10th-calendar day of the month in which the certification expires. When the ~~OKDHS~~DHS area nurse determines medical eligibility for ~~Personal Care~~personal care services, a recertification review date is entered on the system.

(c) **Change in amount of units or tasks.** When the ~~Personal Care~~personal care provider agency determines a need for a change in the amount of units or tasks within the ~~Personal Care~~personal care service, a new ~~SAM~~Service Authorization Model (SAM) packet is completed and submitted to ~~OKDHS~~DHS within ~~five calendar~~five-calendar business days of identifying the assessed need. The change is approved or denied by the ~~OKDHS~~DHS area nurse~~,~~ or designee, prior to implementation.

(d) **Voluntary closure of Personal Care services.** ~~If~~When a member decides ~~Personal Care~~personal care services are no longer needed to meet ~~his/her~~his or her needs, a medical decision is not needed. The member and the ~~OKDHS~~DHS nurse or ~~OKDHS~~DHS county Social Services Specialist completes and signs ~~OKDHS form~~DHS Form 02AG038E, ~~ADv-2,~~ State Plan Personal Care/ADvantage Program Voluntary Withdrawal Request. The ~~OKDHS~~DHS nurse submits closure notification to the provider agency.

(e) **Resuming Personal Care services.** ~~If~~When a member approved for Personal Care services ~~has been~~is without Personal Care services for less than ~~90 days~~90 calendar-days but ~~still~~ has ~~a~~ current medical and SoonerCare financial eligibility approval, Personal Care services may be resumed using the member's previously approved SAM packet. The ~~Personal Care~~personal care provider agency nurse contacts the member to determine when changes in health or service needs occurred. When changes are identified, the provider agency nurse makes a home visit and submits a Personal Care services skilled nursing re-assessment

of need within ~~ten working days~~10-business days of the resumed plan start date, using the State Plan Personal Care Progress Notes, ~~OKDHS form~~DHS Form 02AG044E. ~~If~~When the member's needs dictate, the Personal Care provider agency may submit a request for a change in authorized Personal Care services units with a SAM packet to ~~OKDHS.~~DHS. When no changes occur, the agency nurse documents the contact on State Plan Personal Provider Communication Form 02AG032E and forwards it to the DHS nurse within 10-business days of the resumed plan start date.

(f) **Financial ineligibility.** When the ~~OKDHS~~DHS determines a Personal Care services member does not meet ~~the~~ SoonerCare financial eligibility criteria, the ~~OKDHS~~DHS office notifies the ~~OKDHS~~DHS area nurse to initiate the closure process due to financial ineligibility. Individuals determined financially ineligible for Personal Care services are notified by ~~OKDHS~~DHS in writing of the determination and of their right to appeal the decision. The ~~OKDHS~~DHS nurse submits closure notification to the provider agency.

(g) **Closure due to medical ineligibility.** Individuals determined medically ineligible for Personal Care services are notified by ~~OKDHS~~DHS in writing of the determination and of their right to appeal the decision. The ~~OKDHS~~DHS nurse submits closure notification to the provider agency.

(h) **Termination of State Plan Personal Care Services.**

(1) Personal Care services may be discontinued ~~if:~~when:

(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~~,~~ or other credible documentation, pose a threat to the member or other household visitors; ~~or~~

(C) the member or the other household members use:

(i) angry, insulting, threatening, intimidating, degrading, or sexually inappropriate language; or

(ii) innuendos or behavior towards service provider, whether in the home or through other contact or communications; or

(iii) as supported by professional documentation or other credible documentation.

~~(C)~~(D) the member or family member fails to cooperate with Personal Care service delivery or to comply with ~~OHCA~~Oklahoma Health Care Authority (OHCA) or ~~OKDHS~~DHS rules as supported by professional documentation; ~~or~~

~~(D)~~(E) the member's health or safety is at risk as supported by professional documentation; ~~or~~

~~(E)~~(F) additional services, either "formal" ~~(i.e., paid by SoonerCare or some other funding source)~~such as, paid by

Sooner Care or some other funding source or "informal" ~~(i.e., unpaid)~~such as, unpaid are provided in the home eliminating the need for SoonerCare Personal Care services; ~~or~~

~~(F)~~(G) 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)~~(H) the member refuses to select and/or accept the services of a provider agency or PCA for ~~90 consecutive~~90-consecutive days as supported by professional documentation.

(2) For persons receiving ~~Personal Care~~personal care services, the ~~Personal Care~~personal care provider agency submits documentation with the recommendation to discontinue services to ~~OKDHS.~~DHS. The ~~OKDHS~~DHS nurse reviews the documentation and submits it to the ~~OKDHS Area Nurse~~DHS area nurse for determination. The ~~OKDHS~~DHS nurse notifies the ~~Personal Care~~personal care provider agency or PCA, and the local ~~OKDHS~~DHS county worker of the decision to terminate services. The member is sent an official closure notice informing ~~them~~him or her of ~~their~~ appropriate member rights to appeal the decision to discontinue services.

317:35-15-13.1. Individual ~~Personal Care~~personal care service management

(a) An ~~IPCA~~Individual Personal Care Assistant (IPCA) may be utilized to provide ~~Personal Care~~personal care services when it is documented to be in the best interest of the member to have an IPCA or when there are no qualified ~~Personal Care~~personal care provider agencies available in the member's local area. ~~OHCA will check~~Oklahoma Health Care Authority (OHCA) checks the list of providers ~~that have been~~ barred from Medicare/Medicaid participation to ensure ~~that~~ the IPCA is not listed.

(b) After ~~Personal Care~~personal care services eligibility is established and prior to implementation of ~~Personal Care~~personal care services using an IPCA, the ~~OKDHS~~DHS nurse reviews the care plan with the member and IPCA and notifies the member and IPCA to begin ~~Personal Care~~personal care services delivery. The ~~OKDHS~~DHS nurse maintains the original care plan and forwards a copy of the care plan to the selected IPCA and member within ~~one working~~one-business day of receipt of approval.

(c) The ~~OKDHS~~DHS nurse contacts the member within ~~five working~~five-business days to ensure services are in place and meeting the member's needs and ~~also~~ monitors the care plan for

members with an IPCA. For any member receiving ~~Personal Care~~personal care services utilizing an IPCA, the ~~OKDHS~~DHS nurse makes a home visit at least every six months beginning within ~~90 days of~~90-calendar days from the date of ~~Personal Care~~personal care service initiation. ~~OKDHS~~DHS assesses the member's satisfaction with ~~their~~his or her ~~Personal Care~~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~~DHS area nurse~~,~~ or designee, prior to implementation of the changed number of units.

317:35-15-13.2. ~~IPCA~~Individual personal care assistants (IPCA) provider contractor; billing, training, and problem resolution

While ~~OHCA~~the Oklahoma Health Care Authority (OHCA) is the contractor authorized under federal law, the ~~OKDHS~~Oklahoma Department of Human Services (DHS) nurse initiates initial contracts with qualified individuals for provision of ~~Personal Care~~personal care services ~~as defined in OAC~~per Oklahoma Administrative Code (OAC) 317:35-15-2. The contract renewal for the IPCA is the responsibility of ~~the~~ OHCA.

(1) ~~**Payment for IPCA.**~~**IPCA payment.** Payment for ~~Personal Care~~personal care services is made for care provided in the member's "own home" or in other limited types of living arrangements ~~in accordance with~~per OAC 317:35-15-2(b)~~(1 through 4).~~(1) through (4). Personal care may not be approved when the client lives in the Personal Care Assistant's (PCA's) home except with the approval of DHS Aging Services.

(A) **Reimbursement**. Personal ~~Care~~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~~is 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 IPCA in (i) of this subparagraph, the OHCA ~~(acting as agent for the member-employer)~~, 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~~ensure the individual contractor's ~~social security~~Social Security account may

be properly credited, it is vital that the individual contractor's ~~social security~~Social Security number be entered correctly on each claim.

(iii) The contractor payment fee covers all ~~Personal Care~~personal care services included on the service and care plans developed by the ~~OKDHS~~DHS nurse. 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.

(iv) A member may select more than one IPCA. This may be necessary as indicated by the service and care plans.

(v) The IPCA may provide SoonerCare ~~Personal Care~~personal care services for several households during one week~~,~~ as long as the daily number of paid service units ~~do~~does not exceed eight hours, 32 units per day. The total number of hours per week cannot exceed ~~40.~~40, 160 units.

(B) **Release of wage and/or employment information for IPCAs**. Any inquiry received by the local office requesting wage and/or employment information for an IPCA ~~will be~~is forwarded to the OHCA, Claims Resolution.

(2) **~~Member~~IPCA member selection ~~of IPCA~~**.

Members and/or family members recruit, interview, conduct reference checks, and select the individual ~~to be considered as an~~for IPCA~~.~~ consideration. Prior to placing a ~~Personal Care~~personal care service provider in the member's home, an OSBI background check, ~~and~~a DHS Community Services Worker ~~registry~~Registry check must be completed ~~in accordance with~~per Section 1-1944 through 1-1948 of Title 63 of the Oklahoma Statutes. The ~~OKDHS~~DHS nurse must also check the Certified Nurse Aide Registry. The ~~OKDHS~~DHS nurse must affirm that the applicant's name is not contained on any of the registries. The ~~OKDHS~~DHS nurse ~~will notify the~~notifies OHCA ~~if~~when the applicant is on the ~~registry.~~Registry.

(A) **Persons eligible to serve as ~~individual Personal Care Assistants.~~IPCAs.** Payment is made for ~~Personal Care Services~~personal care services to IPCAs who provide ~~Personal Care~~personal care services who~~ also~~ meet the criteria ~~as defined in~~per OAC 317:35-15-2(c)~~(1 through 8).~~(1) through (8).

(B) **Persons ineligible to serve as IPCAs.** Payment from SoonerCare funds for ~~Personal Care~~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)~~spouse, legal guardian, or parent of a minor child of the member being served~~ (exceptions to~~

~~legal guardian are made only with prior approval from Aging Services Division).~~, exceptions to legal guardian are made only with prior approval from Aging Services Division.

(i) Payment cannot be made to ~~an OKDHS~~a DHS or an OHCA employee. Payment cannot be made to an immediate family member of ~~an OKDHS~~a DHS employee who works in the same county without ~~OKDHS/Aging Services Division~~DHS Aging Services approval. When a family member relationship exists between ~~an OKDHS~~a DHS nurse and an IPCA in the same county, the ~~OKDHS~~DHS nurse cannot manage services for a member whose IPCA is a family member of the ~~OKDHS~~DHS nurse.

(ii) If it is determined that an ~~OKDHS~~a DHS or OHCA employee is interfering in the process of providing ~~Personal Care~~ services for personal or family benefit, ~~he/she will be~~he or she is subject to disciplinary action.

(3) ~~**Orientation of the IPCA.**~~**IPCA orientation.** When a member selects an IPCA, the ~~OKDHS~~DHS nurse contacts the individual to report to the county office to complete the Oklahoma State Department of Health form 805, Uniform Employment Application for Nurse Aide Staff, and the ~~OKDHS form~~DHS Form 06PE039E, Employment Application Supplement, and for a determination of qualifications and orientation. For ~~Personal Care~~personal care members, this process is the responsibility of the ~~OKDHS~~DHS nurse. The IPCA can begin work when:

(A) ~~he/she has been~~he or she was interviewed by the member,

(B) ~~he/she has been~~he or she was oriented by the OKDHS nurse,

(C) ~~he/she has~~he or she executed a contract (OHCA-0026) with the OHCA,

(D) the effective service date ~~has been~~was established,

(E) all registries ~~have been~~were checked and the IPCA's name is not listed,

(F) the Oklahoma State Department of Health Nurse Aide Registry ~~has been~~was checked and no notations were found, and

(G) the OSBI background check ~~has been~~was completed.

(4) **Training of IPCAs**. It is the responsibility of the ~~OKDHS~~DHS nurse to make sure ~~that~~ the 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 IPCA**. When it comes to the attention of the ~~OKDHS~~DHS nurse ~~or OKDHS Social Services Specialist~~ that there is a

problem related to the performance of the IPCA, a counseling conference is held between the member, OKDHS nurse, and worker. The ~~OKDHS~~DHS nurse ~~will counsel~~counsels the IPCA regarding problems with ~~his/her~~his or her performance. Counseling is considered when staff believes ~~that~~ counseling will result in improved performance.

(6) **Termination of the IPCA Provider Agreement**.

(A) A recommendation for the termination of an IPCA's contract is submitted to ~~the~~ OHCA and ~~the~~IPCA services ~~of the IPCA~~ are suspended immediately when:

(i) an IPCA's performance is such that ~~his/her~~his or her continued participation in the program could pose a threat to the health and safety of the member or others; or

(ii) the IPCA failed to comply with the expectations outlined in the PCA Provider Agreement and counseling is not appropriate or ~~has~~was not ~~been~~ effective; or

(iii) an IPCA's name appears on the ~~OKDHS Community Services Worker Registry,~~DHS Community Services Worker Registry, any of the registries listed in Section 1-1947 of Title 63 of the Oklahoma Statutes, even though ~~his/her~~his or her name may not have appeared on the Registry at the time of application or hiring.

(B) The ~~OKDHS~~DHS nurse makes the recommendation for the termination of the IPCA to ~~the OKDHS State Office~~DHS 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~~DHS Adult Protective Services, State Attorney General's Medicaid Unit, ~~the~~ OHCA, and the Oklahoma State Department of Health are notified by the ~~OKDHS~~DHS nurse.

(C) When the problem is related to allegations of abuse, neglect, or exploitation~~,~~ the ~~OKDHS~~DHS nurse follows the process as outlined in OAC 340:100-3-39.

317:35-15-14. Billing procedures for ~~Personal Care~~personal care

Billing procedures for ~~Personal Care Services~~personal care services are contained in the ~~OKMMIS~~Oklahoma Medicaid Management Information Systems (OKMMIS) Billing and Procedure Manual. Questions regarding billing procedures that cannot be resolved through a study of the manual are referred to the ~~OHCA.~~Oklahoma Health Care Authority (OHCA). Contractors for Personal Care bill on ~~CMS-1500.~~CMS-1500 claim form. ~~The~~ OHCA provides instructions to an ~~IPCA~~Individual personal care assistant (IPCA) contracted provider for completion of the claim at the time of the contractor orientation. The contracted provider submits a claim

for each member. The contracted provider prepares claims for services provided and submits the claims to the fiscal agent ~~who is~~ responsible for ~~assuring that the~~ensuring claims ~~have been~~were properly completed. All ~~Personal Care~~personal care contractors must have a unique provider number. New contracted providers ~~will be~~are mailed the provider number after they ~~have been~~are placed on the claims processing contractor's provider file. ~~Service time of~~All services provided in the service recipients home, member's home including Personal Care and Nursing ~~is~~must be documented~~ solely~~ through the ~~Interactive Voice Response Authentication (IVRA)~~Electronic Visit Verification (EVV) system~~ after access to the system is made available by OKDHS~~. Additionally, work completed in the provider's office is documented in the EVV system. The ~~IVRA~~EVV system provides alternate backup solutions ~~should~~if the automated system ~~be~~is unavailable~~. In~~; however, in the event of an ~~IVRA backup~~EVV system failure, the provider ~~will document~~documents time in accordance with ~~their provider agency~~internal policy and procedures backup plan. This documentation is sufficient to account for both in-home and in-office services. The provider agency's backup procedures are only permitted when the ~~IVRA~~EVV system is unavailable.

SUBCHAPTER 17. ADVANTAGE WAIVER SERVICES

317:35-17-1. Overview of long-term medical care services; relationship to ~~QMBP,~~Qualified Medicare Beneficiary Plus (QMBP), ~~SLMB,~~Specified Low-Income Medicare Beneficiary (SLMB), and other Medicaid services eligibility

(a) Long-term medical care for the categorically needy includes:

(1) care in a nursing facility. ~~(refer to OAC 317:35-19);~~Refer to Oklahoma Administrative Code (OAC) 317:35-19;

(2) care in a public or private intermediate care facility for the intellectually disabled. ~~(refer to OAC 317:35-9);~~Refer to OAC 317:35-9;

(3) care of persons age 65 years ~~or~~and older in mental health hospitals. ~~(refer to OAC 317:35-9);~~Refer to OAC 317:35-9;

(4) Home and Community Based Services Waivers for persons with intellectual disabilities. ~~(refer to OAC 317:35-9);~~Refer to OAC 317:35-9;

(5) Personal Care services. ~~(refer to OAC 317:35-15); and~~Refer to OAC 317:35-15; and

(6) the Home and Community Based Services Waiver (ADvantage Waiver) for frail ~~elderly,~~elderly (65 years of age or older), and a targeted group of adults with physical disabilities ~~age~~ 21 to 64 years of age and ~~over~~older who do not have an intellectual disability or a cognitive impairment~~ (ADvantage~~

~~Waiver).~~ related to a developmental disability.

(b) ~~Any time~~When an individual is certified as eligible for SoonerCare coverage of long-term care, ~~the individual~~he or she is also eligible for other SoonerCare services. ADvantage Waiver members do not have a copayment for ADvantage services except for prescription drugs. For members residing in an ADvantage Assisted Living Center, any income beyond ~~150%~~150 percent of the federal benefit rate is available to defray the cost of the ~~Assisted Living~~assisted living services received. The member is responsible for payment to the ~~Assisted Living Services Center~~assisted living services center provider for days of service from the first day of each ~~full month~~full-month in which services ~~have been~~were received until the vendor pay obligation is met. ~~Any time~~When an individual is aged, blind, or disabled and is determined eligible for long-term care, a separate eligibility determination must be made for ~~Qualified Medicare Beneficiary Plus (QMBP)~~QMBP or ~~Specified Low-Income Medicare Beneficiary (SLMB)~~SLMB benefits. An ADvantage program member may reside in a licensed assisted living ~~facility~~services center only ~~if~~when the assisted living ~~center~~services is a certified ADvantage ~~Assisted Living Services~~assisted living services center provider from whom the member is receiving ADvantage ~~Assisted Living~~assisted living services.

317:35-17-3. ADvantage program services

(a) The ADvantage program is a Medicaid Home and Community Based Waiver used to finance non-institutional, long-term care services for elderly and a targeted group of physically disabled adults when there is a reasonable expectation that within a ~~30 day~~30-calendar day period, the person's health, due to disease process or disability, would, without appropriate services, deteriorate and require nursing facility care to arrest the deterioration. Individuals may not be enrolled in ADvantage for the sole purpose of enabling them to obtain Medicaid eligibility. Eligibility for ADvantage is contingent on an individual requiring one or more of the services offered in the ~~waiver~~Waiver at least monthly in order to avoid institutionalization.

(b) The number of individuals who may receive ADvantage services is limited.

(1) To receive ADvantage services, individuals must meet one of the following categories~~:~~. He or she must:

(A) be ~~age~~ 65 years ~~or~~of age and older,; or

(B) be ~~age~~ 21 to 64 ~~or~~years of age ~~older if~~when physically disabled and not developmentally disabled or ~~if age~~when 21 to 64 ~~or~~years of age ~~older~~ and not physically disabled, the person has a clinically documented, progressive

degenerative disease process that responds to treatment and previously ~~has~~ required hospital or nursing facility (NF) level of care services for treatment related to the condition; and requires ADvantage services to maintain the treatment regimen to prevent health deterioration~~,~~; or

(C) ~~if~~when developmentally disabled, and ~~between the ages of 21 and 65,~~21 to 64 years of age; and does not have an intellectual disability or a cognitive impairment related to the developmental disability.

(2) In addition, the individual must meet ~~the following~~ criteria~~:~~ in (A) through (C). He or she must:

(A) require nursing facility level of care ~~[see OAC 317:35-17-2];~~. Refer to Oklahoma Administrative Code (OAC) 317:35-17-2;

(B) meet service eligibility criteria ~~[see OAC 317:35-17-3(f)]; and~~. Refer to OAC 317:35-17-3(f); and

(C) meet program eligibility criteria. ~~[see 317:35-17-3(g)].~~Refer to OAC 317:35-17-3(g).

(c) ADvantage members are eligible for limited types of living arrangements. The specific living arrangements are set forth below.

(1) ADvantage program members are not eligible to receive services while residing in an institutional setting~~,~~ including, but not limited to, licensed facilities, such as a hospital, a nursing facility, ~~a~~ licensed residential care facility, or ~~a~~ licensed assisted living facility, ~~(unless the facility is an ADvantage Assisted Living Center)~~unless the facility is an ADvantage Assisted Living Center or in an unlicensed institutional living arrangement, such as a room and board home/facility.

~~(2) ADvantage program members may receive services in a contracted ADvantage Assisted Living Center; an ADvantage Assisted Living Center is the only housing-with-nursing-supervised personal care services option in which a person may appropriately receive ADvantage services.~~

~~(3)~~(2) Additional living arrangements in which members may receive ADvantage services are the member's own home, apartment or ~~independent living apartment~~independent-living apartment, or a family or friend's home or apartment. A home/apartment unit is defined as a self-contained living space having a lockable entrance to the unit and including a bathroom and food storage/preparation amenities in addition to bedroom/living space.

~~(4)~~(3) ADvantage program members may receive services in a shelter or similar ~~temporary housing arrangement which~~temporary-housing arrangement that may or may not meet the definition of home/apartment, in emergency situations,

for a period not to exceed ~~sixty (60)~~60-calendar days during which location and transition to permanent housing is~~ being~~ sought.

~~(5)~~(4) For ADvantage members who are full-time students, a dormitory room qualifies as an allowable living arrangement in which to receive ADvantage services for the period during which the member is a student.

~~(6)~~(5) Members may receive ADvantage respite services in a nursing facility for a continuous period not to exceed ~~thirty (30) days.~~30-calendar days.

(d) Home and Community Based Waiver Services are outside of the scope of Medicaid State Plan services. The Medicaid ~~waiver~~Waiver allows~~ the~~ OHCA to offer certain Home and Community Based services to an annually capped number of persons who are categorically needy, ~~(refer to OKDHS form 08AX001E (Appendix C-1), Schedule VIII. B. 1.)~~refer to DHS Form Appendix C-1, Schedule VIII. B. 1., and without such services would be institutionalized. The estimated cost of providing an individual's care outside the nursing facility cannot exceed the annual cost of caring for that individual in a nursing facility. When determining the ADvantage service plan cost cap for an individual, the comparable SoonerCare cost to serve that individual in a ~~nursing facility~~NF is estimated.

(e) Services provided through the ADvantage ~~waiver~~Waiver are:

(1) case management;

(2) respite;

(3) adult day health care;

(4) environmental modifications;

(5) specialized medical equipment and supplies;

(6) ~~physical therapy/occupational therapy/speech therapy~~physical, occupational, or speech therapy or consultation;

(7) advanced supportive/restorative assistance;

(8) nursing;

(9) skilled nursing;

(10) ~~home delivered~~home-delivered meals;

(11) hospice care;

(12) medically necessary prescription drugs within the limits of the ~~waiver;~~Waiver;

(13) personal care, ~~(state plan)~~State Plan or ADvantage personal care;

(14) Personal Emergency Response System (PERS);

(15) Consumer-Directed Personal Assistance Services and Supports (CD-PASS);

(16) Institution Transition Services;

(17) assisted living; and

(18) SoonerCare medical services for individuals~~ age~~ 21 years

of age and over within the scope of the State Plan.

(f) The ~~OKDHS~~DHS area nurse or nurse designee makes a determination of service eligibility prior to evaluating the ~~UCAT~~Uniform Comprehensive Assessment Tool (UCAT) assessment for nursing facility level of care. The following criteria are used to make the service eligibility determination:

(1) an open ADvantage Program ~~waiver~~Waiver slot, as authorized by the ~~waiver~~Waiver document approved by the Centers for Medicare and Medicaid Services (CMS), is available to ~~assure~~ensure federal participation in payment for services to the individual. ~~If the OKDHS/ASD~~When the Department of Human Services/Aging Services (DHS/AS) determines all ADvantage ~~waiver~~Waiver slots are filled, the individual cannot be certified ~~on the OKDHS computer system~~by DHS as eligible for ADvantage services, ~~and~~ the individual's name is placed on a waiting list for entry ~~as~~when an open slot becomes available~~.~~;

(2) the individual is in the ADvantage targeted service group. ~~The target group is an individual who is frail and 65 years of age or older or age 21 or older with a physical disability and who does not have intellectual disability or a cognitive impairment.~~The target group are individuals, who:

(A) are frail and 65 years of age and older; or

(B) have a physical disability, are between 21 and 64 years of age, and do not have an intellectual disability or a cognitive impairment; or

(C) have developmental disability, are 21 and 64 years of age, and does not have an intellectual disability or cognitive impairment related to the developmental disability;

(3) the individual is not eligible ~~if he/she~~because he or she poses a physical threat to ~~self~~himself or herself 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~~.~~;

(5) the individual is not eligible ~~if his/her~~when his or her living environment poses a physical threat to ~~self~~himself or herself or others as supported by professional documentation where applicable, and measures to correct hazardous conditions or assist ~~the person to~~individuals move are unsuccessful or not feasible.

(g) The State, as part of the ~~waiver~~Waiver program approval authorization, ~~assures CMS~~ensures Centers for Medicare and Medicaid Services (CMS) that each member's health, safety, or welfare can be maintained in ~~their~~his or her home. ~~If~~When a

member's identified needs cannot be met through provision of ADvantage program or Medicaid State Plan services and other formal or informal services are not in place or immediately available to meet those needs, the individual's health, safety, or welfare in their home cannot be ~~assured.~~ensured. The ~~AA~~ADvantage Administration (AA) determines ADvantage program eligibility through the service plan approval process. An individual is deemed ineligible for the ADvantage program based on the following criteria:

(1) the individual's needs, as identified by UCAT and other professional assessments cannot be met through ADvantage program services, Medicaid State Plan services, and other formal or informal services~~.~~; ~~The State, as part of the waiver program approval authorization, assures CMS that each waiver individual's health, safety, or welfare can be maintained in their home. If a member's identified needs cannot be met through provision of ADvantage program or Medicaid State Plan services and other formal or informal services are not in place or immediately available to meet those needs, the individual's health, safety or welfare in their home cannot be assured.~~

(2) ~~the individual~~one or more members of the individual's household~~, and/or the conditions of the living environment itself,~~ pose a physical threat to self or others as supported by professional documentation~~ and measures to correct conditions are unsuccessful, or are not feasible.~~;

(3) the individual or other household members use threatening, intimidating, degrading, or sexually inappropriate language/innuendo or behavior towards service providers, either in the home or through other contact or communications, and significant efforts ~~have been~~were attempted to correct such behavior, as supported by professional documentation~~.~~ or other credible documentation.

(4) the individual or the individual's authorized agent is uncooperative or refuses to participate in service development or service delivery and these actions result in unacceptable increases of risk to the individual's health, safety, or welfare in ~~their~~his or her home, as determined by the individual, the interdisciplinary team, or the AA~~.~~;

(5) 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~~.~~;

(6) the individual provides false or materially inaccurate information~~ that is~~ necessary to determine program eligibility~~,~~ or withholds information~~ that is~~ necessary to

determine program eligibility.;
(7) the individual does not require at least one ADvantage service monthly.; and
(8) the individual, his or her family member(s), associate(s), or any other person(s) or circumstances as relates to care and coordination in the individual's living environment produces evidence of illegal drug activity or substances used illegally as intoxicants.
(A) This includes:
(i) use, possession, or distribution of illegal drugs;
(ii) abusive use of other drugs, such as medication prescribed by a doctor; or
(iii) use of substances, such as inhalants including, but not limited to:
(I) typewriter correction fluid;
(II) air conditioning coolant;
(III) gasoline;
(IV) propane;
(V) felt tip markers;
(VI) spray paint;
(VII) air freshener;
(VIII) butane;
(IX) cooking spray;
(X) paint; and
(XI) glue;
(iv) observed intoxication, consumption or sensory indicators, such as smell of the use of an drug or intoxicant by the individual, family members, associates, or any other person(s) present at the time care is provided may be construed as evidence indicative of illegal drug activity or intoxication. This includes drug use or intoxicated activity that is menacing to the member or staff providing services;
(v) the observance of drug paraphernalia or any instrument used in the manufacturing, production, distribution, sale, or consumption of drugs or substances including, but not limited to:
(I) smoking pipes used to consume substances other than tobacco;
(II) roach clips containing marijuana cigarettes;
(III) needles and other implements used for injecting drugs into the body;
(IV) plastic bags or other containers used to package drugs;
(V) miniature spoons used to prepare drugs; or
(VI) kits used in the production of synthetic controlled substances including

descriptive materials that accompany the item, describing or depicting its use;

(vi) instructions, oral or written, concerning the item or device including, but not limited to, the manner in which the object is labeled and displayed for sale;

(vii) the typical use of such items in the community; and/or

(viii) testimony of an expert witness regarding use of the item

(h) ~~The~~the case manager provides the AA with professional documentation or other credible documentation to support the recommendation for redetermination of program eligibility. The service providers continue providing services according to the person-centered service plan as provider safety permits until the individual is removed from the ADvantage program. As a part of the procedures requesting redetermination of program eligibility, ~~the OKDHS/ASD will provide~~DHS AS provides technical assistance to the ~~Provider~~provider for transitioning the individual to other services~~.~~, and

(i) ~~Individuals~~individuals determined ineligible for ADvantage program services are notified in writing by ~~OKDHS~~DHS AS of the determination and of ~~their~~the right to appeal the decision.

317:35-17-5. ADvantage program medical eligibility determination

The Oklahoma Department of Human Services(DHS) area nurse~~,~~ or nurse designee, makes the medical eligibility determination utilizing professional judgment, the Uniform Comprehensive Assessment Tool (UCAT)Parts I and III, and other medical information.

(1) When ADvantage care services are requested or the UCAT I is received in the county office, the:

(A) DHS nurse is responsible for completing the UCAT III; and

(B) social service specialist is responsible for contacting the applicant within three business days to initiate the financial eligibility application process.

(2) Categorical relationship must be established for determination of eligibility for ADvantage services. ~~If~~When a categorical relationship to disability was not established, the local social service specialist submits the same information per Oklahoma Administrative Code (OAC) 317:35-5-4(2) to the Level of Care Evaluation Unit (LOCEU) to request a determination of eligibility for categorical relationship. LOCEU renders a decision on the categorical relationship to the person with the disability using the Social Security Administration (SSA) definition. A follow-up is required by the DHS social service specialist with SSA to ensure the

disability decision agrees with the LOCEU decision.
(3) Community agencies complete the UCAT I, and forward the form to the county office. When the UCAT I indicates the applicant does not qualify for Medicaid long-term care services, the applicant is referred to appropriate community resources. Members may ~~also~~ call the care line at ~~800-435-4711.~~1-800-435-4711.
(4) The DHS nurse ~~visits~~completes the UCAT III assessement visit with the member within ~~10 business~~10-business days of receipt of the referral for ADvantage services for an applicant who is Medicaid eligible at the time of the request. The DHS nurse completes the UCAT III assessment visit within ~~20 business~~20-business days of the date the Medicaid application is completed for new applicants.
(5) During the UCAT III assessment visit, the DHS nurse informs the applicant of medical eligibility criteria and provides information about the different long-term care service options. When there are multiple household members applying for the ADvantage program, the UCAT assessment is done for them during the same visit. The DHS nurse documents whether the member chooses nursing facility program services or ADvantage program services and makes a level of care and service program recommendation.
(6) The DHS nurse informs the member and family of agencies certified to deliver ADvantage case management and in-home care services in the local area to obtain the applicant's primary and secondary informed choices, ensuring adherence to conflict free case management requirements.
(A) Providers of ADvantage services for the member, or for those who have an interest in, or are employed by an ADvantage provider for the member must not provide case management or develop the person-centered service plan, except when the ADvantage Administration (AA) demonstrates the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area, also provides other ADvantage services.
(B) ~~If~~When the member and/or family declines to make a provider choice, the DHS nurse documents the decision on Form 02CB001, Member Consents and Rights.
(C) The AA uses a rotating system to select an agency for the member from a list of all local, certified case management and in-home care agencies, ensuring adherence to conflict free case management requirements.
(7) The DHS nurse documents the names of the chosen agencies and the agreement of the member, by dated signature, to receive services provided by the agencies.

(8) When the member's needs require an immediate interdisciplinary team (IDT) meeting with home health agency nurse participation to develop a ~~care plan and~~person-centered service plan, the DHS nurse documents the need for priority processing.
(9) The DHS nurse scores the ~~UCAT, Part III.~~UCAT III. The DHS nurse forwards the ~~UCAT, Parts I and III,~~UCAT III and documentation of financial eligibility, documentation of the member's case management and in-home care agency choices to the area nurse~~,~~ or nurse designee~~,~~ for medical eligibility determination.
(10) ~~If,~~When based upon the information obtained during the assessment, the DHS nurse determines the member may be at risk for health and safety, DHS Adult Protective Services staff is notified immediately and the referral is documented on the UCAT.
(11) Within ~~10 business~~10-business days of receipt of a complete ADvantage application, the area nurse or nurse designee~~,~~ determines medical eligibility using nursing facility level of care criteria and service eligibility criteria per OAC 317:35-17-2 and 317:35-17-3 and enters the medical decision on the system.
(12) Upon notification of financial eligibility from the social service specialist, medical eligibility, and approval for ADvantage entry from the area nurse or nurse designee, the AA communicates with the case management provider to begin care and service plan development. The AA communicates to the case management provider, the member's name, address, case number, Social Security number, ~~the~~ number of units of case management and~~, when applicable,~~ the number of units of home ~~health~~care agency nurse evaluation authorized for service plan development. When the member requires an immediate home visit to develop a ~~service plan~~person-centered within 24 hours, the AA contacts the case management provider directly to confirm availability and ~~sends~~electronically sends the new case packet information to the case management provider ~~via email~~.
(13) When the services must be in place to ensure the health and safety of the member upon discharge to the home from the nursing facility or hospital, a case manager from an ADvantage case management provider selected by the member and referred by the AA follows the ADvantage institution transition, case management procedures for care, and service plan development and implementation.
(14) A new medical level of care determination is required when a member requests any changes in service program, from:
(A) State Plan Personal Care to ADvantage services;

(B) ADvantage to State Plan Personal Care services;
(C) nursing facility to ADvantage services; or
(D) ADvantage to nursing facility services.

(15) A new medical level of care determination is not required when a member requests re-activation of ADvantage services after a short-term stay of ~~90 calendar-days~~90-calendar days or less in a nursing facility when the member ~~has~~ had previous ADvantage services and the ADvantage certification period has not expired.

(16) When a UCAT assessment was completed more than ~~90 calendar-days~~90-calendar days prior to submission to the area nurse or nurse designee for a medical decision, a new assessment is required.

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~~one-business 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.~~; its purpose, philosophy, and the roles and responsibilities of the member, service provider, case manager, and the Oklahoma Department of Human Services (DHS). The case manager will review; update and complete the Uniform Comprehensive Assessment Tool (UCAT); and discuss service needs and ADvantage service providers. The Case Manager notifies ~~in writing~~ the member's UCAT identified primary physician in writing that the member ~~has been~~was 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~~14-calendar days of the receipt of an ADvantage referral, the case manager completes and submits to the AA ~~an individualized care~~a person-centered service 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 person-centered service plan documents no sooner than ~~60 days~~60-calendar 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~~30-calendar days before the end date of the existing person-centered service plan. The case manager submits revisions for denied services to be resubmitted to the AA for approval within 5-business days. Within ~~14 calendar~~14-calendar days of receipt of a Service Plan Review Request (SPR) for short-term authorizations from the AA, the ~~Case Manager~~case manager provides corrected ~~care plan and~~person-centered service plan documentation. Within ~~five calendar~~five-business 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~~person-centered service plan. The ~~care plan~~person-centered and service plan ~~are~~is based on the member's service needs identified by the ~~UCAT, Part III,~~UCAT 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~~person-centered 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~~When 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~~person-centered service 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~~Electronic Visit Verification (EVV) system in the member record any instance in which a member's health or safety would be ~~"at risk" if~~at risk when 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~~person-centered service plan by indicating acceptance or non-acceptance of the plans. The member, the member's legal guardian, or legally authorized representative ~~shall sign~~signs the person-centered service plan in the presence of

the case manager. The signatures of two witnesses are required when the member signs with a mark. ~~If~~When the member refuses to cooperate in development of the person-centered service plan~~, or, if~~or when the member refuses to sign the person-centered 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~~DHS 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~~person-centered service 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 an addenda that ~~allow~~allows the member to achieve stepwise successes in ~~the~~behavior modification ~~of their behavior~~.

(B) The AA may implement a person-centered service plan without the member's signature when~~, for these members,~~ the presence of a document that ~~"requires"~~requires their signature may itself trigger a ~~"conflict".~~conflict. In these circumstances, mental health/behavioral issues may prevent the member from controlling ~~their~~his or her behavior to act in ~~their~~his or her own interest. ~~Since the~~The person by virtue of level of care and the IDT assessment, needs ADvantage services to ~~assure their~~ensure his or her health and safety, the AA may authorize the person-centered service plan ~~if~~when 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~~person-centered service plan, the member may withdraw ~~their~~his or her request for services or request a fair hearing.

(4) ~~CD-PASS Planning and Supports Coordination.~~Consumer-Directed Personal Assistance Services and Supports (CD-PASS) planning and supports coordination.

(A) The ADvantage ~~Case Management~~case management provider assigns ~~to~~ the CD-PASS member a ~~Case Manager~~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~~managers, who complete specialized CD-PASS training are referred to as Consumer-Directed Agent/Case Managers (CDA/CM) with respect to ~~their~~his or her CD-PASS service planning and support role in working with CD-PASS members.

The CDA/CM educates the member about ~~their~~his or her 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"~~authorized representative to assist in the service planning process and in executing member employer responsibilities. ~~If~~When the member chooses to designate an ~~"authorized representative",~~authorized representative the designation and agreement identifying the ~~"willing adult"~~willing adult to assume this role and responsibility is documented with dated signatures of the member, the designee, and the member's ~~Case Manager~~case manager, or ~~the~~ 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".~~authorized representative.

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

(iii) The case manager reviews the designation of ~~Authorized Representative,~~authorized representative, ~~Power of Attorney~~power of attorney, and ~~Legal Guardian~~legal guardian status on an annual basis and includes 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:~~listed in (i) through (v) of the subparagraph.

(i) The person is the center of all planning activities.

(ii) The member and ~~their~~his or her 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~~his or her designated ~~"authorized representative",~~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~~translate the assessment of member needs and preferences into an individually tailored, ~~personalized~~person-centered 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~~is 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 person-centered service plan. The start date must be after:

(i) authorization of services~~,~~;

(ii)~~ after~~ completion and approval of the background checks; and

(ii)~~ after~~ completion of the member employee packets.

(G) Based on outcomes of the planning process, the CDA/CM prepares an ADvantage person-centered 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~~When the plan requires an ~~APSA~~Advanced Personal Service Assistant (APSA) to provide assistance with ~~Health Maintenance~~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~~health maintenance tasks safely and competently;

(i) ~~If~~when the member's APSA ~~has been~~was providing

Advanced Supportive Restorative Assistance to the member for the same tasks in the period immediately prior to being hired as the ~~PSA,~~APSA, additional documentation of competence is not required; and

(ii) ~~If~~when the member and APSA attest that the APSA ~~has been~~was performing the specific ~~Health healthnance~~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~~well-being and the quality of supports and services and assists the member in revising the PSA services plan as needed. ~~If~~When 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 person-centered 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~~when 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~~submits the dispute to the ADvantage Escalated Issues Unit for resolution. The Escalated Issues Unit ~~will work~~works with the member and provider to reach a ~~mutually agreed~~mutually-agreed upon resolution;

(iii) ~~if~~when the dispute cannot be resolved by the ADvantage Escalated Issues Unit it ~~will be~~is heard by the Ethics of Care Committee. The Ethics of Care Committee ~~will make~~makes 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~~backup response capability for

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

(i) Identification of a qualified substitute provider of ~~PSA~~PSA/APSA services and preparation for their quick response to provide backup emergency services, ~~when called upon in emergency circumstances,(including execution of all qualifying background checks, training and employment processes);~~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)~~adult day health, personal care, or nursing facility (NF) respite provider, and preparation for ~~their~~ quick response to provide backup emergency services ~~when called upon in emergency circumstances~~.

(L) ~~If the emergency backup fails, the CDA/CM is to request the AA to~~To obtain authorizations for providers other than PSA and APSA identified as emergency backups, requests the AA authorize and facilitate member access to ~~Adult Day Care,~~adult day health, ~~Agency Personal Care~~agency personal care, or Nursing Facility ~~Respite~~respite services.

(5) The case manager submits the ~~care plan and~~person-centered service plan to the case management supervisor for review. The case management supervisor documents the review/approval of the plans within ~~two working~~two-business 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~~person-centered service plan to the case management supervisor within ~~two working~~two-business days. The case management supervisor returns the approved ~~care plan and~~person-centered service plan to the case manager. Within ~~one working~~one-business day of receiving supervisory approval, the case manager forwards, ~~via postal~~by United States mail, a legible copy of the ~~care plan and~~person-centered 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.~~NF. 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.~~NF.

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

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

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

(b) **Authorization of service plans and amendments to service plans**. The ~~ADvantage Administration (AA)~~AA authorizes the individual person-centered service plan and all service plan amendments for each ADvantage member. When the AA verifies member ADvantage eligibility, service plan cost effectiveness~~, that~~for service providers that 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~~per 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).~~, such as the spouse or parent of a minor child.

(2) The ~~OKDHS/ASD~~DHS AS may ~~under criteria described in~~, per OAC 317:35-15-13, authorize personal care service provision by an Individual PCA ~~(an individual contracted directly with~~

~~OHCA).~~, an individual contracted directly with OHCA. Legally responsible family members are not eligible to serve as Individual ~~PCA's.~~PCAs.

(3) ~~If~~When the service plan authorization or amendment request packet received from case management is complete and the service plan is within ~~cost effectiveness~~cost-effectiveness guidelines, the AA authorizes or denies authorization within ~~five working~~five-business days of receipt of the request. ~~If~~When 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~~When the request packet is not complete, the AA notifies the case manager immediately and puts a ~~"hold"~~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~~DHS 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~~one-business day of the authorization date. A person-centered 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~~5-business days.

(5) For audit purposes~~ (including Program Integrity reviews),~~ 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 or State quality review and audit officials may obtain a copy of specific person-centered 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 person-centered 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 person-centered service plan. The requested changes and justification~~ for them~~ are documented by the service provider and, ~~if~~when initiated by a direct care provider, are submitted to the member's case manager. ~~If~~When in agreement,

the case manager requests the service changes on a ~~care plan and~~ service plan amendment submitted to the AA within ~~five calendar~~five-business days of assessed need. The AA authorizes or denies the ~~care plan and~~person-centered service plan changes per Oklahoma Administrative Code (OAC) 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~~where CD-PASS services are available. The member may contact the AA or ~~by calling~~call 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 person-centered service plan~~ and care plan~~, as appropriate, and submits the new amended person-centered service plan ~~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~~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 person-centered service plan or be eligible for a different service program. ~~If~~When 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~~When unable to obtain the member's consent for voluntary closure, the case manager requests ~~assistance from the AA.~~(AA) assistance. The AA requests that the ~~OKDHS~~DHS 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~~and develop person-centered service plans in a geographic area also provides HCBS.

317:35-17-18. ADvantage services during hospitalization or NF placement

When the member's ~~OKDHS~~DHS social worker, ADvantage case manager, or the AA is informed ~~(by the member, family or service provider)~~by the member, family, or service provider of a member's hospitalization or placement in a nursing facility~~,~~ (NF), that party determines the date of the member's institutionalization and communicates the date, name of the institution, reason for placement, and expected duration for placement~~,~~ to the other ADvantage Program Administrative partners. ~~If~~When a member requires hospital or ~~nursing facility~~NF services, the case manager assists the member ~~in accessing~~access institutional care, periodically monitors the member's progress during the institutional stay and, as appropriate, updates the person-centered service plan and prepares services to start on the date the member is discharged from the institution and returns home. All case management units for ~~"institution transition"~~institution transition services to plan for and coordinate service delivery and to assist the member to safely return home, even ~~if~~when provided while the person is in an institution, are~~ to be~~ considered delivered on and billed for the date the member returns home from institutional care.

(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 the ~~AA~~ADvantage Administration (AA), and coordinates the resumption of services.

(2) **~~NF~~Nursing Facility placement of less than ~~30 days.~~30-calendar days.** When the member returns home from a NF stay of ~~30 days~~30-calendar or less or when notified of the member's anticipated discharge date, the case manager notifies relevant providers, the member's ~~OKDHS~~DHS worker and the AA of the discharge and coordinates the resumption of ADvantage services in the home.

(3) **~~NF~~Nursing Facility placement ~~greater~~longer than ~~30 days.~~30-calendar days.** When the member is scheduled to be discharged and return home from a NF stay that is ~~greater~~longer than ~~30 days,~~30-calendar the member's ~~OKDHS~~DHS worker, ADvantage case manager, or the AA ~~(whoever first receives notification of the discharge)~~, whoever first receives notification of the discharge,

notifies other ADvantage Program Administrative partners to expedite the restart of ADvantage services for the member. ~~In these circumstances, the SPEED process may be used to re-establish ADvantage eligibility to coincide with the date of discharge from the NF.~~ The member's case manager provides ~~"institution transition"~~institution transition case management services to assist the member to re-establish him or herself safely in the home.

317:35-17-22. Billing procedures for ADvantage services

(a) Billing procedures for long-term care medical services are contained in the Oklahoma Medicaid Management Information Systems (OKMMIS) Billing and Procedure Manual. Questions regarding billing procedures ~~which~~that cannot be resolved through a study of the manual ~~should be~~are referred to the Oklahoma Health Care Authority (OHCA).

(b) The Oklahoma Department of Human Services (DHS) Aging Services ~~(DHS/AS)~~(AS) approved ADvantage service plan is the basis for the Medicaid Management Information Systems (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 ADvantage quality assurance, provider audits are used to evaluate ~~whether~~if 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 are turned over to the OHCA Provider Audit Unit for follow-up investigation.

(d) Service time of ~~Personal Care, Case Management, Case Management for tranisitioning, Nursing, Advanced Supportive/ Restorative Assistance, In-Home Respite, CD-PASS Personal Services Assistance, and Advanced Personal Services Assistance~~personal care, case management, case management for transitioning, nursing, advanced supportive/restorative assistance, in-home respite, consumer-directed personal assistance services and supports (CD-PASS), personal services assistance, and advanced personal services assistance is documented solely through the Electronic Visit Verification System (EVV) also known as Interactive Voice Response Authentication (IVRA) system, when provided in the home. Providers are required to use the ~~IVRA~~EVV system ~~after access to the system is made available by OKDHS~~. The ~~IVRA~~EVV system provides alternate backup solutions ~~should~~when the automated system ~~be~~is unavailable. In the event of ~~IVRA backup~~EVV system

failure, the provider documents time in accordance with ~~their agency backup plan; however, backup procedures are only permitted when the IVRA system is unavailable.~~internal policy and procedures. This documentation suffices to account for in-home and office services delivered. Provider agency backup procedures are only permitted when the EVV system is unavailable.

(e) The provider must document the amount of time spent for each service, per ~~OAC~~Oklahoma Administrative Code (OAC) 317:30-5-763. For service codes that specify a time segment in their description, such as 15 minutes, each timed segment equals one unit. Only time spent fulfilling the service for which the provider is authorized, per OAC 317:30-5-763~~, shall be~~is authorized for ~~timed based~~time-based services. Providers ~~shall~~do not bill for a unit of time when not more than one-half of a timed unit is performed. For example, ~~if~~when a unit is defined as 15 minutes, providers ~~should~~do not bill for services performed for less than ~~8~~eight minutes. The rounding rules utilized by the ~~IVRA~~EVV and web-based billing system to calculate the billable ~~amount~~unit-amount of ~~a unit are:~~are, services provided for duration of:

(1) ~~services provided for a duration of~~ less than ~~8 minutes~~8-minutes cannot be rounded up and do not constitute a billable ~~15 minute~~15-minute unit; and

(2) ~~services provided for a duration of 8 to 15~~8 to 15 minutes are rounded up and do constitute a billable ~~15 minute~~15-minute unit.

SUBCHAPTER 19. NURSING FACILITY SERVICES

317:35-19-2. Nursing Facility (NF) program medical eligibility determination

The ~~OKDHS~~DHS area nurse~~,~~ or nurse designee ~~(OHCA, LOCEU makes some determinations when PASRR is involved)~~, determines medical eligibility for nursing facility (NF) services based on the ~~Long Term Care (LTC)~~long term care (LTC) nurse's ~~UCAT, Part III~~Uniform Comprehensive Assessment Tool (UCAT III) assessment of the client's needed level of care, the outcome of the Level II Preadmission Screening and Resident Review (PASRR), ~~if~~when completed, and his or her professional judgment. The Oklahoma Healthcare Authority Level of Care Evaluation Unit makes some determinations when the (PASRR) is involved. Refer to ~~OAC~~Oklahoma Administrative Code (OAC) 317:35-19-7.1(3) for nursing facility level of care medical eligibility requirements.

(1) When NF care services are requested prior to admission, the same rules related to medical eligibility determination identified in OAC 317:35-17-5 for ADvantage services are

followed.
(2) ~~The LTC nurse submits the UCAT, Part III, the Long-Term Care Preadmission Screen form (PASRR), and the NF request for assessment to the area nurse, or nurse designee, for medical eligibility determination.~~The LTC nurse reviews the PASRR Level I in the Oklahoma Health Care Authority system; completes the UCAT III; and enters the date OHCA received the PASRR Level I (LTC-300R) from the NF and admission date to the NF; financial eligibility effective date and notes any Level II PASRR results if available in the UCAT III. This information is submitted to the DHS Area Nurse for medical eligibility determination.
(3) PASRR requirements are identified in OAC 317:35-19-8 and 317:35-19-9.
(4) When it is not possible for the UCAT assessment to be completed prior to admission, the NF is responsible for notifying the ~~OKDHS~~DHS of the admission. ~~Notification will be by mailing or by faxing the OKDHS form ABCDM-83 (Notification Regarding Patient In A Nursing Facility, Intermediate Care Facility for the Mentally Retarded or Hospice), OKDHS form ABCDM-96 (Management of Recipient's Funds), and OKDHS form ABCDM-83-A, Request for Title XIX Nursing Assessment, to the local OKDHS county office.~~Notification is mailed or faxed on DHS Form 08MA083E, Notification regarding Patient In A Nursing Facility, Intermediate Care Facility for the Mentally Retarded or Hospice, and Management Recipient Funds to the local DHS county office. Upon receipt, the ~~OKDHS~~DHS county office processes ~~the ABCDM-83,~~Forms 08MA084E and 08MA084E ~~ABCDM-96, and the ABCDM-83~~Forms 08MA083E and 08MA084E and completes and forwards the ~~OKDHS form ABCDM-37D~~Form 08MA038E ~~(Notice Regarding Financial Eligibility)~~, Notice Regarding Financial Eligibility to the NF. Identified sections of the UCAT reflecting the domains for meeting medical criteria are completed for applicants residing in the NF at the time of assessment. The area nurse~~,~~ or nurse designee, ~~determines~~confirms the date of medical eligibility and records it ~~on~~in the system ~~based on the date of financial eligibility~~. The facility is responsible for performing the PASRR Level I screen and consulting with OHCA staff ~~of the OHCA as to whether~~to determine when a need exists for a Level II screen. The LTC nurse ~~will conduct~~conducts the assessment visit within ~~15 working~~15-business days of ~~request for assessment if~~PASRR clearance when the individual's needs are included in an active ~~ABCDM~~DHS coded case. ~~If~~When the individual's needs are not included in an active ~~ABCDM~~ case, the assessment is conducted within ~~20 working~~20-business days

of ~~the date of the signed application. The LTC nurse forwards the completed preadmission screen, the ABCDM-83-A, and the UCAT, Part III to the area nurse or nurse designee.~~ PASRR clearance.

(5) The area nurse~~,~~ or nurse designee, ~~will evaluate~~evaluates the PASRR Level I screen and the UCAT~~, Part~~ III ~~and consult with staff of the OHCA as to whether a need exists for a Level II screen as necessary.~~in consultation with the DHS nurse when the completed LTC-300R and/or facility documentation shows a need exists for a possible Level II screen. The area nurse or nurse designee consults with OHCA staff as necessary.

(6) The area nurse~~,~~ or nurse designee, ~~will evaluate~~evaluates the UCAT~~, Parts~~ I and III, ~~the Long-Term Care Preadmission Screen form and the physician's diagnosis~~ to determine ~~whether~~if the applicant meets the medical eligibility criteria for NF level of care. Individuals may be ~~medically certified~~medically-certified for NF level of care for various lengths of time depending ~~upon~~on the client's needs~~ of the client~~. The area nurse~~,~~ or nurse designee, enters the medical eligibility decision~~,~~ and~~,~~ when required, the medical certification review date ~~on the system~~into Aging Services Division Electronic Data Entry and Retrieval System (ELDERS) within ~~ten working~~10-business days. A medical eligibility redetermination is not required when a client is discharged from the NF for a period not to exceed ~~90~~90-calendar days and the original certification is current.

(7) ~~If~~When the LTC nurse recommends NF level of care and the client is determined by the area nurse~~,~~ or nurse designee, not to be medically eligible for NF level of care, the LTC nurse can submit additional information to the area nurse~~,~~ or nurse designee. When necessary, a visit by the LTC nurse to obtain additional information ~~can be~~is initiated at the recommendation of the area nurse~~,~~ or nurse designee.

(8) Categorical relationship must be established for determination of eligibility for NF services. ~~If~~When categorical relationship to disability has not~~ already~~ been established, the worker submits the same information ~~described in~~per OAC 317:35-5-4(2) to the LOCEU to request a determination of eligibility for categorical relationship. LOCEU renders a decision on categorical relationship to the disabled applicant using the ~~same~~Social Security Administration (SSA) definition~~ used by SSA~~. A follow-up with the SSA by the ~~OKDHS~~DHS worker is required to ~~be sure that~~ensure the SSA disability decision agrees with the LOCEU decision~~ of LOCEU~~.

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 1. GENERAL SCOPE AND ADMINISTRATION

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

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

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

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

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

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

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

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

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

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

regarding assignment.

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

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

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

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

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

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

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

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

(D) Native Americans providing documentation of ethnicity in accordance with 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. This includes all contraceptives and services rendered.

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

(C) Services furnished to pregnant women, if those services

relate to the pregnancy or to any other medical condition which may complicate the pregnancy.

(D) Smoking and Tobacco Cessation counseling and products.

(E) Diabetic supplies.

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

(A) Inpatient hospital stays.

(B) Outpatient hospital visits.

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

(D) Encounters with the following rendering providers:

(i) Physicians,

(ii) Advanced Practice Nurses,

(iii) Physician Assistants,

(iv) Optometrists,

(v) Home Health Agencies,

(vi) Certified Registered Nurse Anesthetists,

(vii) Anesthesiologist Assistants,

(viii) Durable Medical Equipment providers, and

(ix) Outpatient behavioral health providers.

(E) Prescription drugs.

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

~~(4) Aggregate cost-sharing liabilities in a given calendar year may not exceed 5% of the member's gross annual income.~~

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

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

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

PART 5. DETERMINATION OF MEDICAL ELIGIBILITY FOR ICF/IID, HCBW/MR, AND INDIVIDUALS AGE 65 OR OLDER IN MENTAL HEALTH HOSPITALS

317:35-9-48.1 Determining 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 or other appropriate healthcare provider, and found to have severe dysfunctional deficiencies with findings of at least two standard deviations in at least two 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/IID level of institutional care requires an IQ of 70 or less, or a full-scale functional assessment indicating a functional age composite that does not exceed ~~50%~~fifty percent 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/IID level of care. Children under evaluation, including both intelligence testing and adaptive/functional assessment, by a licensed psychologist or school psychologist certified by the ODE, at age three, age six, and, if medically necessary, thereafter to ascertain continued eligibility for TEFRA under the 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 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-19. Administrative sanctions [REVOKED]

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

~~(1) **"Abuse"** means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also recognizes recipient practices that result in unnecessary cost to the Medicaid program.~~

~~(2) **"Conviction" or "Convicted"** means a judgment of conviction has been entered by a Federal, State, or local court, regardless of whether an appeal from that judgment is pending.~~

~~(3) **"Exclusion"** means items or services which will not be reimbursed under Medicaid because they were furnished by a specific provider who has defrauded or abused the Medicaid program.~~

~~(4) **"Fraud"** means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.~~

~~(5) **"Knowingly"** means that a person, with respect to information:~~

~~(A) has actual knowledge of the information;~~

~~(B) acts in deliberate ignorance of the truth or falsity of the information; or~~

~~(C) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.~~

~~(6) **"Medical Services Providers"** means:~~

~~(A) **"Practitioner"** means a physician or other individual licensed under State law to practice his or her profession or a physician who meets all requirement for employment by the Federal Government as a physician and is employed by the Federal Government in an IHS facility or affiliated with a 638 Tribal facility.~~

~~(B) **"Supplier"** means an individual or entity, other than a~~

~~provider or practitioner, who furnishes health care services under Medicaid or other medical services programs administered by the Oklahoma Health Care Authority.~~

~~(C) **"Provider"** means:~~

~~(i) A hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, or a hospice that has in effect an agreement to participate in Medicaid, or any other medical services program administered by the Oklahoma Health Care Authority, or~~

~~(ii) a clinic, a rehabilitation agency, or a public health agency that has a similar agreement.~~

~~(D) **"Laboratories"** means any laboratory or place equipped for experimental study in science or for testing or analysis which has an agreement with the Oklahoma Health Care Authority to receive Medicaid monies.~~

~~(E) **"Pharmacy"** means any pharmacy or place where medicines are compounded or dispensed or any pharmacist who has an agreement with OHCA to receive Medicaid monies for the dispensing of drugs.~~

~~(F) **"Any other provider"** means any provider who has an agreement with OHCA to deliver health services, medicines, or medical services for the receipt of Medicaid monies.~~

~~(7) **"OIG"** means Office of Inspector General of the Department of Health and Human Services.~~

~~(8) **"Sanctions"** means any administrative decision by OHCA to suspend or exclude a medical service provider(s) from the Medicaid program or any other medical services program administered by the Oklahoma Health Care Authority.~~

~~(9) **"Suspension"** means items or services furnished by a specified provider will not be reimbursed under the Medicaid program.~~

~~(10) **"Willfully"** means proceeding from a conscious motion of the will; voluntary, intending the result which comes to pass; intentional.~~

~~(b) **Basis for sanctions.**~~

~~(1) The Oklahoma Health Care Authority may sanction a medical provider who has an agreement with OHCA for the following reasons:~~

~~(A) Knowingly or willfully made or caused to be made any false statement or misrepresentation of material fact in claiming, or use in determining the right to, payment under Medicaid; or~~

~~(B) Furnished or ordered services under Medicaid that are substantially in excess of the recipient's needs or that fail to meet professionally recognized standards for~~

health care; or

(C) Submitted or caused to be submitted to the Medicaid program bills or requests for payment containing charges or costs that are substantially in excess of customary charges or costs. However, the agency must not impose an exclusion under this section if it finds the excess charges are justified by unusual circumstances or medical complications requiring additional time, effort, or expense in localities in which it is accepted medical practice to make an extra charge in such case.

(2) The agency may base its determination that services were excessive or of unacceptable quality on reports, including sanction reports, from any of the following sources:

(A) The PRO for the area served by the provider or the PRO contracted by OHCA;

(B) State or local licensing or certification authorities;

(C) Peer review committees of fiscal agents or contractors;

(D) State or local professional societies;

(E) Surveillance and Utilization Review Section Reports done by OHCA; or

(F) Other sources deemed appropriate by the Medicaid agency or the OIG.

(3) OHCA must suspend from the Medicaid program any medical services provider who has been suspended from participation in Medicare or Medicaid due to a conviction of a program related crime. This suspension must be at a minimum the same period as the Medicare suspension.

(4) OHCA must also suspend any convicted medical services provider who is not eligible to participate in Medicare or Medicaid whenever the OIG directs such action. Such suspension must be, at a minimum, the same period as the suspension by the OIG.

(c) **Procedure for imposing sanctions.** The procedure for imposing a sanction under this section and the due process accorded in this section is provided at OAC 317:2-1-5.

317:30-3-19.1. Revocation of enrollment and billing privileges in the Medicaid Program. [REVOKED]

OHCA and providers have the right to terminate or suspend contracts with each other. Remedies are provided in this Section that may be used by the agency in addition to a formal contract action against the provider. When the use of these remedies results in a contract action, appropriate due process protections will be afforded to the provider for that contract action. Subsections (1) through (10) are additional remedies

~~under which OHCA may revoke a currently enrolled provider or supplier's SoonerCare billing privileges and any corresponding provider agreement or supplier agreement.~~

~~(1) **Noncompliance**. The provider or supplier is determined not to be in compliance with the enrollment requirements described in OAC 317:30-3-2, or in the enrollment application applicable for its provider or supplier type. All providers and suppliers are granted an opportunity to correct the deficient compliance requirement before a final determination to revoke billing privileges, except for those imposed under subsections (2), (3), (5), or (7) of this Section.~~

~~(A) OHCA may request additional documentation from the provider or supplier to determine compliance if adverse information is received or otherwise found concerning the provider or supplier.~~

~~(B) Requested additional documentation must be submitted within 60 calendar days of request.~~

~~(2) **Provider or supplier conduct**. The provider or supplier, or any owner, managing employee, authorized or delegated official, medical director, supervising physician, or other health care personnel of the provider or supplier is:~~

~~(A) Excluded from the Medicare, Medicaid, or any other Federal health care program, as defined in 42 CFR 1001.2; or~~

~~(B) Is debarred, suspended, or otherwise excluded from participating in any other Federal procurement or nonprocurement program or activity.~~

~~(3) **Felonies**. The provider, supplier, or any owner of the provider or supplier, within the 10 years preceding enrollment or revalidation of enrollment, was convicted of a Federal or State felony offense that OHCA has determined to be detrimental to the best interests of the program and its beneficiaries. Denials based on felony convictions are for a period to be determined by the OHCA, but not less than 10 years from the date of conviction if the individual has been convicted on one previous occasion for one or more offenses. Offenses include but are not limited to:~~

~~(A) Felony crimes against persons, such as murder, rape, assault, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions;~~

~~(B) Financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions;~~

~~(C) Any felony that placed the Medicaid program or its~~

~~beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct; and~~

~~(D) Any felonies that would result in mandatory exclusion under 42 U.S.C. § 1320a-7a of the Social Security Act.~~

~~(4) **False or misleading information**. The provider or supplier certified as "true" misleading or false information on the enrollment application to be enrolled or maintain enrollment in the SoonerCare program. Offenders may be subject to either fines or imprisonment, or both, in accordance with current law and regulations.~~

~~(5) **On-site review**. OHCA determines, upon on-site review, that the provider or supplier is no longer operational to furnish SoonerCare covered items or services, or is not meeting SoonerCare enrollment requirements under statute or regulation to supervise treatment of, or to provide SoonerCare covered items or services for, SoonerCare members.~~

~~(6) **Provider and supplier screening requirements.**~~

~~(A) A provider does not submit an application fee that meets the requirements set forth in 42 CFR 455.460.~~

~~(B) Either of the following occurs:~~

~~(i) OHCA is not able to deposit the full application amount.~~

~~(ii) The funds are not able to be credited to the State of Oklahoma.~~

~~(C) The provider or supplier lacks sufficient funds in the account at the banking institution whose name is imprinted on the check or other banking instrument to pay the application fee; or~~

~~(D) There is any other reason why OHCA is unable to deposit the application fee.~~

~~(7) **Misuse of billing number**. The provider or supplier knowingly sells to or allows another individual or entity to use its billing number. This does not include those providers or suppliers who enter into a valid reassignment of benefits as specified in 42 U.S.C. § 1396a (a)(32) or a change of ownership as outlined in 42 CFR 455.104(c) (within 35 days of a change in ownership).~~

~~(8) **Abuse of billing privileges**. The provider or supplier submits a claim or claims for services that could not have been furnished to a specific individual on the date of service. These instances include but are not limited to situations where the beneficiary is deceased, the directing physician or beneficiary is not in the State or country when services were furnished, or when the equipment necessary for testing is not present where the testing is said to have~~

~~occurred.~~

~~(9) **Failure to report**. The provider or supplier did not comply with the reporting requirements specified in the SoonerCare provider agreement or regulations.~~

~~(10) **Failure to document or provide OHCA access to documentation.**~~

~~(A) The provider or supplier did not comply with the documentation or OHCA access requirements specified in the SoonerCare Provider Agreement.~~

~~(B) A provider or supplier that meets the revocation criteria specified in (10)(A) of this subsection is subject to revocation for a period of not more than 1 year for each act of noncompliance.~~

OAC 317:30-3-19.3. Denial of application for new or renewed provider enrollment contract

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

(1) **"Affiliates"** means persons having a relationship in which any of them directly or indirectly controls or has the ability to control one or more of the others.

(2) **"Applicant"** means providers and/or persons with a five percent or more direct or indirect ownership interest therein, as well as providers' officers, directors, and managing employees.

(3) **"Conviction"** or **"convicted"** means a person has been convicted of a criminal offense pursuant to 42 U.S.C. § 1320a-7(i), or, for civil offenses, has had a judgment of conviction entered against him or her by a Federal, State, or local court, regardless of whether an appeal from the judgment is pending.

(4) **"Person"** means any natural person, partnership, corporation, not-for-profit corporation, professional corporation, or other business entity.

(5) **"Provider"** means any person having or seeking to obtain a valid provider enrollment contract with the Oklahoma Health Care Authority (OHCA) for the purpose of providing services to eligible SoonerCare members and receiving reimbursement therefor.

(b) When deciding whether to approve an application for a new or renewed provider enrollment contract, OHCA may consider the following factors as they relate to the applicant and any of the applicant's affiliates, including, but not limited to:

(1) any false or misleading representation or omission of any material fact or information required or requested by OHCA as part of the application process;

(2) any failure to provide additional information to OHCA after receiving a written request for such additional information;
(3) any false or misleading representation or omission of any material fact in making application for any license, permit, certificate, or registration related to the applicant's profession or business in any State;
(4) any fine, termination, removal, suspension, revocation, denial, consented surrender, censure, sanction, involuntary invalidation of, or other disciplinary action taken against any license, permit, certificate, or registration related to the applicant’s profession or business in any State;
(5) any previous or current involuntary surrender, removal, termination, suspension, ineligibility, exclusion, or otherwise involuntary disqualification from participation in Medicaid in any State, or from participation in any other governmental or private medical insurance program, including, but not limited to, Medicare and Workers' Compensation;
(6) any Medicaid or Medicare overpayment of which the applicant has been notified, as determined exclusively by OHCA that was received, but has not made reimbursement, unless such reimbursement is the subject of an OHCA reimbursement agreement that is not in default,;
(7) any previous failure to correct deficiencies in the applicant's business or professional operations after having received notice of the deficiencies from the OHCA or any State or Federal licensing or auditing authority;
(8) any previous violation of any State or Federal statute or regulation that relates to the applicant's current or past participation in Medicaid, Medicare, or any other governmental or private medical insurance program;
(9) any pending charge or prior conviction of any civil or criminal offense relating to the furnishing of, or billing for, medical care, services, or supplies, or which is considered theft, fraud, or a crime involving moral turpitude;
(10) any pending charge or prior criminal conviction for any felony or misdemeanor offense that could reasonably affect patient care, including, but not limited to, those offenses listed in 317:30-3-19.4;
(11) any denial of a new or renewed provider enrollment contract within the past two (2) years that was based on the applicant's or an affiliate's prior conduct;
(12) any submission of an application that conceals the involvement in the enrolling provider's operation of a person who would otherwise be ineligible to participate in Medicaid or Medicare;

(13) any business entity that is required to register with a State office or agency in order to conduct its operations therein, including, but not limited to, the Oklahoma Secretary of State, any failure to obtain and/or maintain a registration status that is valid, active, and/or in good standing; and

(14) any other factor that impacts the quality or cost of medical care, services, or supplies that the applicant furnishes to SoonerCare members, or otherwise influences the fiscal soundness, effectiveness, or efficiency of the OHCA program.

(c) OHCA shall provide any applicant who is denied a new or renewed provider enrollment contract a written notice of the denial. Any denial shall become effective on the date it is sent to the applicant.

(d) Any OHCA decision to deny a provider's contract application in accordance with this Section shall be a final agency decision that is not administratively appealable.

317:30-3-19.4. Applicants subject to a fingerprint-based criminal background check

(a) Applicants designated as "'high' categorical risk" in accordance with Federal law, including, but not limited to, 42 C.F.R. § 424.518 and 42 C.F.R. Part 455, Subpart E, or if otherwise required by State and/or Federal law, shall be subject to a fingerprint-based criminal background check as a condition of new or renewed contract enrollment.

(b) Any applicant subject to a fingerprint-based criminal background check as provided in subsection (a) of this Section, shall be denied enrollment if he/she has a felonious criminal conviction and may be denied enrollment for a misdemeanor criminal conviction relating, but not limited, to:

(1) The provision of services under Medicare, Medicaid, or any other Federal or State health care program;

(2) Homicide, murder, or non-negligent manslaughter;

(3) Aggravated assault;

(4) Kidnapping;

(5) Robbery;

(6) Abuse, neglect, or exploitation of a child or vulnerable adult;

(7) Human trafficking;

(8) Negligence and/or abuse of a patient;

(9) Forcible rape and/or sexual assault;

(10) Terrorism;

(11) Embezzlement, fraud, theft, breach of fiduciary duty, or other financial misconduct; and/or

(12) Controlled substances, provided the conviction was entered within the preceding ten-year period.

(c) Any OHCA decision denying an application for contract enrollment based on the applicant's criminal history pursuant to OAC 317:30-3-19.4 shall be a final agency decision that is not administratively appealable. However, nothing in this section shall preclude an applicant whose criminal conviction has been overturned on final appeal, and for whom no other appeals are pending or may be brought, from reapplying for enrollment.

317:30-3-19.5. Termination of provider agreements

Pursuant to the terms of OHCA's Standard Provider Agreement, both OHCA and a provider may terminate the agreement without cause on sixty (60) days' notice, or for-cause on thirty (30) days' notice. In addition, OHCA can terminate the agreement immediately in order to protect the health and safety of members, or upon evidence of fraud (including, but not limited to, a credible allegation of fraud as defined by 42 C.F.R. § 455.2). Conduct that may serve as a basis for a for-cause termination of a provider includes, but is not limited to, any of the following:

(1) **Noncompliance.** The provider is determined not to be in compliance with the enrollment requirements described in OAC 317:30-3-2, OAC 317:30-3-19, or in the enrollment application applicable for its provider type. OHCA may, but is not required to, request additional documentation from the provider to determine compliance.

(2) **Provider exclusion, debarment, or suspension.** The provider or any owner, managing employee, authorized or delegated official, medical director, supervising physician, or other health care personnel thereof is:

(A) Excluded from the Medicare, Medicaid, or any other Federal health care program, as defined in 42 C.F.R § 1001.2; or

(B) Debarred, suspended, or otherwise excluded from participating in any other Federal procurement or nonprocurement program or activity.

(3) **Convictions.** Conviction of the provider or any of its affiliates for a Federal or State offense that OHCA has determined to be detrimental to the best interests of the program and its members. Such offenses may include, but are not limited to, those offenses enumerated in OAC 317:30-3-19.3 and OAC 317:30-3-19.4.

(4) **False or misleading information.** The provider submitted or caused to be submitted misleading or false information on its enrollment application to be enrolled or to maintain enrollment in the SoonerCare program. In addition to

termination of a contract, offenders may be referred for prosecution, which could result in fines or imprisonment, or both, in accordance with current law and regulations.

(5) **On-site review.** OHCA determines, upon on-site review, that the provider is no longer operational, able to furnish SoonerCare covered items, or able to safely and adequately render services; or is not meeting SoonerCare enrollment requirements under statute or regulation to supervise treatment of, or to provide SoonerCare covered items or services for SoonerCare members.

(6) **Misuse of billing number.** The provider knowingly sells to or allows another individual or entity to use its billing number. This does not include those providers who enter into a valid reassignment of benefits as specified in 42 U.S.C. § 1396a(a)(32) or a change of ownership as outlined in 42 C.F.R. § 455.104(c) (within thirty-five (35) days of a change in ownership).

(7) **Abuse of billing privileges.** The provider submits a claim or claims for services that reasonably could not have been rendered, or that do not accurately reflect those services actually rendered, to a specific individual on the date of service. These instances include, but are not limited to: upcoding; unbundling of services; services that are purportedly provided to a member who has died prior to the date of service; services that are purportedly provided on a date on which the directing physician or member is not in the State or country or is otherwise physically incapable of providing or receiving the service; or the equipment necessary for testing was not present where the testing is said to have occurred, or was incapable of operating correctly at the supposed time of testing.

(8) **Failure to report.** The provider did not comply with the reporting requirements specified in the SoonerCare Provider Agreement or any applicable State and/or Federal statutes or regulations, including without limitation, changes in the provider's licenses, certifications, and/or accreditations provided at the time of enrollment. Providers shall report and update a change in mailing address within fourteen (14) days of such change.

(9) **Failure to document or provide OHCA access to documentation.**

(A) The provider did not comply with the documentation or OHCA access requirements specified in the SoonerCare Provider Agreement.

(B) OHCA may suspend all SoonerCare payments to a provider who refuses or fails to produce for inspection those financial and other records as are required by 42 C.F.R. §

431.107 and the executed SoonerCare Provider Agreement, until such time as all requested records have been submitted to OHCA for review.

(10) **Adverse audit determinations.** The provider receives an adverse Program Integrity audit that demonstrates fraud, waste, abuse, and/or repeated failure or inability to comply with SoonerCare billing and provision of service requirements.

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-17. Discrimination laws

The Oklahoma Health Care Authority has assured compliance with the regulations of the Department of Health and Human Services, Title 45, Code of Federal Regulations, Part 80 (which implements Public Law 88-352, Civil Rights Act of 1964, Section 601), Part 84 (which implements Public Law 93-112, Rehabilitation Act of 1973, Section 504), Part 90 (which implements Public Law 94-135, Age Discrimination Act of 1975, Section 301), Title 9 of the Education Amendments of 1972; and Executive Orders 11246 and 11375.

(1) These laws and regulations prohibit excluding from participation in, denying the benefits of, or subjecting to discrimination, under any program or activity receiving Federal Financial Assistance any person on the grounds of race, color, sex, national origin, and qualified person on the basis of handicap, or unless program-enabling legislation permits, on the basis of age. Under these requirements, payment cannot be made to vendors providing care and/or services under ~~Federallyassisted~~Federally-assisted programs conducted by the Authority unless such care and service is provided without discrimination on the grounds of race, color, sex, national origin or handicap or without distinction on the basis of age except as legislatively permitted or required.

(2) Written complaints of noncompliance with any of these laws should be made to the Chief Executive Officer of the Oklahoma Health Care Authority, ~~4545~~4345 ~~N.~~North Lincoln ~~Blvd,~~Boulevard, ~~Suite 124,~~ Oklahoma City, Oklahoma 73105, or the Secretary of Health and Human Services, Washington, D.C., or both.

PART 3. GENERAL MEDICAL PROGRAM INFORMATION

317:30-3-44. Personal care

Personal care is a service provided in a ~~recipient's~~member's home. To receive the service, the ~~recipient~~member must have met the appropriate level of care in accordance with procedures found in OAC 317:35-9. In geographic areas designated as ADvantage Program phase in areas, personal care services may be provided by agency providers who contract with the Medicaid agency for the provision of services. The service may be provided by individual personal care providers in geographic areas where there is insufficient agency providers to adequately serve the population.

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. Admission requirements for services must be provided in accordance with Code of Federal Regulations, Title 42 Public Health, Part 441 and 456. Additional information will be required for a SoonerCare compensable approval on enhanced treatment units or in special population programs.

(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. A unit that does not allow clear line of ~~site~~sight due to the presence of walls or doors is considered a separate unit. Each individual unit shall have assigned staff to allow for appropriate and safe monitoring of patients and to provide active treatment.

(c) In an acute care setting, at least one Registered Nurse (RN) must be on duty per unit at all times, with additional RNs to meet program needs. RNs must adhere to Oklahoma Department of Health policy at OAC 310:667-15-3 and OAC 310:667-33-2(a)(3).

(d) 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. At a minimum, the supervising RN must be available by phone and on-site within one hour. If the supervising RN is off-site, then an RN or LPN must be on-site to adhere to a 24 hour nursing care coverage ratio of 1:30 during routine waking hours and 1:40 during time residents are asleep.

(e) 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.

(f) A PRTF will not be considered a specialty treatment program

for SoonerCare without prior approval of the OHCA behavioral health unit.

(g) A treatment program that has been approved as a specialized treatment program must maintain medical records that document the degree and intensity of the psychiatric care delivered to the children.

(h) Criteria for classification as a specialized PRTF will require a staffing ratio of 1:3 at a minimum during 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).

(i) Non-authorized inpatient psychiatric services will not be SoonerCare compensable.

(j) 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.

(k) 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.

(l) 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.

317:30-5-96.5. Disproportionate share hospitals (DSH)

Reimbursement for DSH is determined in accordance with the methodology for inpatient hospital services as described in Attachment 4.19 A of the Medicaid State Plan. Copies of the plan may be obtained by writing the Oklahoma Health Care Authority, ~~4545~~4345 North Lincoln Boulevard, Oklahoma City, OK 73105 or may be downloaded from the OHCA website.

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), certified nurse midwives ~~(NMs)~~(CNMs) or specialized advanced practice nurse practitioners;

(iv) Services and supplies incident to the services of APNs and PAs (including services furnished by certified 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, certified 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.

PART 37. ADVANCED PRACTICE NURSE

317:30-5-375. Eligible providers

The Advanced Practice Nurse must be a registered nurse in good standing with the Oklahoma Board of Nursing, and have acquired knowledge and clinical skills through the completion of a formal program of study approved by the Oklahoma Board of Nursing Registration and have obtained professional certification through the appropriate National Board recognized by the Oklahoma Board of Nursing. Advanced Practice Nurse services are limited to the scope of their practice as defined in 59 O.S. 567.3a and corresponding rules and regulations at OAC 485:10-5-1 through 10-16-9. Rules regarding Certified Nurse Midwives are referenced in OAC 317:30-5-225. Advanced Practice Nurses who practice in states other than Oklahoma must be appropriately licensed in the state in which they practice. In addition, all providers must have a current contract on file with the Oklahoma Health Care Authority.

PART 61. HOME HEALTH AGENCIES

317:30-5-546. Coverage by category

Payment is made for home health services as set forth in this Section.

(1) **Adults.** Payment is made for home health services provided in the ~~patient's~~member's residence to all categorically needy individuals. Coverage for adults is as follows.

(A) **Covered items.**

(i) Part-time or intermittent nursing services;

(ii) Home health aide services;

(iii) Standard medical supplies;

(iv) Durable medical equipment (DME) and appliances; and

(v) Items classified as prosthetic devices.

(B) **Non-covered items.** The following are not covered:

(i) Sales tax;

(ii) Enteral therapy and nutritional supplies;

(iii) Electro-spinal orthosis system (ESO); and

(iv) Physical therapy, occupational therapy, speech pathology, or audiological services.

(2) **Children.** Home Health Services are covered for persons under age 21.

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

PART 75. FEDERALLY QUALIFIED HEALTH CENTERS

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

Health Center "core" services include:

(1) Physicians' services and services and supplies incident to a physician's services;

(2) Services of advanced practice nurse (APNs), physician assistants (PAs), certified nurse midwives (CNMs), or specialized advanced practice nurse practitioners;

(3) Services and supplies incident to the services of APNs, certified nurse midwives, and PAs;

(4) Visiting nurse services to the homebound;

(5) Behavior health professional services as authorized under the FQHC State Plan pages and services and supplies incident thereto;

(6) Preventive primary care services;

(7) Preventive primary dental services.

PART 108. NUTRITION SERVICES

317:30-5-1076. Coverage by category

Payment is made for Nutritional Services as set forth in this section.

(1) **Adults.** Payment is made for six hours of medically necessary nutritional counseling per year by a licensed registered dietician. All services must be prescribed by a physician, physician assistant, advanced practice nurse, or

certified nurse midwife and be face to face encounters between a licensed registered dietitian and the member. Services must be expressly for diagnosing, treating or preventing, or minimizing the effects of illness. Nutritional services for the treatment of obesity is not covered unless there is documentation that the obesity is a contributing factor in another illness.

(2) **Children.** Payment is made for medically necessary nutritional counseling as described above for adults. Nutritional services for the treatment of obesity may be covered for children as part of the EPSDT benefit. Additional services which are deemed medically necessary and allowable under federal regulations may be covered by the EPSDT benefit found at 317:30-3-65 and 317:30-3-65.11.

(3) **Home and Community Based Waiver Services for the Intellectually Disabled.** All providers participating in the Home and Community Based Waiver Services for the intellectually disabled program must have a separate contract with OHCA to provide Nutrition Services under this program. All services are specified in the individual's plan of care.

(4) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the Medicaid allowable for comparable services. Services which are not covered under Medicare should be billed directly to OHCA.

(5) **Obstetrical patients.** Payment is made for a maximum of six hours of medically necessary nutritional counseling per year by a licensed registered dietitian for members at risk for or those who have been recently diagnosed with gestational diabetes. The initial consultation may be in a group setting for a maximum of two hours of class time. Thereafter, four hours of nutritional counseling by a licensed registered dietitian may be provided to the individual if deemed medically necessary, which may include a post-partum visit, typically done at 6 weeks after delivery. All services must be prescribed by a physician, physician assistant, advanced practice nurse or a certified nurse midwife and be face-to-face between a licensed registered dietitian and the member(s). Services must be solely for the prevention, diagnosis, or treatment of gestational diabetes.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 45. INSURE OKLAHOMA

SUBCHAPTER 1. GENERAL PROVISIONS

317:45-1-2. Program limitations

(a) The Insure Oklahoma program is contingent upon federal waiver approval and sufficient funding that is collected and dispersed through a revolving fund within the State Treasury designated as the "Health Employee and Economy Improvement Act (HEEIA) Revolving Fund". This fund is a continuing fund, not subject to fiscal year limitations.

(1) All monies accruing to the credit of the fund are budgeted and expended by the OHCA to implement the program.

(2) The program is funded through a portion of monthly proceeds from the Tobacco Tax, Okla. Stat. '68-302-5 et seq., collected and dispersed through the HEEIA revolving fund, pursuant to Title 68, Section 302-5 (B.1. and D.1.) and Section 402-3 (B.1 and C.1.) of the Oklahoma Statutes.

(3) The program is limited in scope such that available funding is not exceeded. Available funding includes the estimated annual deposits from tax collections, accrued interest, federal matching funds and any other revenue source deposited in the HEEIA Revolving Fund for the purpose of this program. If at any time it becomes apparent there is risk the available funding may be exceeded, OHCA must take action to ensure the Insure Oklahoma program continues to operate within its fiscal capacity.

(A) Insure Oklahoma may limit eligibility based on:

(i) the federally-approved Health Insurance Flexibility and Accountability (HIFA) Waiver/1115 Waiver;

(ii) Tobacco Tax collections; and

(iii) the State Child Health Plan for the State Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act.

(B) The Insure Oklahoma program may limit eligibility when the utilization of services is projected to exceed the spending authority, or, may suspend new eligibility determinations instead, establishing a waiting list.

(i) Applicants, not previously enrolled and participating in the program, submitting new applications for the Insure Oklahoma program are placed on a waiting list. Applications, with the exception of college students, are identified by region and Insure Oklahoma program. Regions are established based on population density statistics as determined through local and national data and may be periodically adjusted to assure statewide availability. Insure Oklahoma program size is determined by OHCA and may be

periodically adjusted.
(ii) The waiting list utilizes a "first in - first out" method of selecting eligible applicants by region and program.
(iii) When an applicant is determined eligible and moves from the waiting list to active participation, the applicant must submit a new application.
(iv) Enrolled applicants who are currently participating in the program are not subject to the waiting list.
(v) For approved employers, if the employer hires a new employee after the employer's program eligibility begins, the new employee is allowed to participate ~~during the employer's current eligibility period~~.
(vi) For approved employers, if the employer has an employee who has a qualifying event after the employer's program eligibility begins, the employee is allowed to make changes pertaining to the qualifying event.

(b) College student eligibility and participation in the Insure Oklahoma program is contingent upon sufficient funding from the Oklahoma legislature. This funding is separate from the funding described in subsection (a) of this Section.

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.

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

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

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

"Employer" means the business entity that pays earned income to employees.

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

"Explanation of Benefit (EOB)" means a statement issued by a carrier that indicates services rendered and financial responsibilities for the carrier and Insure Oklahoma member.

"Full-time Employment" means a normal work week ~~of 24 or more hours.~~per Federal and State regulations.

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

"Individual Plan (IP)" means the safety net program for those qualified individuals who do not have access to Insure Oklahoma ESI.

"In-network" means providers or health care facilities that are part of a benefit plan's network of providers with which it has negotiated a discount, and services provided by a physician or other health care provider with a contractual agreement with the insurance company paid at the highest benefit level.

"Insure Oklahoma (IO)" means a benefit plan purchasing strategy in which the State uses public funds to pay for a portion of the costs of benefit plan coverage for eligible populations.

"Member" means an individual enrolled in the Insure Oklahoma ESI or IP program.

"Modified Adjusted Gross Income (MAGI)" means the financial eligibility determination methodology established by the Patient Protection and Affordable Care Act (PPACA) in 2009.

"OESC" means the Oklahoma Employment Security Commission.

"OHCA" means the Oklahoma Health Care Authority.

"OKDHS" means the Oklahoma Department of Human Services.

"Professional Employer Organization (PEO)" means any person engaged in the business of providing professional employer

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

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

"Premium" means a monthly payment to a carrier or a self-funded plan for benefit plan coverage.

"Qualified Benefit Plan (**QBP)"** means a benefit plan that has been approved by the OHCA for participation in the Insure Oklahoma program.

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

"**Self-funded Plan"** means or meets the definition of an "employee welfare benefit plan" or "benefit plan" as authorized in 29 US Code, Section 1002. The term carrier can be replaced with self-funded plan if applicable in these rules.

"**State"** means the State of Oklahoma, acting by and through the Oklahoma Health Care Authority.

SUBCHAPTER 7. INSURE OKLAHOMA ESI EMPLOYER ELIGIBILITY

317:45-7-2. Employer eligibility determination

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

SUBCHAPTER 9. INSURE OKLAHOMA ESI EMPLOYEE ELIGIBILITY

317:45-9-1. Employee eligibility requirements

(a) Employees must complete and submit the OHCA required forms and application to be considered for participation in the program.

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

(c) All eligible employees described in this section must be enrolled in their employer's qualified benefit plan. Eligible

employees must:

(1) have countable income at or below the appropriate standard according to the family size on the Insure Oklahoma ESI Income Guidelines form;

(A) Effective January 1, 2016, financial eligibility for Insure Oklahoma ESI benefits is determined using the MAGI methodology. Unless questionable, the income of applicants does not require verification. See OAC 317:35-6-39 through OAC 317:35-6-54 for the applicable MAGI rules for determining household composition and countable income.

(B) Income is evaluated on a monthly basis for all individuals included in the case for Insure Oklahoma ESI Benefits.

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

(3) be Oklahoma residents;

(4) furnish, or show documentation of an application for, a Social Security number at the time of application for Insure Oklahoma ESI benefits;

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

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

(7) be age 19 through age 64;

(8) be eligible for enrollment in the employer's qualified benefit plan;

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

(10) select one of the qualified benefit plans the employer is offering; and

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

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

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

(2) the employee is eligible;

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

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

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

(f) College students may enroll in the Insure Oklahoma ESI program as dependents. Effective January 1, 2016, financial eligibility for Insure Oklahoma ESI benefits for college students is determined using the MAGI methodology. See OAC 317:35-6-39 through OAC 317:35-6-54 for the applicable MAGI

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

(g) Dependent children must have countable income at the appropriate standard according to the family size on the Insure Oklahoma ESI Income Limits Guidelines form. Effective January 1, 2016, financial eligibility for Insure Oklahoma ESI benefits is determined using the MAGI methodology. See OAC 317:35-6-39 through OAC 317:35-6-54 for the applicable MAGI rules for determining household composition and countable income. Children found to be eligible for SoonerCare may not receive coverage through Insure Oklahoma.

~~(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 insurance coverage under any Oklahoma State Employee Insurance Plan.~~

(h) ESI approved individuals must notify the OHCA of any changes, including household status and income, that might impact individual and/or dependent eligibility in the program within 10 days of the change.

(i) When the agency responsible for determining eligibility for the member becomes aware of a change in the member's circumstances, the agency will promptly redetermine eligibility for all household members whose eligibility is affected by the change.

SUBCHAPTER 11. INSURE OKLAHOMA IP

PART 3. INSURE OKLAHOMA IP MEMBER HEALTH CARE BENEFITS

317:45-11-10. Insure Oklahoma IP adult benefit

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

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

(1) behavioral health services;

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

(3) family planning supplies and services, meaning an office

visit for a comprehensive family planning evaluation, including obtaining a Pap smear;

(4) women's routine and preventive health care services;

(5) emergency medical condition as defined in 317:30-3-1; and

(6) services delivered to American Indians at Indian Health Service, tribal, or urban Indian clinics.

(c) IP covered adult benefits for in-network services and limits are listed in this subsection. ~~In addition to the benefit-specific limits, there is a maximum lifetime benefit of $1,000,000.~~ Member cost sharing related to premium and co-payments cannot exceed federal maximums with the exception of emergency room visits, in which case the State establishes the maximum for member cost share. Native American adults providing documentation of ethnicity who receive items and services furnished by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services are exempt from co-payments. Coverage for IP services includes:

(1) ~~Anesthesia / Anesthesiologist~~Anesthesia/Anesthesiologist Standby. Covered in accordance with 317:30-5-7. Eligible services are covered for covered illness or surgery including services provided by a Certified Registered Nurse Anesthetist (CRNA) or Anesthesiologist Assistant (AA).

(2) Blood and Blood Products. Processing, storage, and administration of blood and blood products in inpatient and outpatient settings.

(3) Chelation Therapy. Covered for heavy metal poisoning only.

(4) Diagnostic X-ray, including Ultrasound. Covered in accordance with 317:30-5-22(b)(2). PCP referral is required.

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

(6) Inpatient Hospital Benefits. Covered in accordance with 317:30-5-41, 317:30-5-47 and 317:30-5-95.

(7) Preventive Office Visit. For services of evaluation and medical management (wellness exam); one visit per year. This visit counts as an office visit.

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

(9) Outpatient Hospital/Facility Services.

(A) Includes hospital surgery services in an approved outpatient facility including outpatient services and diagnostic services. Prior authorization required for certain procedures.

(B) Therapeutic radiology or chemotherapy on an outpatient basis without limitation to the number of treatments per month for persons with proven malignancies or opportunistic infections.

(C) Physical, Occupational and Speech Therapy services.

Coverage is limited to one evaluation/re-evaluation visit (unit) per discipline per calendar year and 15 visits (units) per discipline per date of service per calendar year. Must be hospital based.

(10) Maternity (Obstetric). Covered in accordance with 317:30-5-22.

(11) Laboratory/Pathology. Covered in accordance with 317:30-5-20.

(12) Mammogram (Radiological or Digital). Covered in accordance with 317:30-5-901.

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

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

(15) Dialysis, Kidney dialysis, and services and supplies, either at home or in a facility.

(16) Oral Surgery. Services are limited to the removal of tumors or cysts.

(17) Behavioral Health (Mental Health and Substance Abuse) Treatment (Inpatient). Covered in accordance with 317:30-5-95.1.

(18) Behavioral Health (Mental Health and Substance Abuse) Treatment (Outpatient). Outpatient benefits are limited to 48 visits per calendar year. Additional visits may be approved as medically necessary.

(A) Agency services. Covered in accordance with 317:30-5-241 and 317:30-5-596.

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

(i) Allopathic or Osteopathic Physicians with a current license and board certification in psychiatry or board eligible in the state in which services are provided, or a current resident in psychiatry practicing as described in 317:30-5-2.

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

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

(iii) Advanced Practice Nurse (certified in a psychiatric mental health specialty), licensed as a registered nurse with a current certification of

recognition from the board of nursing in the state in which services are provided.

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

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

(vi) LBHP services require prior authorization and are limited to ~~8~~4 therapy services per month per member and 8 testing units per year per member.

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

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

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

(22) Pharmacy. Covered in accordance with 317:30-5-72.1 and 317:30-5-72. Prenatal vitamins and smoking cessation products do not count against monthly prescription limits.

(23) Smoking Cessation Products. Products do not count against monthly prescription limits. Covered in accordance with 317:30-5-72.1.

(24) Nutrition Services. Covered in accordance with 317:30-5-1076.

(25) External Breast Prosthesis, Bras and Prosthetic Garments. Covered in accordance with 317:30-5-211.13.

(26) Surgery. Covered in accordance with 317:30-5-8.

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

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

(29) Family Planning Services and Supplies, including Sterilizations. Covered in accordance with 317:30-3-57.

(30) Home Health and Medications, Intravenous (IV) Therapy and Supplies. Covered in accordance with 317:30-5-211.15 and 317:30-5-42.16(b)(3).

(31) Fundus photography.

~~(32) Perinatal dental care for pregnant women. Covered in accordance with 317:30-5-696.~~

(32) Emergency ground ambulance transportation. Covered in accordance with 317:30-5-336.

317:45-11-11. Insure Oklahoma IP adult non-covered services

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

(1) services not considered medically necessary;

(2) any medical service when the member refuses to authorize release of information needed to make a medical decision;
(3) organ and tissue transplant services;
(4) weight loss intervention and treatment including, but not limited to, bariatric surgical procedures or any other weight loss surgery or procedure, drugs used primarily for the treatment of weight loss including appetite suppressants and supplements, and/or nutritional services prescribed only for the treatment of weight loss;
(5) procedures, services and supplies related to sex transformation;
(6) supportive devices for the feet (orthotics) except for the diagnosis of diabetes;
(7) cosmetic surgery, except as medically necessary and as covered in 317:30-3-59(19);
(8) over-the-counter drugs, medicines and supplies except contraceptive devices and products, and diabetic supplies;
(9) experimental procedures, drugs or treatments;
(10) dental services (preventive, basic, major, orthodontia, extractions or services related to dental accident) ~~except for pregnant women and~~ as covered in 317:30-5-696;
(11) vision care and services (including glasses), except services treating diseases or injuries to the eye;
(12) physical medicine including chiropractic and acupuncture therapy;
(13) hearing services;
(14) non-emergency transportation and emergency air transportation;
(15) allergy testing and treatment;
(16) hospice regardless of location;
(17) Temporomandibular Joint Dysfunction (TMD) (TMJ);
(18) genetic counseling;
(19) fertility evaluation/treatment/and services;
(20) sterilization reversal;
(21) Christian Science Nurse;
(22) Christian Science Practitioner;
(23) skilled nursing facility;
(24) long-term care;
(25) stand by services;
(26) thermograms;
(27) abortions (for exceptions, refer to 317:30-5-6);
(28) services of a Lactation Consultant;
(29) services of a Maternal and Infant Health Licensed Clinical Social Worker;
(30) enhanced services for medically high risk pregnancies as found in 317:30-5-22.1;
(31) ultraviolet treatment-actinotherapy;
(32) private duty nursing;
(33) ~~Payment~~payment for removal of benign skin lesions; ~~and~~

(34) ~~Sleep~~sleep studies~~.~~;
(35) prosthetic devices; and
(36) continuous positive airway pressure devices (CPAP).

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 benefit 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 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 he/she completes application;

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

(3) be an Oklahoma resident;

(4) furnish, or show documentation of an application for, a Social Security number at the time of application for Insure Oklahoma IP benefits;

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

(6) be age 19 through 64;

(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 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 benefit plan, the applicant must meet the requirements in subsection (c) of this Section and:

(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 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 Benefits;

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

(e) If employed and working for an employer who does not offer a qualified benefit plan, the applicant must meet the requirements in subsection (c) of this Section and 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 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 Benefits.

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

(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 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 Benefits.

(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) of this Section and the following:

(1) 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) Effective January 1, 2016, financial eligibility for Insure Oklahoma IP 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 Benefits. 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) A OESC eligibility letter;

(B) A OESC weekly unemployment payment statement, or;

(C) A bank statement showing state treasurer deposit.

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

(1) 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) 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 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 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 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.

(k) College students may enroll in the Insure Oklahoma IP program as dependents. Effective January 1, 2016, financial eligibility for Insure Oklahoma IP benefits for college students is determined using the MAGI methodology. See OAC 317:35-6-39 through OAC 317:35-6-54 for the applicable MAGI rules for determining household composition and countable income. Dependent college students must enroll under their parents and all annual gross household income (including parent income) must be included in determining eligibility. Independent college students may apply on their own without parent income included in the household. College student status as dependent or independent is determined by the student's current Free Application for Federal Student Aid (FAFSA). College students

must also provide a copy of their current student schedule to prove full-time student status.

317:45-11-23. Member eligibility period

(a) The rules in this subsection apply to ~~members~~member's eligibility according to 317:45-11-20(a) through (e).

(1) The member's eligibility period begins only after approval of the application and receipt of the premium payment.

(A) If the application is approved and the premium payment is not made by the last day of the same month, eligibility will begin the first day of the next month.

(B) If the application is approved and the premium payment is made between the first and 15th day of the next month, eligibility will begin the first day of the second consecutive month.

(C) If the application is approved and the premium payment is not made within 45 days, eligibility will not begin.

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

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

(4) If the employee is determined eligible for Insure Oklahoma IP, he/she is approved for a period not greater than 12 months.

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

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

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

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

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-21. Appeals procedures for nursing facilities

Appeal procedures for denial, failure to renew, or termination of a nursing facility agreement are described at OAC ~~317:2-1-8~~317:30-5-124(h). The Oklahoma State Department of Health, by agreement, continues to be responsible for hearings for licensure and certification as the survey agency.

PART 3. GENERAL MEDICAL PROGRAM INFORMATION

317:30-3-43. Services in an Intermediate Care Facility for ~~the Mentally Retarded~~Individuals with Intellectual Disabilities(ICF/IID)

Services in an ~~ICF/MR~~ICF/IID facility are provided to individuals per OAC 317:30-5-122 and OAC 317:35-9-45.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 4. LONG TERM CARE HOSPITALS

317:30-5-63. Trust funds

When a new ~~recipient~~member is admitted to a long term care hospital, the administrator will complete and send to the county office the Management of Recipient's Funds form to indicate whether or not the ~~recipient~~member has requested the administrator to handle personal funds. If the administrator agrees to handle the ~~recipient's~~member's funds, the Management of Recipient's Funds form will be completed each time funds or other items of value, other than monthly income, are received.

(1) ~~By using the Management of Recipient's Funds form as a source document, the facility personnel will prepare a Ledger Sheet for Recipient's Account in a form acceptable to the Authority, for each recipient for whom they are holding funds or other items of value. This form is used to keep an accurate accounting of all receipts and expenditures and the amount of money on hand at all times. This form is to be available in the facility for inspection and audit.~~The facility may use electronic ledgers and bank statements as the source documentation for each member for whom they are holding funds or other items of value. This information must be available at all times for inspection and audit purposes. The facility must have written policies that ensure complete accounting of the ~~recipient's~~member's personal funds.

All ~~recipient's~~member's funds which are handled by the facility must be clearly identified and maintained separately from funds belonging to the facility or to private patients. When the total sum of all funds for all ~~recipients~~members is $250.00 or more, they must be deposited by the facility in a local bank account designated as ~~"Recipient's Trust Funds."~~"Recipient's Trust Funds". The funds are not to be commingled with the operating funds of the facility. Each resident in an ~~ICF/MR facility~~intermediate care facility for individuals with intellectual disabilities (ICF/IID) must be allowed to possess and use money in normal ways or be learning to do so.

(2) The facility is responsible for notifying the county office at any time a ~~recipient's~~member's account reaches or exceeds the maximum reserve by use of the Accounting-Recipient's Personal Funds and Property form. This form is also prepared by the facility when the ~~recipient~~member dies or is transferred or discharged, and at the time of the county eligibility review of the ~~recipient~~member.

(3) The Management of Recipient's Funds form, the Accounting-Recipient's Personal Funds and Property form, and the Ledger Sheets for Recipient's Account ~~can be obtained from the local county DHS office~~are available online at www.okdhs.org.

(4) When the ownership or operation of the facility is discontinued or where the facility is sold and the ~~recipients'~~members' trust funds are to be transferred to a successor facility, the status of all ~~recipient's~~member's trust funds must be verified by the ~~Authority~~OHCA and/or the buyer must be provided with written verification by an independent public accountant of all residents' monies and properties being transferred, and a signed receipt obtained from the owner. All transfers of ~~recipient's~~a member's trust funds must be acknowledged, in writing, by the transferring facility and proper receipts given by the receiving facility.

(5) Unclaimed funds or other property of deceased ~~recipients~~member's, with no known heirs, must be reported to the Oklahoma Tax Commission. ~~If it remains unclaimed for a certain period, the money or property escheats to the State.~~

(6) It is permissible to use an individual trust fund account to defray the cost of last illness, outstanding personal debts and burial expenses of a deceased ~~recipient~~member of ~~this Authority~~the OHCA; however, any remaining balance of unclaimed funds must be reported to the Oklahoma Tax Commission. The Unclaimed Property Division, Oklahoma Tax Commission, State Capitol Complex, Oklahoma City, Oklahoma, is to be notified for disposition instructions on any unclaimed funds or property. No money is to be sent to the Oklahoma Tax Commission until so instructed by the Unclaimed

Property Division.

(7) Books, records, ledgers, charge slips and receipts must be on file in the facility for a period of six (6) years and available at all times in the facility for inspection and audit purposes.

PART 9. LONG TERM CARE FACILITIES

317:30-5-120. Eligible providers

Long ~~Term Care Facilities~~term care facilities may receive payment for the provision of nursing care under the Title XIX Medicaid Program only when they are properly licensed and certified by the Oklahoma Department of Health, meet Federal and State requirements and hold a valid ~~written agreement~~contract with the Oklahoma Health Care Authority~~ (Agreement to Provide Long Term Care Services under the Medicaid Act (Agreement)~~(OHCA) to provide long term care services. All long term care facility ~~Agreements~~contracts are time limited with specific effective and expiration dates~~ and can be issued for no more than a twelve month period. Whenever possible, the agreement expiration date will correspond with the certification period by the State Survey Agency~~.

317:30-5-121. Coverage by category

(a) **Adults.** Payment is made for compensable long term care for adults after the ~~patient~~member has been determined medically eligible to receive such care.

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

317:30-5-122. Levels of care

(a) This rule sets forth the criteria used to determine whether an individual who is seeking SoonerCare payment for long term care services needs services at the level of Skilled Nursing Facility, or Intermediate Care Facility for ~~People with Mental Retardation (ICF/MR)~~Individuals with Intellectual Disabilities (ICF/IID). The criteria set forth in this Section must be used when determining level of care for individuals seeking SoonerCare coverage of either facility-based institutional long term care services or Home and Community Based Services (HCBS) Waivers.

(b) The level of care provided by a long term care facility or through a HCBS Waiver is based on the nature of the person's needs and the care, services, and treatment required from appropriately qualified personnel. The level of care review is a determination of an individual's physical, mental, and social/emotional status to determine the appropriate level of care required. In addition to level of care requirements, other applicable eligibility criteria must be met.

(1) **Skilled Nursing facility.** Payment is made for the Part A

coinsurance and deductible for Medicare covered skilled nursing facility care for dually eligible, categorically needy individuals.

(2) **Nursing Facility.** Care provided by a nursing facility to ~~patients~~members who require professional nursing supervision and a maximum amount of nonprofessional nursing care due to physical conditions or a combination of physical and mental conditions.

(3) **Intermediate Care Facility for ~~the Mentally Retarded~~Individuals with Intellectual Disabilities.** Care for persons with intellectual disabilities or related conditions to provide health and/or habilitative services in a protected residential setting. To qualify for ~~ICF/MR~~ICF/IID level of care, persons must have substantial functional limitations in three or more of the following areas of major life activity:

(A) ~~Self-care~~**Self-care**. The individual requires assistance, training, or supervision to eat, dress, groom, bathe, or use the toilet.

(B) ~~Understanding and use of language~~**Understanding and use of language**. The individual lacks functional communication skills, requires the use of assistive devices to communicate, does not demonstrate an understanding of ~~request~~requests, or is unable to follow two-step instructions.

(C) ~~Learning~~**Learning**. The individual has a valid diagnosis of intellectual disability as defined in the Diagnostic and Statistical Manual of Mental Disorders.

(D) ~~Mobility~~**Mobility**. The individual requires the use of assistive devices to be mobile and cannot physically self-evacuate from a building during an emergency without assistive device.

(E) ~~Self-direction~~**Self-direction**. The individual is ~~7~~seven (7) years old or older and significantly at risk in making age appropriate decisions or an adult who is unable to provide informed consent for medical care, personal safety, or for legal, financial, habilitative, or residential issues, and/or has been declared legally incompetent. The individual is a danger to himself or others without supervision.

(F) ~~Capacity for independent living~~**Capacity for independent living**. The individual who is ~~7~~seven (7) years old or older and is unable to locate and use a telephone, cross the street safely, or understand that it is unsafe to accept rides, food, or money from strangers. ~~or~~Or an adult who lacks basic skills in the areas of shopping, preparing food, housekeeping, or paying bills.

317:30-5-123. ~~Patient~~Member certification for long term care

(a) **Medical eligibility.** Initial approval of medical eligibility

for long-term care is determined by the Oklahoma Department of Human Services (OKDHS) area nurse, or nurse designee. The certification is obtained by the facility at the time of admission.

(1) **Pre-admission screening.** Federal ~~Regulations~~regulations govern the State's responsibility for Preadmission Screening and Resident Review (PASRR) for individuals with mental illness and intellectual disability. PASRR applies to the screening or reviewing of all individuals for mental illness or intellectual disability or related conditions who apply to or reside in Title XIX certified nursing facilities regardless of the source of payment for the nursing facility(NF) services and regardless of the individual's or resident's known diagnoses. The ~~nursing facility (NF)~~NF must independently evaluate the Level I PASRR Screen regardless of who completes the form and determine whether or not to admit an individual to the facility. Nursing facilities which inappropriately admit a person without a PASRR Screen are subject to recoupment of funds. PASRR is a requirement for nursing facilities with dually certified (both Medicare and Medicaid) beds. There are no PASRR requirements for Medicare skilled beds that are not dually certified, nor is PASRR required for individuals seeking residency in an intermediate care facility for ~~the mentally retarded (ICF/MR)~~individuals with intellectual disabilities (ICF/IID).

(2) **PASRR Level I screen.**

(A) Form ~~LTC-300~~LTC-300R, Nursing Facility Level of Care Assessment, must be completed by an authorized NF official or designee. An authorized NF official or designee must consist of one of the following:

(i) The ~~nursing facility~~NF administrator or co-administrator;

(ii) A licensed nurse, social service director, or social worker from the ~~nursing facility~~NF; or

(iii) A licensed nurse, social service director, or social worker from the hospital.

(B) Prior to admission, the authorized NF official must evaluate the properly completed OHCA Form ~~LTC-300~~LTC-300R and the Minimum Data Set (MDS), if available. Any other readily available medical and social information is also used to determine if there currently exists any indication of mental illness ~~(MI)~~, an intellectual disability, or other related condition, or if such condition existed in the applicant's past history. Form ~~LTC-300~~LTC-300R constitutes the Level I PASRR Screen and is utilized in determining whether or not a Level II Assessment is necessary prior to allowing the ~~patient~~member to be admitted. The NF is also responsible for consulting with the Level of Care

Evaluation Unit (LOCEU) regarding any mental ~~illness/intellectual~~illness, or an intellectual disability related condition information that becomes known either from completion of the MDS or throughout the resident's stay.

(C) The ~~nursing facility~~NF is responsible for determining from the evaluation whether or not the ~~patient~~member can be admitted to the facility. A "yes" response to any question from Form ~~LTC-300~~LTC-300R, Section E, will require the ~~nursing~~ facility to contact the LOCEU for a consultation to determine if a Level II Assessment is needed. If there is any question as to whether or not there is evidence of mental illness, an intellectual disability, or related condition, LOCEU should be contacted prior to admission. The original Form ~~LTC-300~~LTC-300R must be submitted by mail to the LOCEU within 10 days of the resident admission. SoonerCare payment may not be made for a resident whose ~~LTC-300~~LTC-300R requirements have not been satisfied in a timely manner.

(D) Upon receipt and review of the Form ~~LTC-300~~LTC-300R, the LOCEU may, in coordination with the OKDHS area nurse, re-evaluate whether a Level II PASRR assessment may be required. If a Level II Assessment is not required, the process of determining medical eligibility continues. If a Level II is required, a medical decision is not made until the results of the Level II Assessment are known.

(3) **Level II Assessment for PASRR.**

(A) Any one of the following three circumstances will allow a ~~patient~~member to enter the ~~nursing facility~~NF without being subjected to a Level II PASRR Assessment.

(i) The ~~patient~~member has no current indication of mental illness or intellectual disability or other related condition and there is no history of such condition in the ~~patient's~~member's past.

(ii) The ~~patient~~member does not have a diagnosis of intellectual disability or related condition.

(iii) An individual may be admitted to an NF if he/she has indications of mental illness or an intellectual disability or other related condition, but is not a danger to self and/or others, and is being released from an acute care hospital as part of a medically prescribed period of recovery (Exempted Hospital Discharge). If an individual is admitted to an NF based on Exempted Hospital Discharge, it is the responsibility of the NF to ensure that the individual is either discharged by the 30th day or that a Level II has been requested and is in process. Exempted Hospital Discharge is allowed only if all three of the following conditions are met:

(I) The individual must be admitted to the NF directly from a hospital after receiving acute inpatient care at the hospital (not including psychiatric facilities);

(II) The individual must require NF services for the condition for which he/she received care in the hospital; and

(III) The attending physician must certify in writing before admission to the facility that the individual is likely to require less than 30 days of ~~nursing facility~~NF services. The NF will be required to furnish this documentation to OHCA upon request.

(B) If the ~~patient~~member has current indications of mental illness or intellectual disability or other related condition, or if there is a history of such condition in the ~~patient's~~member's past, the ~~patient~~member cannot be admitted to the ~~nursing facility~~NF until the LOCEU is contacted for consultation to determine if a Level II PASRR Assessment must be performed. Results of any Level II PASRR Assessment ordered must indicate that ~~nursing facility~~NF care is appropriate prior to allowing the ~~patient~~member to be admitted.

(C) The OHCA~~,~~ LOCEU~~,~~ authorizes Advance Group Determinations for the mental illness and intellectual disability ~~Authorities~~authorities in the following categories listed in (i) through (iii) of this subparagraph. Preliminary screening by the LOCEU may indicate eligibility for ~~nursing facility~~NF level of care prior to consideration of the provisional admission.

(i) **Provisional admission in cases of delirium.** Any person with mental illness, intellectual disability, or related condition that is not a danger to self ~~and or~~and/or others, may be admitted to a Title XIX certified NF if the individual is experiencing a condition that precludes screening, i.e., effects of anesthesia, medication, unfamiliar environment, severity of illness, or electrolyte imbalance.

(I) A Level II evaluation is completed immediately after the delirium clears. The LOCEU must be provided with written documentation by a physician that supports the individual's condition which allows provisional admission as defined in (i) of this subparagraph.

(II) Payment for NF services will not be made after the provisional admission ending date. If an individual is determined to need a longer stay, the individual must receive a Level II evaluation before continuation of the stay may be permitted and

payment made for days beyond the ending date.

(ii) **Provisional admission in emergency situations.** Any person with a mental illness, an intellectual disability, or related condition, who is not a danger to self and/or others, may be admitted to a Title XIX certified ~~nursing facility~~NF for a period not to exceed seven days pending further assessment in emergency situations requiring protective services. The request for Level II evaluation must be made immediately upon admission to the NF if a longer stay is anticipated. The LOCEU must be provided with written documentation from OKDHS Adult Protective Services which supports the individual's emergency admission. Payment for NF services will not be made beyond the emergency admission ending date.

(iii) **Respite care admission.** Any person with mental illness, an intellectual disability, or related condition, who is not a danger to self and/or others, may be admitted to a Title XIX certified ~~nursing facility~~NF to provide respite to in-home caregivers to whom the individual is expected to return following the brief NF stay. Respite care may be granted up to 15 consecutive days per stay, not to exceed 30 days per calendar year.

(I) In rare instances, such as illness of the caregiver, an exception may be granted to allow 30 consecutive days of respite care. However, in no instance can respite care exceed 30 days per calendar year.

(II) Respite care must be approved by LOCEU staff prior to the individual's admission to the NF. The NF provides the LOCEU with written documentation concerning circumstances surrounding the need for respite care, the date the individual wishes to be admitted to the facility, and the date the individual is expected to return to the caregiver. Payment for NF services will not be made after the respite care ending date.

(4) **Resident Review.**

(A) The ~~nursing~~ facility's routine resident assessment will identify those individuals previously undiagnosed as ~~intellectally disaled~~intellectually disabled or mentally ill. A new condition of intellectual disability or mental illness must be referred to LOCEU by the NF for determination of the need for the Level II Assessment. The facility's failure to refer such individuals for a Level II Assessment may result in recoupment of funds.

(B) A Level II Resident Review may be conducted the following year for each resident of a ~~nursing facility~~NF

who was found to experience a serious mental illness with no primary diagnosis of dementia on his or her pre-admission Level II, to determine whether, because of the resident's physical and mental condition, the resident requires the level of services provided by a ~~nursing facility~~NF and whether the resident requires specialized services.

(C) A significant change in a resident's mental condition could trigger a Level II Resident Review. If such a change should occur in a resident's condition, it is the responsibility of the ~~nursing facility~~NF to notify the LOCEU of the need to conduct a resident review.

(5) **Results of Level II Pre-Admission Assessment and Resident Review.** Through contractual arrangements between the OHCA and the mental ~~illness/intellectual~~illness or intellectual disability authorities, individualized assessments are conducted and findings presented in written evaluations. The evaluations determine if ~~nursing facility~~NF services are needed, if specialized services or less than specialized services are needed, and if the individual meets the federal PASRR definition of mental illness or intellectual disability or related conditions. Evaluations are delivered to the LOCEU to process formal, written notification to ~~patient~~member, guardian, NF, and interested parties.

(6) **Readmissions~~,~~ and interfacility transfers.** The Preadmission Screening process does not apply to readmission of an individual to ~~an~~a NF after transfer for a continuous hospital stay, and then back to the NF. There is no specific time limit on the length of absence from the ~~nursing facility~~NF for the hospitalization. Inter-facility transfers are also subject to preadmission screening. In the case of transfer of a resident from ~~an~~a NF to a hospital or to another NF, the transferring NF is responsible for ensuring that copies of the resident's most recent ~~LTC-300~~LTC-300R and any PASRR evaluations accompany the transferring resident. The receiving NF must submit an updated ~~LTC-300~~LTC-300R that reflects the resident's current status to LOCEU within ~~10~~ten (10) days of the transfer. Failure to do so could result in possible recoupment of funds. LOCEU should also be contacted prior to admitting out-of-state NF applicants with mental illness or intellectual disability or related condition, so that PASRR needs can be ascertained. Any PASRR evaluations previously completed by the referring state should be forwarded to LOCEU as part of this PASRR consultation.

(7) **PASRR appeals process.**

(A) Any individual who has been adversely affected by any PASRR determination made by the State in the context of either a preadmission screening or an annual resident review may appeal that determination by requesting a fair

hearing. If the individual does not consider the PASRR decision a proper one, the individual or their authorized representative must contact the local county OKDHS office to discuss a hearing. Forms for requesting a fair hearing (OKDHS Form 13MP001E, Request for a Fair Hearing), as well as assistance in completing the forms, can be obtained at the local county OKDHS office. Any request for a hearing must be made no later than 20 days following the date of written notice. Appeals of these decisions are available under OAC 317:2-1-2. All individuals seeking an appeal have the same rights, regardless of source of payment. Level I determinations are not subject to appeal.

(B) When the individual is found to experience mental illness, an intellectual disability, or related condition through the Level II Assessment, the PASRR determination made by the ~~intellectual disability/mental illness~~mental illness or intellectual disability authorities cannot be countermanded by the ~~Oklahoma Health Care Authority~~OHCA, either in the claims process or through other utilization control/review processes, or by the ~~Oklahoma~~ State Department of Health. Only appeals determinations made through the fair hearing process may overturn a PASRR determination made by the ~~intellectual disability /mental illness~~mental illness or intellectual disability authorities.

(b) **Determination of Title XIX medical eligibility for long term care.** The determination of medical eligibility for care in a ~~nursing facility~~NF is made by the OKDHS area nurse, or nurse designee. The procedures for determining ~~Nursing Facility (NF)~~NF program medical eligibility are found in OAC 317:35-19. Determination of ~~ICF/MR~~ICF/IID medical eligibility is made by LOCEU. The procedures for obtaining and submitting information required for a decision are outlined below.

(1) **Pre-approval of medical eligibility.** Pre-approval of medical eligibility for private ~~ICF/MR~~ICF/IID care is based on results of a current comprehensive psychological evaluation by a licensed psychologist or state staff psychologist, documentation of intellectual disability or related condition prior to age 22, and the need for active treatment according to federal standards. Pre-approval is made by LOCEU analysts.

(2) **Medical eligibility for ~~ICF/MR~~ICF/IID services.** Within 30 calendar days after services begin, the facility must submit the original of the Nursing Facility Level of Care Assessment ~~(Form LTC-300)~~(Form LTC-300R) to LOCEU. Required attachments include current (within 90 days of requested approval date) medical information signed by a physician, a current (within 12 months of requested approval date) psychological evaluation, a copy of the pertinent section of

the Individual Developmental Plan or other appropriate documentation relative to discharge planning and the need for ~~ICF/MR~~ICF/IID level of care, and a statement that the member is not an imminent threat of harm to self or others (i.e., suicidal or homicidal). If pre-approval was determined by LOCEU and the above information is received, medical approval will be entered on MEDATS.

(3) **Categorical relationship.** Categorical relationship must be established for determination of eligibility for long-term medical care. If categorical relationship to disability has not already been established, the proper forms and medical information are submitted to LOCEU. (Refer to OAC 317:35-5-4). In such instances, LOCEU will render a decision on categorical relationship using the same definition as used by the Social Security Administration (SSA). A follow-up is required by the OKDHS worker with SSA to be sure that their disability decision agrees with the decision of LOCEU.

317:30-5-124. Facility licensure

(a) **Nursing home license required.** A ~~nursing facility~~NF must meet state nursing home licensing standards to provide, on a regular basis, health related care and services to individuals who do not require hospital care.

(1) In order for long term care facilities to receive payment from the ~~Authority~~OHCA for the provision of nursing care, they must be currently licensed under provisions of Title 63 O.S., Nursing Home Care Act, ~~1995,~~ Section ~~1-1901~~1-1900.1, et seq.

(2) The State Department of Health is responsible for the issuance, renewal, suspension, and revocation of a facility's license in addition to the enforcement of the standards. The denial, suspension, or revocation of a facility's license is subject to appeal to the State Department of Health. All questions regarding a facility's license should be directed to the State Department of Health.

(b) **Certification survey.** The ~~Oklahoma~~ State Department of Health is designated as the State Survey Agency and is responsible for determining a long term care facility's compliance with Title XIX requirements. The results of the survey are forwarded to the OHCA by the State Survey Agency.

(c) **Certification period.** The certification period of a long term care facility is determined by the State Survey Agency. In the event the facility's deficiencies are found to be of such serious nature as to jeopardize the health and safety of the ~~patient~~member, the State Survey Agency may terminate (de-certify) the facility's certification period and notify the ~~Authority~~OHCA. Upon notification by the State Survey Agency, the ~~Authority~~OHCA will notify the facility by certified letter that the ~~Agreement~~contract is being terminated. The letter will

indicate the effective date and specify the time period that payment may continue in order to allow orderly relocation of ~~recipient/patients~~the members. The decision to terminate a facility's certification by the State Survey Agency is subject to appeal to the State Department of Health. ~~The decision to terminate a facility's Agreement by the Authority (for a reason other than the facility decertification or suspension/revocation of the facility license) is subject to appeal to the Oklahoma Health Care Authority (see OAC 317:2-1-8 for grievance procedures and process).~~

~~(d) **Certification with deficiencies.**~~

~~(1) When an ICF/MR facility is certified to be in compliance with the Title XIX requirements but has deficiencies which must be corrected, an Agreement may be executed, subject to the facility's resolution of deficiencies according to the approved plan of correction. Following the visit by the State Survey Agency, one of two actions may occur:~~

~~(A) The State Survey Agency will notify the Authority that all deficiencies have been corrected or acceptable progress has been made toward correction. The Authority, by letter, will notify the facility of the action and the Agreement may run to the expiration date; or~~

~~(B) The State Survey Agency will notify the Authority that some or all of the deficiencies have not been corrected and circumstances require that the **automatic cancellation date** be invoked. The Authority, by certified letter, will notify the facility, owners of the facility and regulatory agencies when the automatic cancellation date is invoked.~~

~~(2) The Agreement will terminate as a result of the automatic cancellation date being invoked. In accordance with federal regulations, payment for current residents of the facility can continue for no more than thirty (30) days from the date the automatic cancellation date is invoked, to permit an orderly relocation of patients. Payment cannot be made for patients admitted after the automatic cancellation date is invoked. The decision to invoke a facility's automatic cancellation date is subject to appeal to the State Department of Health.~~

(d) **Certification with deficiencies.** Certification of any facility that has been found to have deficiencies by the State Survey Agency will be governed by 42 CFR 442.110 (certification period for ICF/IID with standard-level deficiencies) or 42 CFR 442.117 (termination of certification for ICFs/IID whose deficiencies pose immediate jeopardy).

(e) **~~Agreement~~Contract procedures.**

(1) A facility participating in the Medicaid program will be notified by ~~letter from~~ the ~~Authority~~OHCA ~~60~~75 days prior to the expiration of the existing ~~Agreement~~contract. ~~New Agreement forms will be sent to be completed if the facility wishes to continue participation in the Medicaid Program.~~The

facility must complete a new contract to continue participation in the SoonerCare program.

~~(2) Two copies of the Agreement to Provide Long Term Care Services under the Medicaid Act (Agreement) will be sent to the facility for completion. Both signed copies of the Agreement (signed with original signature only of owner, operator or administrator and properly notarized) must be returned to the OHCA.~~

~~(3)~~(2) When the ~~Agreement~~contract is received, approved by the ~~Authority~~OHCA, and the HCFA-1539 has been received from the State Department of Health indicating the facility's certification period, the ~~Agreement~~contract will be completed. ~~A copy of the executed Agreement will be returned to the facility where it must be maintained for a period of six years for inspection purposes.~~

~~(4)~~(3) Intermediate care facilities for ~~the mentally retarded~~individuals with intellectual disabilities(ICF/IID) wishing to participate in the ~~ICF/MR~~ICF/IID program must be approved and certified by the State Survey Agency as being in compliance with the ~~ICF/MR~~ICF/IID regulations (42 CFR 442 Subpart C). It is the responsibility of a facility to request the State Survey Agency perform a survey of compliance with ~~ICF/MR~~ICF/IID regulations.

(A) When the ~~Authority~~OHCA has received notification of a facility's approval as an ~~ICF/MR~~ICF/IID and the Title XIX survey of compliance has begun, the ~~Agreement~~contract will be sent to the facility for completion.

(B) A facility which has been certified as an ~~ICF/MR~~ICF/IID and has ~~an Agreement~~a contract with the ~~Authority~~OHCA will be paid only for ~~recipient/patients who~~members that have been approved for ~~ICF/MR~~ICF/IID level of care. When the facility is originally certified to provide ~~ICF/MR~~ICF/IID services, payment for ~~recipient/patients~~member's currently residing in the facility who are approved for a NF level of care will be made if such care is appropriate to the ~~recipient/patient's~~member's needs.

~~(f) **New facilities.** Any new facility in Oklahoma must receive, from the State Department of Health, a Certificate of Need. When construction of a new facility is completed and licensure and certification is imminent, facilities wishing to participate in the Title XIX Medicaid Program should request, by letter, an Agreement form When the Authority has received notification from the State Department of Health of the new facility's licensure, the Agreement will be sent to the facility for completion, if not previously sent.~~

~~(1) It is the responsibility of the new facility to request the State Survey Agency to perform a survey for Title XIX compliance.~~

~~(2) The effective date of the provider Agreement will be subsequent to completion of all requirements for participation in the Medicaid Program. In no case can payment be made for any period prior to the effective date of the facility's certification.~~

(f) **New facilities.** Any new facility in Oklahoma must receive a Certificate of Need from the State Department of Health. It is the responsibility of the new facility to request the State Survey Agency to perform a survey for Title XIX compliance.

(1) When construction of a new facility is completed and licensure and certification is imminent, facilities wishing to participate in the Title XIX Medicaid Program may apply electronically to become a Medicaid contracted provider.

(2) In no case can payment be made for any period prior to the effective date of the facility's certification.

(g) **Change of ownership.** The acquisition of a facility operation, either whole or in part, by lease or purchase, or if a new ~~FEIN~~Federal Employer Identification Number is required, constitutes a change of ownership. The new owner must follow provisions of the Nursing Home Care Act at Title 63 O.S. Section 1-1905 (D) (relating to transfers in ownership) and OAC 310:675-3-8 (relating to notice of change), as applicable. When such change occurs, it is necessary that a new ~~Agreement~~contract be completed between the new owner and the ~~Authority~~OHCA in order that payment can continue for the provision of nursing care. ~~If there is any doubt about whether a change of ownership has occurred, the facility owner should contact the State Department of Health for a final determination.~~

(1) **License changes due to change of ownership.** State Law prescribes specific requirements regarding the transfer of ownership of a ~~nursing facility~~NF from one person to another. When a transfer of ownership is contemplated, the buyer/seller or lessee/lessor must notify the State Department of Health~~, in writing, of the forthcoming transfer at least thirty (30) days~~ prior to the final transfer and apply for a new facility license.

(2) **Certificate of Need.** A change of ownership is subject to review by the ~~Oklahoma~~ State Department of Health. Any person contemplating the acquisition of a ~~nursing facility~~NF should contact ~~Certificate of Need Division of~~ the State Department of Health for further information regarding Certificate of Need requirements.

~~(A) When a long term care facility changes ownership, federal regulations require automatic assignment of the Agreement to the new owner. An assigned Agreement is subject to all applicable statutes and regulations under which it was originally issued. This includes but is not limited to:~~

~~(i) any existing plan of correction,~~

~~(ii) any expiration date,~~
~~(iii) compliance with applicable health and safety regulations, and~~
~~(iv) compliance with any additional requirements imposed by the Medicaid agency.~~
~~(B) The new owner must obtain a Certificate of Need as well as a new facility license from the State Department of Health. Pending notification of licensure of the new owner, no changes are made to the Authority's' facility records (i.e., provider number) with the exception of change in administrator or change in name, if applicable.~~
~~(C) When notification and licensure from the State Department of Health is received, procedures for transmitting forms to the facility and completing the Agreement, as described in Agreement Procedures for New Facilities, will be followed.~~
~~(D) The effective date of a facility's change of ownership is the date specified on the new license issued by the State Department of Health to the new owner or lessee.~~
(A) The new owner must obtain a Certificate of Need as well as a new facility license from the State Department of Health. Pending notification of licensure, no changes will be made to the OHCA's facility records with the exception of change in administrator or change in name, if applicable.
(B) When a change in ownership does occur, the OHCA will automatically assign the contract to the new owner per federal regulation. By signing the contract, the new owner is representing to the OHCA that they meet the requirements of the contract and the requirements for participation in the Medicaid program. The new owner's contract is subject to the prior owner's contract terms and conditions that were in effect at the time of transfer of ownership, including compliance with all appropriate federal regulations.

(h) A nursing facility or ICF/IID dissatisfied with an action taken by the OHCA that is appealable as a matter of right pursuant to Subpart D of Part 431 of Title 42 of the Code of Federal Regulations, shall be afforded a hearing as provided by 42 CFR 431.153 or 431.154.

317:30-5-125. Trust funds

When a new ~~recipient~~member is admitted to a nursing facility, the administrator will complete and send to the county office the Management of Recipient's Funds form to indicate whether or not the ~~recipient~~member has requested the administrator to handle personal funds. If the administrator agrees to handle the ~~recipient's~~member's funds, the Management of Recipient's Funds form will be completed each time funds or other items of

value, other than monthly income, are received.

(1) ~~By using the Management of Recipient's Funds form as a source document, the facility personnel will prepare a Ledger Sheet for Recipient's Account in a form acceptable to the Authority, for each recipient for whom they are holding funds or other items of value. This form is used to keep an accurate accounting of all receipts and expenditures and the amount of money on hand at all times. This form is to be available in the facility for inspection and audit.~~The facility may use electronic ledgers and bank statements as the source documentation for each member for whom they are holding funds or other items of value. This information must be available at all times for inspection and audit purposes. The facility must have written policies that ensure complete accounting of the ~~recipient's~~member's personal funds. All ~~recipient's~~member funds which are handled by the facility must be clearly identified and maintained separately from funds belonging to the facility or to private patients. When the total sum of all funds for all ~~recipients~~members is $250.00 or more, they must be deposited by the facility in a local bank account designated as "Recipient's Trust Funds." The funds are not to be commingled with the operating funds of the facility. Each resident in an ~~ICF/MR~~ICF/IID facility must be allowed to possess and use money in normal ways or be learning to do so.

(2) The facility is responsible for notifying the county office at any time a ~~recipient's~~member's account reaches or exceeds the maximum reserve by use of the Accounting-Recipient's Personal Funds and Property form. This form is also prepared by the facility when the ~~recipient~~member dies or is transferred or discharged, and at the time of the county eligibility review of the ~~recipient~~member.

(3) The Management of Recipient's Funds form, the Accounting-Recipient's Personal Funds and Property form, and the Ledger Sheets for Recipient's Account ~~can be obtained from the local county DHS office~~are available online at www.okdhs.org.

(4) When the ownership or operation of the facility is discontinued or where the facility is sold and the ~~recipients'~~members' trust funds are to be transferred to a successor facility, the status of all ~~recipient's~~members' trust funds must be verified by the ~~Authority~~OHCA and/or the buyer must be provided with written verification by an independent public accountant of all residents' monies and properties being transferred, and a signed receipt obtained from the owner. All transfers of r~~ecipient's~~a member's trust funds must be acknowledged, in writing, by the transferring facility and proper receipts given by the receiving facility.

(5) Unclaimed funds or other property of deceased ~~recipients~~members, with no known heirs, must be

reported to the Oklahoma Tax Commission. ~~If it remains unclaimed for a certain period, the money or property escheats to the State.~~

(6) It is permissible to use an individual trust fund account to defray the cost of last illness, outstanding personal debts and burial expenses of a deceased ~~recipient~~member of ~~this Authority~~the OHCA; however, any remaining balance of unclaimed funds must be reported to the Oklahoma Tax Commission. The Unclaimed Property Division, Oklahoma Tax Commission, State Capitol Complex, Oklahoma City, Oklahoma, is to be notified for disposition instructions on any unclaimed funds or property. No money is to be sent to the Oklahoma Tax Commission until so instructed by the Unclaimed Property Division.

(7) Books, records, ledgers, charge slips and receipts must be on file in the facility for a period of six (6) years and available at all times in the facility for inspection and audit purposes.

317:30-5-127. Notification of nursing facility changes

It is important that the nursing facility keep the ~~Authority's Service Contracts Operations Unit~~OHCA Provider Enrollment and Contracts Unit informed of any change in administrator, operator, mailing address, or telephone number of the facility. Inaccurate information can cause a delay in receipt of payments or correspondence. The facility should also report all changes to the ~~Oklahoma~~ State Department of Health and the Oklahoma State Board of Nursing Homes.

317:30-5-128. Private rooms [REVOKED]

~~A private room may be provided for a recipient only on the written order of the patient's attending physician and only if the long term care facility agrees to collect any additional cost from someone other than the patient or spouse. The determination by the attending physician that a private room is needed will be on an individual patient basis and be for a period of not more than thirty (30) days. The physician's signed written order, must give full medical reasons for the need of this special service and the order must be included as a part of the individual patient's record in the facility. A redetermination in writing, by the patient's attending physician must be made for this special service each subsequent thirty (30) days to support a charge for a private room.~~

317:30-5-129. Required monthly notifications

(a) The Notification Regarding Patient in a Nursing Facility or ~~ICF/MR~~ICF/IID form is completed and forwarded to the local DHS office by the facility each time a ~~recipient~~member is admitted to or discharged from the facility ~~except for~~

~~therapeutic leave or hospital leave~~.
(b) A Computer Generated Notice or the Notice to Client Regarding Long-Term Medical Care form is used by the county office to notify the ~~recipient~~member and the facility of the amount of money, if any, the ~~recipient~~member is responsible for paying to the facility and the action taken with respect to the ~~patient's~~member's eligibility for nursing facility care. This form reflects dates of transfer between facilities and termination of eligibility for any reason.

317:30-5-131.2. Quality of care fund requirements and report
(a) **Definitions.** The following words and terms, when used in this Section, have the following meaning, unless the context clearly indicates otherwise:

~~(1) **"Nursing Facility and Intermediate Care Facility for Individuals with Intellectual Disabilities"** means any home, establishment, or institution or any portion thereof, licensed by the State Department of Health as defined in Section 1-1902 of Title 63 of the Oklahoma Statutes.~~

~~(2) **"Quality of Care Fee"** means the fee assessment created for the purpose of quality care enhancements pursuant to Section 2002 of Title 56 of the Oklahoma Statutes upon each nursing facility and intermediate care facility for individuals with intellectual disabilities licensed in this State.~~

~~(3) **"Quality of Care Fund"** means a revolving fund established in the State Treasury pursuant to Section 2002 of Title 56 of the Oklahoma Statutes.~~

~~(4) **"Quality of Care Report"** means the monthly report developed by the Oklahoma Health Care Authority to document the staffing ratios, total patient gross receipts, total patient days, and minimum wage compliance for specified staff for each nursing facility and intermediate care facility for individuals with intellectual disabilities licensed in the State.~~

~~(5) **"Staffing ratios"** means the minimum direct-care-staff-to-resident ratios pursuant to Section 1-1925.2 of Title 63 of the Oklahoma Statutes and pursuant to OAC 310:675-1 et seq.~~

~~(6) **"Peak In-House Resident Count"** means the maximum number of in-house residents at any point in time during the applicable shift.~~

~~(7) **"Staff Hours worked by Shift"** means the number of hours worked during the applicable shift by direct-care staff.~~

~~(8) **"Direct-Care Staff"** means any nursing or therapy staff who provides direct, hands-on care to residents in a nursing facility and intermediate care facility for individuals with intellectual disabilities pursuant to Section 1-1925.2 of Title 63 of the Oklahoma Statues, pursuant to OAC 310:675-1 et seq., and as defined in subsection (c) of this Section.~~

~~(9) **"Major Fraction Thereof"** is defined as an additional threshold for direct-care-staff-to-resident ratios at which another direct-care staff person(s) is required due to the peak in-house resident count exceeding one-half of the minimum direct-care-staff-to-resident ratio pursuant to Section 1-1925.2 of Title 63 of the Oklahoma Statutes.~~
~~(10) **"Minimum wage"** means the amount paid per hour to specified staff pursuant to Section 5022.1 of Title 63 of the Oklahoma Statutes.~~
~~(11) **"Specified staff"** means the employee positions listed in the Oklahoma Statutes under Section 5022.1 of Title 63 and as defined in subsection (d) of this Section.~~
~~(12) **"Total Patient Days"** means the monthly patient days that are compensable for the current monthly Quality of Care Report.~~
~~(13) **"Total Gross Receipts"** means all cash received in the current Quality of Care Report month for services rendered to all residents in the facility. Receipts should include all Medicaid, Medicare, Private Pay and Insurance including receipts for items not in the normal per diem rate. Charitable contributions received by the nursing facility are not included.~~
~~(14) **"Service rate"** means the minimum direct-care-staff-to-resident rate pursuant to Section 1-1925.2 of Title 63 of Oklahoma Statutes and pursuant to OAC 310:675-1 et seq.~~
(1) **"Annualize"** means that the calculations, including, for example, total patient days, gross revenue, or contractual allowances and discounts, is divided by the total number of applicable days in the relevant time period.
(2) **"Direct-Care Staff"** means any nursing or therapy staff who provides direct, hands-on care to residents in a nursing facility and intermediate care facility for individuals with intellectual disabilities pursuant to Section 1-1925.2 of Title 63 of the Oklahoma Statues, pursuant to OAC 310:675-1 et seq., and as defined in subsection (c) of this Section.
(3) **"Major Fraction Thereof"** is defined as an additional threshold for direct-care-staff-to-resident ratios at which another direct-care staff person(s) is required due to the peak in-house resident count exceeding one-half of the minimum direct-care-staff-to-resident ratio pursuant to Section 1-1925.2 of Title 63 of the Oklahoma Statutes.
(4) **"Minimum wage"** means the amount paid per hour to specified staff pursuant to Section 5022.1 of Title 63 of the Oklahoma Statutes.
(5) **"Nursing Facility and Intermediate Care Facility for Individuals with Intellectual Disabilities"** means any home, establishment, or institution or any portion thereof, licensed by the State Department of Health (OSDH) as defined in Section 1-1902 of Title 63 of the Oklahoma Statutes.

(6) **"Peak In-House Resident Count"** means the maximum number of in-house residents at any point in time during the applicable shift.
(7) **"Quality of Care Fee"** means the fee assessment created for the purpose of quality care enhancements pursuant to Section 2002 of Title 56 of the Oklahoma Statutes upon each nursing facility and intermediate care facility for individuals with intellectual disabilities licensed in this State.
(8) **"Quality of Care Fund"** means a revolving fund established in the State Treasury pursuant to Section 2002 of Title 56 of the Oklahoma Statutes.
(9) **"Quality of Care Report"** means the monthly report developed by the Oklahoma Health Care Authority (OHCA) to document the staffing ratios, total patient gross receipts, total patient days, and minimum wage compliance for specified staff for each nursing facility and intermediate care facility for individuals with intellectual disabilities licensed in the State.
(10) **"Service rate"** means the minimum direct-care-staff-to-resident rate pursuant to Section 1-1925.2 of Title 63 of Oklahoma Statutes and pursuant to OAC 310:675-1 et seq.
(11) **"Specified staff"** means the employee positions listed in the Oklahoma Statutes under Section 5022.1 of Title 63 and as defined in subsection (d) of this Section.
(12) **"Staff Hours worked by Shift"** means the number of hours worked during the applicable shift by direct-care staff.
(13) **"Staffing ratios"** means the minimum direct-care-staff-to-resident ratios pursuant to Section 1-1925.2 of Title 63 of the Oklahoma Statutes and pursuant to OAC 310:675-1 et seq.
(14) **"Total Gross Receipts"** means all cash received in the current Quality of Care Report month for services rendered to all residents in the facility. Receipts should include all Medicaid, Medicare, private pay, and insurance including receipts for items not in the normal per diem rate. Charitable contributions received by the nursing facility are not included.
(15) **"Total Patient Days"** means the monthly patient days that are compensable for the current monthly Quality of Care Report.

(b) **Quality of care fund assessments.**

(1) The ~~Oklahoma Health Care Authority (OHCA)~~OHCA was mandated by the Oklahoma Legislature to assess a monthly service fee to each ~~Licensed Nursing Facility~~licensed nursing facility in the State. The fee is assessed on a per patient day basis. The amount of the fee is uniform for each facility type. The fee is determined as six percent (6%) of the average total gross receipts divided by the total days for

each facility type.

~~(2) In determination of the fee for the time period beginning October 1, 2000, a survey was mailed to each licensed nursing facility requesting calendar year 1999 Total Patient Days, Gross Revenues and Contractual Allowances and Discounts. This data is used to determine the amount of the fee to be assessed for the period of 10-01-00 through 06-30-01. The fee is determined by totaling the "annualized" gross revenue and dividing by the "annualized" total days of service. "Annualized" means that the surveys received that do not cover the whole year of 1999 are divided by the total number of days that are covered and multiplied by 365.~~

~~(3) The fee for subsequent State Fiscal Years is determined by using the monthly gross receipts and census reports for the six month period October 1 through March 31 of the prior fiscal year, annualizing those figures, and then determining the fee as defined above. As per 56 O.S. Section 2002, as amended, the fees are frozen at the amount in effect at July 1, 2004. Also, the fee will be monitored to never surpass the federal maximum.~~

(2) Annually the Nursing Facilities Quality of Care Fee shall be determined by using the daily patient census and patient gross receipts report received by the OHCA for the most recent available twelve months and annualizing those figures. Also, the fee will be monitored to never surpass the federal maximum.

~~(4)~~(3) The fee is authorized through the Medicaid State Plan and by the Centers for Medicare and Medicaid Services ~~(CMS)~~ regarding waiver of uniformity requirements related to the fee.

~~(5)~~(4) Monthly reports of Gross Receipts and Census are included in the monthly Quality of Care Report. The data required includes, but is not limited to, the Total Gross Receipts and Total Patient Days for the current monthly report.

~~(6)~~(5) The method of collection is as follows:

(A) The ~~Oklahoma Health Care Authority~~OHCA assesses each facility monthly based on the reported patient days from the Quality of Care Report filed two months prior to the month of the fee assessment billing. As defined in this subsection, the total assessment is the fee times the total days of service. The ~~Oklahoma Health Care Authority~~OHCA notifies the facility of its assessment by the end of the month of the Quality of Care Report submission date.

(B) Payment is due to the ~~Oklahoma Health Care Authority~~OHCA by the 15th of the following month. Failure to pay the amount by the 15th or failure to have the payment mailing postmarked by the 13th will result in a

debt to the State of Oklahoma and is subject to penalties of 10% of the amount and interest of 1.25% per month. The Quality of Care Fee must be submitted no later than the 15th of the month. If the 15th falls upon a holiday or weekend (Saturday-Sunday), the fee is due by 5 p.m. (Central Standard Time) of the following business day (Monday-Friday).

(C) The monthly assessment, including applicable penalties and interest, must be paid regardless of any appeals action requested by the facility. If a provider fails to pay the ~~Authority~~OHCA the assessment within the time frames noted on the second invoice to the provider, the assessment, applicable penalty, and interest will be deducted from the facility's payment. Any change in payment amount resulting from an appeals decision will be adjusted in future payments. Adjustments to prior months' reported amounts for gross receipts or patient days may be made by filing an amended part C of the Quality of Care Report.

(D) The Quality of Care fee assessments excluding penalties and interest are an allowable cost for ~~Oklahoma Health Care Authority~~OHCA Cost Reporting purposes.

(E) The Quality of Care fund, which contains assessments collected ~~excluding~~including penalties and interest as described in this subsection and any interest attributable to investment of any money in the fund, must be deposited in a revolving fund established in the State Treasury. The funds will be used pursuant to Section 2002 of Title 56 of the Oklahoma Statutes.

(c) **Quality of care direct-care-staff-to resident-ratios.**

(1) ~~Effective September 1, 2000, all~~All nursing facilities and intermediate care facilities for individuals with intellectual disabilities (ICFs/IID) subject to the Nursing Home Care Act, in addition to other state and federal staffing requirements, must maintain the minimum direct-care-staff-to-resident ratios or direct-care service rates as cited in Section 1-1925.2 of Title 63 of the Oklahoma Statutes and pursuant to OAC 310:675-1 et seq.

(2) For purposes of staff-to-resident ratios, direct-care staff are limited to the following employee positions:

(A) Registered Nurse
(B) Licensed Practical Nurse
(C) Nurse Aide
(D) Certified Medication Aide
(E) Qualified Intellectual Disability Professional (ICFs/IID only)
(F) Physical Therapist
(G) Occupational Therapist
(H) Respiratory Therapist

(I) Speech Therapist
(J) Therapy Aide/Assistant

(3) The hours of direct care rendered by persons filling non-direct care positions may be used when those persons are certified and rendering direct care in the positions listed in OAC 317:30-5-131.2(c)(2) when documented in the records and time sheets of the facility.

(4) In any shift when the direct-care-staff-to-resident ratio computation results in a major fraction thereof, direct-care staff is rounded to the next higher whole number.

(5) To document and report compliance with the provisions of this subsection, nursing facilities and intermediate care facilities for individuals with intellectual disabilities must submit the monthly Quality of Care Report pursuant to subsection (e) of this Section.

(d) **Quality of care minimum wage for specified staff.** ~~Effective November 1, 2000, all~~All nursing facilities and private intermediate care facilities for individuals with intellectual disabilities receiving Medicaid payments, in addition to other federal and state regulations, must pay specified staff not less than in the amount of $6.65 per hour. Employee positions included for purposes of minimum wage for specified staff are as follows:

(1) Registered Nurse
(2) Licensed Practical Nurse
(3) Nurse Aide
(4) Certified Medication Aide
(5) Other Social Service Staff
(6) Other Activities Staff
(7) Combined Social Services/Activities
(8) Other Dietary Staff
(9) Housekeeping Supervisor and Staff
(10) Maintenance Supervisor and Staff
(11) Laundry Supervisor and Staff

(e) **Quality of care reports.** ~~Effective September 1, 2000, all~~All nursing facilities and intermediate care facilities for individuals with intellectual disabilities must submit a monthly report developed by the ~~Oklahoma Health Care Authority~~OHCA, the Quality of Care Report, for the purposes of documenting the extent to which such facilities are compliant with the minimum direct-care-staff-to-resident ratios or direct-care service rates.

(1) The monthly report must be signed by the preparer and by the Owner, authorized Corporate Officer, or Administrator of the facility for verification and attestation that the reports were compiled in accordance with this section.

(2) The Owner or authorized Corporate Officer of the facility must retain full accountability for the report's accuracy and completeness regardless of report submission method.

(3) Penalties for false statements or misrepresentation made by or on behalf of the provider are provided at 42 U.S.C. Section 1320a-7b ~~which states, in part, *"Whoever...(2) at any time knowingly and willfully makes or causes to be made any false statement of a material fact for use in determining rights to such benefit or payment...shall (i) in the case of such statement, representation, concealment, failure, or conversion by any person in connection with furnishing (by that person) of items or services for which payment is or may be made under this title (42 U.S.C. '1320 et seq.), be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one year, or both."*~~.

(4) The Quality of Care Report must be submitted by 5 p.m. (CST) on the 15th of the following month. If the 15th falls upon a holiday or a weekend (Saturday-Sunday), the report is due by 5 p.m. (CST) of the following business day (Monday - Friday).

(5) The Quality of Care Report will be made available in an electronic version for uniform submission of the required data elements.

(6) Facilities must submit the monthly report through the OHCA Provider Portal.

(7) Should a facility discover an error in its submitted report for the previous month only, the facility must provide to the Long Term Care Financial Management Unit written notification with adequate, objective, and substantive documentation within five business days following the submission deadline. Any documentation received after the five business day period will not be considered in determining compliance and for reporting purposes by the ~~Oklahoma Health Care Authority~~OHCA.

(8) An initial administrative penalty of $150.00 is imposed upon the facility for incomplete, unauthorized, or non-timely filing of the Quality of Care Report. Additionally, a daily administrative penalty will begin upon the ~~Authority~~OHCA notifying the facility in writing that the report was not complete or not timely submitted as required. The $150.00 daily administrative penalty accrues for each calendar day after the date the notification is received. The penalties are deducted from the Medicaid facility's payment. For 100% private pay facilities, the penalty amount(s) is included and collected in the fee assessment billings process. Imposed penalties for incomplete reports or non-timely filing are not considered for ~~Oklahoma Health Care Authority~~OHCA Cost

Reporting purposes.
(9) The Quality of Care Report includes, but is not limited to, information pertaining to the necessary reporting requirements in order to determine the facility's compliance with subsections (b) and (c) of this Section. Such reported information includes, but is not limited to: total gross receipts, patient days, available bed days, direct care hours, Medicare days, Medicaid days, number of employees, monthly resident census, and tenure of ~~Certified Nursing Assistants~~certified nursing assistants, nurses, directors of nursing, and administrators.
(10) Audits may be performed to determine compliance pursuant to subsections (b), (c), and (d) of this Section. Announced/unannounced on-site audits of reported information may also be performed.
(11) Direct-care-staff-to-resident information and on-site audit findings pursuant to subsection (c), will be reported to the ~~Oklahoma State Department of Health~~OSDH for their review in order to determine "willful" non-compliance and assess penalties accordingly pursuant to Title 63 Section 1-1912 through Section 1-1917 of the Oklahoma Statutes. The ~~Oklahoma State Department of Health~~OSHD informs the ~~Oklahoma Health Care Authority~~OHCA of all final penalties as required in order to deduct from the Medicaid facility's payment. Imposed penalties are not considered for ~~Oklahoma Health Care Authority~~OHCA Cost Reporting purposes.
(12) If a Medicaid provider is found non-compliant pursuant to subsection (d) based upon a desk audit and/or an on-site audit, for each hour paid to specified staff that does not meet the regulatory minimum wage of $6.65, the facility must reimburse the employee(s) retroactively to meet the regulatory wage for hours worked. Additionally, an administrative penalty of $25.00 is imposed for each non-compliant staff hour worked. For Medicaid facilities, a deduction is made to their payment. Imposed penalties for non-compliance with minimum wage requirements are not considered for ~~Oklahoma Health Care Authority~~OHCA Cost Reporting purposes.
(13) Under OAC 317:2-1-2, Long Term Care facility providers may appeal the administrative penalty described in (b)(5)(B) and (e)(8) and (e)(12) of this section.
(14) Facilities that have been authorized by the ~~Oklahoma State Department of Health (OSDH)~~OSDH to implement flexible staff scheduling must comply with OAC 310:675-1 et seq. The authorized facility is required to complete the flexible staff scheduling section of Part A of the Quality of Care Report. The Owner, authorized Corporate Officer or Administrator of the facility must complete the flexible staff scheduling signature block, acknowledging their OSDH

authorization for Flexible Staff Scheduling.

317:30-5-132. Cost reports

Each Medicaid-participating long term care facility is required to submit an annual uniform cost report, designed by OHCA, for the state fiscal year just completed. The state fiscal year is July 1 through June 30. The reports must be submitted to the OHCA on or before the last day of October of the subsequent year.

(1) The report must be prepared on the basis of generally accepted accounting principles and the accrual basis of accounting, except as otherwise specified in the cost report instructions.

(2) The cost report must be filed using the Secure Website. The instructions and data entry screen simulations will be made available on the OHCA public website~~ under the Provider/Long Term Care Facility/Cost Reporting options~~.

(3) When there is a change of operation or ownership, the selling or closing ownership is required to file a cost report for that portion of the fiscal year it was in operation. The successor ownership is correspondingly required to file a cost report for that portion of the fiscal year it was in operation. These "Partial Year Reports" must be filed on paper or electronically by e-mail (not on the secure website system) to the Finance Division of the OHCA on the forms and by the instructions found on the OHCA public website (see directions as noted above).

~~(4) Cost report instructions are available on the public website at OKHCA.org/Provider/Opportunitiesforliving life/longtermcarefacilities~~.

~~(5)~~(4) Normally, all ordinary and necessary expenses net of any offsets of credits incurred in the conduct of an economical and efficiently operated business are recognized as allowable. Allowable costs include all items of Medicaid-covered expense which nursing facilities incur in the provision of routine services. "Routine services" include, but are not limited to, regular room, dietary and nursing services, minor medical and surgical supplies, over-the-counter medications, transportation, dental examinations, dentures and related services, eye glasses, routine eye examinations, and the use and maintenance of equipment and facilities essential to the provision of routine care. Allowable costs must be considered reasonable, necessary and proper, and shall include only those costs that are considered allowable for Medicare purposes and that are consistent with federal Medicaid requirements. (The guidelines for allowable costs in the Medicare program are set forth in the Medicare Provider Reimbursement Manual ("PRM"), HCFA-Pub. 15.) Ancillary items reimbursed outside

the nursing facility rate are not included in the cost report and are not allowable costs.

~~(6)~~(5) All reports are subject to on-site audits and are deemed public records.

317:30-5-133. Payment methodologies

(a) **Private Nursing Facilities.**

(1) **Facilities.** Private Nursing Facilities include:

(A) Nursing Facilities serving adults (NF),

(B) Nursing Facilities serving Aids Patients ~~(NF-Aids)~~,

(C) Nursing Facilities serving Ventilator Patients ~~(NF-Vents)~~,

(D) Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID),

(E) Intermediate Care Facilities with 16 beds or less serving ~~Severely~~severely or ~~Profoundly~~profoundly intellectually disabled ~~Patients (Acute ICF/IID)~~members, and

(F) Payment will be made for non-routine nursing facility services identified in an individual treatment plan prepared by the State ~~MR~~Intellectual Disabilities (ID) Authority. Services are limited to individuals approved for NF and specialized services as the result of a ~~PASRR/MR~~PASRR/ID Level II screen. The per diem add-on is calculated as the difference in the statewide average standard private ~~MR~~ID base rate and the statewide NF ~~facility~~ base rate. If the standard private ID average base rate falls below the standard NF base rate or equals the standard facility base rate for regular NFs, the payment will not be adjusted for specialized services.

(2) **Reimbursement calculations.** Rates for ~~Private Nursing Facilities~~private NFs will be reviewed periodically and adjusted as necessary through a public process. Payment will be made to ~~Private Nursing Facilitie~~private NFs pursuant to the methodology described in the Oklahoma Title XIX State Plan.

(b) **Public Nursing Facilities.** Reimbursement for public ~~Intermediate Care Facilities for Individuals with Intellectual Disabilities(ICFs/IID)~~ICFs/IID shall be based on each facility's reasonable cost and shall be paid on an interim basis with an annual retroactive adjustment. Reasonable costs shall be based on Medicare principles of cost reimbursement as set forth in the provider reimbursement manual.

317:30-5-133.1. Routine services

(a) Nursing facility care includes routine items and services that must be provided directly or through appropriate arrangement by the facility when required by SoonerCare residents. Charges for routine services may not be made to

resident's personal funds or to resident family members, guardians, or other parties who have responsibility for the resident. If reimbursement is available from Medicare or another public or private insurance or benefit program, those programs are billed by the facility. In the absence of other available reimbursement, the facility must provide routine services from the funds received from the regular SoonerCare vendor payment and the SoonerCare resident's applied income, or spend down amount.

(b) The ~~Oklahoma Health Care Authority~~OHCA will review the listing periodically for additions or deletions, as indicated. Routine services are ~~patient~~member specific and provided in accordance with standard medical care. Routine ~~Services~~services include, but are not limited to:

(l) Regular room~~;~~.

(2) Dietary Services:

(A) regular diets~~;~~;

(B) special diets~~;~~;

(C) salt and sugar substitutes~~;~~;

(D) supplemental feedings~~;~~;

(E) special dietary preparations~~;~~;

(F) equipment required for preparing and dispensing tube and oral feedings~~;~~; and

(G) special feeding devices (furnished or arranged for)~~;~~.

(3) Medically related social services to attain or maintain the highest practicable physical, mental and ~~psycho social~~psycho-social well-being of each resident, nursing care, and activities programs (costs for a private duty nurse or sitter are not allowed)~~;~~.

(4) Personal services - personal laundry services for residents (does not include dry cleaning)~~;~~.

(5) Personal hygiene items (personal care items required to be provided does not include electrical appliances such as shavers and hair dryers, or individual personal batteries), to include:

(A) shampoo, comb, and brush;

(B) bath soap;

(C) disinfecting soaps or specialized cleansing agents when indicated to treat or prevent special skin problems or to fight infection;

(D) razor and/or shaving cream;

(E) nail hygiene services; and

(F) sanitary napkins, douche supplies, perineal irrigation equipment, solutions, and disposable douches~~;~~.

(6) Routine oral hygiene items, including:

(A) toothbrushes ;

(B) toothpaste ;

(C) dental floss ;

(D) lemon glycerin swabs or equivalent products ; and

(E) denture cleaners, denture adhesives, and containers for dental prosthetic appliances such as dentures and partial dentures.

(7) Necessary items furnished routinely as needed to all ~~patients~~members, e.g., water pitcher, cup and tray, towels, wash cloths, hospital gowns, emesis basin, bedpan, and urinal.

(8) The facility will furnish as needed items such as alcohol, applicators, cotton balls, tongue depressors~~. Also~~ and, first aid supplies, including small bandages, ointments and preparations for minor cuts and abrasions, and enema supplies, ~~including~~ disposable enemas, gauze, 4 x 4's ABD pads, surgical and micropore tape, telfa gauze, ace bandages, etc.

(9) Over the counter drugs (non-legend) not covered by the prescription drug program (PRN or routine). In general, nursing facilities are not required to provide any particular brand of non-legend drugs, only those items necessary to ensure appropriate care.

(A) If the physician orders a brand specific non-legend drug with no generic equivalent, the facility must provide the drug at no cost to the ~~patient~~member. If the physician orders a brand specific non-legend drug that has a generic equivalent, the facility may choose a generic equivalent, upon approval of the ordering physician;

(B) If the physician does not order a specific type or brand of non-legend drug, the facility may choose the type or brand;

(C) If the member, family, or other responsible party ~~(excluding nursing facility)~~(excluding the nursing facility) prefers a specific type or brand of non-legend drug rather than the ones furnished by the facility, the member, family or responsible party may be charged the difference between the cost of the brand the resident requests and the cost of the brand generally provided by the facility. (Facilities are not required to provide an unlimited variety of brands of these items and services. It is the required assessment of resident needs, not resident preferences, that will dictate the variety of products facilities need to provide);

(D) Before purchasing or charging for the preferred items, the facility must secure written authorization from the member, family member, or responsible party indicating his or her desired preference, as well as the date and signature of the person requesting the preferred item. The signature may not be that of an employee of the facility. The authorization is valid until rescinded by the maker of the instrument~~;~~.

(10) The facility will furnish or obtain any necessary

equipment to meet the needs of the ~~patient~~member upon physician order. Examples include: trapeze bars and overhead frames, foot and arm boards, bed rails, cradles, wheelchairs and/or geriatric chairs, foot stools, adjustable crutches, canes, walkers, bedside commode chairs, hot water bottles or heating ~~pad~~pads, ice bags, sand bags, traction equipment, IV stands, etc.~~;~~

(11) Physician prescribed lotions, ointments, powders, medications and special dressings for the prevention and treatment of decubitus ulcers, skin tears and related conditions, when medications are not covered under the Vendor Drug Program or other third party payer~~;~~.

(12) Supplies required for dispensing medications, including needles, syringes including insulin syringes, tubing for IVs, paper cups, medicine containers, etc.~~;~~

(13) Equipment and supplies required for simple tests and examinations, including scales, sphygmomanometers, stethoscopes, clinitest, acetest, dextrostix, pulse oximeters, blood glucose meters and test strips, etc.~~;~~

(14) Underpads and diapers, waterproof sheeting and pants, etc., as required for incontinence or other care.

(A) If the assessment and care planning process determines that it is medically necessary for the resident to use diapers as part of a plan to achieve proper management of incontinence, and if the resident has a current physician order for adult diapers, then the facility must provide the diapers without charge;

(B) If the resident or the family requests the use of disposable diapers and they are not prescribed or consistent with the facility's methods for incontinent care, the resident/family would be responsible for the expense~~;~~.

(15) Oxygen for emergency use, or intermittent use as prescribed by the physician for medical necessity~~;~~.

(16) Other physician ordered equipment to adequately care for the ~~patient~~member and in accordance with standard patient care, including infusion pumps and supplies, and nebulizers and supplies, etc.

(17) Dentures and Related Services. Payment for the cost of dentures and related services is included in the daily rate for routine services. The projected schedule for routine denture services must be documented on the Admission Plan of Care and on the Annual Plan of Care. The medical records must also contain documentation of steps taken to obtain the ~~service~~services. When the provision of denture services is medically appropriate, the nursing facility must make timely arrangements for the provision of these services by licensed dentists. In the event ~~dentures~~denture services are not medically appropriate, the treatment plan must reflect

the reason the ~~service is~~services are not considered appropriate, ~~i.e.~~e.g., the ~~patient~~member is unable to ingest solid nutrition~~,~~ or is comatose, etc. When the need for dentures is identified, one set of complete dentures or partial dentures and one dental examination is considered medically appropriate every three years. One rebase and/or one reline is considered appropriate ~~each~~every three years. It is the responsibility of the nursing facility to ensure that the member has adequate assistance in the proper care, maintenance, identification and replacement of these items. The nursing facility cannot set up payment limits which result in barriers to obtaining denture services. However, the nursing facility may restrict the providers of denture services to providers who have entered into payment arrangements with the facility. The facility may also choose to purchase a private insurance dental coverage product for each SoonerCare member. ~~The~~At a minimum, the policy must cover ~~at a minimum~~ all denture services included in routine services. The member cannot be expected to pay any co-payments and/or deductibles. If a difference of opinion occurs between the nursing facility, member, and/or family regarding the provision of dentures services, the OHCA will be the final authority. All members and/or families must be informed of their right to appeal at the time of admission and yearly thereafter. The member cannot be denied admission to a facility because of the need for denture services.

(18) Vision Services. Routine eye examinations for the purpose of medical screening or prescribing or changing glasses and the cost of glasses are included in the daily rate for routine services. This does not include follow-up or treatment of known eye disease such as diabetic retinopathy, glaucoma, conjunctivitis, corneal ulcers, iritis, etc. Treatment of known eye disease is a benefit of the ~~patient's~~member's medical plan. The projected schedule for routine vision care must be documented on the Admission Plan of Care and on the Annual Plan of Care. The medical record must contain documentation of the steps that have been taken to access the service. When vision services are not appropriate, documentation of why vision services are not medically appropriate must be included in the treatment plan. For example, ~~patient~~the member is comatose, unresponsive, blind, etc. Nursing Home providers may contract with individual eye care providers, providers groups or a vision plan to provide routine vision services to their members. The member cannot be expected to pay any co-payments and/or deductibles.

(A) The following minimum level of services must be included:

(i) Individuals 21 to 40 years of age are eligible for

one routine eye examination and one pair of glasses every 36 months (three years).

(ii) Individuals 41 to 64 years of age are eligible for one routine eye examination and one pair of glasses every 24 months (2 years).

(iii)~~Individuals~~ Individuals 65 years of age or older are eligible for one routine eye examination and one pair of glasses ~~each~~every 12 months (yearly).

(B) It is the responsibility of the nursing facility to ensure that the member has adequate assistance in the proper care, maintenance, identification and replacement of these items. When vision services have been identified as a needed service, nursing facility staff will make timely arrangements for provision of these services by licensed ophthalmologists or optometrists. If a difference of opinion occurs between the nursing facility, member, and/or family regarding the provision of vision services, the OHCA will be the final authority. All members and/or families must be informed of their right to appeal at admission and yearly thereafter. The member cannot be denied admission to the facility because of the need for vision services.

(19) An attendant to accompany SoonerCare eligible members during SoonerRide Non-Emergency Transportation (NET). Please refer to OAC 317:30-5-326 through OAC 317:30-5-327.9 for SoonerRide rules regarding members residing in a nursing facility. And

(20) Influenza and pneumococcal vaccinations.

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

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

PART 1. SERVICES

317:35-9-4. Services in Intermediate Care Facility for ~~persons with Mental Retardation~~Individuals with Intellectual Disabilities (public and private)

(a) Services in a private Intermediate Care Facility for ~~persons with Mental Retardation (ICF/MR)~~Individuals with Intellectual Disabilities (ICF/IID) may be provided to members requiring health or habilitative services above the level of room and board. Services are provided to members who meet level of care and eligibility requirements per OAC 317:30-5-122 and 317:35-9-45.

(b) Services in a public ~~ICF/MR~~ICF/IID may be provided to members who require health or habilitative services above the level of room and board. Services are provided to members who meet level of care requirements per OAC 317:30-5-122.

PART 5. DETERMINATION OF MEDICAL ELIGIBILITY FOR ICF/IID, HCBW/IID, AND INDIVIDUALS AGE 65 OR OLDER IN MENTAL HEALTH HOSPITALS

317:35-9-45. Determination of medical eligibility for care in a private Intermediate Care Facility for ~~Persons with Mental Retardation~~Individuals with Intellectual Disabilities(ICF/IID)

(a) **Pre-approval of medical eligibility.** Pre-approval of medical eligibility for private ~~ICF/MR~~ICF/IID care is based on level of care requirements per OAC 317:30-5-122. Pre-approval is not necessary for individuals with a severe or profound intellectual disability. Pre-approval is made by Oklahoma Health Care Authority (OHCA) Level of Care Evaluation Unit (LOCEU) analysts.

(b) **Application for ~~ICF/MR~~ICF/IID services.** Within 30 calendar days after services begin, the facility must submit:

(1) ~~the~~The original of the ~~ICF/MR~~ICF/IID Level of Care Assessment form (LTC-300) to LOCEU. Required attachments include:

(A) Current (within 90 days of requested approval date) medical information signed by a physician.

(B) A current (within 12 months of requested approval date) psychological evaluation by a licensed Psychologist or State staff supervised by a licensed Psychologist. The

evaluation must include intelligence testing that yields a full-scale intelligence quotient, a full-scale functional or adaptive assessment, as well as the age of onset.

(C) A copy of the pertinent section of the Individual Plan or other appropriate documentation relative to the ~~ICF/MR~~ICF/IID admission and the need for ~~ICF/MR~~ICF/IID level of care.

(D) A statement that the member is not an imminent threat of harm to self or others (i.e., suicidal or homicidal).

(2) If pre-approval was determined by LOCEU and the above information is received, medical approval will be entered on an electronic medical case list known as MEDATS. Pre-approval is not needed for individuals with a severe or profound intellectual disability.

(c) **Categorical relationship.** Categorical relationship must be established for determination of eligibility for long-term medical care. If categorical relationship has not already been established, the proper forms and medical information are submitted to LOCEU. (Refer to OAC 317:35-5-4). In such instances LOCEU will render a decision on categorical relationship using the same definition as used by ~~thewith~~the SSA. A follow-up is required by the OKDHS social worker with the SSA to be sure that their disability decision agrees with the decision of LOCEU.

(d) **Medical eligibility for ~~ICF/MR~~ICF/IID services.**

(1) Individuals must require active treatment per 42 CFR 483.440.

(2) Individuals must have a diagnosis of an intellectual disability or a related condition based on level of care requirements per OAC 317:30-5-122 and results of a current comprehensive psychological evaluation by a licensed Psychologist or State staff supervised by a licensed Psychologist.

(A) Per the Diagnostic and Statistical Manual of Mental Disorders, intellectual disability is a condition characterized by a significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior and originating before 18 years of age.

(B) Per 42 CFR 435.1010, persons with related conditions means individuals who have a severe, chronic disability that meets the following conditions:

(i) It is attributable to cerebral palsy or epilepsy~~; or~~.

(ii) ~~it~~It is attributable to any other condition, other than mental illness, found to be closely related to intellectual disability because this condition results in impairment of general intellectual functioning or

adaptive behavior similar to that of persons with intellectual disability and requires treatment or services similar to those required for these persons.

(iii) It is manifested before the person reaches age 22.

(iv) It is likely to continue indefinitely.

(v) It results in substantial functional limitations in three or more areas of major life activity per OAC 317:30-5-122.

(C) Conditions closely related to intellectual disability include, but are not limited to the following:

(i) autism or autistic disorder, childhood disintegrative disorder, Rett syndrome and pervasive developmental disorder, not otherwise specified (only if "typical autism");

(ii) severe brain injury (acquired brain injury, traumatic brain injury, stroke, anoxia, meningitis);

(iii) fetal alcohol syndrome;

(iv) chromosomal disorders (Down syndrome, fragile x syndrome, Prader-Willi syndrome);and

(v) other genetic disorders (Williams syndrome, spina bifida, phenylketonuria).

(D) The following diagnoses do not qualify as conditions related to intellectual disability. Nevertheless, a person with any of these conditions is not disqualified if there is a simultaneous occurrence of a qualifying condition:

(i) learning disability;

(ii) behavior or conduct disorders;

(iii) substance abuse;

(iv) hearing impairment or vision impairment;

(v) mental illness that includes psychotic disorders, adjustment disorders, reactive attachment disorders, impulse control disorders, and paraphilias;

(vi) borderline intellectual functioning, developmental disability that does not result in an intellectual impairment, developmental delay or "at risk" designations;

(vii) physical problems (such as multiple sclerosis, muscular dystrophy, spinal cord injuries and amputations);

(viii) medical health problems (such as cancer, acquired immune deficiency syndrome and terminal illnesses);

(ix) milder autism spectrum disorders (such as Asperger's disorder and pervasive developmental disorder not otherwise specified if not "atypical autism");

(x) neurological problems not associated with intellectual deficits (such as Tourette's syndrome, fetal alcohol effects and non-verbal learning disability);or
(xi) mild traumatic brain injury (such as minimal brain injury and post-concussion syndrome).

SUBCHAPTER 19. NURSING FACILITY SERVICES

317:35-19-8. Pre-admission screening and resident review

(a) Federal ~~Regulations~~regulations govern the State's responsibility for Preadmission Screening and Resident Review (PASRR) of individuals with mental illness and intellectual disabilities. PASRR applies to the screening or reviewing of all individuals for mental illness ~~or~~, an intellectual disability, or related conditions who apply to or reside in Medicaid certified nursing facilities regardless of the source of payment for the nursing facility (NF) services and regardless of the individual's or resident's known diagnoses. The NF must independently evaluate the Level I PASRR Screen regardless of who completes the form and determine whether or not to admit an individual to the facility. If an individual is admitted ~~to the NF~~ inappropriately, the NF is subject to recoupment of Medicaid funds and penalties imposed by CMS. Federal financial participation (FFP) may not be paid until results of any needed PASRR Level II evaluations are received. PASRR is a requirement for nursing facilities with dually certified (both Medicare and Medicaid) beds. There are no PASRR requirements for Medicare skilled beds that are not dually certified, nor is PASRR required for individuals seeking residency in an intermediate care facility for ~~the mentally retarded (ICF/MR)~~individuals with intellectual disabilities (ICF/IID).
(b) For Medicaid applicants, medical and financial eligibility determinations are also required.

317:35-19-9. PASRR screening process

(a) **Level I screen for PASRR.**
(1) OHCA Form LTC-300R, Nursing Facility Level of Care Assessment, must be completed by an authorized NF official or designee. An authorized NF official or designee must consist of one of the following:
(A) The ~~nursing facility~~NF administrator or co-administrator;
(B) A licensed nurse, social service director, or social worker from the ~~nursing~~ facility; or
(C) A licensed nurse, social service director, or social worker from the hospital.

(2) Prior to admission, the authorized NF official must evaluate the properly completed OHCA Form LTC-300R and the Minimum Data Set (MDS), if available, as well as all other readily available medical and social information, to determine if there currently exists any indication of mental illness (MI), intellectual disability (ID), or other related condition, or if such condition existed in the applicant's past history. Form LTC-300R constitutes the Level I PASRR Screen and is utilized in determining whether or not a Level II is necessary prior to allowing the ~~patient~~member to be admitted.

(3) The ~~nursing facility~~NF is responsible for determining from the evaluation whether or not the ~~patient~~member can be admitted to the facility. A "yes" response to any question from Form LTC-300R, Section E, will require the ~~nursing facility~~NF to contact the Level of Care Evaluation Unit (LOCEU) for a consultation to determine if a Level II assessment is needed. The ~~NF~~facility is also responsible for consulting with the LOCEU regarding any ~~MI/ID /related~~mental illness, an intellectual disability, or related condition information that becomes known either from completion of the MDS or throughout the resident's stay. The original Form LTC-300R must be submitted to the LOCEU by mail within ~~10~~ten (10) days of the resident's admission. SoonerCare payment may not be made for a resident whose LTC-300R requirements have not been satisfied in a timely manner.

(4) Upon receipt and review of the PASRR eligibility information packet, the LOCEU may, in coordination with the Oklahoma Department of Human Services (OKHDS) area nurse, re-evaluate whether a Level II PASRR assessment may be required. If a Level II assessment is not required, as determined by the LOCEU, the area nurse, or nurse designee, documents this and continues with the process of determining medical eligibility. If a Level II is required, a medical decision is not made until the area nurse is notified of the outcome of the Level II assessment. The results of the Level II assessment are considered in the medical eligibility decision. The area nurse, or nurse designee, makes the medical eligibility decision within ten (10) working days of receipt of the medical information when a Level II assessment is not required. If a Level II assessment is required, the area nurse makes the decision within five working days if appropriate.

(b) **Pre-admission Level II assessment for PASRR.** The authorized official is responsible for consulting with the OHCA LOCEU in determining whether a Level II assessment is necessary. The decision for Level II assessment is made by the LOCEU.

(1) Any one of the following three (3) circumstances will allow a ~~patient~~member to enter the ~~nursing facility~~NF without being subjected to a Level II PASRR assessment:

(A) The ~~patient~~member has no current indication of mental illness or an intellectual disability or other related condition and there is no history of such condition in the ~~patient's~~member's past;

(B) The ~~patient~~member does not have a diagnosis of an intellectual disability or related condition; or

(C) The ~~patient~~member has indications of mental illness or an intellectual disability or other related condition, but is not a danger to self and/or others, and is being released from an acute care hospital as part of a medically prescribed period of recovery (Exempted Hospital Discharge). If an individual is admitted to an NF based on Exempted Hospital Discharge, it is the responsibility of the NF to ensure that the individual is either discharged by the 30th day or that a Level II has been requested and is in process. Exempted Hospital Discharge is allowed only if all of the following three (3) conditions are met:

(i) The individual must be admitted to the NF directly from a hospital after receiving acute inpatient care at the hospital (not including psychiatric facilities);

(ii) The individual must require NF services for the condition for which he/she received care in the hospital; and

(iii) The attending physician must certify before admission to the facility that the individual is likely to require less than ~~30~~thirty (30) days of nursing facility services. The ~~nursing facility~~NF will be required to furnish documentation to the OHCA upon request.

(2) If the ~~patient~~member has current indications of mental illness or an intellectual disability or other related condition, or if there is a history of such condition in the ~~patient's~~member's past, the ~~patient~~member cannot be admitted to the ~~nursing facility~~NF until the LOCEU is contacted to determine if a Level II PASRR assessment must be performed. Results of any Level II PASRR assessment ordered must indicate that ~~nursing facility~~NF care is appropriate prior to allowing the ~~patient~~member to be admitted.

(3) The OHCA Level of Care Evaluation Unit authorizes Advance Group Determinations for the MI and ~~MR~~ID Authorities in the categories listed in the following categories listed in (A) through (C) of this paragraph. Preliminary screening by the LOCEU should indicate eligibility for ~~nursing facility~~NF

level of care prior to consideration of the provisional admission.

(A) **Provisional admission in cases of delirium.** Any person with mental illness, an intellectual disability or related condition who is not a danger to self and/or others, may be admitted to a ~~Medicaid~~Title XIX certified NF if the individual is experiencing a condition that precludes screening, i.e., effects of anesthesia, medication, unfamiliar environment, severity of illness, or electrolyte imbalance.

(i) A Level II evaluation is completed immediately after the delirium clears. LOCEU must be provided with written documentation by a physician that supports the individual's condition which allows provisional admission as defined in (i) of this subparagraph.

(ii) Payment for NF services will not be made after the provisional admission ending date. If an individual is determined to need a longer stay, the individual must receive a Level II evaluation before continuation of the stay may be permitted and payment made for days beyond the ending date.

(B) **Provisional admission in emergency situations.** Any person with a mental illness, an intellectual disability or related condition, who is not a danger to self and/or others, may be admitted to a ~~Medicaid~~Title XIX certified ~~nursing facility~~NF for a period not to exceed seven days pending further assessment in emergency situations requiring protective services. The request for Level II evaluation must be made immediately upon admission to the NF if a longer stay is anticipated. LOCEU must be provided with written documentation from Adult Protective Services or the ~~nursing~~ facility which supports the individual's emergency admission. Payment for NF services will not be made beyond the emergency admission ending date.

(C) **Respite care admission.** Any person with mental illness, an intellectual disability or related condition, who is not a danger to self and/or others, may be admitted to a ~~Medicaid~~Title XIX certified ~~nursing facility~~NF to provide respite to in-home caregivers to whom the individual is expected to return following the brief NF stay. Respite care may be granted up to ~~15~~fifteen (15) consecutive days per stay, not to exceed ~~30~~thirty (30) days per calendar year.

(i) In rare instances, such as illness of the caregiver, an exception may be granted to allow ~~30~~thirty (30) consecutive days of respite care.

However, in no instance can respite care exceed ~~30~~thirty (30) days per calendar year.

(ii) Respite care must be approved by LOCEU staff prior to the individual's admission to the NF. The NF provides the LOCEU with written documentation concerning circumstances surrounding the need for respite care, the date the individual wishes to be admitted to the facility, and the date the individual is expected to return to the caregiver. Payment for NF services will not be made after the respite care ending date.

(c) **PASRR Level II resident review.** The resident review is used primarily as a follow-up to the pre-admission assessment.

(1) The ~~nursing~~ facility's routine resident assessment will identify those individuals previously undiagnosed as intellectually disabled or ~~MI~~mentally ill. A new condition of intellectual disabilities or ~~MI~~mental illness must be referred to LOCEU by the NF for determination of the need for the Level II. The facility's failure to refer such individuals for a Level II assessment may result in recoupment of funds and/or penalties from CMS.

(2) A Level II resident review may be conducted the following year for each resident of a ~~nursing facility~~NF who was found to experience a serious mental illness with no primary diagnosis of dementia on his or her pre-admission Level II to determine whether, because of the resident's physical and mental condition, the resident requires specialized services.

(3) A Level II resident review may be conducted for each resident of a ~~nursing facility~~NF who has mental illness or an intellectual disability or other related condition when there is a significant change in the resident's mental condition. If such a change should occur in a resident's condition, it is the responsibility of the ~~nursing~~ facility to have a consultation with the LOCEU concerning the need to conduct a resident review.

(4) Individuals who were determined to have a serious mental illness ~~(as defined by CMS)~~ on their last PASRR Level II evaluation will receive a resident review at least within one year of the previous evaluation.

(d) **Results of pre-admission Level II assessment and Resident Review.** Through contractual arrangements between the ~~Oklahoma Health Care Authority~~OHCA and the ~~Mental Illness/Mental Retardation Authorities/Community Mental Health Centers~~Mental Illness/Intellectual Disabilities Authorities/ Community Mental Health Centers, individualized assessments are conducted and findings presented in written evaluative reports. The reports recommend if ~~nursing facility~~NF services are needed, if

specialized services or less than specialized services are needed, and if the individual meets the federal PASRR definition of mental illness or intellectual disability or related conditions. Evaluative reports are delivered to the OHCA's LOCEU within federal regulatory and state contractual timelines to allow the LOCEU to process formal, written notification to ~~patient~~member, guardian, NF and significant others.

(e) **Evaluation of pre-admission Level II or Resident Review assessment to determine Medicaid medical eligibility for long term care.** The determination of medical eligibility for care in a ~~nursing facility~~NF is made by the area nurse (or nurse designee) unless the individual has an intellectual disability or related condition or a serious mental illness~~ (as defined by CMS)~~. The procedures for obtaining and submitting information required for a decision are outlined in this subsection. When an active long term care ~~patient~~member enters the facility and nursing care is being requested:

(1) The pre-admission screening process must be performed and must allow the ~~patient~~member to be admitted.

(2) The facility will notify the local county office by the OKDHS Form 08MA083E, Notification Regarding Patient in a Nursing Facility, Intermediate Care Facility for the Mentally Retarded or Hospice and Form 08MA084E, Management of Recipient's Funds, of the member's admission.

(3) The local county office will send the NF the OKDHS Form 08MA038E, Notice Regarding Financial Eligibility, indicating actions that are needed or have been taken regarding the member.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 3. HOSPITALS

317:30-5-40. Eligible providers

(a) All general medical/surgical hospitals and critical access hospitals eligible for reimbursement under this Part must be licensed by the appropriate state survey agency, meet Medicare conditions of participation, and have a current contract on file with the Oklahoma Health Care Authority (OHCA).

(b) Children specialty hospitals must be appropriately licensed and certified and have a current contract with the OHCA.

(c) Eligibility requirements for specialized rehabilitation hospitals are covered in OAC 317:30-5-110; inpatient psychiatric hospitals are covered in OAC 317:30-5-95~~. Requirements for~~; and long term care hospitals are ~~found~~covered in OAC 317:30-5-60.

(d) Certain providers who provide professional and other services within an inpatient or outpatient hospital require separate contracts with the OHCA.

(e) Reimbursement for laboratory services is made in accordance with the Clinical Laboratory Improvement Amendment of 1988 (CLIA). These regulations provide that payment may be made only for services furnished by a laboratory that meets CLIA conditions. Eligible providers must be certified under the CLIA program and have obtained a CLIA ID number from the Center for Medicare and Medicaid Services (CMS) and have a current contract on file with this Authority.

317:30-5-49. ~~Child abuse~~Reporting suspected abuse

~~(a) Instances of child abuse and/or neglect are to be reported in accordance with State Law. Section 7103 of Title 10 of the Oklahoma Statutes mandates reporting suspected abuse or neglect to the Oklahoma Department of Human Services. Section 7104 of Title 10 of the Oklahoma Statutes further requires reporting of criminally injurious conduct to the nearest law enforcement agency.~~

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

~~(c) The Child Abuse Unit of the Oklahoma Child Welfare Unit is responsible for coordination and consultation with the individual designated. In turn, the hospital is responsible for prompt notification to the Child Abuse Unit of any case of suspected medical neglect or withholding of medically-indicated treatment from disabled infants with life-threatening conditions. This information must be communicated to Child Abuse Unit, Child Welfare Services, P.O. Box 25352, Oklahoma City, OK 73125, Telephone: (405) 521-2283. Should a report need to be made when the office is closed, telephone the statewide toll-free Child Abuse Hot Line: 1-800-522-3511.~~
~~(d) Each Hospital should provide the name, title and telephone number of the designated individual and return it to the OHCA. This information is updated annually as part of the contract renewal. Should the designation change before that time, OHCA should be furnished revised information.~~

Instances of child abuse and/or neglect are to be reported in accordance with State law. Any person suspecting child abuse or neglect shall immediately report it to the Oklahoma Department of Human Services (OKDHS) hotline, at 1-800-522-3511. Any person suspecting abuse, neglect, or exploitation of a vulnerable adult shall immediately report it to the local OKDHS County Office, municipal or county law enforcement authorities, or, if the report occurs after normal business hours, the OKDHS hotline. 10A O.S. § 1-2-101; 43A O.S. § 10-104. Health care professionals who are requested to report incidents of domestic abuse by adult victims with legal capacity shall promptly make a report to the nearest law enforcement agency, per 22 O.S. § 58.

PART 23. PODIATRISTS

317:30-5-260. Eligible providers

~~Payment is made for compensable services to podiatrists licensed in the state where they practice. Each podiatrist must have a current contract with the Oklahoma Health Care Authority (OHCA).~~Payment can be made to a podiatrist licensed in the state where they practice, who has a current contract on file with the Oklahoma Health Care Authority (OHCA).

PART 29. RENAL DIALYSIS FACILITIES

317:30-5-305. Eligible providers

~~Payment is made to Medicare certified Renal Dialysis Centers which have a current contract with the Oklahoma Health Care Authority for compensable services provided on or after June 1, 1987.~~Payment can be made to a Medicare certified Renal Dialysis Center when its clinical services are under the medical direction of a physician licensed by the Oklahoma State Board of Medical Licensure and Supervision, the Oklahoma Board of

Osteopathic Examiners, or the appropriate licensing body of the state where the provider is located. Renal Dialysis Centers must also have a current contract on file with the Oklahoma Health Care Authority.

PART 45. OPTOMETRISTS

317:30-5-430. Eligible providers

Payment can be made to a licensed optometrist who has a current ~~Memorandum of Agreement~~contract on file with the Oklahoma Health Care Authority (OHCA) for services within the scope of Optometric practice as defined ~~in state law.~~by controlling State law; provided, however, that services performed by out-of-state providers shall only be compensable to the extent that they are covered services.

PART 87. BIRTHING CENTERS

317:30-5-890. Eligible providers

Eligible providers are birthing centers that are currently licensed by the Oklahoma State Health Department and meet the requirements listed in ~~(1) - (4)~~(1)-(5) of this subsection:

(1) Have a current written agreement with a board certified ~~OB/GYN~~Obstetrician-Gynecologist (OB-GYN) to provide coverage for consultation, collaboration or referral services as defined by the American College of Nurse-Midwives.

(2) Have a current medical director who is a board certified ~~OB/GYN~~OB-GYN and is responsible for establishing patient protocols and other functions as defined in requirements for state licensure. This individual may, or may not, be the physician providing individual patient coverage for consultation, collaborative or referral service.

(3) Have a written agreement with a referral hospital which is a Class II hospital. Class II hospital is defined as a facility with 24 hour availability of ~~OB/GYN~~OB-GYN and capability of performing a C-section within 30 minutes of the decision to operate. The 30 minute timeframe is subject to each hospital's unique circumstance, logistical issues that include, but are not limited to, obtaining informed consent, transporting the patient, and any other potential problems that may arise.

(4) Must be accredited by the Commission for the Accreditation of Freestanding Birth Centers.

(5) Have a current contract on file with the Oklahoma Health Care Authority.

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PART 83. RESIDENTIAL BEHAVIOR MANAGEMENT SERVICES

317:30-5-742.2. Individual plan of care and prior authorization of services

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

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

(1)**Assessment**.

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

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

(C) **Limitations**. Assessments are compensable on behalf of a member who is seeking services for the first time from the therapeutic foster care agency. This service is not compensable if the member has previously received or is currently receiving services from the agency unless there has been a gap in service of more than six (6) months and it has been more than one (1) year since the previous assessment.

(D) **Documentation requirements.** The assessment must include all elements and tools required by the OHCA. In the case of children under the age of ~~18~~eighteen (18), it is performed with the direct, active face-to-face participation of the child and parent or guardian. The child's level of participation is based on age, developmental and clinical appropriateness. The assessment must include all related diagnoses from the most recent

DSM edition. The assessment must contain but is not limited to the following:

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

(ii) Source of information;

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

(iv) Gender;

(v) Birth ~~Date~~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~~Dated signature of parent or guardian participating in the face-to-face assessment. ~~Signature~~Signatures are required for members over the age of ~~14~~fourteen (14);

(xiv) Bio-Psychosocial information which must include:

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

(II) History of the presenting problem;

(III) Previous psychiatric treatment history, include treatment for psychiatric; substance use; drug and alcohol addiction; and other addictions;

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

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

(VI) Trauma, abuse, neglect, violence, and/or sexual assault history of self and/or others, including Department of Human Services (DHS) involvement;

(VII) ~~Family and social history, include MH, SA, Addictions, Trauma/Abuse/Neglect;~~Family and social history including psychiatric, substance use, drug and alcohol addiction, other addictions, and trauma/abuse/neglect;

(VIII) Educational attainment, difficulties and history;

(IX) Cultural and religious orientation;

(X) Vocational, occupational and military history;

(XI) Sexual history, including HIV, AIDS, and STD at-risk behaviors;

(XII) Marital or significant other relationship history;

(XIII) Recreation and leisure history;

(XIV) Legal or criminal record, including the identification of key contacts, (e.g. attorneys, probation officers);
(XV) Present living arrangements;
(XVI) Economic resources; and
(XVII) Current support system, including peer and other recovery supports.

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

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

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

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

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

(A) **Signature Requirement**. A written individual plan of care following a comprehensive evaluation for each member must be formulated by the provider agency staff within ~~30~~thirty (30) days of admission with documented input from the member, legal guardian ~~(OKDHS/OJA) staff~~(OKDHS/Office of Juvenile Affairs (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~~An individual plan of care is not valid until all dated signatures are present, including signatures from the member (if fourteen (14) or over), the legal guardian, the foster parent (when applicable) and the treatment provider(s). If necessary, an individual plan of care may be faxed to a required signatory to have them review, sign and fax it back to the

provider before its implementation; however, the provider must obtain the original signature for the clinical file within ~~30~~thirty (30) days. No stamped or photocopied signatures are allowed. This plan must be revised and updated every three (3) months with documented involvement of the legal guardian and resident.

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

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

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

(E) **Documentation requirements.** Comprehensive and integrated service plan content must address the following:

(i) member strengths, needs, abilities, and preferences~~(SNAP)~~ (SNAP);

(ii) identified presenting challenges, problems, needs and diagnosis;

(iii) specific goals for the member;

(iv) objectives that are specific, attainable, realistic, and time-limited;

(v) each type of service and estimated frequency to be received;

(vi) the practitioner(s) name and credentials that will be providing and responsible for each service;

(vii) any needed referrals for service;

(viii) specific discharge criteria; and

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

~~(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.~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(iii) **Qualified Practitioners.** CM II, LBHP or a Licensure Candidate and LBHP may perform PSR, following development of an individual plan of care curriculum approved by an LBHP or Licensure Candidate. PSR staff must be appropriately and currently trained in a recognized ~~behavioral/ management~~ behavioral/management intervention program such as MANDT or ~~CAPE~~Controlling Aggressive Patient Environment (CAPE) or trauma informed methodology. The CM II must have immediate access to an LBHP who can provide clinical oversight of

the CM II and collaborate with the CM II in the provision of services. A minimum of one (1) monthly face-to-face consultation with an LBHP is required.

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

(v) ~~Limitations~~**Limitations.**

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

(II) PSR services are intended for children with Serious Emotional Disturbance (SED), and children with other emotional or behavioral disorders. Children under age ~~6~~six (6), unless a prior authorization for children ages ~~4~~four (4) and ~~5~~five (5) has been granted by OHCA or its designated agent based on a finding of medical necessity, are not eligible for PSR services.

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

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

achieve the maximum reduction of the mental and/or behavioral health disability and to restore the member to their best possible functional level.

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

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

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

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

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

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

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

(VIII) Credentials of the qualified provider;

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

(viii) ~~Non-Covered Services~~**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~~ one and one half (1.5) hours daily.

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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. Tooth extraction must have medical need documented;

(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/IID level of care, similar to the scope of services available to individuals under age 21.

(C) Limited dental services are available for members who meet all medical criteria, but need dental clearance to obtain organ transplant approval. Providers must obtain prior authorization before delivery of dental service, with the exception of evaluation and extractions. All requests must be filed on the currently approved ~~ADA~~American Dental Association (ADA) form and must include diagnostic images, six-point periodontal charting, narratives and comprehensive treatment plans. The OHCA will notify the provider of determination using OHCA Prior Authorization Request Decision form. Prior authorized services must be billed exactly as they appear on the prior authorization request. The following dental services are available:

(i) ~~Comprehensive~~comprehensive oral evaluation,

(ii) two image bitewings,

(iii) prophylaxis,

(iv) fluoride application,

(v) limited restorative procedures, and

(vi) periodontal scaling/root planing.

(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 should precede any images, and chart documentation must include image 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 dentist for more than six months. An examination should precede any images, and chart documentation must include images 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) **Limited oral evaluation.** This procedure is only compensable to the same dentist or practice for two visits prior to a comprehensive or periodic evaluation examination being completed.

(D) **Images.** To be SoonerCare compensable, images must be of diagnostic quality and medically necessary. A clinical examination must precede any images, and chart documentation must include member history, prior images, caries risk assessment and both dental and general health needs of the member. The referring dentist is responsible for providing properly identified images of acceptable quality with a referral, if that provider chooses to expose and submit for reimbursement prior to referral. Periapical images must include at least three millimeters beyond the apex of the tooth being imaged. Panoramic films and two bitewings are considered full mouth images. Full mouth images as noted above or traditional (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 images by the same dentist/dental office are considered a complete series if the number of individual images equals or exceeds the traditional number for a complete series. Panoramic films are only compensable when chart documentation clearly indicates reasons for the exposure based on clinical findings. This type of exposure is not to rule out or evaluate 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 once every 36 months if medical necessity is documented.

(F) **Dental prophylaxis.** This procedure is provided once every 184 days including topical application of fluoride.

(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 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 images and/or written documentation explaining the extent of decay must be available for review, if requested.

(iv) Placement of a stainless steel crown is allowed once for a minimum period of 24 months. No other 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.

(H) **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 images and/or written documentation explaining the extent of decay must be available for review, if requested.

(iii) Placement of a stainless steel crown excludes placement of any other type of crown for a period of 24 months. No other restoration on that tooth is compensable during that period of time.

(I) **Pulpotomies and pulpectomies.**

(i) Therapeutic pulpotomies and pulpal debridement are allowable once per lifetime. Pre-and post-operative periapical images 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 five years;

(III) Tooth numbers E and F before six years;

(IV) Tooth numbers N and Q before five years;

(V) Tooth numbers D and G before five years.

(ii) 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.

(J) **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) Pre and post-operative periapical images must be available for review.

(v) Pulpal debridement may be performed for the relief of pain while waiting for the decision from the OHCA.

(vi) Providers are responsible for any follow-up treatment required due to a failed root canal therapy for 24 month post completion.

(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.

(K) **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.

(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 images 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) Pre and post-operative images must be available.

(L) **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.

(M) **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.

(N) **Protective restorations.** This restoration includes removal of decay, if present, and 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.

(O) **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, certified 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 that addresses the 5A's, 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.

(P) **Diagnostic casts and oral/facial images**. Diagnostic casts or oral/facial images may be requested by OHCA or representatives of OHCA. If cast or images are received they will be considered supporting documentation and may be used to make a determination for authorization of services. Submitted documentation used to base a decision will not be returned. Providers will be reimbursed for either the study model or images.

(i) Documentation of photographic images must be kept in the client's medical record and medical necessity identified on the submitted electronic or paper claim.

(ii) Oral/facial photographic images are allowed under the following conditions:

(I) When radiographic images do not adequately support the necessity for requested treatment.

(II) When photo images better support medical necessity for the requested treatment rather than diagnostic models.

(III) If a comprehensive orthodontic workup has not been performed.

(iii) For photographic images, the oral/facial portfolio must include a view of the complete lower arch, complete upper arch, and left and right maximum intercuspation of teeth.

(I) Maximum intercuspation refers to the occlusal position of the mandible in which the cusps of the teeth of both arches fully interpose themselves with the cusps of the teeth of the opposing arch.

(II) Intercuspation defines both the anterior-posterior and lateral relationships of the mandible and the maxilla, as well as the superior-inferior relationship known as the vertical dimension of occlusion.

(iv) Study models or photographic images not in compliance with the above described diagnostic guidelines will not be compensable. The provider may be allowed to resubmit new images that adhere to the diagnostic guidelines. If the provider does not provide appropriate documentation, the request for treatment will be denied.

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. 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 bitewings and periapical films or images of tooth/teeth involved or the edentulous areas if not visible in the bitewings. Images must be submitted with film mounts and each film or print must be of diagnostic quality. Images must be identified by the tooth number and include date of exposure, member name, member ID, provider name, and provider ID. All 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 images, digital media, photographs, or printouts 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 in the member's records. 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 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 images 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 must document the member's oral hygiene and flossing ability in the member's records.

(ii) Teeth that 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 images 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.

(ii) The tooth must be decayed to such an extent to prevent proper cuspal or incisal function.

(iii) The clinical crown is fractured or destroyed by one-half or more.

(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)(iv) of this paragraph should be clearly visible on the submitted images 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 improved oral hygiene documented for at least 12 months in the 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 three or more of the six point measurements five millimeters or greater, or have multiple areas of image supported bone loss, subgingival calculus and must involve two or more teeth per quadrant for consideration. This procedure is not allowed on members under the age 12. This procedure is not allowed in conjunction with any other periodontal surgery.

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 images 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 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~~Early and Periodic Screening, Diagnosis and Treatment (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.~~e.g., 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, 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 or oral/facial images 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)~~(4) 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.

(5) For photographic images, the oral/facial portfolio must show a view of the complete lower arch, complete upper arch, and left and right maximum intercuspation of teeth.

(A) Maximum intercuspation refers to the occlusal position of the mandible in which the cusps of the teeth of both arches fully interpose themselves with the cusps of the teeth of the opposing arch.

(B) Intercuspation defines both the anterior-posterior and lateral relationships of the mandible and the maxilla, as well as the superior-inferior relationship known as the vertical dimension of occlusion.

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-2.1. Program Integrity Audits/Reviews

~~(a) This section applies to all contractors/providers:~~

~~(1) **"Contractor/provider"** means any person or organization that has signed a provider agreement with the Oklahoma Health Care Authority (OHCA).~~

~~(2) **"Extrapolation"** means the methodology of estimating an unknown value by projecting, with a calculated precision (i.e., margin of error), the results of a probability sample to the universe from which the sample was drawn.~~

~~(3) **"Probability sample"** means the standard statistical methodology in which a sample is selected based on the theory of probability (a mathematical theory used to study the occurrence of random events).~~

~~(4) "**Universe**" means all paid claims or types of paid claims audited/reviewed during a specified timeframe.~~

~~(5) "**Sample**" means a statistically valid number of claims obtained from the universe of claims audited/reviewed.~~

~~(6) "**Error Rate**" means the percentage of dollars of audited claims found to be billed in error.~~

~~(b) An OHCA audit/review includes the following:~~

~~(1) An examination of provider records, by either an on-site or desk audit. Claims may be examined for compliance with provider contracts, relevant federal and state laws and regulations, including but not limited to the Oklahoma Administrative Code.~~

~~(2) An initial audit/review report contains preliminary findings. Upon receipt of the findings, a provider may elect to:~~

~~(A) Remit the identified overpayment to OHCA;~~

~~(B) Request informal reconsideration of the initial report per OAC 317:30-3-2.1(b)(3); or~~

~~(C) Request a formal appeal of the initial report per OAC 317:30-3-2.1(b)(4).~~

~~(3) An informal reconsideration period. If a provider requests an informal reconsideration, the provider shall provide any and all documentation or relevant information to clear any misunderstandings and/or findings identified in the initial report. Only claims identified by the provider for reconsideration will be reviewed by the OHCA. Any claims or findings not identified by the provider for reconsideration~~

~~will be deemed waived by the provider if the provider chooses to later appeal the reconsideration finding. The reconsideration findings will replace the initial findings and be identified as the final report.~~

~~(4) The right to a formal appeal, if requested by the provider. A request for reconsideration does not limit a provider's right to a formal appeal. However, all claims not specifically identified by the provider for further audit/review at reconsideration will be deemed waived by the provider for purposes of a formal audit appeal. Additionally, the provider must specifically identify each claim to be contested on appeal and any claim not identified in the appeal will be deemed waived on appeal.~~

~~(5) If the provider does not request either a reconsideration or a formal appeal within the specified timeframe, the initial report will become the final report and the provider will be obligated to reimburse OHCA for any identified overpayment, which amount shall be immediately due and payable to OHCA.~~

~~(c) When OHCA conducts a probability sample audit, the sample claims are selected on the basis of recognized and generally accepted sampling methods. If an audit reveals an error rate exceeding 10%, OHCA shall extrapolate the error rate to the universe of the dollar amount of the audited paid claims.~~

~~(1) When using statistical sampling, OHCA uses a sample that is sufficient to ensure a minimum confidence level of 95%.~~

~~(2) When calculating the amount to be recovered, OHCA ensures that all overpayments and underpayments reflected in the probability sample are totaled and extrapolated to the universe from which the sample was drawn.~~

~~(3) OHCA does not consider non-billed services or supplies when calculating underpayments and overpayments.~~

~~(d) If a probability sample audit reveals an error rate of 10% or less, the provider will be required to reimburse OHCA for any overpayments noted during the audit/review.~~

(a) This section applies to all contracted providers. The following words and terms, when used in this Section, shall have the following meaning:

(1) **"Contractor/provider"** means any person or organization that has signed a provider agreement with the Oklahoma Health Care Authority (OHCA).

(2) **"Extrapolation"** means the methodology of estimating an unknown value by projecting, with a calculated precision (i.e., margin of error), the results of a probability sample to the universe from which the sample was drawn.

(3) **"Probability sample"** means the standard statistical methodology in which a sample is selected based on the theory

of probability (a mathematical theory used to study the occurrence of random events).

(4) "**Universe**" means all paid claims or types of paid claims audited/reviewed during a specified timeframe.

(5) "**Sample**" means a statistically valid number of claims obtained from the universe of claims audited/reviewed.

(6) "**Error Rate**" means the percentage of dollars of audited claims found to be billed in error.

(b) An OHCA audit/review includes an examination of provider records, by either an on-site or desk audit. Claims may be examined for compliance with provider contracts and/or relevant Federal and State laws and regulations, as well as for practices indicative of fraud, waste, and/or abuse of the SoonerCare program, including, but not limited to, inappropriate coding and consistent patterns of overcharging.

(c) An initial audit/review report contains preliminary findings. Within twenty (20) days of the date of the audit/review report, a provider may elect to:

(1) Remit the identified overpayment to OHCA;

(2) Request informal reconsideration of the initial audit report per OAC 317:30-3-2.1(d); or

(3) Request a formal appeal of the initial audit report per OAC 317:30-3-2.1(e).

(d) If a provider requests an informal reconsideration, the provider, within twenty (20) days of the date of the audit/review report, shall:

(1) Produce any and all written existing documentation that is relevant to, and could reasonably be used to clarify or rebut findings as identified in the initial report. Documents submitted for reconsideration shall not be altered or created for purposes of the audit; and

(2) Specifically identify those claims and findings to be reviewed for reconsideration. Any claims or findings not specifically identified by the provider for reconsideration will be deemed to have been waived by the provider for purposes of both the informal reconsideration and the formal appeal, if requested. The reconsideration findings will replace the initial findings and be identified as the final audit report.

(e) A request for an informal reconsideration does not limit a provider's right to a formal appeal as long as any formal appeal of the final audit report is received by the OHCA Legal Docket Clerk within twenty (20) days of the date of the final audit report. However, all claims and findings not specifically identified by the provider upon an informal reconsideration request will be deemed to have been waived by the provider for purposes of a subsequent formal audit appeal. Additionally, the

provider must specifically identify each claim to be contested on appeal, and any remaining appealable claim that has not already been waived during the informal reconsideration and is not specifically identified in the initial appeal filing, will be deemed waived on appeal.

(f) If the provider does not request either an informal reconsideration or a formal appeal within the specified timeframe, the initial report will become the final audit report and the provider will be obligated to reimburse OHCA for any identified overpayment, which amount shall be immediately due and payable to OHCA. OHCA may, at its discretion, withhold the overpayment amount from the provider's future payments.

(g) When OHCA conducts a probability sample audit, the sample claims are selected on the basis of recognized and generally accepted sampling methods. If an audit reveals an error rate exceeding 10%, OHCA shall extrapolate the error rate to the universe of the dollar amount of the audited paid claims.

(1) When using statistical sampling, OHCA uses a sample that is sufficient to ensure a minimum confidence level of 95%.

(2) When calculating the amount to be recovered, OHCA ensures that all overpayments and underpayments reflected in the probability sample are totaled and extrapolated to the universe from which the sample was drawn.

(3) OHCA does not consider non-billed services or supplies when calculating underpayments and overpayments.

(h) If a probability sample audit reveals an error rate of 10% or less, the provider will be required to reimburse OHCA for any overpayments noted during the audit/review.

317:30-3-4.1. Uniform Electronic Transaction Act

~~The Oklahoma Health Care Authority enacts the provisions of the Uniform Electronic Transaction Act as provided in this Section with the exception to the act as provided in this Section.~~These rules regulate the format, use, and retention of electronic records and signatures generated, sent, communicated, received, or stored by the Oklahoma Health Care Authority (OHCA), in conformity with the Uniform Electronic Transaction Act, found at Section 15-101 et seq. of Title 12A of the Oklahoma Statutes.

~~(1) **Scope of Act.** The Electronic Transaction Act applies to an electronic record and an electronic signature created with a record that is generated, sent, communicated, received or stored by the Oklahoma Health Care Authority.~~

~~(2)~~(1) **Use of electronic records and electronic signatures.** The rules regarding electronic records and electronic signatures apply when both parties agree to conduct business electronically. Nothing in these regulations requires parties

to conduct business electronically. However, should a party have the capability and desire to conduct business electronically with the ~~Oklahoma Health Care Authority~~OHCA, then the following guidelines must be adhered to:

(A) Only employees designated by the provider's agency may make entries in the member's medical record. All entries in the member's medical record must be dated and authenticated with a method established to identify the author. The identification method may include computer keys, Private/Public Key Infrastructure (PKIs), voice authentication systems that utilize a personal identification number (PIN) and voice authentication, or other codes. Providers must have a process in place to deactivate an employee's access to records upon termination of employment of the designated employee.

(B) When PKIs, computer key/code(s), voice authentication systems or other codes are used, a signed statement must be completed by the agency's employee documenting that the chosen method is under the sole control of the person using it and further demonstrate that:

(i) A list of PKIs, computer key/code(s), voice authentication systems or other codes can be verified;

(ii) All adequate safeguards are maintained to protect against improper or unauthorized use of PKIs, computer keys, or other codes for electronic signatures; and

(iii) Sanctions are in place for improper or unauthorized use of computer key/code(s), PKIs, voice authentication systems or other code types of electronic signatures.

(C) There must be a specific action by the author to indicate that the entry is verified and accurate. Systems requiring an authentication process include, but are not limited to:

(i) Computerized systems that require the provider's employee to review the document on-line and indicate that it has been approved by entering a unique computer key/code capable of verification;

(ii) A system in which the provider's employee signs off against a list of entries that must be verified in the member's records;

(iii) A mail system that sends transcripts to the provider's employee for review;

(iv) A postcard identifying and verifying the accuracy of the record(s) signed and returned by the provider's employee; or

(v) A voice authentication system that clearly identifies the author by a designated personal identification number or security code.

(D) Auto-authentication systems that authenticate a report prior to the transcription process do not meet the stated requirements and will not be an acceptable method for the authentication process.

(E) The authentication of an electronic medical record (signature and date entry) ~~is expected on the day the record is completed. If~~must occur within three (3) days of the provision of the underlying service, including those instances in which the electronic medical record is transcribed by someone other than the provider~~, the signature of the rendering provider and date entry is expected within three business days from the day the record is completed~~. Before any claim is submitted to OHCA for payment of a provided service, the provider must authenticate the electronic medical records relating to that service.

(F) Records may be edited by designated administrators within the provider's facility. Edits must be in the form of a correcting entry which preserves entries from the original record. Edits must be completed prior to claims submission or no later than ~~45~~forty-five (45) days after the date of service, whichever ~~is later~~occurs first.

(G) Use of the electronic signature, for clinical documentation, shall be deemed to constitute a signature and will have the same effect as a written signature on the clinical documentation. The section of the electronic record documenting the service provided must be authenticated by the employee or individual who provided the described service.

(H) Any authentication method for electronic signatures must:

(i) be unique to the person using it;

(ii) identify the individual signing the document by name and title;

(iii) be capable of verification, assuring that the documentation cannot be altered after the signature has been affixed;

(iv) be under the sole control of the person using it;

(v) be linked to the data in such a manner that if the data is changed, the signature is invalidated; and

(vi) provide strong and substantial evidence that will make it difficult for the signer to claim that the electronic representation is not valid.

(I) Failure to properly maintain or authenticate medical

records (i.e., signature and date entry) may result in the denial or recoupment of SoonerCare payments.

~~(3)~~(2) **Record retention for provider medical records.** Providers must retain electronic medical records and have access to the records in accordance with guidelines found at OAC 317:30-3-15.

~~(4)~~(3) **Record retention for documents submitted to OHCA electronically.**

(A) The ~~Oklahoma Health Care Authority's~~OHCA's system provides that receivers of electronic information may both print and store the electronic information they receive. The ~~Oklahoma Health Care Authority~~OHCA is the custodian of the original electronic record and will retain that record in accordance with a disposition schedule as referenced by the Records Destruction Act. The ~~Oklahoma Health Care Authority~~OHCA will retain an authoritative copy of the transferable record as described in the Electronic Transaction Act that is unique, identifiable and unalterable.

(i) **Manner and format of electronic signature.** The manner and format required by the ~~Oklahoma Health Care Authority~~OHCA will vary dependent upon whether the sender of the document is a member or a provider. In the limited case where a provider is a client, the manner and format is dependent upon the function served by the receipt of the record. In the case the function served is a request for services, then the format required is that required by a recipient. In the case the function served is related to payment for services, then the format required is that required by a provider.

(ii) **~~Recipient~~Member format requirements.** The ~~Oklahoma Health Care Authority~~OHCA will allow members to request SoonerCare services electronically. An electronic signature will be authenticated after a validation of the data on the form by another database or databases.

(iii) **Provider format requirements.** The ~~Oklahoma Health Care Authority~~OHCA will permit providers to contract with the ~~Oklahoma Health Care Authority~~OHCA, check and amend claims filed with the ~~Oklahoma Health Care Authority~~OHCA, and file prior authorization requests with the ~~Oklahoma Health Care Authority~~OHCA. Providers with a social security number or federal employer's identification number will be given a personal identification number (PIN). After using the PIN to access the database, a PIN will be required to transact business electronically.

(B) Providers with the assistance of the O~~klahoma Health Care Authority~~OHCA will be required to produce and enforce a security policy that outlines who has access to their data and what transaction employees are permitted to complete as outlined in the policy rules for electronic records and electronic signatures contained in paragraph two (2) of this section.

(C) Third Party billers for providers will be permitted to perform electronic transaction as stated in paragraph two (2) only after the provider authorizes access to the provider's PIN and a power of attorney by the provider is executed.

~~(5)~~(4) **Time and place of sending and receipt.** The provisions of the Electronic Transaction Act apply to the time and place of sending and receipt ~~with the exception of a power~~. Should a power failure, Internet interruption or Internet virus~~. Should any of the exceptions in this paragraph occur, confirmation is required by the receiving party.~~ occur, confirmation by the receiving party will be required to establish receipt.

~~(6)~~(5) **Illegal representations of electronic transaction.** Any person who fraudulently represents facts in an electronic transaction, acts without authority, or exceeds ~~their~~his or her authority to perform an electronic transaction may be prosecuted under all applicable criminal and civil laws.

317:30-3-30. Signature requirements

(a) For medical review purposes, the Oklahoma Health Care Authority (OHCA) requires that all services provided and/or ordered be authenticated by the author. The method used shall be a ~~hand written~~handwritten signature, electronic signature, or signature attestation statement. Stamped signatures are not acceptable. Pursuant to ~~federal~~Federal and/or ~~state~~State law, there are some circumstances for which an order does not need to be signed.

(1) Facsimile of original written or electronic signatures are acceptable for the certifications of terminal illness for hospice.

(2) Orders for clinical diagnostic tests are not required to be signed. If the order for the clinical diagnostic test is unsigned, there must be medical documentation by the treating physician that he/she intended the clinical diagnostic test be performed. This documentation showing the intent that the test be performed must be authenticated by the author via a ~~hand written~~handwritten or electronic signature.

(3) Orders for outpatient prescription drugs are not required to be signed. If the order for a prescription drug is

unsigned, there must be medical documentation by the treating physician that he/she intended that the prescription drug be ordered. This documentation showing the intent that the prescription drug be ordered must be authenticated by the author via a ~~hand written~~handwritten or electronic signature.

(b) A ~~hand written~~handwritten signature is a mark or sign by an individual on a document to signify knowledge, approval, acceptance, or obligation. The authentication of a medical record (signature and date entry) ~~is expected on the day the record is completed. If the medical record is transcribed by someone other than the provider, the signature of the rendering provider and date entry is expected within three business days from the day the record is completed.~~must occur within three (3) days of provision of the underlying service, including those instances in which the electronic medical record is transcribed by someone other than the provider. Before any claim is submitted to the OHCA for payment of a provided service, the provider must authenticate the electronic medical records relating to that service.

(1) If a signature is illegible, the OHCA will consider evidence in a signature log or attestation statement to determine the identity of the author of a medical record entry.

(2) If the signature is missing from an order, the OHCA will disregard the order during the review of the claim.

(3) If the signature is missing from any other medical documentation, the OHCA will accept a signature attestation from the author of the medical record entry.

(c) Providers may include in the documentation they submit a signature log that lists the typed or printed name of the author associated with initials or an illegible signature.

(1) The signature log may be included on the actual page where the initials or illegible signature are used or may be a separate document.

(2) The OHCA will not deny a claim for a signature log that is missing credentials.

(3) The OHCA will consider all submitted signature logs regardless of the date they were created.

(d) Providers may include in the documentation they submit a signature attestation statement. In order to be considered valid for medical review purposes, an attestation statement must be signed and dated by the author of the medical record entry and must contain sufficient information to identify the member.

(1) The OHCA will not consider signature attestation statements where there is no associated medical record entry.

(2) The OHCA will not consider signature attestation statements from someone other than the author of the medical record entry in question.

(3) The OHCA will consider all signature attestation statements that meet the above requirements regardless of the date the attestation was created, except in those cases where the regulations or rules indicate that a signature must be in place prior to a given event or a given date.

(e) Providers may use electronic signatures as an alternate signature method.

(1) Providers must use a system and software products which are protected against modification and must apply administrative procedures which are adequate and correspond to recognized standards and laws.

(2) Providers utilizing electronic signatures bear the responsibility for the authenticity of the information being attested to.

(3) Providers utilizing electronic signatures must comply with OAC 317:30-3-4.1.

(f) Nothing in this section is intended to absolve the provider of their obligations in accordance with the conditions set forth in their SoonerCare contract and the rules delineated in OAC 317:30.