January 13, 2022
1:00 – 3:30 PM

Charles Ed McFall Board Room

AGENDA

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

II. Action Item: Approval of Minutes of the November 4th, 2021: **Medical Advisory Committee Meeting**

III. Public Comments (2 minute limit)

IV. MAC Member Comments/Discussion

V. Legislative Update**: Katelynn Burns, Legislative Liaison**

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

VII. SoonerCare Operations: **Traylor Rains, Deputy State Medicaid Director**

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

- **A. APA WF 21-02A OHS ADvantage Waiver Services and State Plan Personal Care Services**
- **B. APA WF 21-02B OHS ADvantage Waiver Services and State Plan Personal Care Services**
- **C. APA WF 21-25 Non-Emergency Transportation (NEMT) Driver Compliance**
- **D. APA WF 21-27 Policy Reference Clean Up - Timely Filing**
- **E. APA WF 21-30 Eliminate Community-Based Extended (CBE) and Community Based Transitional (CBT) Levels of Care**
- **F. APA WF 21-31 Applied Behavior Analysis (ABA) Revisions**
- **G. APA WF 21-33 Improve 340B Shared Savings Methodology**
- **H. APA WF 21-34 Reimbursement Methodology for Providers of CCBH Services**
- **I. APA WF 21-44 Independent Clinical Psychologist Services for Adults**

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

X. Future Meeting: **Chairman, Jason Rhynes, O.D.**
March 10, 2022
May 12, 2022
July 14, 2022

September 8, 2022
November 10, 2022

XI. Adjourn **Chairman, Jason Rhynes, O.D.**

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

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

Delegates present were: Ms. Sarah Baker, Ms. Debra Billingsly, Dr. Erin Balzer, Dr. Joe Catalano, Mr. Victor Clay, Dr. Steven Crawford, Ms. Wanda Felty, Ms. Terrie Fritz, Ms. Allison Garrison, Mr. Mark Jones, Ms. Jennifer King, Dr. Craig Kupiec, Ms. Annette Mays, Ms. Melissa Miller, Dr. Daniel Post, Ms. Toni Pratt-Reid, Dr. Jason Rhynes, Ms. Mitzi McCullock, and Dr. Whitney Yeates.

Alternates present were: Mr. Steven Buck and Mr. Terry Bryce, providing a quorum.

***Delegates absent without an alternate were*:** Ms. Mary Brinkley, Mr. Steve Goforth, Dr. J'Dene Rogers, Mr. James Patterson, Dr. Raymond Smith, Dr. Dwight Sublett, Mr. Jeff Tallent, and Mr. William Whited.

II. Approval of the September 9, 2021 Minutes

Medical Advisory Committee

The motion to approve the minutes was by Mr. Victor Clay and seconded by Dr. Joe Catalano and passed unanimously.

III. Public Comments (2 minute limit):

There were no public comments.

IV. MAC Member Comments/Discussion:

Chairman, Jason Rhynes, O.D.

V. SoonerCare Operations Update:

Traylor Rains, Deputy State Medicaid Director

Mr. Rains presented the SoonerCare Operations update to the committee. Information is based on data for September 2021. Patient Centered Medical Home enrollment is at 630,482 which is down by 2,372. Sooner Care Traditional has a current enrollment of 467,631 which is 22,779 more than the previous month. Expansion has an enrollment of 181,747 and Insure Oklahoma has a total enrollment of 10,731. In total, SoonerCare enrollment is at 1,121,953. Total in-state providers is up 523 giving a total of 46,585. For more detailed information, please see item 5 in the MAC agenda.

VIII. 1115 Waiver Post Award Forum:

Sandra Puebla, Senior Director of Federal & State Authorities

Pursuant to federal regulation the state is required to annually report on the progress of the Oklahoma 1115(a) Waiver other wise known as SoonerCare Choice. A posting soliciting feedback from the public was placed on the OHCA public site on October 15th through November 15, 2021. On August 28th, OHCA SoonerCare Choice Waiver was approved for a period of five years, August 31, 2018, through December 31, 2023. The annual Post Award Forum reports the waivers progress for Calendar year 2020. The following amendments were submitted to CMS for the 1115(a) Waiver. One, was to add the newly eligible adult group to the Patient Centered Medical Homes, effective July 1, 2020, to complement the agencies request to expand Medicaid, which was also set to be effective July 1, 2020. It was submitted on May 1, 2020, and it was withdrawn August 17, 2020, as the state needed more time.

The second request to phase off the Insure Oklahoma Individual Plan with an effective date of July 1, 2021. It was submitted on November 16, 2020, and the amendment is currently still pending official CMS approval. The demonstrations most recent semi-annual report highlighted the program COVID-19 Pandemic National Health Emergency as a key challenge during 2020, however, OHCA took Immediate action to make the crisis response a notable achievement. Agency staff, contractors, and partners successfully transitioned to a remote work force while maintaining essential operations to best serve the members and our providers.

In 2020 OHCA received serval approvals on the disaster relief request from our Federal partners at CMS to provide flexibilities which waived or modified certain requirements to support the SoonerCare Choice Program, its members, and its providers. The flexibilities included Telehealth, COVID-19 testing and treatment, increase pharmacy benefits, and increase flexibilities regarding member recertifications, PA requirements, provider enrollment, revalidation requirements to ensure un-interrupted coverage. Staff provided virtual trainings on topics such as Child Health, Claims Submissions, Outpatient Behavioral Health, PCMH, Telehealth, and Coverage Services.

The HMP continues to produce a return on investment, particularly, health expenditures are less for those engaged with HMP, and the rate of the emergency room use is lower among those participants. Individuals engaged with the Health Access Networks also show to have a lower utilization rate at the emergency room. Programs operated through the 1115(a) Waiver must be

budget neutral, which means that the cost for care provided under that authority is equal to or less than what would have been spent otherwise.

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

Sandra Puebla, Senior Director of Federal & State Authorities

APA WF 21-22 Title XXI Dental Revisions for Pregnant Women — The proposed revisions will amend policy to provide certain dental benefits to pregnant women covered under the Title XXI State Plan. The revisions are needed to comply with parity federal regulations which instruct the State to provide services that are medically necessary to the unborn child.

Budget Impact: The estimated budget impact for SFY2022 will be an increase in the total amount of $185,934; with $49,626 in state share. The estimated budget impact for SFY2023 will be an increase in the total amount of $371,869; with $98,731 in state share.

Tribal Consultation: September 7, 2021

The rule change motion to approve was by Dr. Whitney Yeates and seconded by Dr. Steven Crawford and passed unanimously.

APA WF # 21-26 Afghan Refugees - The proposed policy will update eligibility determinations related to Afghan nationals with certain immigration statuses entering the U.S. to align with federal law.

Budget Impact: The estimated budget impact for SFY 2022 will be an increase in the total amount of $3,841,000; with $889,082 in state share. The estimated budget impact for SFY 2023 will be an increase in the total amount of $6,913,800; with $1,894,554 in state share.

Tribal Consultation: November 2, 2021

The rule change motion to approve was by Dr. Steven Crawford and seconded by Dr. J. Daniel Post and passed unanimously.

X. **Election of Chairman and Vice-Chairman:**

Chairman, Jason Rhynes, O.D.

Dr. Steven Crawford made a motion for the election of officers for 2022. Dr. Jason Rhynes was nominated for Chair by Dr. Steven Crawford and seconded by Mr. Victor Clay and passed unanimously. Ms. Wanda Felty was nominated for Vice Chairman by Ms. Terrie Fritz and seconded by Dr. Joe Catalano. Dr. J. Daniel Post was also nominated for Vice-Chairman by Dr. Jason Rhynes and seconded by Dr. Joe Catalano. Roll call was taken with 1 Abstaining, 5 votes for Dr. J. Daniel Post and 16 votes for Ms. Wanda Felty.

XI. MAC Meeting Dates for Calendar 2022:

Chairman, Jason Rhynes, O.D.

January 13, 2022
March 10, 2022
May 12, 2022
July 14, 2022
September 8, 2022
November 10, 2022

XII. **New Business:**

Chairman, Jason Rhynes, O.D.

No new business was identified.

XIII. Adjourn:

Chairman, Jason Rhynes, O.D.

Chairman Rhynes asked for a motion to adjourn. Motion was provided by Dr. Arlen Foulks and seconded by Dr. Joe Catalano, there was no dissent and the meeting adjourned at 1:56pm.

OKLAHOMA
Health Care Authority

FINANCIAL REPORT

For the Four Month Period Ending October 31, 2021
Submitted to the CEO & Board

- Revenues for OHCA through October, accounting for receivables, were **$2,254,713,951** or **5.5% under** budget.
- Expenditures for OHCA, accounting for encumbrances, were **$2,017,611,716** or **7.2% under** budget.
- The state dollar budget variance through October is a positive **$25,367,265.**
- The budget variance is primarily attributable to the following (in millions):

Expenditures:		
Medicaid Program Variance		22.8
Administration		1.0
Revenues:		
Drug Rebate		2.4
Medical Refunds		(0.4)
Taxes and Fees		(0.5)
Total FY 22 Variance	**$**	**25.3**

ATTACHMENTS

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures: OHCA
SFY 2022, For the Four Month Period Ending October 31, 2021

REVENUES	FY22 Budget YTD	FY22 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 442,874,852	$ 442,874,852	$ -	0.0%
Federal Funds	1,638,151,404	1,497,709,632	(140,441,772)	(8.6)%
Tobacco Tax Collections	15,522,510	16,232,199	709,689	4.6%
Quality of Care Collections	30,094,374	28,748,165	(1,346,210)	(4.5)%
Prior Year Carryover	6,033,960	6,033,960	-	0.0%
Federal Deferral - Interest	52,194	52,194	-	0.0%
Rate Preservation Fund	54,712,684	54,712,684	-	0.0%
Drug Rebates	111,360,457	122,997,303	11,636,846	10.4%
Medical Refunds	12,567,024	10,600,393	(1,966,631)	(15.6)%
Prior Year Carryover Supplemental Hospital Offset Payment Program	3,415,272	3,415,272	-	0.0%
Supplemental Hospital Offset Payment Program	70,354,486	70,354,486	-	0.0%
GME Federal Disallowance Repayment - OU/OSU	-	-	-	0.0%
Other Revenues	874,804	982,811	108,007	12.3%
TOTAL REVENUES	**$ 2,386,014,020**	**$ 2,254,713,951**	**$ (131,300,070)**	**(5.5)%**

EXPENDITURES	FY22 Budget YTD	FY22 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 21,712,170**	**$ 18,883,752**	**$ 2,828,418**	**13.0%**
ADMINISTRATION - CONTRACTS	**$ 53,174,696**	**$ 53,788,632**	**$ (613,936)**	**(1.2)%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	20,575,731	16,435,020	4,140,711	20.1%
Acute Fee for Service Payments:				
Hospital Services	503,991,468	454,965,916	49,025,552	9.7%
Behavioral Health	6,344,172	8,072,548	(1,728,376)	(27.2)%
Physicians	218,965,012	162,307,974	56,657,037	25.9%
Dentists	72,868,566	54,120,100	18,748,466	25.7%
Other Practitioners	26,438,985	21,003,817	5,435,168	20.6%
Home Health Care	16,308,877	9,898,855	6,410,022	39.3%
Lab & Radiology	26,538,334	13,914,454	12,623,881	47.6%
Medical Supplies	24,532,085	23,624,884	907,200	3.7%
Ambulatory/Clinics	130,836,339	146,372,373	(15,536,034)	(11.9)%
Prescription Drugs	352,592,731	318,610,691	33,982,040	9.6%
OHCA Therapeutic Foster Care	157,348	161,999	(4,651)	(3.0)%
Other Payments:				
Nursing Facilities	220,412,634	241,447,228	(21,034,593)	(9.5)%
Intermediate Care Facilities for Individuals with Intellectual Disabilities Private	22,250,480	21,471,238	779,242	3.5%
Medicare Buy-In	69,486,887	69,565,015	(78,128)	(0.1)%
Transportation	33,482,369	29,495,022	3,987,347	11.9%
Money Follows the Person-OHCA	70,511	82,178	(11,667)	(16.5)%
Electronic Health Records-Incentive Payments	108,975	108,975	-	0.0%
Part D Phase-In Contribution	27,259,231	27,293,211	(33,980)	(0.1)%
Supplemental Hospital Offset Payment Program	322,256,424	322,256,424	-	0.0%
Telligen	3,825,643	3,731,409	94,234	2.5%
Total OHCA Medical Programs	**2,099,302,803**	**1,944,939,332**	**154,363,471**	**7.4%**
OHCA Non-Title XIX Medical Payments	89,382	-	89,382	0.0%
TOTAL OHCA	**$ 2,174,279,050**	**$ 2,017,611,716**	**$ 156,667,334**	**7.2%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ 211,734,970**	**$ 237,102,235**	**$ 25,367,265**	

OKLAHOMA HEALTH CARE AUTHORITY

Total Medicaid Program Expenditures
by Source of State Funds
SFY 2022, For the Four Month Period Ending October 31, 2021

Category of Service	Total	Health Care Authority	Quality of Care Fund	HEEIA	SHOPP Fund	BCC Revolving Fund	Other State Agencies
SoonerCare Choice	$ 16,435,020	$ 16,432,260	$ -	$ -	$ -	$ 2,761	$ -
Inpatient Acute Care	612,963,246	275,687,552	162,229	1,161,725	248,813,045	383,724	86,754,971
Outpatient Acute Care	240,037,885	176,996,530	13,868	1,476,191	59,829,284	1,722,013	-
Behavioral Health - Inpatient	34,215,196	4,967,393	-	153,139	11,649,911	-	17,444,752
Behavioral Health - Psychiatrist	5,069,339	3,105,155	-	-	1,964,184	-	-
Behavioral Health - Outpatient	6,062,583	-	-	-	-	-	6,062,583
Behavioral Health-Health Home	2,911,855	-	-	-	-	-	2,911,855
Behavioral Health Facility- Rehab	68,129,136	-	-	-	-	64,683	68,129,136
Behavioral Health - Case Management	1,954,867	-	-	-	-	-	1,954,867
Behavioral Health - PRTF	3,853,761	-	-	-	-	-	3,853,761
Behavioral Health - CCBHC	56,771,866	-					56,771,866
Residential Behavioral Management	6,560,808	-	-	-	-	-	6,560,808
Targeted Case Management	21,400,357	-	-	-	-	-	21,400,357
Therapeutic Foster Care	161,999	161,999	-	-	-	-	-
Physicians	200,415,025	161,171,332	19,367	1,411,585	-	1,117,276	36,695,466
Dentists	54,139,050	54,102,539	-	18,950	-	17,561	-
Mid Level Practitioners	346,616	345,700	-	785	-	131	-
Other Practitioners	20,765,330	20,474,093	148,788	107,343	-	35,105	-
Home Health Care	9,902,631	9,898,036	-	3,775	-	819	-
Lab & Radiology	14,084,168	13,851,642	-	169,715	-	62,811	-
Medical Supplies	23,667,158	22,703,468	903,844	42,274	-	17,572	-
Clinic Services	149,475,611	143,538,363	-	826,928	-	98,470	5,011,850
Ambulatory Surgery Centers	2,772,486	2,733,268	-	36,947	-	2,271	-
Personal Care Services	3,076,333	-	-	-	-	-	3,076,333
Nursing Facilities	241,447,228	127,022,237	114,416,685	-	-	8,305	-
Transportation	29,368,657	28,326,593	911,582	65,367	-	65,114	-
IME/DME/GME	43,490,540	-	-	-	-	-	43,490,540
ICF/IID Private	21,471,238	15,627,122	5,844,117	-	-	-	-
ICF/IID Public	7,029,890	-	-	-	-	-	7,029,890
CMS Payments	96,858,226	96,720,357	137,869	-	-	-	-
Prescription Drugs	318,946,330	317,291,544	-	335,639	-	1,319,147	-
Miscellaneous Medical Payments	191,733	186,467	-	-	-	5,265	-
Home and Community Based Waiver	86,859,551	-	-	-	-	-	86,859,551
Homeward Bound Waiver	24,202,678	-	-	-	-	-	24,202,678
Money Follows the Person	82,178	82,178	-	-	-	-	-
In-Home Support Waiver	8,565,581	-	-	-	-	-	8,565,581
ADvantage Waiver	59,469,724	-	-	-	-	-	59,469,724
Family Planning/Family Planning Waiver	792,617	-	-	-	-	-	792,617
Premium Assistance*	14,705,177	-	-	14,705,177.49	-	-	-
Telligen	3,731,409	3,731,409	-	-	-	-	-
Electronic Health Records Incentive Payments	108,975	108,975	-	-	-	-	-
Total Medicaid Expenditures	**$ 2,512,494,056**	**$ 1,495,266,214**	**$ 122,558,348**	**$ 20,515,540**	**$ 322,256,424**	**$ 4,923,029**	**$ 547,039,185**

* Includes $14,541,158.30 paid out of Fund 245

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures:
Other State Agencies
SFY 2022, For the Four Month Period Ending October 31, 2021

REVENUE	FY22 Actual YTD
Revenues from Other State Agencies	134,702,473
Federal Funds	437,205,339
TOTAL REVENUES	**$ 571,907,812**

EXPENDITURES	Actual YTD
Department of Human Services	
Home and Community Based Waiver	86,859,551
Money Follows the Person	-
Homeward Bound Waiver	24,202,678
In-Home Support Waivers	8,565,581
ADvantage Waiver	59,469,724
Intermediate Care Facilities for Individuals with Intellectual Disabilities Public	7,029,890
Personal Care	3,076,333
Residential Behavioral Management	4,504,146
Targeted Case Management	19,331,954
Total Department of Human Services	**213,039,856**
State Employees Physician Payment	
Physician Payments	36,695,466
Total State Employees Physician Payment	**36,695,466**
Education Payments	
Graduate Medical Education	-
Indirect Medical Education	38,096,396
Direct Medical Education	2,105,656
DSH	3,288,488
Total Education Payments	**43,490,540**
Office of Juvenile Affairs	
Targeted Case Management	636,609
Residential Behavioral Management	2,056,662
Total Office of Juvenile Affairs	**2,693,272**
Department of Mental Health	
Case Management	1,954,867
Inpatient Psychiatric Free-standing	17,444,752
Outpatient	6,062,583
Health Homes	2,911,855
Psychiatric Residential Treatment Facility	3,853,761
Certified Community Behavioral Health Clinics	56,771,866
Rehabilitation Centers	68,129,136
Total Department of Mental Health	**157,128,819**
State Department of Health	
Children's First	-
Sooner Start	313,660
Early Intervention	1,021,970
Early and Periodic Screening, Diagnosis, and Treatment Clinic	370,494
Family Planning	210,666
Family Planning Waiver	581,951
Maternity Clinic	-
Total Department of Health	**2,498,742**
County Health Departments	
EPSDT Clinic	75,927
Family Planning Waiver	-
Total County Health Departments	**75,927**
State Department of Education	**38,970**
Public Schools	**370,855**
Medicare DRG Limit	**83,725,754**
Native American Tribal Agreements	**4,251,768**
Department of Corrections	**1,663,437**
JD McCarty	**1,365,780**
Total OSA Medicaid Programs	**$ 547,039,185**
OSA Non-Medicaid Programs	**$ 44,970,865**
Accounts Receivable from OSA	**$ 20,102,237**

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

Fund 205: Supplemental Hospital Offset Payment Program Fund

SFY 2022, For the Four Month Period Ending October 31, 2021

REVENUES		FY 22 Revenue
SHOPP Assessment Fee		66,917,706
SHOPP Assessment Fee - Expansion		3,401,601
Prior Year Carryover - SHOPP Expansion		3,415,272
Federal Draws	$	262,987,536
Interest		35,179
Penalties		-
State Appropriations		(15,100,000)
TOTAL REVENUES	$	321,657,294

EXPENDITURES	Quarter	Quarter	Quarter	Quarter		FY 22 Expenditures
Program Costs:	7/1/21 - 9/30/21	10/1/21 - 12/31/21	1/1/22 - 3/31/22	4/1/22 - 6/30/22		
Hospital - Inpatient Care	123,788,329	125,024,716			$	248,813,045
Hospital -Outpatient Care	29,774,968	30,054,316			$	59,829,284
Psychiatric Facilities-Inpatient	5,795,705	5,854,206			$	11,649,911
Rehabilitation Facilities-Inpatient	977,160	987,024			$	1,964,184
Total OHCA Program Costs	160,336,162	161,920,262	-	-	$	322,256,424
Total Expenditures					$	322,256,424

CASH BALANCE		
	$	(599,130)

*** Expenditures and Federal Revenue processed through Fund 340

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 230: Nursing Facility Quality of Care Fund
SFY 2022, For the Four Month Period Ending October 31, 2021

REVENUES	Total Revenue	State Share
Quality of Care Assessment	$ 28,739,897	$ 28,739,897
*Quality of Care Penalties (*Non-Spendable Revenue)*	$ 93,820	$ 93,820
Interest Earned	8,267	$ 8,267
TOTAL REVENUES	$ 28,841,985	$ 28,841,985

EXPENDITURES	FY 22 Total $ YTD	FY 22 State $ YTD	Total State $ Cost
Program Costs			
Nursing Facility Rate Adjustment	$ 80,160,378	$ 16,621,710	
Eyeglasses and Dentures	77,709	$ 16,113	
Personal Allowance Increase	985,220	$ 204,242	
Coverage for Durable Medical Equipment and Supplies	903,844	$ 187,367	
Coverage of Qualified Medicare Beneficiary	344,252	$ 71,363	
Part D Phase-In	137,869	$ 137,869	
ICF/IID Rate Adjustment	1,589,438	$ 329,579	
Acute Services ICF/IID	2,309,411	$ 478,856	
Non-emergency Transportation - Soonerride	911,582	$ 188,968	
NF Covid-19 Supplemental Payment	33,193,378	$ 6,801,323	
ICF Covid-19 Supplemental Payment	1,945,268	$ 398,585	
Ventilator NF DME Supplemental Payment		$ -	
Total Program Costs	**$ 122,558,348**	**$ 25,435,976**	**$ 25,435,976**
Administration			
OHCA Administration Costs	$ 98,332	$ 49,166	
DHS-Ombudsmen	152,137	152,137	
OSDH-Nursing Facility Inspectors	-	-	
Mike Fine, CPA	-	-	
Total Administration Costs	**$ 250,469**	**$ 201,303**	**$ 201,303**
Total Quality of Care Fee Costs	**$ 122,808,818**	**$ 25,637,279**	
TOTAL STATE SHARE OF COSTS			**$ 25,637,279**

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 2022, For the Four Month Period Ending October 31, 2021

REVENUES	FY 21 Carryover	FY 22 Revenue	Total Revenue
Prior Year Balance	$ 12,826,511		
State Appropriations	-		
Federal Draws - Prior Year	115,189		
Total Prior Year Revenue			12,941,700
Tobacco Tax Collections	-	13,350,467	13,350,467
Interest Income	-	56,186	56,186
Federal Draws	-	11,768,247	11,768,247
TOTAL REVENUES	$ 12,941,700	$ 25,174,900	$ 38,116,601

EXPENDITURES		FY 21 Expenditures	FY 22 Expenditures	Total State $ YTD
Program Costs:				
	Employer Sponsored Insurance		$ 14,541,158	$ 14,541,158
	College Students/ESI Dental		164,019	34,004
Individual Plan				
	SoonerCare Choice		$ -	$ -
	Inpatient Hospital		1,157,985	240,574
	Outpatient Hospital		1,460,955	303,625
	BH - Inpatient Services-DRG		151,700	31,553
	BH -Psychiatrist		-	-
	Physicians		1,394,726	289,921
	Dentists		18,926	3,935
	Mid Level Practitioner		785	163
	Other Practitioners		106,510	22,139
	Home Health		3,775	783
	Lab and Radiology		167,456	34,821
	Medical Supplies		40,487	8,420
	Clinic Services		812,574	168,922
	Ambulatory Surgery Center		36,947	7,684
	Skilled Nursing		-	-
	Prescription Drugs		328,324	68,395
	Transportation		65,142	13,541
	Premiums Collected			36,714
Total Individual Plan			$ 5,746,292	$ 1,231,190
	College Students-Service Costs		$ 64,071	$ 13,328
Total OHCA Program Costs			$ 20,515,540	$ 15,819,680
Administrative Costs				
	Salaries	$ 2,283	$ 412,055	$ 414,338
	Operating Costs	2,121	920	3,042
	E&E Development DXC	-	-	-
	Contract - DXC	7,584	130,489	138,073
Total Administrative Costs		$ 11,988	$ 543,465	$ 555,453
Total Expenditures				$ 16,375,133
NET CASH BALANCE		$ 12,929,713	$ 8,811,755.38	$ 21,741,468

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 250: Belle Maxine Hilliard Breast and Cervical Cancer Treatment Revolving Fund
SFY 2022, For the Four Month Period Ending October 31, 2021

REVENUES	FY 22 Revenue	State Share
Tobacco Tax Collections	$ 266,436	$ 266,436
TOTAL REVENUES	**$ 266,436**	**$ 266,436**

EXPENDITURES	FY 22 Total $ YTD	FY 22 State $ YTD	Total State $ Cost
Program Costs			
SoonerCare Choice	$ 2,761	$ 497	
Inpatient Hospital	383,724	$ 69,255	
Outpatient Hospital	1,722,013	$ 310,316	
Inpatient Services-DRG	-	$ -	
Psychiatrist	-	$ -	
TFC-OHCA	-	$ -	
Nursing Facility	8,305	$ 1,501	
Physicians	1,117,276	$ 201,350	
Dentists	17,561	$ 3,162	
Mid-level Practitioner	131	$ 23	
Other Practitioners	35,105	$ 6,327	
Home Health	819	$ 148	
Lab & Radiology	62,811	$ 11,332	
Medical Supplies	17,572	$ 3,167	
Clinic Services	98,470	$ 17,730	
Ambulatory Surgery Center	2,271	$ 409	
Prescription Drugs	1,319,147	$ 237,800	
Transportation	65,114	$ 11,731.04	
Miscellaneous Medical	5,265	$ 951.00	
Total OHCA Program Costs	**$ 4,858,346**	**$ 875,700**	
OSA DMHSAS Rehab	64,683	11,655	
Total Medicaid Program Costs	**$ 4,923,029**	**$ 887,355**	
TOTAL STATE SHARE OF COSTS			**$ 887,355**

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

Combining Statement of Revenues, Expenditures and Changes in Fund Balance

SFY 2022, For the Four Month Period Ending October 31, 2021

	Administration Fund 200	Supplemental Hospital Offset Payment Program Fund 205	Quality of Care Fund 230	Rate Preservation Fund 236	Federal Deferral Fund 240	HEEIA Fund 245	Belle Maxine Hilliard Breast & Cervical Cancer Treatment (Tobacco) Fund 250	Medicaid Program (Tobacco) Fund 255	Medicaid Program Fund 340	Clearing Account 1807B	Total Cash Balance
October Beginning Fund Balance:											
Prior year	38,652,578	2,913,409	25,267	33,453,218	13,821,907	12,929,713	-	-	469,575,706	78,880,292	650,252,090
Current year	(8,610,623)	2,037,065	55,508	41,034,513	40,102	4,181,305	-	-	106,361,342		145,099,211
Total	30,041,955	4,950,474	80,774	74,487,731	13,862,010	17,111,018	-	-	575,937,048	78,880,292	795,351,301
October Revenues:											
Prior year	1,643,826	-	-	-	-	-	-	-	22,135	-	1,665,961
Current year	4,500,066	35,132,504	7,589,154	-	12,092	5,913,757	61,980	3,713,860	635,249,500	23,625,287	715,798,198
Total	6,143,891	35,132,504	7,589,154	-	12,092	5,913,757	61,980	3,713,860	635,271,635	23,625,287	717,464,160
October Expenditures:											
Prior year	1,386,480	-	-	-	-	-	-	-	-	-	1,386,480
Current year	10,932,961	-	-	-	-	3,466,583	-	-	705,718,981	-	720,118,526
Total	12,319,441	-	-	-	-	3,466,583	-	-	705,718,981		721,505,005
Operating Transfers In											
Prior year											
Current year	6,433,843	-	-	13,678,171	-	-	-	-	117,241,156	-	137,353,170
Total	6,433,843	-	-	13,678,171	-	-	-	-	117,241,156	-	137,353,170
Operating Transfers Out											
Prior year	2,028,654	-	-	-	-	-	-	-	-		2,028,654
Current year	-	37,550,969	7,548,240	-	-	91,726	61,980	3,713,860	-	76,350,162	125,316,937
Total	2,028,654	37,550,969	7,548,240	-	-	91,726	61,980	3,713,860	-	76,350,162	127,345,591
Change in CY Fund Balance	***(8,609,676)***	***(381,401)***	***96,421***	***54,712,684***	***52,194***	***6,536,753***	***-***	***-***	***153,133,017***	***(52,724,875)***	***152,815,117***
Ending Fund Balance	**28,271,594**	**2,532,008**	**121,688**	**88,165,902**	**13,874,101**	**19,466,465**	**-**	**-**	**622,730,859**	**26,155,417**	**801,318,035**

OKLAHOMA HEALTH CARE AUTHORITY
HEALTHY ADULT PROGRAM EXPENDITURES - OHCA
SFY 2022, For the Four Month Period Ending October 31, 2021

PROGRAM / ACTIVITY	FY22 BUDGETED EXPENDITURES Full Year	FY22 BUDGETED EXPENDITURES Year to Date	FY22 ACTUAL EXPENDITURES YTD through October	BUDGET VARIANCE (Over)/ Under
OHCA MEDICAID PROGRAMS				
Managed Care				
SoonerCare Choice	7,985,095	2,610,512	-	2,610,512
Total Managed Care	**7,985,095**	**2,610,512**	**-**	**2,610,512**
Fee for Service				
Hospital Services:				
Inpatient Acute Care	184,706,909	60,384,638	51,553,875	8,830,763
SHOPP	139,202,076	68,305,439	68,305,439	-
Outpatient Acute Care	231,534,433	75,693,949	36,829,523	38,864,426
Total Hospitals	**555,443,418**	**204,384,027**	**156,688,837**	**47,695,189**
Behavioral Mental Health:				
Inpatient Services - DRG	-	-		-
Psychiatrist	23,211,440	7,215,091	2,757,928	4,457,162
TFC-OHCA	-	-	-	-
Total Behavioral Mental Health	**23,211,440**	**7,215,091**	**2,757,928**	**4,457,162**
Physicians & Other Providers:				
Physicians	234,345,474	76,484,754	23,831,415	52,653,339
Dentists	36,072,392	11,792,897	6,157,919	5,634,978
Mid-Level Practitioner	509,907	166,700	60,805	105,895
Other Practitioners	23,592,129	7,086,288	2,596,199	4,490,090
Home Health Care	13,948,341	4,560,035	110,842	4,449,193
Lab & Radiology	42,531,656	13,904,580	2,701,114	11,203,466
Medical Supplies	7,962,529	2,603,135	1,285,313	1,317,821
Clinic Services	68,296,196	20,148,492	19,149,542	998,950
Ambulatory Clinics	3,304,022	1,080,161	582,796	497,365
Total Physicians & Other Providers	**430,562,646**	**137,827,042**	**56,475,946**	**81,351,096**
Nursing Facilities & Misc Medical Payments	**251,106**	**82,092**	**11,177**	70,916
Transportation	**17,782,097**	**5,813,378**	**3,619,846**	2,193,532
Prescription Drugs	**311,724,401**	**101,909,900**	**70,038,751**	31,871,149
Total OHCA Medicaid Programs	**1,346,960,203**	**459,842,042**	**289,592,486**	**170,249,556**

OHCA Monthly Metrics
January 2022
(November 2021 Data)

SOONERCARE ENROLLMENT/EXPENDITURES

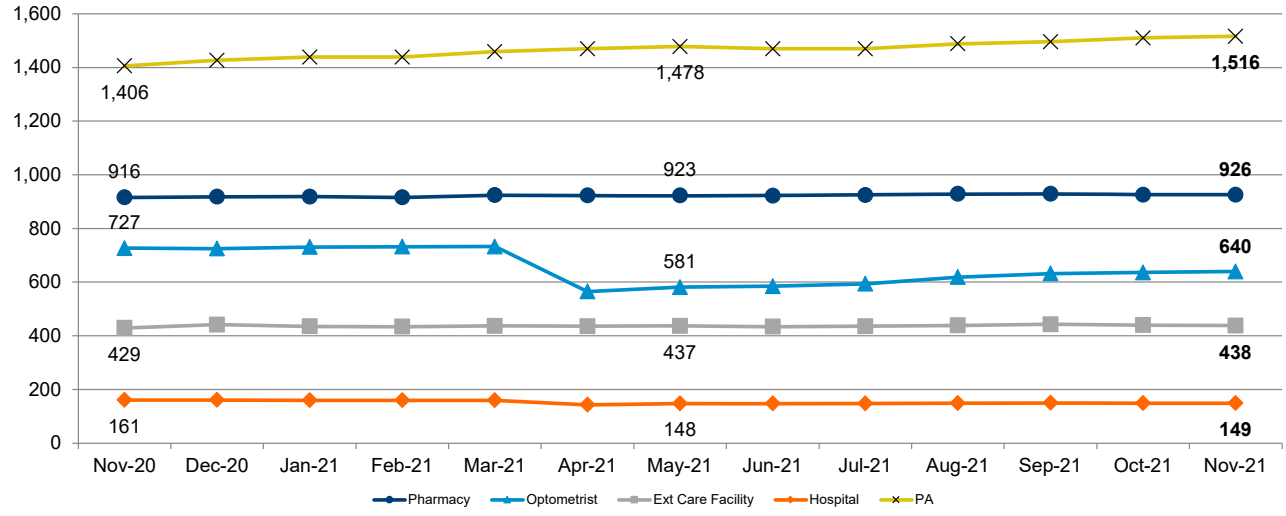
Delivery System		Enrollment November 2021	Children November 2021	Adults November 2021	Enrollment Change	Total Expenditures November	PMPM November 2021
SoonerCare Choice Patient-Centered Medical Home		**757,852**	**544,401**	**213,451**	**19,261**	**$228,677,891**	
	Children/Parents & Expansion	713,550	530,278	183,272	19,429	$178,824,477	$251
	Aged/Blind/Disabled & BCC	44,302	14,123	30,179	-168	$49,853,414	$1,125
SoonerCare Traditional		**386,568**	**117,770**	**268,798**	**2,361**	**$272,719,286**	
	Children/Parents & Expansion	262,268	113,014	149,254	680	$133,093,977	$507
	Aged/Blind/Disabled & BCC	124,300	4,756	119,544	1,681	$139,625,308	$1,123
Insure Oklahoma (ESI)		**10,409**	**421**	**9,988**	**-261**	**$3,404,000**	$327
SoonerPlan		**10,846**	**90**	**10,756**	**-2,200**	**$40,645**	$4
TOTAL (UNDUPLICATED)		**1,165,675**	**662,682**	**502,993**	**19,161**	**$504,841,821**	$433

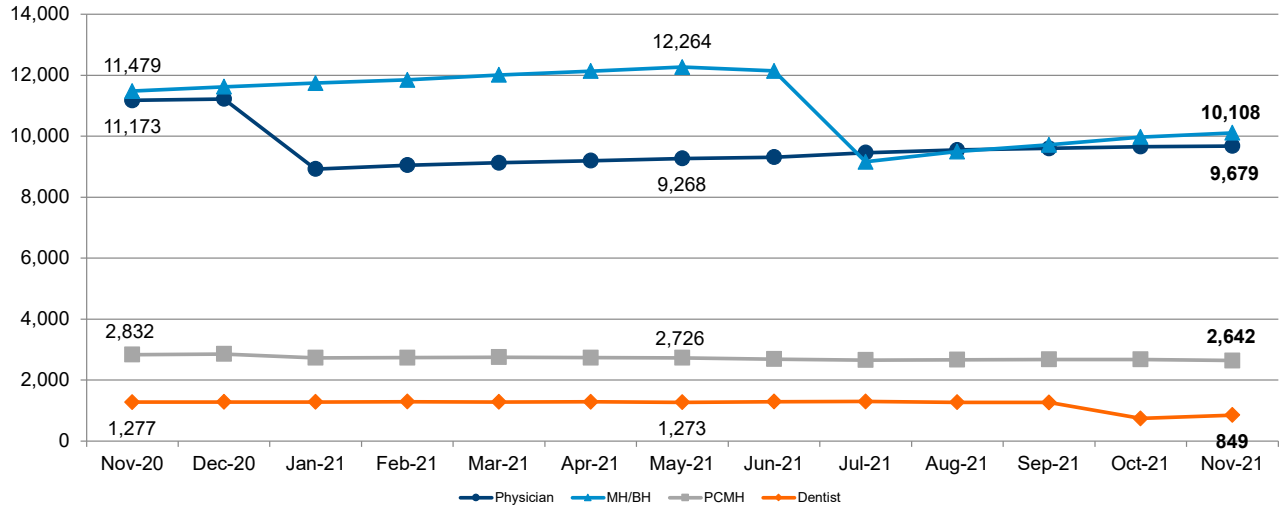
Total Expansion members = 207,606 (52% in PCMH). TEFRA is included with ABD. OTHER is included with Children/Parents. ABD - Traditional includes LTC and HCBS Waiver. Other - Traditional includes Q1 and SLMB.

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

IN-STATE CONTRACTED PROVIDERS

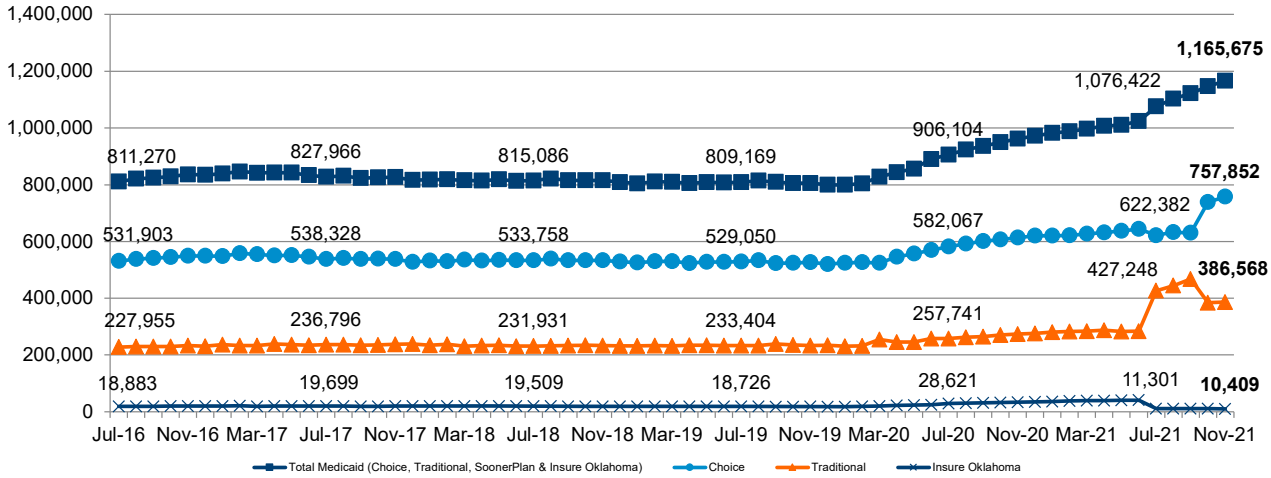
Total In-State Providers: 46,476 (-30) **(In-State Providers counted multiple times due to multiple locations, programs, types, and specialties)**

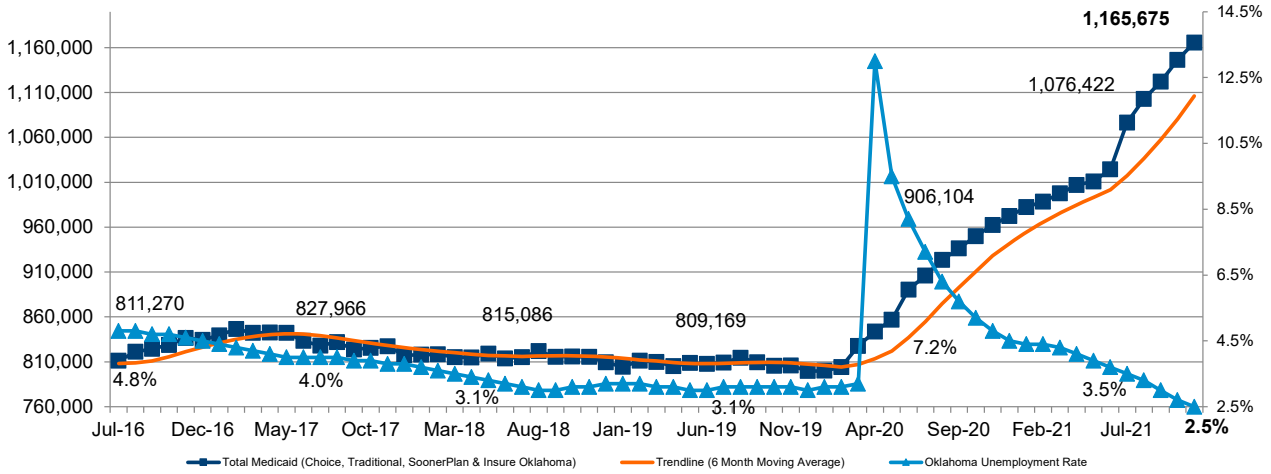




*In general, decreases are due to contract renewal. Decrease during contract renewal period is typical during all renewal periods.
MH/BH is Mental Health and Behavioral Health providers. PCMH is Patient-Centered Medical Home (Choice) providers.

ENROLLMENT BY MONTH





Oklahoma Unemployment Rate is from the Bureau of Labor Statistics 'Local Area Unemployment Statistics' (https://www.bls.gov/lau/) and is seasonally adjusted.

In June 2017 there were changes to the passive renewal system criteria that reduced the number of passively renewed members by 2/3rds. Increase in March 2020 due to COVID-19 economic impact and relief measures (Continuity of care by postponing recertifications). **Expansion was effective in July 2021.**

January MAC
Proposed Rules Amendment Summaries

The following work folders were posted on the Oklahoma Health Care Authority (OHCA) public website for a public comment period.

APA WF 21-02A OHS ADvantage Waiver Services and State Plan Personal Care Services – The proposed revisions will align policy with the recently approved 1915c ADvantage waiver renewal and current State Plan Personal Care services authority. Updated policy will provide clarity surrounding eligible provider certification and will also modify procedures to reflect current business practices. Final revisions will correct formatting and grammatical errors.

Budget Impact: Budget neutral

Public comment period: December 15, 2021 – January 18, 2022
Tribal consultation: November 2, 2021
OHCA Board meeting: January 19, 2022
Effective date: September 2022

APA WF 21-02B OHS ADvantage Waiver Services and State Plan Personal Care Services – The proposed revisions will add language to establish guidelines and criteria regarding how an ADvantage member and/or provider are to report critical and non-critical incidents. Additional revisions will align policy with the recently approved 1915c ADvantage waiver renewal and current State Plan Personal Care services authority which will modify procedures to reflect current business practices. Final revisions will correct grammatical errors.

Budget Impact: Budget neutral

Public comment period: December 15, 2021 – January 18, 2022
Tribal consultation: November 2, 2021
OHCA Board meeting: January 19, 2022
Effective date: September 2022

APA WF 21-25 Non-Emergency Transportation (NEMT) Driver Compliance — The proposed revisions will add language to the Agency's non-emergency transportation (NEMT) policy that assure compliance with recent changes made to federal regulations that any NEMT provider or individual driver will meet prescribed minimum requirements.

Budget Impact: Budget neutral

Public comment period: November 2, 2021 - November 17, 2021
Tribal Consultation: November 2, 2021
OHCA Board meeting: January 19, 2022
Effective date: Contingent upon Governor approval; estimated effective date: March 7, 2022

APA WF 21-27 Policy Reference Clean Up - Timely Filing- The proposed revisions will update a section of policy which describes the process when an individual is determined retroactively eligible for Social Security Disability or Supplemental Security Income (SSI). Current policy states that payment will be made for medical services only if the claim is received within twelve (12)

months. Updated policy will refer to two relevant sections of policy: “Timely Filing Limitation” (six months) and “Resolution of Claim Payment” (twelve months if claim initially filed timely).

Budget Impact: Budget neutral

Public comment period: December 15, 2021 – January 18, 2022
Tribal consultation: November 2, 2021
OHCA Board meeting: January 19, 2022
Effective date: September 2022

WF 21-30 Eliminate Community Based Extended (CBE) and Community Based Transitional (CBT) Levels of Care - The proposed revisions will eliminate CBE and CBT levels of care. These facilities contract with the OHCA as a type of Psychiatric Residential Treatment Facility (PRTF); however, there is only one contracted CBE facility and zero CBT facilities. The contracted CBE facility will transition to a standard PRTF with the corresponding rate. Other revisions will reorganize policy for clarity and correct grammatical errors.

Budget impact: The standard PRTF per diem is $336.57. The current CBE rate is $319.54, a $17.03 difference. There were 6,090 paid days for the CBE for SFY 2021.The proposed permanent rule changes will result in a budget impact of $103,712.70 with $33,198.4 in state match for SFY2023. ***For the increased rate, the PRTF will be required to provide 2 additional physician visits per month and 4 additional active treatment hours per week.*** **The State match will be paid by the Department of Mental Health and Substance Abuse Services.**

Public comment period: December 15, 2021 – January 18, 2022
Tribal consultation: November 2, 2021
OHCA Board meeting: January 19, 2022
Effective date: September 2022

APA WF 21-31 Applied Behavior Analysis (ABA) Revisions — The proposed revisions will establish new documentation and signature requirements to ensure accuracy and completeness in clinical documentation as well as better individualized treatment plans for members. Additionally, the proposed changes will clarify the conditions under which concurrent billing codes can be used for the treatment of members.

Budget impact: Budget neutral

Public comment period: December 15, 2021 – January 18, 2022
Tribal consultation: November 2, 2021
OHCA Board meeting: January 19, 2022
Effective date: September 2022

APA WF 21-33 Improve 340B Shared Savings Methodology — The proposed revisions will modify existing rules and the State Plan to improve the identification of 340B drugs and non 340B drug purchases. These revisions will require providers to bill the Agency with a procedure code modifier, on outpatient and hospital claims, that will identify a 340B drug from a non 340B drug. Additional revisions will adjust the methodology by which Medicare crossover claims are included on drug rebate invoices to 340B providers.

Budget impact: The proposed rule changes can potentially result in a reduction to the Agency's overall revenue collections. The combined potential federal and state revenue loss is a total of $3,070,428; $1,002,188 in state share for SFY2023.

Public comment period: December 15, 2021 – January 18, 2022
Tribal consultation: November 2, 2021
OHCA Board meeting: January 19, 2022
Effective date: September 2022

APA WF 21-34 Reimbursement Methodology for Providers of CCBH Services – The proposed revisions update and clarify language regarding covered CCBH services. The revisions also update language regarding reimbursement of CCBH services in alignment with changes to the Oklahoma Medicaid State Plan. These changes included language related to rebasing frequency and scope updates to the Prospective Payment System (PPS) rates. Other revisions will clarify the definition of "Client Assessment Record (CAR)."

Budget Impact: Budget neutral

Public comment period: December 15, 2021 – January 18, 2022
Tribal consultation: September 7, 2021
OHCA Board meeting: January 19, 2022
Effective date: September 2022

APA WF 21-44 Independent Clinical Psychologist Services for Adults – The proposed revisions update policy to reflect that adults covered by Medicaid can access services provided by licensed clinical psychologists who bill independently and are practicing within state scope of practice. Services provided by independently contracted clinical psychologists were previously a State Plan benefit only available to children.

Budget impact: The proposed permanent rule changes will result in a total budget impact of $1,723,105; with $361,938 in state match for SFY2022. The state match will be paid by the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS).

Public comment period: Dec. 29, 2021- January 13, 2022
Tribal consultation: November 2, 2021
OHCA Board meeting: January 19, 2022
Effective date: Contingent upon Governor's approval; estimated effective date: March 7, 2022

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 ADvantage Administration (AA) certifies ADvantage Program service providers, except pharmacy providers, ~~must be certified by the ADvantage Program ADvantage Administration (AA)~~ and ~~must~~they have a current signed SoonerCare (Medicaid) contract on file with the Oklahoma Health Care Authority (OHCA), the State Medicaid agency.

(1) The provider programmatic-certification process ~~must verify~~verifies the provider meets licensure, certification, and training standards as specified in the waiver document~~ and agrees to ADvantage Program Conditions of Participation~~. ~~Providers~~All providers, except nursing facility (NF) respite; medical equipment and supplies; and environmental modification providers, must obtain programmatic-certification to be ADvantage program certified.

(2) The provider financial-certification ~~process must verify that~~verifies the provider uses sound business management practices and has a financially-stable business. All providers, except for ~~nursing facility (NF)~~NF respite~~,~~; medical equipment and supplies; and environmental modification providers, ~~must~~will obtain financial certification to be ADvantage program certified.

(3) At minimum, provider financial certification is re-evaluated annually.

~~(3)~~ (4) Providers may fail to gain or may lose ADvantage program certification due to failure to meet programmatic or financial standards.

~~(4) At a minimum, provider financial certification is reevaluated annually.~~(5) All provider service types must agree to the Conditions of Provider Participation and Service Standards.

~~(5) The Oklahoma Department of Human Services (DHS) Aging Services (AS) evaluates adult day health and 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. Providers of 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) ~~DHS AS~~The Oklahoma Human Services (OKDHS) Community Living, Aging and Protective Services (CAP) does not authorize the member's CD-PASS services provider to also have an active power of attorney ~~of a~~for the member ~~to be the member's CD-PASS services provider~~.

(7) ~~DHS AS~~OKDHS CAP may authorize a member's legally-responsible spouse or legal guardian to be SoonerCare (Medicaid) reimbursed, per 1915(c) ADvantage Program as a personal care, service provider. Authorization for a spouse or legal guardian as a provider requires the criteria in (A) through (D) of this paragraph and monitoring provisions to be met.

(A) Authorization for a spouse or legal guardian to be ~~the~~a member's care provider ~~for a member~~ may occur only when the member is offered ~~a choice of providers~~provider choice and documentation demonstrates:

(i) ~~no~~No provider included on the Certified Agency Report (CAR) or in the member's service area, has available staffing~~;~~. ~~This is as evidenced by supportive documentation, which~~Documentation also affirms ~~no provider within the members service area can staff and~~ all area providers attempt to employ staff to serve; or

(ii) ~~the~~The member's needs are so complex that unless the spouse or legal guardian provides the care, the member's risk level would increase; and

(iii) ~~it~~It is mentally or physically detrimental for someone other than the spouse or legal guardian to provide care. This is evidenced by ~~the~~ documentation from a qualified clinician or medical provider, such as a physician or licensed psychologist.

(B) The service ~~must~~:

(i) ~~meet the~~Meets service or support definition ~~of a service/support~~ as outlined in the federally-approved waiver document;

(ii) ~~be~~Is necessary to avoid institutionalization;

(iii) ~~be~~Is a ~~service/support~~service or support specified in the person-centered service plan;

(iv) ~~be~~Is provided by a person who meets the provider qualifications and training standards specified in the waiver for that service;

(v) ~~be~~Is paid at a rate that does not exceed ~~that which would otherwise be~~what is paid to a provider of a similar service and does not exceed what ~~is allowed by~~ OHCA allows for ~~the payment of~~ personal care or personal assistance

services~~; an~~ payment; and

(vi) ~~not be~~Is not an activity the spouse or legal guardian would ordinarily perform or is responsible to perform.

(C) The spouse or legal guardian service provider complies with:

(i) ~~providing~~Providing no more than forty (40) service hours of services in a ~~seven-day (7-day)~~seven (7) day period;

(ii) ~~planned~~Planned work schedules that ~~must be~~are available in advance for the member's case manager, and variations to the schedule ~~must be~~are noted and supplied to the case manager two (2) weeks in advance unless the change is due to an emergency;

(iii) ~~maintaining~~Maintaining and submitting time sheets and other required documentation for hours paid; and

(iv) ~~the~~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 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 monitors, through quarterly documentation~~ submitted by~~ the case manager~~,~~ submits, the continued appropriateness of the policy exception that allows the spouse or legal guardian to serve as the member's paid caregiver.

(8) ~~Providers of durable~~Durable medical equipment and supplies ~~must~~providers comply with Oklahoma Administrative Code 317:30-5-210(2) regarding delivery proof~~ of delivery~~ for items shipped to the member's residence.

(9) ~~DHS AS~~OKDHS CAP periodically performs a programmatic audit of: ~~adult day health, assisted living, case management, home care (providers of skilled nursing, personal care, in-home respite, and advanced supportive/restorative assistance and therapy services) and CD-PASS providers. When due to a programmatic audit, a provider Plan of Correction (POC) is required, the AA may stop new cases and referrals to the provider until the (POC) is approved, implemented, and follow-up review occurs. Depending on the nature and severity of problems discovered during a programmatic audit and at the discretion of the DHS AS, members determined to be at risk for health or safety may be transferred from a provider requiring a POC to another provider.~~

(A) Adult day health;

(B) Assisted living;

(C) Case Management;

(D) Home care:

(i) Skilled nursing;
(ii) Personal care;
(iii) In-home respite; and
(iv) Advanced supportive or restorative assistance; and
(v) Therapy services; and
(E) CD-PASS providers.
(10) When, due to a programmatic audit, a provider plan of correction (POC) is required, the AA may stop new cases and referrals to the provider until the POC is approved, implemented, and a follow-up review occurs. Depending on the nature and severity of problems discovered during a programmatic audit (and at OKDHS CAP discretion), members determined to be at risk for health or safety may be transferred from a provider requiring a POC to another provider.

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

SUBCHAPTER 15. STATE PLAN PERSONAL CARE SERVICES

317:35-15-1. Overview of long-term medical care services; relationship to ~~QMBP, SLMB,~~Qualified Medicare Beneficiary Plus (QMBP), Specified Low-Income Medicare Beneficiary (SLMB), and other SoonerCare services and eligibility

~~Long-term medical care for the categorically needy includes care in a nursing facility (refer to OAC 317:35-19), public and private intermediate care facility for individuals with intellectual disabilities (refer to OAC 317:35-9), persons age 65 years or older in mental health hospitals (refer to OAC 317:35-9), Home and Community Based Waiver Services for the Intellectually Disabled (refer to OAC 317:35-9), Home and Community Based Waiver Services for the ADvantage program (refer to OAC 317:35-17), and Personal Care services (refer to this subchapter). Personal Care provides services in the member's own home. Any time an individual is certified as eligible for SoonerCare coverage of long-term care, the individual is also eligible for other SoonerCare services. Another application is not required. Any time an aged, blind, or disabled individual is determined eligible for long-term care, a separate determination must be made to see if eligibility conditions as a Qualified Medicare Beneficiary Plus (QMBP) or Specified Low-Income Medicare Beneficiary (SLMB) are met. Another application for QMBP or SLMB benefits is not required.~~

(a) Long-term medical care for the categorically needy includes:

(1) Care in a nursing facility, per Oklahoma Administrative Code (OAC) 317:35-19;

(2) Public and private intermediate care facility for individuals with intellectual disabilities (ICF/IID), per OAC 317:35-9;

(3) Persons age sixty-five (65) years or older in mental health hospitals, per OAC 317:35-9;

(4) Home and Community-Based Waiver Services for the Intellectually Disabled, per OAC 317:35-9;

(5) Home and Community-Based Waiver Services for the ADvantage program, per OAC 317:35-17; and

(6) State Plan Personal Care services, per OAC 317:35-15.

(b) State Plan Personal Care provides services in the member's own home. Any time an individual is certified as eligible for long-term care SoonerCare coverage, the member is also eligible for other SoonerCare services. Another application is not required. Any time an aged, blind, or disabled individual is determined eligible for long-term care, a separate determination is made to

check if the member meets eligibility conditions as a QMBP or an SLMB. Another application for QMBP or SLMB benefits is not required.

317:35-15-2. State Plan Personal ~~care~~Care (SPPC) services

(a) ~~Personal care~~SPPC services ~~is assistance to an individual~~assist a member in carrying out Activities of Daily Living (ADLs) or ~~in carrying out~~ Instrumental Activities of Daily Living (IADLs) directly related to the member's personal care needs ~~to prevent~~. SPPC services prevent or minimize physical health regression or deterioration. ~~Personal care service requires~~SPPC services require a skilled nursing assessment to: ~~of need, development of a care plan to meet identified personal care needs, care plan oversight, and periodic re-assessment and updating, of the care plan, when necessary. Personal care services do not include technical services, such as 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.~~

(1) Assess a member's needs;

(2) Develop a care plan to meet the member's identified personal care needs;

(3) Manage care plan oversight; and

(4) Periodically reassess and update the care plan when necessary.

(b) SPPC services do not include technical services, such as:

(1) Suctioning;

(2) Tracheal care;

(3) Gastrostomy-tube feeding or care;

(4) Specialized feeding due to choking risk;

(5) Applying compression stockings;

(6) Bladder catheterization;

(7) Colostomy irrigation;

(8) Wound care;

(9) Applying prescription lotions or topical ointments;

(10) Range of motion exercises; or

(11) Operating equipment of technical nature, such as a patient lift or oxygen equipment.

~~(b)~~(c) ~~Personal care~~SPPC members may receive services in limited types of living arrangements~~. The specific living arrangements are set forth below.~~ as per (1) through (5) of this subsection.

(1) ~~Personal care~~SPPC 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.~~

(A) Licensed facilities, such as a:

(i) Hospital;

(ii) Nursing facility;

(iii) Licensed residential care facility; or

(iv) Licensed assisted living facility; or

(B) In an unlicensed institutional living arrangement, such as a room and board home or facility.

(2) SPPC is not approved when the member lives in the personal care assistant's (PCA) or the individual personal care assistant's (IPCA) home, except with Oklahoma Human Services (OKDHS) Medicaid Services Unit approval.

(~~2) Additional living arrangements in which members~~(3) Members may receive ~~personal care services are~~SPPC services in the member's own home, apartment, or a family member's 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~~storage and preparation amenities in addition to ~~bedroom/living~~bedroom and living space.

~~(3)~~(4) For ~~personal care~~SPPC members who are full-time students, a dormitory room qualifies as an allowable living arrangement ~~in which~~ to receive ~~personal care services for the period during which the member is a student.~~SPPC services.

~~(4)~~(5) With prior OKDHS Health Care Management Nurse III approval ~~of the DHS area nurse, personal care~~SPPC services may be provided in an educational or employment setting to assist the member to achieve vocational goals identified in the care plan.

~~(c)~~(d) ~~Personal care services may be provided by an individual employed by the member referred to as an individual personal care assistant (IPCA) or by a personal care assistant (PCA)~~A member may employ an IPCA to provide SPPC services. An IPCA may provide SPPC services when he or she is employed by a home care agency, provided the home care agency is certified ~~to provide personal care services~~ and contracted with the Oklahoma Health Care Authority (OHCA) to provide ~~personal care~~SPPC services. Before providing SPPC services, ~~DHS must determine an~~OKDHS determines whether the IPCA ~~to be~~is qualified to provide personal care services and the IPCA is not identified as ~~formal/informal~~formal or informal support for member ~~before they can provide services~~. Persons eligible to serve

as either IPCAs or ~~PCAS must:~~PCAs:

(1) ~~be~~Are at least ~~18~~eighteen (18) years of age;

(2) ~~have~~Have no pending notation related to abuse, neglect, or exploitation as reported by the Oklahoma State Department of Health Nurse Aide Registry;

(3) ~~not be~~Are not included in the ~~DHS~~OKDHS Community Services Worker Registry;

(4) ~~not be~~Are not convicted of a crime ~~or~~and do not have ~~any~~a criminal background history or registry listings that prohibit employment per ~~O.S. Title 63, Section 1-1950.1;~~Title 63 of the Oklahoma Statutes Section 1-1944 through 1-948;

(5) ~~demonstrate~~Demonstrate the ability to understand and carry out assigned tasks;

(6) ~~not be~~Are not a legally responsible family member~~, such as a spouse, legal guardian, or parent of a minor child~~ of the member being served, such as a spouse, legal guardian, or a minor child's parent ~~exceptions may be made for a legal guardian to provide services only with prior approval from DHS Aging Services~~;

(7) ~~have~~Have a verifiable work history ~~and/or~~or personal references, and verifiable identification; and

(8) ~~meet~~Meet any additional requirements outlined in the contract and certification requirements with OHCA.

~~(d)~~(e) ~~Eligibility for Personal Care~~SPPC services eligibility is contingent on ~~an individual~~a member requiring one (1) or more of the services offered at least monthly ~~that include~~including personal care, meal preparation, housekeeping, laundry, shopping or errands, or specified special tasks to meet ADL or IADL assessed needs.

317:35-15-3. Application for State Plan Personal Care (SPPC) services

(a) **Requests for ~~Personal Care.~~SPPC services.** ~~A request for Personal Care is made to the local OKDHS office or ADvantage Administration (AA).~~ The SPPC application process initiates when an online application is completed for SPPC services. A written financial application is not required for an ~~individual~~applicant who has an active SoonerCare case. A financial application for ~~Personal Care~~SPPC services is initiated when there is no active SoonerCare case. The Medicaid application is signed by the applicant, parent, spouse, guardian or someone ~~else~~ acting on the applicant's behalf. All financial eligibility conditions ~~of financial eligibility must be~~are verified and documented in the case record. When current available information ~~already available in the local office~~ establishes eligibility, the information may be used by recording source and date of information. If the applicant also wishes to apply for a State Supplemental Payment,

either the applicant or ~~his/her~~his or her guardian, or a person acting on the applicant's behalf, such as an authorized representative or power-of-attorney, ~~must sign~~signs the application form.

(b) ~~**Date of application.**~~ **Application date.** The application date is when the benefits request is received and entered into the electronic system by OKDHS. Exceptions can occur when OKDHS has contracts with certain providers who accept and obtain applications and appropriate documentation. Once the documentation, for the SooonerCare eligibility determination, has been obtained, the contract provider will forward the application and all applicable documentation to either the OKDHS county office or the Medicaid Services Unit-ADvantage Administration.

~~(1) The date of applications is:~~

~~(A) the date the applicant or someone acting on his/her behalf signs the application in the county office;~~

~~(B) the date the application is stamped into the county office when the application is initiated outside the county office; or~~

~~(C) the date when the request for SoonerCare is made orally and the financial application form is signed later.~~

~~(2) An exception to paragraph (1) of this subsection would occur when OKDHS has contracts with certain providers to take applications and obtain documentation. After the documentation is obtained, the contract provider forwards the application and documentation to the OKDHS county office of the applicant's county of residence for SoonerCare eligibility determination. The application date is the date the applicant signed the application form for the provider.~~

(c) **Eligibility status.** Financial and medical eligibility ~~must be~~is established before services can be initiated.

317:35-15-4. ~~Determination of~~State Plan Personal Care (SPPC) services medical eligibility ~~for Personal Care~~ determination

(a) **Eligibility.** The Oklahoma ~~Department of~~ Human Services ~~(DHS)~~(OKDHS) ~~area nurse~~Health Care Management Nurse (HCMN) III determines medical eligibility for ~~personal care~~SPPC services based on the Uniform Comprehensive Assessment Tool (UCAT) ~~Part III~~ and the determination that the member has unmet care needs that require personal care ~~services.~~assistance. ~~Personal care~~SPPC services are initiated to support the regular care provided in the member's home. ~~Personal care~~SPPC services are not intended to take the place of regular care, ~~and~~ general maintenance tasks, or meal preparation ~~shared or done for one another~~provided by natural supports, such as spouses or other adults who live in the same household. Additionally, ~~personal care~~SPPC services are not furnished when they principally benefit the family unit. To be

eligible for ~~personal care~~SPPC services, the ~~individual must:~~applicant:

(1) ~~have~~Has adequate informal supports~~ consisting of~~. This means there is adult supervision that is present or available to contribute to care~~,~~ or decision-making ability, as documented on the UCAT~~ Part III, to~~. To remain in his or her home without risk to his or her health, safety, and well-being, the ~~individual:~~applicant:

(A) ~~must have~~Has the decision-making ability to respond appropriately to situations that jeopardize his or her health and safety, or has available supports that compensate for his or her lack of ability as documented on the UCAT ~~Part III~~; or

(B) ~~who has his or her~~Has his or her decision-making ability, ~~but~~ lacks the physical capacity to respond appropriately to situations that jeopardize health and safety, and ~~was informed by the DHS nurse~~an OKDHS HCMN I or II informed him or her of potential risks and consequences~~, may be eligible.~~of remaining in the home.

(2) ~~require a plan of care involving the planning and administration of services delivered under the supervision of professional personnel;~~Requires a care plan for planning and administering services delivered under a professional personnel's supervision;

(3) ~~have~~Has a physical impairment or combination of physical and mental impairments as documented on the UCAT~~ Part III~~. An ~~individual~~applicant who poses a threat to ~~self~~himself or herself or others, as supported by professional or credible documentation~~ or other credible documentation~~, may not be approved for ~~Personal Care~~SPPC services. An individual who is actively psychotic or believed to be in danger of potential harm to ~~self~~himself or herself or others may not be approved ~~for personal care services~~;

(4) ~~not have members of the household or~~Does not have household members or persons who routinely visit the household who, as supported by professional or credible documentation~~ or other credible documentation~~, pose a threat of harm or injury to the ~~individual~~applicant or other household visitors;

(5) ~~lack~~Lacks the ability to meet personal care needs without additional supervision or assistance, or to communicate needs to others; and

(6) ~~require~~Requires 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) **"Activities of Daily Living" (ADL)** means ~~activities of daily living are~~ activities that reflect the applicant's or member's ability to perform self-care tasks essential for sustaining health and safety, such as:

(A) ~~bathing;~~Bathing;

(B) ~~eating;~~Eating;

(C) ~~dressing;~~Dressing;

(D) ~~grooming;~~Grooming;

(E) ~~transferring includes~~Transferring, including activities such as getting in and out of a tub or moving from bed to chair;

(F) ~~mobility;~~Mobility;

(G) ~~toileting;~~Toileting; and

(H) ~~bowel/bladder~~Bowel or bladder control.

(2) **"ADLs score of three (3) or greater"** means the applicant or member cannot do at least one (1) ADL at all or needs some help with two (2) or more ADLs.

(3) **"~~Consumer~~Applicant or Member support very low ~~need~~"** means the applicant's or member's UCAT ~~Part III Consumer~~ Support score is zero (0), ~~which~~this indicates, in the UCAT ~~Part III~~ assessor's clinical judgment, the formal and informal sources are sufficient for the applicant's or member's present need level ~~of member need~~ in most functional areas.

(4) **"~~Consumer~~Applicant or Member support low ~~need~~"** means the member's UCAT ~~Part III Consumer~~ Support score is five (5), ~~which~~this indicates, in the UCAT ~~Part III~~ assessor's clinical judgment, the support from formal and informal sources are nearly sufficient for the applicant's or member's present need level ~~of member need~~ in most functional areas. The applicant or 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) **"~~Consumer~~Applicant or Member support moderate ~~need~~"** means the UCAT ~~Part III Consumer~~applicant or member score is fifteen (15), ~~which~~this indicates, in the UCAT ~~Part III~~ assessor's clinical judgment, the formal and informal support is available, but overall, it is inadequate, changing, fragile, or otherwise problematic. The applicant or member requires additional assistance that usually includes personal care assistance with one (1) or more 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 (1) or more of the following:~~Informal caregiver support is considered questionable

or unreliable due to one (1) or more criteria in (A) through (D) of this paragraph:

(A) ~~care~~Care or support is required continuously with no relief or backup available;

(B) ~~informal~~Informal support lacks continuity due to conflicting responsibilities such as work or child care;

(C) ~~care or support is provided by persons~~Persons with advanced age or disability~~; or~~ provide care; or

(D) ~~institutional~~Institutional placement can reasonably be expected with any loss of existing support.

(6) **"~~Consumer~~Applicant or Member support high ~~need~~"** means the ~~member's~~member UCAT ~~Part III Consumer~~ score is twenty-five (25) ~~which~~this indicates, in the UCAT ~~Part III~~ assessor's clinical judgment, the formal and informal supports are not sufficient as there is very little or no support available to meet ~~a~~the applicant's or member's high degree of ~~member~~ need.

(7) **"Community ~~services worker~~"Services Worker"** means any 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.

(8) **"Community Services Worker Registry"** means ~~a~~an OKDHS established registry established by the ~~DHS,~~OKDHS per Section (§) 1025.1 of Title 56 of the Oklahoma Statutes (O.S.) ~~to list~~listing community services workers ~~against whom~~who have a final investigative finding of abuse, neglect, or exploitation, per 43A O.S. § 10-103, involving a frail elderly~~,~~ person, ~~disabled person(s),~~ or person(s) with developmental or other disabilities was made by ~~DHS~~OKDHS or an administrative law judge~~; and amended in 2002, to include the listing of SoonerCare (Medicaid) personal care assistants (PCAs) providing personal care services~~.

(9) **"Instrumental ~~activities of daily living (IADL)~~"Activities of Daily Living (IADL)"** means those daily activities that reflect the applicant or member's ability to perform household chores and tasks within the community essential for sustaining health and safety, such as:

(A) ~~shopping;~~Shopping;

(B) ~~cooking;~~Cooking;

(C) ~~cleaning;~~Cleaning;

(D) ~~managing~~Managing money;

(E) ~~using~~Using a phone;

(F) ~~doing~~Doing laundry;

(G) ~~taking~~Taking medication; and

(H) ~~accessing~~Accessing transportation.

(10) **"IADLs score is at least six (6)"** means the applicant or

member needs some help with at least three (3) IADLs or cannot do two (2) IADLs at all.

(11) **"IADLs score of eight (8) or greater"** means the applicant or member needs some help with at least four (4) IADLs or the member cannot do two (2) IADLs at all and needs some help with one (1) or more other IADLs.

(12) **"MSQ"** means the ~~mental status questionnaire.~~Mental Status Questionnaire.

(13) **"MSQ moderate risk range"** means a total weighted-score of seven (7) to eleven (11) that indicates an orientation-memory-concentration impairment or memory impairment.

(14) **"Nutrition moderate risk"** means ~~the~~a total weighted UCAT ~~Part III~~ Nutrition score is eight (8) or ~~more~~greater that indicates poor appetite or weight loss combined with special diet requirements, medications, or difficulties in eating.

(15) **"Social ~~resources~~Resource score is eight (8) or more"** means the applicant or 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~~SPPC.** The medical eligibility minimum criteria for ~~personal care~~SPPC services are the minimum UCAT ~~Part III~~ score criteria that ~~a~~an applicant or member ~~must meet~~meets for medical eligibility ~~for personal care~~ and are:

(1) ADLs score is five (5) or greater; or has an IADLs score of eight (8) or greater; or Nutrition score is (8) or greater; or the MSQ score is seven (7) or greater; or the ADLs score is three (3) and IADLs score is at least six (6); and

(2) ~~Consumer~~Applicant or Member Support score is fifteen (15) or more; or ~~Consumer~~Applicant or Member Support score is five (5) and the Social Resources score is eight (8) or ~~more.~~greater.

(d) **Medical eligibility determination.** ~~Medical~~OKDHS HCMN III determines medical eligibility for ~~personal care~~SPPC services ~~is determined by the DHS. The medical decision for personal care is made by the DHS area nurse~~ utilizing the UCAT ~~Part III~~.

(1) Categorical relationship ~~must be~~is established for SPPC services financial eligibility determination ~~of eligibility for personal care~~. ~~When categorical relationship to Aid to the Disabled was not established but there is an extremely emergent need for personal care, and current medical information is not available, the local office authorizes a medical examination. When authorization is necessary, the county director issues Form 08MA016E, Authorization for Examination, and Form 08MA02E, Report of Physician's Examination, to a licensed medical or osteopathic health care professional, refer to Oklahoma Administrative Code (OAC) 317:30-5-1. The licensed health care professional cannot be in a medical facility internship,~~

~~residency, or fellowship program or in the full time employment of the Veterans Administration, United States Public Health Service, or other agency. The 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) definition. A follow-up is required by the DHS county worker with (SSA) to ensure the SSA disability decision is also the LOCEU decision.~~

(A) When categorical relationship to Aid to the Disabled is not established, but there is an extremely emergent need for personal care, and current medical information is not available, the local office authorizes a medical examination.

(B) When authorization is necessary, the county director issues Form 08MA016E, Authorization for Examination, and Form 08MA02E, Report of Physician's Examination, to a licensed medical or osteopathic health care professional, refer to Oklahoma Administrative Code (OAC) 317:30-5-1.

(C) The licensed health care professional cannot be in a medical facility internship, residency, or fellowship program or in the full-time employment of the Veterans Administration, United States Public Health Service, or other agency.

(D) The OKDHS county worker submits the information to the Level of Care Evaluation Unit (LOCEU) to request a medical eligibility determination for categorical relationship. LOCEU renders a decision on the categorical relationship using the Social Security Administration (SSA) definition. The OKDHS county worker is required to conduct a follow-up with SSA to ensure the SSA disability decision is also the LOCEU decision.

(2) Approved contract agencies or the ADvantage Administration (AA) may complete ~~UCAT Part I for intake and screening and forward the form to the county office.~~the electronic application. This alerts the social services specialist (SSS) of application date.

(3) Upon ~~receipt of the referral, DHS county staff may initiate the UCAT, Part I.~~referral receipt, OKDHS SSS starts the financial eligibility determination.

(4) The ~~DHS nurse~~OKDHS HCMN I or II is responsible for completing the UCAT ~~Part III~~ assessment visit within ~~ten-business (10-business)~~ten (10) business days of the personal care ~~referral~~application for the applicant who is SoonerCare eligible at the time of the request. The ~~DHS nurse~~OKDHS HCMN I or II completes the assessment visit within ~~twenty-business~~

~~(20-business)~~twenty (20) business days of the referral for the applicant not determined SoonerCare eligible at the time of the request. When the ~~UCAT Part I~~application indicates the request is from an individual who resides at home and an immediate response is required to ensure the applicant's health and safety ~~of the person~~, to prevent an emergency situation, or to avoid institutional placement, the UCAT ~~Part III~~ assessment visit has top-scheduling priority.

(5) During the assessment visit, the ~~DHS nurse~~OKDHS HCMN I or II completes the UCAT ~~Part III~~ and reviews rights to privacy, fair hearing, provider choice, and the pre-service acknowledgement agreement with the member. The ~~DHS nurse informs~~OKDHS HCMN I or II gives the applicant ~~of~~information about medical eligibility criteria and ~~provides information about DHS~~OKDHS long-term care service options. ~~The DHS nurse~~OKDHS HCMN I or II documents 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 the UCAT~~ Part III~~. When, based on the information obtained during the assessment, the ~~DHS nurse~~OKDHS HCMNI or II 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~~ Part III~~.

(A) When SPPC services are not sufficient to meet the applicant's or member's needs~~ cannot be met by personal care services alone~~, the ~~DHS nurse informs the applicant of the~~OKDHS HCMN I or II provides information about other community long-term care service options. The ~~DHS nurse~~OKDHS HCMN I or II assists ~~the applicant~~ in accessing service options ~~selected by~~ the applicant or member selects in addition to, or in place of, ~~Personal Care~~SPPC services.

(B) When multiple household members are applying for SoonerCare ~~personal care~~SPPC services, the UCAT ~~Part III~~ assessment is done for all the household members at the same time.

(C) The ~~DHS nurse informs~~OKDHS HCMN I or II provides the applicant~~ of the~~ or member with information about the qualified agencies in his or her local area that provide services and obtains the applicant's or member's primary and secondary~~ choice of agencies.~~agency choice. When the applicant or family declines to choose a primary personal care service agency, the ~~DHS nurse selects an agency from a list of all available agencies, using~~ a round-robin rotation system~~.~~ is used for agency selection. The ~~DHS nurse~~OKDHS HCMN I or II documents the selected personal care provider agency's name ~~of the selected personal care provider agency~~.

(6) The ~~DHS nurse~~OKDHS HCMN I or II completes the UCAT ~~Part III~~in the electronic system and ~~sends it to~~ the ~~DHS area nurse for~~OKDHS HCMN III makes the medical eligibility determination. ~~Personal care~~SPPC service eligibility is established on the date medical eligibility is approved and financial eligibility is established. This date serves as the certification date for services to be initiated.

(A) When the time length ~~of time~~ from the initial assessment to the date of service eligibility determination exceeds ~~ninety-calendar (90-calendar)~~ninety (90) calendar days, a new UCAT ~~Part III and~~ assessment ~~visit~~ is required.

(B) The ~~DHS area nurse~~OKDHS HCMN III assigns a medical certification period of not more than thirty-six (36) months for persons eighteen (18) years of age and older or not more than twelve (12) months for persons younger than eighteen (18) years of age. The service plan period ~~under the Service Authorization Model (SAM)~~ is for ~~a period of~~ twelve (12) months ~~and is provided by the DHS nurse~~.

(7) The ~~DHS area nurse notifies the DHS county worker~~SSS is notified via ~~Electronic Data Entry and Retrieval System (ELDERS)~~the electronic system of the personal care certification. ~~The authorization line is open via automation from ELDERS.~~

(8) Upon ~~establishment of personal care~~establishing SPPC certification, the ~~DHS nurse contacts~~OKDHS HCMN I or II notifies the applicant's or member's preferred provider agency, or when necessary, the secondary provider agency or the provider agency selected by the round robin rotation system. Within ~~one-business (1-business)~~one (1) business day of provider agency acceptance, the ~~DHS nurse forwards~~OKDHS HCMN I or II submits the ~~referral~~ information via electronic system to the provider agency for ~~SAM~~ plan development. Refer to OAC 317:35-15-8(a).

(9) Following the ~~SAM packet~~provider agency's SPPC plan development, and within ~~three-business (3-business)~~three (3) business days of receipt ~~of the packet~~ from the provider agency, the ~~DHS nurse~~OKDHS HCMN I or II reviews the documentation to ensure agreement with the plan. Once agreement is established, the ~~packet~~plan is authorized ~~by the designee~~ or submitted to the ~~area nurse~~OKDHS HCMN III for review.

(10) Within ~~ten-business (10-business)~~ten (10) business days of the SPPC plan receipt ~~of the SAM case~~ from the ~~DHS nurse, the DHS area nurse~~OKDHS HCMN I or II, the OKDHS HCMN III authorizes or denies the ~~SAM~~plan units. If the ~~SAM case~~plan fails to meet standards for authorization, ~~the case~~it is returned to the ~~DHS nurse~~OKDHS HCMN I or II for further justification.

(11) Within ~~one-business (1-business)~~one (1) business day of knowledge of the authorization, the ~~DHS nurse forwards~~OKDHS

HCMN I or II submits the ~~service~~ plan authorization to the provider agency~~.~~ via electronic system.

317:35-15-5. General financial eligibility requirements for State Plan Personal Care

Financial eligibility for ~~Personal Care~~SPPC is determined using the rules on income and resources according to the eligibility group ~~to which~~ the ~~individual~~member is related~~.~~ to. Income and resources are evaluated on a monthly basis for all ~~individuals~~ members requesting payment for ~~Personal Care~~SPPC who are categorically related to ~~ABD;~~Aged, Blind, or Disabled (ABD); maximum countable monthly income and resource standards for individuals related to ABD are found on ~~OKDHS~~Oklahoma Human Services (OKDHS) form 08AX001E (Appendix C-1), Schedule VI ~~(QMBP program standards).~~Qualified Medicare Beneficiary Plus program standards.

317:35-15-6. Determining financial eligibility of categorically needy individuals

Financial eligibility for ~~Personal Care~~State Plan Personal Care (SPPC) services for categorically needy individuals is determined as follows:

(1) **Financial eligibility for ~~MAGI~~Modified Adjusted Gross Income (MAGI) eligibility groups.** See MAGI eligibility rules in Subchapter 6 of this Chapter to determine financial eligibility ~~for MAGI eligibility groups~~.

(2) **Financial ~~eligibility/categorically~~eligibility or categorically related to ~~ABD.~~Aged, Blind, and Disabled.** In determining income and resources for the ~~individual~~member related to ABD, the "family" includes the individual and spouse, if any. To be categorically needy, the countable income ~~must be~~is less than the categorically needy standard as shown on the OKDHS form 08AX001E (Appendix C-1), Schedule VI ~~(QMBP standard).~~Qualified Medicare Beneficiary Plus standard. If ~~an individual and~~a member and his or her spouse cease to live together for reasons other than institutionalization or receipt of the ADvantage waiver or ~~HCBW/MR~~a Home and Community Based Waiver, ADvantage or Developmental Disabilities services, income and resources are considered available to each other through the month in which they are separated. Mutual consideration ceases with the month after the month in which the separation occurs. Any amounts ~~which are actually contributed~~ to the spouse after the mutual consideration has ended are considered.

(3) **Determining financial eligibility for State Plan Personal Care~~.~~ (SPPC).** For individuals determined categorically needy for ~~Personal Care,~~SPPC, the member will not pay a vendor payment

for ~~Personal Care~~SPPC services.

317:35-15-7. Certification for State Plan Personal Care

(a) **State Plan Personal Care (SPPC) certification period.** The first month of the ~~Personal Care~~SPPC certification period ~~must be~~is the first month the member ~~was~~is determined financially and medically eligible for ~~Personal Care,~~SPPC ~~both financially and medically~~. When eligibility or ineligibility for ~~Personal Care~~SPPC is established, the local OKDHS office updates the computer-generated ~~form~~notice and the appropriate notice is mailed to the member.

(b) **Financial certification period.** The financial certification period for ~~Personal Care~~SPPC services is ~~12~~twelve (12) months. ~~Redetermination of eligibility~~Eligibility redetermination is completed according to the categorical relationship.

(c) **Medical certification period.** A medical certification period of not more than thirty-six (36) months is assigned for ~~an~~a ~~individual~~member who is approved for ~~Personal Care.~~SPPC. The certification period for ~~Personal Care~~SPPC services is based on the Uniform Comprehensive Assessment Tool ~~(UCAT)~~ evaluation and clinical judgment of the Oklahoma ~~Department of~~ Human Services ~~(DHS) area nurse or designee.~~HCMN III.

317:35-15-8. Agency State Plan ~~personal care~~Personal Care (SPPC) service authorization and monitoring

(a) Within ~~10-business~~ten (10) business days of referral receipt ~~of the referral~~ for ~~personal care~~SPPC services, the personal care provider agency nurse completes ~~a Service Authorization Model (SAM) visit in the home to assess on~~an assessment of the member's personal care service needs and completes and submits ~~the packet~~a person-centered plan based on the member's needs to the ~~DHS nurse.~~Oklahoma Human Services (OKDHS) Health Care Management Nurse (HCMN) I or II. The ~~member's SAM packet includes DHS Forms:~~plan includes the:

(1) ~~02AG044E, Personal Care Progress Notes;~~Adv/SPPC-Nurse Evaluation;

(2) ~~02AG030E, Personal Care Planning Schedule/Service Plan;~~SPPC-Service Planning; and

(3) ~~02AG029E, Personal Care Plan.~~SPPC Member Service Agreement.

(b) When more than one (1) person in the household ~~was~~is referred to receive ~~personal care~~SPPC or ADvantage services, all household members' ~~SAM packets~~plans are discussed and developed with the eligible members so service delivery is coordinated to achieve the most efficient use of resources. The number of SPPC service units ~~of personal care service~~ authorized for each individual is distributed between all eligible family members. ~~to ensure that the absence of one family member~~This ensures one (1) family member's absence does not adversely affect the family member(s)

remaining in the home. When one (1) or more persons in the same household with ~~a epersonal care~~a SPPC member ~~were~~is referred to or ~~are receiving~~receives other formal services, such as ADvantage or Developmental Disability Services, then those services are coordinated as well.

(c) The personal care provider agency receives documentation from ~~DHS as~~the OKDHS HCMN I or II for authorization to begin services. The agency ~~delivers~~provides a copy of the ~~care~~ plan ~~Form 02AG029E and the Personal Care Planning Schedule/Service Plan~~ to the member upon initiating services.

(d) Prior to the provider agency placing a ~~personal care assistant~~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 ~~DHS~~OKDHS Community Services Worker Registry check ~~must be~~is completed per Sections 1-1944 through 1-1948 of Title 63 of the Oklahoma Statutes. Payment is made for PCAs who provide ~~personal care~~SPPC services and meet criteria ~~OAC 317:35-15-2(c)(1) 1 through 8).~~Oklahoma Administrative Code (OAC) 317:35-15-2(c) (1) through (8).

(e) The provider agency nurse monitors the member's care plan ~~of care~~.

(1) The personal care provider agency nurse or staff contacts the member within ~~five-business~~five (5) business days of authorized document receipt ~~of the authorized document~~ in order to ensure services ~~were~~are implemented according to the authorized care plan ~~of care~~.

(2) The provider agency nurse makes a ~~SAM home~~monitoring visit using the Adv/SPPC Nurse Evaluation at least every six (6) months to assess the member's satisfaction with his or her care and to evaluate the ~~SAM packet~~care plan for adequacy of goals and authorized units. Whenever a ~~home~~monitoring visit is made, the provider agency nurse documents findings in the ~~Personal Care Progress Notes.~~electronic system. The provider agency ~~forwards a copy of the Progress Notes to the DHS nurse~~submits monitoring documentation to the OKDHS HCMN I or II for review within ~~five-business~~five (5) business days of the visit. A registered nurse (RN) conducts the monitoring visit when the PCA is performing hands-on personal care. ~~The~~A licensed practical nurse may only conduct 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~~An RN also co-signs the progress notes.

(3) ~~Requests by the~~The provider agency ~~nurse~~nurse's requests to change the number of authorized units ~~authorized~~ in the ~~SAM packet~~SPPC plan are submitted via the electronic system to

~~(DHS)~~the OKDHS HCMN III ~~and are approved or denied by the (DHS) area nurse or designee,~~to approve or deny prior to changed number of authorized units~~ unit~~ implementation.

(4) Annually, or more frequently when the member's needs change, the provider agency nurse re-assesses the member's ~~need's~~needs and develops a new ~~SAM packet~~plan to meet the member's needs. The provider agency nurse ~~conducts a home visit and~~ completes and submits the annual reassessment documents to the ~~DHS nurse~~OKDHS HCMN I or II no sooner than ~~60-calendar~~sixty (60) calendar days before the existing service plan end-date, and no later than ~~14-calendar~~fourteen (14) calendar days prior to service.

(5) When the member is unstaffed, the provider agency nurse or staff communicates with the member and makes efforts to re-staff. ~~It is recommended the provider agency contacts unstaffed members weekly by phone to actively monitor the health and safety of the member and documents ongoing efforts to provide staff.~~When consecutively unstaffed for seven (7) calendar days, or fewer depending on the member's needs, the provider agency nurse or staff contacts the unstaffed member weekly by phone to actively monitor the member's health and safety and documents ongoing efforts to provide staff using the electronic system. When the member is unstaffed for ~~30-calendar~~thirty (30) days, the provider agency notifies the ~~DHS nurse on Form 02AG032E, Provider Communication Form.~~OKDHS HCMN I or II via the Case Note for SPPC thirty (30) day unstaffed note in the electronic system. The DHS nurse The HCMN I or II contacts the member and when the member chooses, initiates a member transfer ~~of the member~~ to another provider agency that can provide staff.

317:35-15-8.1. Agency State Plan Personal Care services; billing, and problem resolution

The ADvantage Administration (AA) certifies qualified personal care provider agencies and facilitates the execution of the agencies' SoonerCare (Medicaid) contracts on ~~behalf of~~ the Oklahoma Health Care ~~Authority~~Authority's (OHCA) behalf. OHCA checks the list of providers barred from Medicare/SoonerCare (Medicaid) participation to ensure that the personal care services agency is not listed.

(1) **Payment for State Plan ~~personal care.~~Personal Care (SPPC).** Payment for ~~personal care~~SPPC services is made for care provided in the member's ~~"own home"~~own home or in other limited living arrangement types~~ of living arrangements~~, per ~~OAC~~Oklahoma Administrative Code (OAC) 317:35-15-2(b)(1 through 4).

(A) **~~Use of provider~~Provider agency~~.~~ use.** To provide ~~personal care~~SPPC services, an agency must be licensed by the Oklahoma State Department of Health, ~~meet~~meets certification

standards identified by ~~the~~ Oklahoma ~~Department of~~ Human Services ~~(DHS),~~ (OKDHS), and ~~possess~~possesses a current SoonerCare (Medicaid) contract.

(B) **Reimbursement.** ~~Personal care~~SPPC services payment on a member's behalf ~~of a member~~ is made according to the service type ~~of service~~ and number of ~~units of personal care services authorized in the Service Authorization Model (SAM) packet.~~authorized service units.

(i) The amount paid to provider agencies for each service unit ~~of service~~ is determined according to established SoonerCare (Medicaid) rates for the ~~Personal Care~~personal care services. Only authorized units contained in each eligible member's individual ~~SAM packet~~plan are eligible for reimbursement. Provider agencies serving more than one ~~personal care service~~ member residing in the same residence ensure the members' ~~SAM packets~~plans combine units in the most efficient manner to meet the needs of all eligible persons in the residence.

(ii) ~~Payment for personal care~~SPPC services payment is for tasks performed in accordance ~~per OAC 317:30-5-951 only when listed on an~~with the authorized care plan ~~of care.~~per OAC 317:30-5-951. Payment for personal care skilled nursing service is made on the member's behalf ~~of the member~~ for ~~assessment/evaluation~~assessment, evaluation, and associated service planning per ~~SAM~~ nursing visit.

(iii) ~~Service~~SPPC 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~~service 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. When the member is dissatisfied with the ~~Personal Care~~SPPC 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 is referred to the ~~DHS~~OKDHS State Plan Care Unit to attempt to resolve the issue(s). The member has the right to appeal to OHCA per OAC 317:2-1-2.

(B) When a PCA performance issue is identified, provider agency staff conducts a counseling conference with the member ~~and/or~~or the PCA as appropriate. Provider agency

staff counsels the PCA regarding problems with ~~his/her~~his or her performance.

(3) **Persons ineligible to serve as ~~PCAs.~~a PCA.** Payment from SoonerCare funds for ~~personal care~~SPPC 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 a minor child, ~~to whom he/she~~when he or she is providing ~~personal care~~SPPC services ~~(exceptions may be made for legal guardians with prior approval from the Department of Human Services/Aging Services (DHS/AS)~~.

317:35-15-8.2. State Plan Personal Care Eligible Provider Exception [REVOKED]

~~The Oklahoma Department of Human Services (OKDHS) Aging Services (AS) may authorize a member's legal guardian to be eligible for SoonerCare (Medicaid) reimbursement when he or she is hired by a home care provider agency as a personal care service provider. Authorization for a legal guardian as a provider requires the criteria in (1) though (4) of this Section and monitoring provisions to be met.~~

~~(1) Authorization for a legal guardian to be the member's care provider may occur only when the member is offered a choice of providers and documentation demonstrates:~~

~~(A) Another provider is not available; or~~

~~(B) The member's needs are so extensive that the legal guardian providing the care is prohibited from obtaining employment.~~

~~(2) The service must:~~

~~(A) Fall under the State Plan Personal Care (SPPC) program guidelines;~~

~~(B) Be necessary to avoid institutionalization;~~

~~(C) Be a service and/or support specified in the person-centered service plan;~~

~~(D) Be provided by a person who meets provider qualifications;~~

~~(E) Be paid at a rate that does not exceed what would be paid to a provider of a similar service and does not exceed what is allowed by Medicaid (SoonerCare)for the payment of personal care or personal assistance services; and~~

~~(F) Not be an activity the legal guardian would ordinarily perform or is responsible to perform.~~

~~(3) The legal guardian service provider complies with:~~

~~(A) Providing no more that forty (40) hours of services in a seven (7) calendar day period;~~

~~(B) Planned work schedules that must be available in advance for the member's home care agency. Variations to the schedule must be noted and supplied to the home care agency two (2)~~

~~weeks in advance unless the change is due to an emergency;~~
~~(C) Utilization of the Electronic Visit Verification System (EVV) also known as the Interactive Voice Response Authentication (IVRA) system; and~~
~~(D) Being identified and monitored by the home care agency.~~
~~(4) The home care agency is required to submit a request and obtain approval for eligible provider exceptions to OKDHS AS prior to employing a legal guardian as a member's personal care assistant (PCA). Eligible provider exceptions require the home care agency to:~~
~~(A) Provide monitoring and complete the Eligible Provider Exception Six Month Review document, when in the member's home completing the six-month Nurse Evaluation document in the Medicaid waiver information system; and~~
~~(B) Annually complete the Eligible Provider Exception Request and submit it with the annual Service Authorization Model (SAM) documentation no later than forty-five (45) calendar days prior to the previous eligible provider exception service authorization end date.~~

317:35-15-9. ~~Redetermination of financial~~Financial eligibility for State Plan Personal Care

The ~~OKDHS county Social Services Specialist must complete~~Oklahoma Human Services social services specialist completes a ~~redetermination of~~ financial eligibility redetermination before the end of the certification period. A notice is generated only if there is a change ~~which affects~~affecting the member's financial eligibility.

317:35-15-10. ~~Redetermination of medical~~Medical eligibility redetermination for ~~personal care~~State Plan Personal Care (SPPC) services

(a) **Medical eligibility redetermination.** The Oklahoma ~~Department of~~ Human Services ~~(DHS) area nurse must complete a~~(OKDHS) Health Care Management Nurse (HCMN) III completes a medical redetermination ~~of medical eligibility~~ before the end of the long-term care medical certification period.

(b) **Recertification.** The ~~DHS nurse~~OKDHS HCMN I or II re-assesses the ~~personal care services member,~~SPPC service members eighteen (18) years of age and older, for medical re-certification based on the member's needs and level of caregiver support required, using the Uniform Comprehensive Assessment Tool (UCAT) ~~Part III~~ at least every thirty-six (36) months. ~~Those members, who are~~Members younger than eighteen (18) years of age, are re-evaluated by the ~~DHS nurse~~OKDHS HCMN I or II using the UCAT ~~Part III~~ on a twelve (12) month basis or sooner when needed. During this re-certification assessment, the ~~DHS nurse~~OKDHS HCMN I or II informs

the member of the state's other SoonerCare (Medicaid) long-term care options. The ~~DHS nurse~~OKDHS HCMN I or II submits the re-assessment to the ~~DHS area nurse~~OKDHS HCMN III for recertification. Documentation is sent to the ~~DHS~~OKDHS area nurse no later than the ~~tenth-calendar (10th-calendar)~~tenth (10th) calendar day of the month ~~in which the~~ certification expires. When the ~~DHS area nurse~~OKDHS HCMN III determines medical eligibility for ~~personal care~~SPPC services, a recertification review date is entered on the system.

(c) **Change in amount of units or tasks.** When the ~~personal care~~SPPC provider agency determines a need for a change in the amount of units or tasks ~~within the personal care~~in the service, a ~~new Service Authorization Model (SAM) packet~~care plan is completed and submitted to ~~DHS~~OKDHS within five (5) business days of identifying the assessed need. The OKDHS HCMN III approves or denies the change ~~is approved or denied by the DHS area nurse or designee,~~ prior to implementation.

(d) **~~Voluntary closure of personal care services.~~SPPC services voluntary closure.** When a SPPC member decides personal care services are no longer needed to meet his or her needs, a medical decision is not needed. The member ~~and the DHS nurse or DHS county Social Services Specialist completes and signs DHS Form 02AG038E, State Plan Personal Care/ADvantage Program~~is sent a Voluntary Withdrawal Request~~.~~ for confirmation and signature, and the request is entered into the electronic system upon receipt. ~~The DHS nurse submits~~A closure notification is submitted to the provider agency~~.~~ via the electronic system.

(e) **Resuming personal care services.** When a SPPC member approved for ~~personal care~~SPPC services is without ~~personal care~~ services for less than ~~ninety-calendar (90-calendar)~~ninety (90) calendar days, but the member has current medical and SoonerCare (Medicaid) financial eligibility approval, ~~personal care~~SPPC services may be resumed using the member's previously approved ~~SAM packet.~~plan. The 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~~completes an assessment visit and submits ~~a personal care~~a SPPC services skilled nursing need re-assessment ~~of need~~ within ~~ten-business (10-business)~~ten (10) business days of the resumed plan start date~~, using the State Plan Personal Care Progress Notes, DHS Form 02AG044E~~. When the member's needs dictate, the personal care provider agency may submit a request for a change in authorized ~~personal care services~~SPPC service units~~ with a SAM packet to 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 ten-business (10-business)~~in the electronic system for the OKDHS HCMN I or II ten (10) business days of the resumed plan start date.

(f) **Financial ineligibility.** When the ~~DHS~~OKDHS social services specialist (SSS) determines a ~~personal care services~~ member does not meet SoonerCare (Medicaid) financial eligibility criteria, the ~~DHS office notifies the DHS area nurse~~OKDHS HCMN III is notified to initiate the closure process due to financial ineligibility. ~~Individuals determined~~When OKDHS determines a member to be financially ineligible for ~~personal care~~SPPC services, ~~are notified by DHS~~they notify the member of the determination, and his or her right to appeal the decision ~~in writing of the determination and of their right to appeal the decision~~. ~~The DHS nurse submits~~A closure notification is submitted to the provider agency.

(g) **Closure due to medical ineligibility.** ~~Individuals determined~~When OKDHS determines to be medically ineligible for ~~personal care~~SPPC services ~~are notified by DHS~~, they notify the member of the determination, and his or her right to appeal the decision, in writing ~~of the determination and of their right to appeal the decision~~. When medical eligibility redetermination is not made prior to current medical eligibility expiration, the existing medical eligibility certification is automatically extended until care level ~~of care~~ redetermination is established. For members:

(1) ~~who~~Who are not hospitalized or in an extended medical care facility, the existing medical eligibility certification is extended for a maximum ~~sixty-calendar (60-calendar) days~~sixty (60) calendar days from the date of the previous medical eligibility expiration date;

(2) ~~who~~Who are hospitalized or in an extended medical care facility, the existing medical eligibility certification is extended for ~~thirty-calendar (30-calendar)~~thirty (30) calendar days from the date of discharge from the facility or for ~~sixty-calendar (60-calendar)~~sixty (60) calendar days from the date of previous medical eligibility expiration date, whichever is longer;

(3) ~~whose~~Whose medical eligibility redetermination is not made by applicable extended deadline, the member is determined to be ~~no longer~~ medically ~~eligible;~~ineligible; or

(4) ~~who~~Who no longer meet medical eligibility or cannot be located to complete the redetermination assessment, ~~the area nurse or nurse designee,~~the HCMN I or II notifies the HCMN III. The HCMN III updates the system's medical eligibility end date and notifies the ~~DHS State Plan Care Unit (SPCU) nurse~~HCMN I or II of effective end date. ~~The DHS SPCU nurse submits~~A closure notification is submitted to the provider agency.

(h) **~~Termination of State Plan personal care services.~~Personal Care services termination.**

(1) ~~Personal care~~State Plan Personal Care (SPPC) services may be discontinued when:

(A) ~~the~~Professional documentation supports the member poses a threat to self or others~~ as supported by professional documentation~~;

(B) ~~other~~Other household members ~~of the household~~ or persons who routinely visit the household who, as ~~supported by~~ professional or credible documentation ~~or other credible documentation,~~supports, pose a threat to the member or other household visitors;

(C) ~~the~~The member or the other household members use threatening, intimidating, degrading, or sexually inappropriate language ~~and/or~~or innuendo or behavior towards service providers, either in the home or through other contact or communications~~; and efforts~~. Efforts to correct such behavior ~~were~~are unsuccessful as ~~supported by~~ professional or credible documentation ~~or other credible documentation.~~supports;

(D) ~~the~~The member or family member fails to cooperate with ~~Personal Care~~SPPC service delivery or to comply with Oklahoma Health Care Authority (OHCA) or ~~DHS~~OKDHS rules as ~~supported by~~ professional or credible documentation~~;~~ supports;

(E) ~~the~~The member's health or safety is at risk as~~ supported by~~ professional or credible documentation~~;~~ supports;

(F) ~~additional~~Additional services, either "formal" such as, paid by Sooner Care (Medicaid) or some other funding source or "informal" such as, unpaid are provided in the home ~~eliminating~~. This eliminates the need for SoonerCare ~~personal care~~SPPC services;

(G) ~~the individual's~~The member's living environment poses a physical threat to self or others as ~~supported by~~ professional or credible documentation supports~~ where applicable~~, and measures to correct hazardous conditions or assist the person to move are unsuccessful or are not feasible; or

(H) ~~the~~The member refuses to select ~~and/or~~or accept ~~the services of~~ a provider agency or ~~personal care assistant (PCA)~~Personal Care Assistant (PCA) service for ~~ninety-consecutive (90-consecutive)~~ninety (90) consecutive days as ~~supported by~~ professional or credible documentation~~.~~ supports.

(2) For ~~persons~~members receiving ~~personal care~~SPPC services, the ~~personal care~~ provider agency submits documentation with the recommendation to discontinue services to ~~DHS.~~OKDHS. The ~~DHS nurse~~OKDHS HCMN I or II reviews the documentation and submits it to the ~~DHS area nurse~~OKDHS HCMN III for

determination. The ~~DHS nurse notifies the~~ personal care provider agency or PCA and the local ~~DHS county worker~~OKDHS social services specialist is notified of the decision to terminate services~~.~~ via the electronic system. The member is sent an official closure notice informing him or her of appropriate member rights to appeal the decision to discontinue services.

317:35-15-12. Case changes

Any time there are changes ~~which affect~~affecting the State Plan Personal Care case~~,~~ eligibility, computer generated notices are issued.

317:35-15-13.1. Individual personal care assistant (IPCA) service management

(a) An Individual Personal Care Assistant (IPCA) may be utilized to provide ~~personal care~~SPPC services when it is documented to be in the member's best interest ~~of the member~~ to have an IPCA, or when there are no qualified personal care provider agencies available in the member's local area. Oklahoma Health Care Authority (OHCA) checks the list of providers barred from Medicare/Medicaid participation to ensure the IPCA is not listed.

(b) After ~~personal care~~SPPC services eligibility is established, and prior to implementation of ~~personal care~~SPPC services using an IPCA, the ~~DHS nurse~~OKDHS Health Care Management Nurse I or II reviews the care plan with the member and IPCA and notifies ~~the member and IPCA~~them to begin ~~personal care~~SPPC services delivery. The ~~DHS nurse~~OKDHS HCMN I or II maintains the original care plan and forwards a copy ~~of the care plan~~ to the selected IPCA and member within ~~one-business~~one (1) business day of approval receipt ~~of approval~~.

(c) The ~~DHS nurse~~HCMN I or II contacts the member within ~~five-business~~five (5) business days to ensure services are in place and meeting the member's needs. The HCMN I or II also ~~and~~ monitors the care plan for members with an IPCA. For any member receiving ~~personal care~~SPPC services utilizing an IPCA, the ~~DHS nurse~~OKDHS HCMN I or II makes a home visit at least every six (6) months beginning within ~~90-calendar~~ninety (90) calendar days from the date of ~~personal care~~ service initiation. ~~DHS~~OKDHS HCMN I or II assesses the member's satisfaction with his or her ~~personal care~~SPPC 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~~are approved by the ~~DHS area nurse or designee,~~HCMN III prior to implementation ~~of the changed number of units~~.

317:35-15-13.2. Individual personal care assistants (IPCA)

provider contractor; billing, training, and problem resolution

While the Oklahoma Health Care Authority (OHCA) is the contractor authorized under federal law, the Oklahoma ~~Department of~~ Human Services ~~(DHS) nurse~~(OKDHS) Health Care Management Nurse (HCMN) I or II initiates initial contracts with ~~qualified individuals for provision of personal care~~eligible members to provide SPPC services per Oklahoma Administrative Code (OAC) 317:35-15-2. ~~The~~OHCA is responsible for IPCA contract renewal ~~for the IPCA is the responsibility of OHCA~~.

(1) **IPCA payment.** Payment for ~~personal care~~SPPC services is made for care provided in the member's ~~"own home"~~own home or in other limited types of living arrangements per OAC 317:35-15-2(b)(1) through (4). ~~Personal care~~SPPC services may not be approved when the ~~client~~member lives in the Personal Care Assistant's ~~(PCA's)~~ (PCA) home, except with the approval of ~~DHS~~OKDHS Community Living, Aging Services~~.~~ and Protective Services.

(A) **Reimbursement.** Personal care payment for a member is made according to the number of personal care units ~~of service~~ identified in the service plan.

(i) The amount per unit ~~amounts~~ paid to individual contractors is determined according to the established rates. A service plan is developed for each ~~eligible individual~~member in the home and service units ~~of service~~ are assigned to meet ~~the~~each member's needs ~~of each member~~. The service plans combine units ~~in the most efficient manner~~efficiently to meet ~~the needs of~~ all eligible ~~persons~~members needs in the household.

(ii) From the total amounts ~~billed by~~ the IPCA bills in (i) of this subparagraph, ~~the~~ OHCA, acting as agent for the member-employer, withholds the appropriate FICA tax percentage ~~of FICA tax~~ and sends it to the Internal Revenue Service as the individual contractor's contribution toward Social Security coverage. To ensure the Social Security account is credited, the individual contractor's Social Security ~~account may be properly credited, it is vital that the individual contractor's Social Security~~ number ~~be~~is entered correctly on each claim.

(iii) The contractor payment fee covers all ~~personal care~~SPPC services included on the service and care plans ~~developed by the DHS nurse.~~the OKDHS HCMN I or II develops. Payment is only made for eligible members' direct services and care ~~of the eligible member(s) only~~. The ~~area nurse, or designee,~~OKDHS HCMN III, authorizes the number of ~~units of~~ service units the member receives.

(iv) A member may select more than one (1) IPCA. ~~This may~~

~~be~~The service and care plan indicates when this is necessary~~ as indicated by the service and care plans~~.

(v) The IPCA may provide SoonerCare ~~personal care~~SPPC services for several households during one (1) week as long as the daily number of paid service units does not exceed eight (8) hours, ~~32~~thirty-two (32) units per day. ~~The total number of~~Total weekly hours ~~per week~~ cannot exceed ~~40, 160 units.~~forty (40), one-hundred and sixty (160) units.

(B) **~~Release of~~IPCA wage ~~and/or~~or employment information ~~for IPCAs.~~release.** Any inquiry received by the local office requesting wage ~~and/or~~or employment information ~~for an IPCA~~ is forwarded to~~ the~~ OHCA, Claims Resolution.

(2) **IPCA member selection.** Members ~~and/or~~or family members recruit, interview, conduct reference checks, and select ~~the individual~~applicants for IPCA consideration. Prior to placing ~~a personal care service provider~~an IPCA in the member's home, an ~~OSBI~~Oklahoma State Bureau of Investigation (OSBI) background check~~, a DHS~~ and an OKDHS Community Services Worker Registry check ~~must be~~are completed per Section 1-1944 through 1-1948 of Title 63 of the Oklahoma Statutes~~.~~ (O.S. 63 §§ 1-1944 through 1-948). The ~~DHS nurse must also check~~OKDHS HCMN I or II also checks the Certified Nurse Aide Registry. The ~~DHS nurse must affirm that~~OKDHS HCMN I or II affirms the applicant's name is not contained on any of the registries. The ~~DHS nurse~~OKDHS HCMN I or II notifies OHCA when the applicant is on ~~the Registry.~~any registry.

(A) **Persons eligible to serve as IPCAs.** ~~Payment~~SPPC services payment is made ~~for personal care services~~ to IPCAs ~~who provide personal care services~~ who meet the criteria per OAC 317:35-15-2(c)(1) through (8).

(B) **Persons ineligible to serve as IPCAs.** ~~Payment~~SPPC services payment from SoonerCare funds ~~for personal care services~~ may not be made to an individual who is ~~a~~the member's legally responsible family member, such as a 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~~.

(i) Payment cannot be made to ~~a DHS or~~ an OKDHS or OHCA employee. Payment cannot be made to an immediate family member of a ~~DHS~~an OKDHS employee who works in the same county without ~~DHS Aging Services~~OKDHS Medicaid Services Unit approval. When a family member relationship exists between ~~a DHS nurse~~an OKDHS HCMN I or II and an IPCA in the same county, the ~~DHS nurse~~OKDHS HCMN I or II cannot manage services for a member whose IPCA is ~~a~~his or her family member~~ of the DHS nurse~~.

(ii) If it is determined that ~~an a DHS~~an OKDHS HCMN I or II or an OHCA employee is interfering in ~~the process of providing services~~service provision for personal or family benefit, ~~he or she~~the employee is subject to disciplinary action.

(3) **IPCA orientation.** When a member selects an IPCA, the ~~DHS nurse contacts~~OKDHS HCMN I or II notifies the ~~individual~~selected IPCA ~~to report to the county office~~ to complete the Oklahoma State Department of Health ~~form~~(OSDH) Form 805, Uniform Employment Application for Nurse Aide Staff, and the ~~DHS~~OKDHS Form 06PE039E, Employment Application Supplement, and for a qualification determination ~~of qualifications~~ and orientation~~.~~ determination. For ~~personal care~~SPPC members, this process is the ~~responsibility of the DHS nurse.~~OKDHS HCMN I or II responsibility. The IPCA can begin work ~~when:~~after:

(A) ~~he or she was interviewed by the member,~~The member interviews him or her;

(B) ~~he or she was oriented by the~~The OKDHS nurse~~,~~ orients him or her;

(C) ~~he or she executed a~~A contract (OHCA-0026) is executed with the OHCA~~,~~;

(D) ~~the~~The effective service date ~~was~~is established~~,~~;

(E) ~~all~~All registries ~~were~~are checked and the IPCA's name is not listed~~,~~;

(F) ~~the Oklahoma State Department of Health~~OSDH Nurse Aide Registry ~~was~~is checked and no notations ~~were~~are found~~,~~; and

(G) ~~the~~ OSBI background check ~~was~~is completed.

(4) **~~Training of IPCAs.~~IPCA training.** It is the ~~responsibility of the DHS nurse~~OKDHS HCMN I or II responsibility to make sure the IPCA has the training needed to carry out the care plan ~~of care~~ prior to each member's service initiation ~~for each member~~.

(5) **Problem resolution related to ~~the~~IPCA performance ~~of the IPCA~~**. When it comes to ~~the attention of~~ the ~~DHS nurse that~~OKDHS HCMN I or II attention there is a problem related to ~~the~~ IPCA performance ~~of the IPCA~~, a counseling conference is held between the member, OKDHS ~~nurse,~~HCMN I or II, and ~~worker.~~IPCA. The ~~DHS nurse~~OKDHS HCMN I or II counsels the IPCA regarding problems with his or her performance~~. Counseling is considered when staff believes counseling will result~~ when doing so results in improved performance.

(6) **~~Termination of the~~ IPCA Provider Agreement~~.~~ termination.**

(A) ~~A~~An IPCA contract termination recommendation ~~for the termination of an IPCA's contract~~ is submitted to OHCA and IPCA services are suspended immediately when~~:~~ the IPCA:

(i) ~~an IPCA's performance is such that his or her continued participation in the program could~~

~~pose~~Performance poses a threat to the member's health and safety ~~of the member~~ or to others; or

(ii) ~~the IPCA failed~~Failed to comply with ~~the expectations outlined in the~~ PCA Provider Agreement expectations and counseling is not appropriate or ~~was not~~ effective; or

(iii) ~~an IPCA's name~~Name appears on the ~~DHS~~OKDHS Community Services Worker Registry~~,~~ or any ~~of the registries~~registry listed in ~~Section 1-1947 of Title~~O.S. 63 ~~of the Oklahoma Statutes,~~ § 1-1947, even ~~though his or her name may not have appeared on the Registry~~when his or her name is not on the registry at the time of application or hiring.

(B) The ~~DHS nurse~~OKDHS HCMN makes the IPCA termination recommendation ~~for the termination of the IPCA to DHS~~to OKDHS Community Living, Aging and Protective Services Medicaid Services Unit (MSU), ~~who notifies~~MSU then notifies the OHCA Legal Division of the recommendation. When the problem is related to abuse, neglect, or exploitation allegations ~~of abuse, neglect, or exploitation, DHS~~OKDHS Adult Protective Services, State Attorney General's Medicaid Unit, OHCA, and ~~the Oklahoma State Department of Health~~OSDH are notified ~~by the DHS nurse~~.

(C) When the problem is related to abuse, neglect, or exploitation allegations, ~~of abuse, neglect, or exploitation~~ the ~~DHS nurse~~OKDHS HCMN follows the process, ~~as outlined in~~per OAC 340:100-3-39.

317:35-15-14. Billing procedures for State Plan personal care

Billing procedures for ~~personal care~~State Plan Personal Care (SPPC) services are contained in the Oklahoma Medicaid Management Information Systems (OKMMIS) Billing and Procedure Manual. Questions regarding billing procedures that cannot be resolved through ~~a study of~~studying the manual are referred to the Oklahoma Health Care Authority (OHCA). ~~Contractors for Personal Care~~SPPC contractors bill on CMS-1500 claim form. OHCA provides instructions to ~~an~~a contracted Individual ~~personal care assistant~~Personal Care Assistant (IPCA) ~~contracted provider~~ for claim completion ~~of the claim~~ at the ~~time of the contractor~~contractor's 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 responsible for ensuring claims ~~were~~are properly completed. All personal care contractors must have a unique provider number. New contracted providers are mailed the provider number after ~~they are~~being placed on the claims processing contractor's provider file. All services provided in the ~~service recipients~~member's

home, ~~member's home~~ including Personal Care and Nursing~~ must be~~, and all work completed in the provider's office, are documented through the Electronic Visit Verification (EVV) system. ~~Additionally, work completed in the provider's office is documented in the EVV system.~~ The EVV system provides alternate backup solutions if the automated system is unavailable; however, in the event of an EVV system failure, the provider documents time in accordance with internal provider agency 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 EVV system is unavailable.

317:35-15-15. ~~Referral for social services~~Social services referral

In many situations, members ~~who are~~ receiving medical services through SoonerCare (Medicaid) need social services. The OKDHS ~~nurse~~HCMN I or II may make referrals for social services to the OKDHS ~~worker~~social services specialist (SSS) in the local office. In addition to these referrals, a member, or another individual acting on the member's behalf, may initiate a social services request~~ for social services may be initiated by a member or by another individual acting upon behalf of a member~~.

(1) ~~The~~ OKDHS ~~Social Services Specialist~~SSS ~~is responsible for providing~~provides the indicated services, or ~~for referral~~makes referrals to the appropriate ~~resource outside the Department~~outside resources if the services are not available within ~~the Department.~~OKDHS.

(2) ~~Among the~~OKDHS SSS provided services~~ provided by the OKDHS Social Services Specialist are:~~

(A) ~~Services that will enable individuals~~Enable members to attain ~~and/or~~or maintain ~~as~~ good physical and mental health ~~as possible~~;

(B) ~~Services to assist patients~~Assist members who ~~are receiving~~receive care outside their own homes in planning for and returning to their own homes or to other alternate care;

(C) ~~Services to encourage~~Encourage the development and maintenance of family and community ~~interest~~interests and ties;

(D) ~~Services to promote~~Promote member's maximum independence in ~~the management of~~managing their own affairs;

(E) ~~Protective~~Include protective services~~, including evaluation of~~ that evaluate the need for and ~~arranging for~~arrange guardianship; and

(F) ~~Appropriate~~Offer family planning services, ~~which include assisting the~~including family assistance in acquiring means to responsible parenthood. Services are offered in making the necessary referral and follow-up.

SUBCHAPTER 17. ADVANTAGE WAIVER SERVICES

317:35-17-5. ADvantage program medical eligibility determination

The Oklahoma ~~Department~~ of Human Services ~~(DHS)~~OKDHS area nurse or nurse designee, makes the medical eligibility determination utilizing professional judgment, the Uniform Comprehensive Assessment Tool (UCAT) ~~- Parts I and III~~, and any other available medical information.

(1) When ADvantage care services are requested or the ~~UCAT I~~application is received ~~in the county office~~, the:

(A) ~~DHS~~OKDHS nurse ~~is responsible for completing~~completes the UCAT ~~- III~~; and

(B) ~~social service~~Social services specialist (SSS) ~~is responsible for contacting~~contacts the applicant within three (3) business days to initiate the financial eligibility application process.

(2) Categorical relationship ~~must be~~is established for ADvantage services eligibility determination ~~of eligibility for ADvantage services~~. When a member's categorical relationship to a disability ~~was~~is not established, the local ~~social service specialist~~SSS submits the same information, per Oklahoma Administrative Code (OAC) 317:35-5-4(2) to the Level of Care Evaluation Unit (LOCEU) of the Oklahoma Health Care Authority to request a medical categorical relationship eligibility determination ~~of eligibility for categorical relationship~~. LOCEU ~~renders a decision~~decides on the categorical relationship to ~~the person with~~ the disability using the Social Security Administration (SSA) definition. ~~A~~An SSS follow-up with SSA is required ~~by the DHS social service specialist with SSA~~ to ensure the disability decision agrees with the LOCEU decision.

(3) Community agencies and waiver service applicants may complete the ~~UCAT I,~~application and forward ~~the form~~ to ~~the county office.~~OKDHS. ~~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 call the care line at 1-800-435-4711.~~

(4) ~~The DHS~~When an applicant is Medicaid eligible at the request time, an OKDHS nurse completes the UCAT ~~III~~ assessment ~~visit~~ with the ~~member~~applicant within ~~10-business~~ten (10) business days of referral receipt ~~of the referral~~ for ADvantage services ~~for an applicant who is Medicaid eligible at the time of the request~~. The ~~DHS~~OKDHS nurse completes the UCAT ~~III~~ assessment ~~visit~~ within ~~20-business~~twenty (20) business days of the date the Medicaid application is completed for new applicants.

(5) For initial level of care (LOC), the OKDHS nurse assesses the applicant through an electronic format such as phone or

video conference, using the UCAT unless there are limiting factors which necessitate a face-to-face assessment.

(A) The OKDHS nurse determines LOC based upon the assessment outcome unless the applicant is medically ineligible. In this case, a face-to-face visit is scheduled to either validate the initial electronic format assessment or to provide additional documentation to support the applicant meeting medical LOC.

(B) Applicants are not denied access to the waiver solely based on an assessment completed through an electronic format.

~~(5)~~(6) During the UCAT ~~III~~ assessment ~~visit~~, the ~~DHS~~OKDHS 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~~OKDHS nurse documents whether the ~~member~~applicant chooses nursing facility program services or ADvantage program services and makes ~~a level of care~~an LOC and service program recommendation.

~~(6)~~(7) The ~~DHS~~OKDHS nurse informs the ~~member~~applicant 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,~~provider choice, ensuring adherence to conflict free case management requirements.

(A) ~~Providers of~~ ADvantage ~~services for the member,~~providers, or ~~for~~ those who have an interest in~~,~~ or are employed by an ADvantage provider, ~~for the member must not~~do not provide case management or develop the person-centered service plan~~,~~. ~~except~~The only exception is when the ADvantage Administration ~~(AA)~~ demonstrates ~~the only~~there are no more than two (2) willing and qualified ~~entity~~entities to provide case management ~~and/or~~and develop person-centered service plans in a geographic area, and those agencies also ~~provides~~provide other ADvantage services.

(B) When the ~~member and/or~~applicant or family declines to make a provider choice, the ~~DHS~~OKDHS nurse documents the decision on ~~Form 02CB001, Member Consents and Rights.~~the consents and rights document.

(C) ~~The AA~~OKDHS uses a rotating system to select ~~an agency~~agencies for the ~~member~~applicant from a list of all local, certified case management and in-home care ~~agencies,~~providers, ensuring adherence to conflict free case management requirements.

~~(7)~~(8) The ~~DHS~~OKDHS nurse documents ~~the~~chosen agency names ~~of the chosen agencies~~, or the choice to decline to select

agencies, and the applicant's agreement ~~of the member, by dated signature,~~ to receive waiver services ~~provided by the agencies~~.
~~(8)~~(9) When the ~~member's~~applicant's needs require an immediate interdisciplinary team (IDT) meeting with the case manager and home ~~health~~care provider agency nurse participation to develop a person-centered service plan, the ~~DHS~~OKDHS nurse documents the priority processing need ~~for priority processing~~.
~~(9)~~(10) The ~~DHS~~OKDHS nurse ~~scores the UCAT III. The DHS nurse~~ forwards the completed 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)~~(11) When ~~based upon the information obtained during~~the OKDHS nurse determines the UCAT ~~the~~ assessment~~, the DHS nurse determines~~indicates the member ~~may be~~health and safety are at risk ~~for health and safety~~, ~~DHS~~OKDHS Adult Protective Services staff is notified immediately and the referral is documented on the UCAT.
~~(11)~~(12) Within ~~10-business~~ten (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~~LOC 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)~~(13) Upon SSS financial eligibility notification ~~of financial eligibility from the social service specialist, medical eligibility,~~ and medical eligibility 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,~~AA provides the member's demographic and assessment information, and the number of ~~units of~~ case management and ~~the number of units of~~ home care ~~agency~~ nurse evaluation units authorized for service plan development. When the member requires an immediate home visit to develop a person-centered ~~within 24 hours, the~~plan, AA contacts the case management provider directly to confirm availability and request IDT priority ~~electronically sends the new case packet information to the case management provider~~.
~~(13)~~(14) When ~~the~~a member is being discharged from a nursing facility or hospital and transferred home, services ~~must be~~are in place to ensure the member's health and safety ~~of the member upon discharge to the home from the nursing facility or hospital, a~~. The member's chosen case manager ~~from an ADvantage case management provider selected by the member and referred by the AA~~ follows the ADvantage ~~institution~~institutional

transition~~,~~ case management procedures for care, and service plan development and implementation.

~~(14)~~(15) A new medical ~~level of care~~LOC determination is required when a member requests any ~~changes~~change in service ~~program,~~setting, from:

(A) State Plan Personal Care (SPPC) services to ADvantage services;

(B) ADvantage to ~~State Plan Personal Care~~SPPC services;

(C) ~~nursing~~Nursing facility to ADvantage services; or

(D) ADvantage to nursing facility services.

~~(15)~~(16) A new medical ~~level of care~~LOC determination is not required when a member requests ADvantage services re-activation ~~of ADvantage services~~ after ~~a short-term stay of 90-calendar~~staying ninety (90) calendar days or less in a nursing facility when the member had previous ADvantage services and the ADvantage certification period has not expired~~.~~ by the date the member is discharged.

~~(16)~~(17) When a UCAT assessment ~~was~~is completed more than ~~90-calendar~~ninety (90) calendar days prior to submission to the area nurse or nurse designee for a medical decision, a new assessment is required.

317:35-17-16. Member annual level of care re-evaluation and annual service plan reauthorization

(a) The ADvantage case manager reassesses the member's needs annually using the Uniform Comprehensive Assessment Tool (UCAT) ~~Parts I and III~~, then evaluates the member's progress ~~of the member~~ toward person-centered service plan goals and objectives. The ADvantage case manager develops the annual person-centered service plan with the member and interdisciplinary team and submits the person-centered service plan to the ADvantage Administration (AA) for authorization. The ADvantage case manager initiates the UCAT reassessment and ~~development of~~develops the annual person-centered service plan at least forty (40) calendar days, but not more than sixty (60) calendar days, prior to the existing plan's end date~~ of the existing person-centered service plan~~. The ADvantage case manager provides AA the ~~reassessment~~ person-centered service plan ~~packet~~reassessment documents no less than thirty (30) calendar days prior to the existing plan's end date~~ of the existing plan~~. The reassessment ~~person-centered service plan packet includes~~documents include the person-centered service plan, UCAT ~~Parts I and III~~, Nursing Assessment and Monitoring Tool and supporting documentation.

(b) For medical eligibility reassessment, ~~The~~ Oklahoma ~~Department of~~ Human Services ~~(DHS)~~(OKDHS) recertification nurse reviews the UCAT ~~Parts I and III~~the ADvantage case manager submitted~~ by the ADvantage case manager for a level of care redetermination~~. When

policy defined criteria for nursing facility ~~level of care~~LOC cannot be determined or justified from available documentation or through direct contact with the ADvantage case manager, the member is referred to the local OKDHS nurse. ~~UCAT Parts I and IIIare completed in the member's home by the DHS nurse. The DHS nurse submits the UCAT evaluation to the area nurse or nurse designee, to make the medical eligibility level of care determination.~~The OKDHS nurse then re-assesses the applicant using the UCAT through an electronic format such as a phone and video conference, unless there are limiting factors which necessitate a face-to-face assessment.

(1) The OKDHS nurse determines LOC based on the assessment's outcome unless the applicant is determined to be medically ineligible. In this case, a face-to-face visit is scheduled to either validate the electronic format assessment or provide additional documentation to support the applicant meeting medical LOC.

(2) Applicants are not medically denied access to the waiver solely based on an assessment completed through an electronic format.

(c) When medical eligibility redetermination is not made prior to the current medical eligibility expiration, the existing medical eligibility certification is automatically extended.

(1) For members who are not receiving inpatient~~,~~ acute care, long term acute care, rehab or skilled nursing services, the existing medical eligibility certification is extended for a maximum of sixty (60) calendar days from the date of the previous medical eligibility expiration date.

(2) For members who are receiving inpatient~~,~~ acute care, long term acute care, rehab or skilled nursing services, the existing medical eligibility certification is extended for thirty (30) calendar days from the facility discharge date, ~~of discharge from the facility~~ or ~~the~~for sixty (60)calendar days from the previous medical eligibility's date~~ of the previous medical eligibility date~~, whichever is longer.

(3) When the medical eligibility redetermination is not made by the applicable extended deadline, the member ~~is determined to~~ no longer ~~meet~~meets medical eligibility. The area nurse or nurse designee updates the system's medical eligibility end date~~ and simultaneously notifies AA electronically~~.

(d) When ~~DHS~~OKDHS determines a member no longer meets medical eligibility~~,~~ to receive waiver services, the:

(1) ~~area~~Area nurse or nurse designee updates the medical eligibility end date~~ and notifies the AA electronically~~;

(2) AA communicates to the member's ADvantage case manager that the member ~~was determined to~~ no longer ~~need~~meets medical

eligibility for ADvantage as of the eligibility determination effective date ~~of the eligibility determination~~; and

(3) ADvantage case manager communicates with the member and when requested, assists with access to other services.

317:35-17-27 Incident reporting

(a) **Reporting requirement.** Certified ADvantage provider staff should report critical and non-critical incidents involving the health and welfare of ADvantage Waiver members to the Oklahoma Human Services Medicaid Services Unit (MSU).

(b) **Critical incidents.** Critical incidents are events with potential to cause significant risk or serious harm to an ADvantage member's safety or well-being. Critical Incidents Reports (CIR) are completed for:

(1) Suspected maltreatment including abuse, neglect, or exploitation, per Section 10-103 of Title 43A of the Oklahoma Statutes (43A O.S. § 10-103);

(2) Attempted suicide or suicidal ideation exhibition;

(3) Unexpected or questionable death;

(4) Falls or injuries requiring medical attention;

(5) Residence loss due to disaster;

(6) An interruption of needed medical supports;

(7) Lost or missing members;

(8) A medication error requiring medical attention;

(9) Use of physical restraints; or

(10) Allegations related to Personal Care Assistant (PCA) or Personal Service Assistant (PSA).

(c) **Non-critical incidents.** Non-critical incidents are events with potential to cause risk to an ADvantage member's safety and well-being, but do not rise to the critical incident level. Non-critical incidents include:

(1) Falls or injuries that do not require medical attention;

(2) Theft allegations;

(3) Threatening or inappropriate behavior;

(4) Substance abuse or use;

(5) Serious allegations related to a provider agency; and

(6) Law enforcement involvement due to challenging behaviors.

(d) **Incident notification requirements.** The reporting provider documents and submits to MSU incidents included in (b) and (c) of this Section in the electronic system on the CIR document, within one business day of becoming aware of the incident. The reporting provider notifies other persons or entities as required by law or regulation, including:

(1) When a service recipient dies, per OAC 340:100-3-35; and

(2) Investigative authorities immediately in cases of suspected maltreatment, as applicable, including:

(A) Local law enforcement;

(B) The Office of Client Advocacy when the alleged perpetrator is a community service worker, per OAC 340:2-3-33; and

(C) Adult Protective Services when the alleged perpetrator is not a community service worker per 43A O.S. § 10-104.

(e) **Internal Investigation.** The provider completes an internal investigation of all critical incidents, unless directed otherwise by an authorized government entity.

(1) All provider investigative reports are submitted to the MSU within ten (10) working days after the initial CIR is completed.

(2) The provider coordinates internal critical incident investigation and response efforts with governmental investigative authorities as required by law.

(3) Provider supervisory staff run a monthly report from the electronic system to review all critical incidents submitted to the MSU. Doing so ensures proper handling and dispensation occurs, as required by the Centers for Medicare and Medicaid Services.

(f) **Escalated issues.** The Escalated Issues (EI) team reviews all CIR and determines whether the appropriate response occurred. EI coordinates their investigation and response efforts with governmental investigative authorities as required by law. For non-critical incident reports, EI reviews and works with the member, the member's informal support, provider, and others to verify appropriate actions are taken to identify barriers to service, prevent future incidents, and assure continued member health and welfare. Investigation results are communicated to the member, legal guardian, or next of kin as appropriate.

(g) **Members and their representatives.** Upon entry into the program and at least annually, each member is provided with resources and contact information to self-report complaints, abuse, neglect, exploitation, or other issues.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 32. SOONERRIDE NON-EMERGENCY TRANSPORTATION (NEMT)

317:30-5-326. Provider eligibility

~~The Oklahoma Health Care Authority (OHCA) is responsible for assuring that necessary transportation is available to all eligible SoonerCare members who are in need of SoonerCare medical services in accordance with Section 431.53 of Title 42 of the Code of Federal Regulations. The agency contracts with a broker to provide the most appropriate, and least costly mode of transportation necessary to meet the individual needs of SoonerCare members statewide. Payment for covered services to the broker is made pursuant to the methodology described in the Oklahoma Title XIX State Plan.~~

The Oklahoma Health Care Authority (OHCA) is responsible for assuring that necessary transportation is available to all eligible SoonerCare members who are in need of SoonerCare medical services in accordance with Section 431.53 of Title 42 of the Code of Federal Regulations.

(1) The agency contracts with a broker to provide the most appropriate, and least costly mode of transportation necessary to meet the individual needs of SoonerCare members statewide.

(2) All SoonerRide contracted providers must meet the standards and requirements outlined in the Oklahoma Medicaid State Plan, the SoonerRide provider manual and contract, as well as all applicable federal and state laws/regulations.

(3) Payment for covered services to the broker is made pursuant to the methodology described in the Oklahoma Medicaid State Plan.

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

SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME

PART 1. DETERMINATION OF QUALIFYING CATEGORICAL RELATIONSHIPS

317:35-5-4. Determining categorical relationship to the disabled

An individual is related to disability if he/she is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death, or which has lasted (or can be expected to last) for a continuous period of not less than twelve (12) months.

(1) **Determination of categorical relationship to the disabled by Social Security Administration (SSA).** The procedures outlined in (A) through (G) of this paragraph are applicable when determining categorical relationship based on a SSA disability decision:

(A) **Already determined eligible for Social Security disability benefits.** If the applicant states he/she is already receiving Social Security benefits on the basis of disability, the information is verified by seeing the applicant's notice of award or the Social Security benefit check. If the applicant states an award letter approving Social Security disability benefits has been received but a check has not been received, this information is verified by seeing the award letter. Such award letter or check establishes categorical relationship. The details of the verification used are recorded in the case record.

(B) **Already determined eligible for Supplemental Security Income (SSI) on disability.** If the applicant, under age sixty-five (65), states he/she is already receiving SSI on the basis of his/her disability (or that a written notice of SSI eligibility on disability has been received but has not yet received a check) this information is verified by seeing the written notice or check. If neither are available, the county clears on the terminal system for the Supplemental Data Exchange (SDX) record. The SDX record shows, on the terminal, whether the individual has been approved or denied for SSI. If the individual has been approved for such benefits, the county uses this terminal clearance to establish disability for categorical relationship. The details of the verification used are recorded in the case record.

(C) **Pending SSI/SSA application or has never applied for SSI.** If the applicant says he/she has a pending SSI/SSA application, an SDX record may not appear on the terminal. Therefore, it is requested that the applicant bring the notice regarding the action taken on his/her SSI/SSA application to the county office as soon as it is received. The other conditions of eligibility are established while awaiting the SSI/SSA decision. When the SSI/SSA notice is presented, the details of the verification are recorded in the case record and the indicated action is taken on the Title XIX application. If the applicant says he/she has never applied for SSI/SSA but appears potentially eligible from the standpoint of unearned income and has an alleged disability which would normally be expected to last for a period of twelve (12) months, he/she is referred to the SSA office to make SSI/SSA application immediately following the filing of the Title XIX application.

(D) **Already determined ineligible for SSI.** If the applicant says he/she has been determined ineligible for SSI, the written notice of ineligibility from SSA is requested to determine if the denial was based on failure to meet the disability definition. If the SSI notice shows ineligibility was due to not meeting the disability definition, and the applicant says the medical condition has not worsened since the SSI denial, the Title XIX application is denied for the same reason. If written notice is not available, the SDX record on the terminal system is used. This record shows whether the individual has been determined eligible or ineligible for SSI. If he/she has been determined ineligible, the payment status code for ineligibility is shown. The definition of this code is found on OKDHS Appendix Q in order to determine the reason for SSI ineligibility. If the reason for SSI ineligibility was based on failure to meet the disability definition, the Title XIX application is denied for the same reason and the details of the verification are recorded in the case record. If the reason for SSI ineligibility was based on some reason other than failure to meet the disability definition (and therefore, a determination of disability was not made), the Level of Care Evaluation Unit (LOCEU) must determine categorical relationship. In any instance in which an applicant who was denied SSI on "disability" states the medical condition has worsened since the SSI denial, he/she is referred to the SSA office to reapply for SSI immediately following the filing of the Title XIX application.

(E) **Already determined ineligible for Social Security disability benefits.** If the applicant says he/she has been

determined ineligible for Social Security disability benefits, he/she is requested to provide written notice of ineligibility to determine if the denial was based on failure to meet the disability definition. If the SSA notice shows ineligibility was due to not meeting the disability definition, and the applicant says the medical condition has not worsened since the denial, the Title XIX application is denied for the same reason. The details of the verification used are recorded in the case record. If the written notice is not available, third party query procedure (TPQY) is used to verify the denial and the reason for ineligibility. If the reason for ineligibility was based on failure to meet the disability definition, the Title XIX application is denied for the same reason and the details of the verification are recorded in the case record. If the reason for ineligibility was based on some reason other than failure to meet the disability definition (and a determination of disability was, thus, not made), the LOCEU must determine categorical relationship. In any instance in which an applicant who was denied Social Security benefits on disability states the medical condition has worsened since the denial, he/she is referred to the SSA office to reapply immediately following the filing of the Title XIX application.

(F) **Determined retroactively eligible for SSA/SSI due to appeal.** If an individual becomes retroactively eligible for SSA/SSI due to a decision on an appeal, categorical relationship is established as of the effective date of the retroactive disability decision. Payment will be made for medical services only if the claim is received ~~within twelve (12) months from the date of medical services~~timely, per Oklahoma Administrative Code (OAC) 317:30-3-11. After the submission of a timely claim, a claim may be resubmitted, per OAC 317:30-3-11.1. If the effective date of the retroactive disability decision does not cover the period of the medical service because the SSA/SSI application was made subsequent to the service, a medical social summary with pertinent medical information is sent to the LOCEU for a categorical relationship decision for the time period of the medical service.

(G) **SSA/SSI appeal with benefits continued.** A Title XIX recipient who has filed an appeal due to SSA's determination that he/she is no longer disabled may continue to receive SSA benefits. The recipient has the option to have Title XIX benefits continued until the appeal decision has been reached. After the decision has been reached, the appropriate case action is taken. If SSA's decision is

upheld, an overpayment referral is submitted for any Title XIX benefits the recipient received beginning with the month that SSA/SSI determined the recipient did not meet disability requirements.

(H) **Applicant deceased.** Categorical relationship to the disabled is automatically established if an individual dies while receiving a medical service or dies as a result of an illness for which he/she was hospitalized if death occurs within two (2) months after hospital release. The details of the verification used are recorded in the case record.

(2) **Determination of categorical relationship to the disabled by the LOCEU.**

(A) A disability decision from the LOCEU to determine categorical relationship to the disabled is required only when SSA makes a disability decision effective after medical services were received or when the SSA will not make a disability decision. The LOCEU is advised of the basis for the referral. SSA does not make disability decisions on individuals who:

(i) have been determined ineligible by SSA on some condition of eligibility other than disability,

(ii) have unearned income in excess of the SSI standard and, therefore, are not referred to SSA, or

(iii) do not have a disability which would normally be expected to last twelve (12) months but the applicant disagrees.

(B) A disability decision from the LOCEU is not required if the disability obviously will not last twelve (12) months and the individual agrees with the short term duration. The case record is documented to show the individual agrees with the short term duration.

(C) The local DHS office is responsible for submitting a medical social summary on DHS form ABCDM-80-D 08MA022E with pertinent medical information substantiating or explaining the individual's physical and mental condition. The medical social summary should include relevant social information such as the worker's personal observations, details of the individual's situation including date of onset of the disability, and the reason for the medical decision request. The worker indicates the beginning date for the categorical relationship to disability. Medical information submitted might include physical exam results, psychiatric, lab, and x-ray reports, hospital admission and discharge summaries, and/or doctors' notes and statements. Copies of medical and hospital bill and DHS Form 08MA005E are not normally considered pertinent medical information by themselves. Current (less than ninety (90) days old) medical information

is required for the LOCEU to make a decision on the client's current disability status. If existing medical information cannot be obtained without cost to the client, the county administrator authorizes either payment for existing medical information or one general physical examination by a medical or osteopathic physician of the client's choice. The physician cannot be in an intern, residency or fellowship program of a medical facility, or in the full-time employment of Veterans Administration, Public Health Service or other Agency. Such examination is authorized by use of DHS form 08MA016E, Authorization for Examination and Billing. The DHS worker sends the 08MA016E and DHS form 08MA080E, Report of Physician's Examination, to the physician who will be completing the exam.

(3) **Responsibility of Medical Review Team in the LOCEU.** The responsibilities of the Medical Review Team in the LOCEU include:

(A) The decision as to whether the applicant is related to Aid to the Disabled.

(B) The effective date (month and year) of eligibility from the standpoint of disability. (This date may be retroactive for any medical service provided on or after the first day of the third month prior to the month in which the application was made.)

(C) A request for additional medical and/or social information when additional information is necessary for a decision.

(D) When the LOCEU has made a determination of categorical relationship to disability and SSA later renders a different decision, the Oklahoma Health Care Authority (OHCA) uses the effective date of the SSA approval or denial as their date of disability approval or denial. No overpayment will occur based solely on the SSA denial superseding the LOCEU approval.

(E) Public Law 97-248, the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982, provides coverage to certain disabled children living in the home if they would qualify for Medicaid as residents of nursing facilities, ICF/IIDs, or inpatient acute care hospital stays expected to last not less than sixty (60) days. In addition to disability, LOCEU determines the appropriate level of care and cost effectiveness.

(4) **Determination of categorical relationship to the disabled based on Tuberculosis (TB) infection.** Categorical relationship to disability is established for individuals with a diagnosis of TB. An individual is related to disability for TB related services if he/she has verification of an active TB infection

established by a medical practitioner.

(5) **Determination of categorical relationship to the disabled for TEFRA.** Section 134 of TEFRA allows states, at their option, to make Medicaid benefits available to children, under nineteen (19) years of age, living at home who are disabled as defined by the SSA, even though these children would not ordinarily be eligible for SSI benefits because of the deeming of parental income or resources. Under TEFRA, a child living at home who requires the level of care provided in an acute care hospital (for a minimum of sixty (60) days), nursing facility or intermediate care facility for individuals with intellectual disabilities, is determined eligible using only his/her income and resources as though he/she were institutionalized.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 6. INPATIENT PSYCHIATRIC AND SUBSTANCE USE DISORDER SERVICES

317:30-5-95.22. Coverage for children

(a) In order for services to be covered, services in psychiatric units of general hospitals, psychiatric hospitals, and PRTF programs must meet the requirements in OAC 317:30-5-95.25 through 317:30-5-95.30. OHCA rules that apply to inpatient psychiatric coverage for individuals aged twenty-one (21) and under are found in Sections OAC 317:30-5-95.22 through 317:30-5-95.42.

(b) The following words and terms, when used in OAC 317:30-5-95.22 through 317:30-5-95.42, shall have the following meaning, unless the context clearly indicates otherwise:

(1) **"Acute"** means care delivered in a psychiatric unit of a general hospital or psychiatric hospital that provides assessment, medical management and monitoring, and short-term intensive treatment and stabilization to individuals experiencing acute episodes of behavioral health disorders.

(2) **"Acute II"** means care delivered in a psychiatric unit of a general hospital or psychiatric hospital; however, services at this level of care are designed to serve individuals under twenty-one (21) who need longer-term, more intensive treatment, and a more highly-structured environment than they can receive in family and other community-based alternatives to hospitalization. However, care delivered in this setting is less intense than the care provided in Acute.

(3) **"Border placement"** means placement in an inpatient psychiatric facility that is in one (1) of the states that borders Oklahoma (Arkansas, Colorado, Kansas, Missouri, New Mexico, and Texas).

(4) **"Border status"** means placement in a facility in a state that does not border Oklahoma, but which facility routinely provides inpatient psychiatric services to SoonerCare members.

(5) **"Chemical dependency/substance abuse services/detoxification"** means services offered to individuals with a substance-related disorder whose biomedical and emotional/behavioral problems are sufficiently severe to require inpatient care.

~~(6) **"Community-based extended"** means a PRTF with sixteen (16) beds or more but less than thirty (30) beds. The typical facility is not a locked facility.~~

~~(7) **"Community-based transitional (CBT)"** means a PRTF level of~~

~~care designed for individuals under twenty-one (21) who require the continued structure and psychiatric intervention of twenty-four (24) hour care, but are ready to begin transitioning from more intense residential treatment into the community. It is the intent that members admitted to this level of care should be able to attend public school. Community-based transitional facilities are non-secure PRTFs with sixteen (16) beds or less.~~

~~(8)~~(6) **"Enhanced treatment unit or specialized treatment"** means an intensive residential treatment unit that provides a program of care to a population with special needs or issues requiring increased staffing requirements, co-morbidities, environmental accommodations, specialized treatment programs, and longer lengths of stay.

~~(9)~~(7) **"Evidence-based practice (EBP)"** means programs or practices that are supported by research methodology and have produced consistently positive patterns of results in accordance with the Substance Abuse and Mental Health Services Administration (SAMHSA).

~~(10)~~(8) **"Out-of-state placement"** means a placement for intensive or specialized services not available in Oklahoma requiring additional authorization procedures and approval by the OHCA Behavioral Health Unit.

~~(11)~~(9) **"Public facilities"** means Oklahoma government owned or operated facilities.

~~(12)~~(10) **"Trauma-informed"** means the recognition and responsiveness to the presence of the effects of past and current traumatic experiences in the lives of members.

317:30-5-95.29. Medical necessity criteria Acute II and PRTF admissions for children

~~(a)~~ Acute II and PRTF admissions for individuals under twenty-one (21) must meet the terms and conditions in (1), (2), (3), (4), (5) and one (1) of the terms and conditions of (6)(A) through (D) of this subsection.

(1) A primary diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) with the exception of V-codes, adjustment disorders, and substance-related disorders, accompanied by detailed symptoms supporting the diagnosis. Members eighteen (18) to twenty (20) years of age may have a diagnosis of any personality disorder. Adjustment or substance-related disorders may be a secondary diagnosis.

(2) Conditions are directly attributed to a mental disorder as the primary reason for professional attention (this does not include placement issues, criminal behavior, or status offenses).

(3) Patient has either received treatment in an acute setting or it has been determined by the OHCA, or its designated agent,

that the current disabling symptoms could not or have not been manageable in a less-intensive treatment program.

(4) Member must be medically stable.

(5) Requires twenty-four (24) hour observation and treatment as evidenced by:

(A) Intensive behavioral management;

(B) Intensive treatment with the family/guardian and child in a structured milieu; and

(C) Intensive treatment in preparation for re-entry into community.

(6) Within the past fourteen (14) calendar days, the patient has demonstrated an escalating pattern of self-injurious or assaultive behaviors as evidenced by any of (A) through (D) below. Exceptions to the fourteen (14) day requirement may be made in instances when evidence of the behavior could not have reasonably been discovered within fourteen (14) days (e.g., sexual offenses).

(A) Suicidal ideation and/or threat.

(B) History of/or current self-injurious behavior.

(C) Serious threats or evidence of physical aggression.

(D) Current incapacitating psychosis or depression.

~~(b) CBT admissions for children must meet the terms and conditions in (1) through (6) of this subsection.~~

~~(1) A primary diagnosis from the DSM-V with the exception of V-codes, adjustment disorders, and substance-related disorders, accompanied by detailed symptoms supporting the diagnosis. Members eighteen (18) to twenty (20) years of age may have a diagnosis of any personality disorder.~~

~~(2) Conditions are directly attributed to a mental disorder as the primary reason for professional attention (this does not include placement issues, criminal behavioral, or status offenses).~~

~~(3) Patient has either received treatment in Acute, Acute II, PRTF or children's crisis unit setting (refer to OAC 317:30-5-241.4), or it has been determined by OHCA or its designated agent that the current disabling symptoms could not or have not been manageable in a less-intensive treatment program.~~

~~(A) Patient must have tried and failed a lower level of care or is stepping down from a higher level of care.~~

~~(B) Clinical documentation must support need for CBT, rather than facility-based crisis stabilization, therapeutic foster care, intensive treatment foster care, or intensive outpatient services.~~

~~(C) There is clear evidence to support a reasonable expectation that stepping down to a lower level of care would result in rapid and marked deterioration of functioning in at least two (2) of the five (5) critical areas, listed below,~~

~~placing the member at risk of need for acute stabilization/inpatient care.~~

~~(i) Personal safety;~~

~~(ii) Cognitive functioning;~~

~~(iii) Family relations;~~

~~(iv) Interpersonal relations; or~~

~~(v) Educational/vocational performance.~~

~~(4) Child must be medically stable.~~

~~(5) Within the past fourteen (14) calendar days, the patient must have demonstrated an escalating pattern of self-injurious or assaultive behavior as evidenced by any of (a)(5)(A) through (D) above. Exceptions to the fourteen (14) day requirement may be made in instances when evidence of the behavior could not have reasonably been discovered within fourteen (14) days (e.g., sexual offenses).~~

~~(6) Within the past fourteen (14) calendar days, the patient's behaviors have created significant functional impairment.~~

317:30-5-95.30. Medical necessity criteria for Acute II and PRTF continued stay for children

~~(a)~~ For continued stay in Acute II and PRTF programs, members must meet the terms and conditions contained in (1), (2), (3), (4), and either (5) or (6) of this subsection:

(1) A primary diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) with the exception of V codes, adjustment disorders, and substance abuse-related disorders, accompanied by detailed symptoms supporting the diagnosis. In lieu of a qualifying primary diagnosis, members eighteen (18) to twenty (20) years of age may have a secondary diagnosis of any personality disorder.

(2) Conditions are directly attributed to a psychiatric disorder as the primary reason for continued stay (this does not include placement issues, criminal behavior, or status offenses).

(3) There is documented continuing need for twenty-four (24) hour observation and treatment as evidenced by:

(A) Intensive behavioral management.

(B) Intensive treatment with the family/guardian and child in a structured milieu.

(C) Intensive treatment in preparation for re-entry into community.

(4) Documented efforts of working with child's family, legal guardian and/or custodian and other human service agencies toward a tentative discharge date.

(5) Patient is making measurable progress toward the treatment objectives specified in the treatment plan.

(A) Progress is measured in behavioral terms and reflected in the patient's treatment and discharge plans.

(B) Patient has made gains toward social responsibility and independence.

(C) There is active, ongoing psychiatric treatment and documented progress toward the treatment objective and discharge.

(D) There are documented efforts and evidence of active involvement with the family, guardian, child welfare worker, extended family, etc.

(6) Child's condition has remained unchanged or worsened.

(A) Documentation of regression is measured in behavioral terms and reflected in the patient's treatment and discharge plans.

(B) If condition is unchanged, there is evidence of re-evaluation of the treatment objectives and therapeutic interventions.

~~(b) For continued stay in a CBT, members must meet the terms and conditions found in (1) through (5) of this subsection.~~

~~(1) A primary diagnosis from the DSM-V with the exception of V codes, adjustment disorders, and substance use disorders, accompanied by detailed symptoms supporting the diagnosis. Members eighteen (18) to twenty (20) years of age may have a diagnosis of any personality disorder.~~

~~(2) Conditions are directly attributed to a psychiatric disorder as the primary reason for continued stay (this does not include placement issues, criminal behavior, or status offenses).~~

~~(3) There is documented continued need for twenty-four (24) hour observation and treatment as evidenced by:~~

~~(A) Patient making measurable progress toward the treatment objectives specified in the treatment plan.~~

~~(B) Clinical documentation clearly indicates continued significant functional impairment in two (2) of the following five (5) critical areas, as evidenced by specific clinically relevant behavior descriptors:~~

~~(i) Personal safety;~~

~~(ii) Cognitive functioning;~~

~~(iii) Family relations;~~

~~(iv) Interpersonal relations; or~~

~~(v) Educational/vocational performance.~~

~~(4) Clinical documentation includes behavioral descriptors indicating patient's response to treatment and supporting patient's ability to benefit from continued treatment at this level of care.~~

~~(5) Documented, clear evidence of consistent, active involvement by patient's primary caregiver(s) in the treatment process.~~

317:30-5-95.33. Individual plan of care for children

(a) An individual plan of care (IPC) is a written plan developed

for each member within four (4) calendar days of admission to an Acute, Acute II, or a PRTF that directs the care and treatment of that member. The IPC must be recovery-focused, trauma-informed, and specific to culture, age, and gender and include:

(1) A primary diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) with the exception of V-codes, adjustment disorders, and substance abuse-related disorders, accompanied by a detailed description of the symptoms supporting the diagnosis. Members eighteen (18) to twenty (20) years of age may have a diagnosis of any personality disorder. Adjustment or substance-related disorders may be a secondary diagnosis;

(2) The current functional level of the individual;

(3) Treatment goals and measurable, time-limited objectives;

(4) Any orders for psychotropic medications, treatments, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures recommended for the health and safety of the member;

(5) Plans for continuing care, including review and modification to the IPC; and

(6) Plan for discharge, all of which is developed to improve the member's condition to the extent that the inpatient care is no longer necessary.

(b) The IPC:

(1) Must be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the individual member and reflects the need for inpatient psychiatric care;

(2) Must be developed by a team of professionals in consultation with the member, his or her parents or legal guardians [for members under the age of eighteen (18)], or others in whose care he or she will be released after discharge. This team must consist of professionals as specified below:

(A) For a member admitted to a psychiatric hospital or PRTF, by the "interdisciplinary team" as defined by OAC 317:30-5-95.35(b)(2), per 42 C.F.R. §§ 441.155 and 483.354; or

(B) For a member admitted to a psychiatric unit of a general hospital, by a team comprised of at least:

(i) An allopathic or osteopathic physician with a current license and a board certification/eligible in psychiatry, or a current resident in psychiatry practicing as described in OAC 317:30-5-2(a)(1)(U); and

(ii) A registered nurse (RN) with a minimum of two (2) years of experience in a mental health treatment setting; and

(iii) An LBHP.

(3) Must establish treatment goals that are general outcome statements and reflective of informed choices of the member served. Additionally, the treatment goals must be appropriate to the member's age, culture, strengths, needs, abilities, preferences, and limitations;
(4) Must establish measurable and time-limited treatment objectives that reflect the expectations of the member served and parents/legal guardians (when applicable), as well as being age, developmentally, and culturally appropriate. When modifications are being made to accommodate age, developmental level, or a cultural issue, the documentation must be reflected on the IPC. The treatment objectives must be achievable and understandable to the member and the parents/legal guardians (when applicable). The treatment objectives also must be appropriate to the treatment setting and list the frequency of the service;
(5) Must prescribe an integrated program of therapies, activities, and experiences designed to meet the objectives;
(6) Must include specific discharge and aftercare plans that are appropriate to the member's needs and effective on the day of discharge. At the time of discharge, aftercare plans will include referral to medication management, outpatient behavioral health counseling, and case management, to include the specific appointment date(s), names, and addresses of service provider(s) and related community services to ensure continuity of care and reintegration for the member into his or her family, school, and community;
(7) Must be reviewed, at a minimum, every nine (9) calendar days for members admitted to Acute; every fourteen (14) calendar days for members admitted to Acute II or non-specialty PRTF; every twenty-one (21) calendar days for members admitted to an OHCA-approved longer-term treatment program or specialty Acute II or PRTF~~; and every thirty (30) calendar days for members admitted to a CBT PRTF~~. Review must be undertaken by the appropriate team specified in OAC 317:30-5-95.33(b)(2), above, to determine that services being provided are or were required on an inpatient basis, and to recommend changes in the IPC as indicated by the member's overall adjustment, progress, symptoms, behavior, and response to treatment;
(8) Development and review must satisfy the utilization control requirements for recertification [42 C.F.R. §§ 456.60(b), 456.160(b), and 456.360(b)], and establishment and periodic review of the IPC (42 C.F.R. §§ 456.80, 456.180, and 456.380); and,
(9) Each IPC and IPC review must be clearly identified as such and be signed and dated individually by the member, parents/legal guardians [for members under the age of eighteen

(18)], and required team members. ~~All IPCs and IPC reviews must be signed by the member upon completion, except when a member is too physically ill or the member's acuity level precludes him or her from signing. If the member is too physically ill or the member's acuity level precludes him or her from signing the IPC and/or the IPC review at the time of completion, the member must sign the plan when his or her condition improves, but before discharge. The documentation should indicate the reason the member was unable to sign and when the next review will occur to obtain the signature. IPCs and IPC reviews are not valid until completed and appropriately signed and dated. All requirements for the IPCs and IPC reviews must be met; otherwise, a partial per diem recoupment will be merited. If the member's parent/legal guardian is unable to sign the IPC or IPC review on the date it is completed, then within seventy-two (72) hours the provider must in good faith and with due diligence attempt to telephonically notify the parent/legal guardian of the document's completion and review it with them. Documentation of reasonable efforts to make contact with the member's parent/legal guardian must be included in the clinical file. In those instances where it is necessary to mail or fax an IPC or IPC review to a parent/legal guardian or Oklahoma Department of Human Services/Oklahoma Office of Juvenile Affairs (OKDHS/OJA) worker for review, the parent/legal guardian and/or OKDHS/OJA worker may fax back his or her signature. The provider must obtain the original signature for the clinical file within thirty (30) days. Stamped or photocopied signatures are not allowed for any parent/legal guardian or member of the treatment team.~~

(A) All IPCs and IPC reviews must be signed by the member upon completion, except when a member is too physically ill or the member's acuity level precludes him or her from signing.

(i) If the member is too physically ill or the member's acuity level precludes him or her from signing the IPC and/or the IPC review at the time of completion, the member must sign the plan when his or her condition improves, but before discharge.

(ii) The documentation should indicate the reason the member was unable to sign and when the next review will occur to obtain the signature.

(B) IPCs and IPC reviews are not valid until completed and appropriately signed and dated.

(i) All requirements for the IPCs and IPC reviews must be met; otherwise, a partial per diem recoupment will be merited.

(ii) If the member's parent/legal guardian is unable to sign the IPC or IPC review on the date it is completed, then within seventy-two (72) hours the provider must in good faith and with due diligence attempt to telephonically notify the parent/legal guardian of the document's completion and review it with them.

(iii) Documentation of reasonable efforts to make contact with the member's parent/legal guardian must be included in the clinical file.

(iv) In those instances where it is necessary to mail or fax an IPC or IPC review to a parent/legal guardian or Oklahoma Department of Human Services/Oklahoma Office of Juvenile Affairs (OKDHS/OJA) worker for review, the parent/legal guardian and/or OKDHS/OJA worker may fax back his or her signature. The provider must obtain the original signature for the clinical file within thirty (30) days. Stamped or photocopied signatures are not allowed for any parent/legal guardian or member of the treatment team.

(10) Medically necessary Early and Periodic Screening, ~~Diagnosis~~Diagnostic and Treatment (EPSDT) services shall be provided to members, under the age of twenty-one (21), who are residing in an inpatient psychiatric facility, regardless of whether such services are listed on the IPC. Reimbursement for the provision of medically necessary EPSDT services to individuals under age twenty-one (21), while the member is residing in an inpatient psychiatric facility, will be provided in accordance with the Oklahoma Medicaid State Plan.

317:30-5-95.34. Active treatment for children

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

(1) **"Active treatment"** means implementation of a professionally developed and supervised individual plan of care (IPC) that involves the member and his or her family or guardian from the time of an admission, and through the treatment and discharge process.

(2) **"Discharge/transition planning"** means a patient-centered, interdisciplinary process that begins with an initial assessment of the member's needs at the time of admission and continues throughout the member's stay. Active collaboration with the member, family, and all involved outpatient practitioners and agencies should be ongoing throughout treatment so that effective connections remain intact. Needed services may consist of the wraparound process through Systems of Care, counseling, case management, and other supports in the member's community.

The linkages with these supports should be made prior to discharge to allow for a smooth transition.

(3) **"Expressive group therapy"** means art, music, dance, movement, poetry, drama, psychodrama, structured therapeutic physical activities, and experiential (e.g.<u>,</u> ropes course), recreational, or occupational therapies that encourage the member to express themselves emotionally and psychologically.

(4) **"Family therapy"** means interaction between an LBHP or licensure candidate, member, and family member(s) to facilitate emotional, psychological, or behavioral changes and promote successful communication and understanding.

(5) **"Group rehabilitative treatment"** means behavioral health remedial services, as specified in the individual care plan, which are necessary for the treatment of the existing primary behavioral health disorders and/or any secondary alcohol and other drug (AOD) disorders in order to increase the skills necessary to perform activities of daily living (ADL).

(6) **"Individual rehabilitative treatment"** means a face-to-face, one-on-one interaction which is performed to assist a member who is experiencing significant functional impairment due to the existing primary behavioral health disorder and/or any secondary AOD disorder, in order to increase the skills necessary to perform ADL.

(7) **"Individual therapy"** means a method of treating existing primary behavioral health disorders and/or any secondary AOD disorders using face-to-face, one-on-one interaction between an LBHP or licensure candidate and a member to promote emotional or psychological change to alleviate disorders.

(8) **"Process group therapy"** means a method of treating existing primary behavioral health disorders and/or secondary AOD disorders using the interaction between an LBHP or licensure candidate, and two (2) or more members to promote positive emotional and/or behavioral change.

(b) Inpatient psychiatric programs must provide "active treatment". Families and/or guardians must be notified of the dates and times of treatment team meetings and be welcomed to attend. Family members must attend family therapy weekly for continued SoonerCare reimbursement. Reasons for exceptions to this requirement must be well-documented in the member's treatment plan. Family therapy attendance by family members is not a requirement for individuals in the age range of eighteen (18) up to twenty-one (21). Active treatment also includes ongoing assessment, diagnosis, intervention, evaluation of care and treatment, and planning for discharge and aftercare under the direction of a physician.

(c) For individuals ~~age~~<u>ages</u> eighteen (18) up to twenty-one (21), the active treatment program must be appropriate to the needs of the member and be directed toward restoring and maintaining optimal

levels of physical and psychiatric-social functioning. The services and the IPC must be recovery-focused, trauma-informed, specific to culture, age, and gender, and provided face to face. Services, including type and frequency, will be specified in the IPC.
(d) A treatment week consists of seven (7) calendar days. In an Acute setting, the treatment week begins the day of admission. In Acute II and PRTF, the treatment week starts on Sunday and ends on Saturday. Active treatment service components are provided as per item (e) below if the services are provided within a seven (7) day treatment week. A chart outlining active treatment component requirements and timelines may also be found at www.okhca.org. If a member has a length of stay of less than seven (7) days, the treatment week is considered a partial treatment week. Active treatment requirements, when provided during a partial treatment week, are delivered as per item (f) below. An hour of treatment must be sixty (60) minutes. When appropriate to meet the needs of the child, the sixty (60) minute timeframe may be split into sessions of no less than fifteen (15) minutes each, on the condition that the active treatment requirements are fully met by the end of the treatment week.
(e) For individuals under age eighteen (18), the components of active treatment consist of face-to-face integrated therapies that are provided on a regular basis and will remain consistent with the member's ongoing need for care. The services and IPC must be recovery-focused, trauma-informed, and specific to culture, age, and gender. Individuals receiving services in an Acute setting must receive seventeen (17) hours of documented active treatment services each week, with seven (7) of those hours dedicated to core services as described in (1) below. Individuals in Acute II and PRTFs must receive fourteen (14) hours of documented active treatment services each week, with four and a half (4.5) of those hours dedicated to core services as described in (1) below. ~~Individuals in CBT PRTFs must receive ten (10) hours of documented active treatment services each week, with four and a half (4.5) of those hours dedicated to core services as described in (1) below.~~ Upon fulfilling the core service hours requirement, the member may receive either the elective services listed in (2) below or additional core services to complete the total required hours of active treatment. The following components meet the minimum standards required for active treatment, although an individual child's needs for treatment may exceed this minimum standard:

(1) **Core services.**

(A) **Individual treatment provided by the physician.** Individual treatment provided by the physician is required three (3) times per week for Acute and one (1) time a week in Acute II and PRTFs. Individual treatment provided by the physician will never exceed ten (10) calendar days between

sessions in Acute II and PRTFs, and never exceed seven (7) calendar days in a specialty Acute II and specialty PRTF~~, and never exceed thirty (30) calendar days in CBTs~~. Individual treatment provided by the physician may consist of therapy or medication management intervention for Acute, Acute II, and PRTF programs.

(B) **Individual therapy.** LBHPs or licensure candidates performing this service must use and document an approach to treatment such as cognitive behavioral treatment, narrative therapy, solution-focused brief therapy, or another widely accepted theoretical framework for treatment. Ongoing assessment of the member's status and response to treatment, as well as psycho-educational intervention, are appropriate components of individual therapy. Individual therapy must be provided in a confidential setting. The therapy must be goal-directed, utilizing techniques appropriate to the member's plan of care and the member's developmental and cognitive abilities. Individual therapy must be provided two (2) hours per week in Acute and one (1) hour per week in Acute II and PRTFs by an LBHP or licensure candidate. One (1) hour of family therapy may be substituted for one (1) hour of individual therapy at the treatment team's discretion.

(C) **Family therapy.** The focus of family therapy must be directly related to the goals and objectives on the individual member's plan of care. Family therapy must be provided one (1) hour per week in Acute, Acute II, and PRTFs. One (1) hour of individual therapy addressing relevant family issues may be substituted for a family session in an instance in which the family is unable to attend a scheduled session by an LBHP or licensure candidate.

(D) **Process group therapy.** The focus of process group therapy must be directly related to goals and objectives on the individual member's plan of care. The individual member's behavior and the focus of the group must be included in each member's medical record. This service does not include social skills development or daily living skills activities and must take place in an appropriate confidential setting, limited to the therapist, appropriate hospital staff, and group members. Group therapy must be provided three (3) hours per week in Acute and two (2) hours per week in Acute II and PRTFs by an LBHP or licensure candidate. In lieu of one (1) hour of process group therapy, one (1) hour of expressive group therapy provided by an LBHP, licensure candidate, or licensed therapeutic recreation specialist may be substituted.

(E) **Transition/discharge planning.** Transition/discharge planning must be provided one (1) hour per week in Acute and thirty (30) minutes per week in Acute II and PRTFs.

Transition/discharge planning can be provided by any level of inpatient staff.

(2) **Elective services.**

(A) **Expressive group therapy.** Through active expression, ~~inner-strengths~~inner strengths are discovered that can help the member deal with past experiences and cope with present life situations in more beneficial ways. The focus of the group must be directly related to goals and objectives on the individual member's plan of care. Documentation must include how the member is processing emotions/feelings. Expressive therapy must be a planned therapeutic activity, facilitated by staff with a relevant bachelor's degree and/or staff with relevant training, experience, or certification to facilitate the therapy.

(B) **Group rehabilitative treatment.** Examples of educational and supportive services, which may be covered under the definition of group rehabilitative treatment services, are basic living skills, social skills (re)development, interdependent living, self-care, lifestyle changes, and recovery principles. Each service provided under group rehabilitative treatment services must have goals and objectives directly related to the IPC.

(C) **Individual rehabilitative treatment.** Services are provided to reduce psychiatric and behavioral impairment and to restore functioning consistent with the requirements of independent living and enhanced self-sufficiency. This service includes educational and supportive services regarding independent living, self-care, social skills (re)development, lifestyle changes, and recovery principles and practices. Each individual rehabilitative treatment service provided must have goals and objectives directly related to the IPC and the member's diagnosis.

(D) **Recreation therapy.** Services are provided to reduce psychiatric and behavioral impairment and to restore, remediate, and rehabilitate an individual's level of functioning and independence in life activities. Services are provided to promote health and wellness, as well as reduce or eliminate barriers caused by illness or disabling conditions that limit or restrict a member from participating in life activities. Recreational therapy can be provided in an individual or group setting. If the only activities prescribed for the individual are primarily diversional in nature, (i.e., to provide some social or recreational outlet for the individual), it will not be regarded as active treatment. If provided, recreational therapy must be a planned therapeutic activity, facilitated by a licensed therapeutic recreation specialist.

(E) **Occupational therapy.** Services are provided to address developmental and/or functional needs related to the performance of self-help skills, adaptive behavioral, and/or sensory, motor, and postural development. Services include therapeutic goal-directed activities and/or exercises used to improve mobility and ADL functions when such functions have been impaired due to illness or injury. Services must be provided by an occupational therapist appropriately licensed in the state in which he or she practices.

(F) **Wellness resource skills development.** Services include providing direction and coordinating support activities that promote physical health. The focus of these activities should include areas such as nutrition, exercise, support to avert and manage physical health concerns like heart disease, diabetes, and cholesterol, and guidance on the effects that medications have on physical health. Services can include ~~individual/ group~~individual/group support, exercise groups, and individual physical wellness plan development, implementation, and assistance.

(3) **Modifications to active treatment.** When a member is too physically ill, or his or her acuity level precludes him or her from active behavioral health treatment, documentation must demonstrate that alternative clinically-appropriate services were provided.

(f) Active treatment components, furnished during a partial treatment week, are provided as per item (1) through (4) below. A chart outlining active treatment component requirements and timelines may also be found at www.okhca.org. Assessments/evaluations may serve as the initial individual or family session if completed by an LBHP or licensure candidate. Start and stop time must be documented. Active treatment begins the day of admission. Days noted are calendar days.

(1) **Individual treatment provided by the physician.**

(A) In Acute, by day two (2), one (1) visit is required. By day four (4), two (2) visits are required. By day seven (7), three (3) visits are required.

(B) In Acute II and PRTFs, one (1) visit during admission week is required. In PRTFs, ~~not including CBTs,~~ one (1) visit during the admission week is required, then once a week thereafter. ~~In CBT, one (1) visit is required within seven (7) days of admission, then once a month thereafter.~~ Individual treatment provided by the physician will never exceed ten (10) days between sessions in Acute II and PRTFs, never exceed seven (7) days in specialty Acute II and specialty PRTFs ~~and never exceed thirty (30) days in CBTs~~. The completion of a psychiatric evaluation or a combined psychiatric evaluation and a history and physical (H&P)

evaluation may count as the first visit by the physician if the evaluation was personally rendered by the psychiatrist. If the member is admitted on the last day of the admission week, then the member must be seen by a physician within sixty (60) hours of admission time.

(2) **Individual therapy.**

(A) In Acute, by day three (3), thirty (30) minutes of treatment are required. By day five (5), one (1) hour of treatment is required. Beginning on day seven (7), two (2) hours of treatment are required each week. This does not include admission assessments/evaluations or psychosocial evaluations unless personally (face to face) rendered by the LBHP or licensure candidate.

(B) In Acute II and PRTFs, by day six (6), thirty (30) minutes of treatment must be documented. Beginning on day seven (7), one (1) hour of treatment is required each week. The treatment week is defined as Sunday through Saturday. Individual therapy may not exceed a total of ten (10) days between sessions. This does not include admission assessment/evaluation or psychosocial evaluations unless personally (face to face) rendered by the LBHP or licensure candidate.

(3) **Family therapy.**

(A) In Acute, by day six (6), thirty (30) minutes of treatment must be documented. Beginning on day seven (7), one (1) hour of treatment is required each week. This does not include admission assessments/evaluation or psychosocial evaluations unless personally (face to face) rendered by the LBHP or licensure candidate and the assessments/evaluation or psychosocial evaluation has not been used to substitute the initial individual therapy requirement.

(B) In Acute II and PRTFs, by day six (6), thirty (30) minutes of treatment must be documented. Beginning on day seven (7), one (1) hour of treatment is required each week. This does not include admissions assessment/evaluation or psychosocial evaluation unless personally (face to face) rendered by the LBHP or licensure candidate and the assessment/evaluation or psychosocial evaluation has not been used to substitute the initial individual therapy requirement. Family therapy provided by the LBHP or licensure candidate should not exceed ten (10) days in between sessions.

(4) **Process group therapy.**

(A) In Acute, by day three (3), one (1) hour of treatment is required. By day five (5), two (2) hours of treatment are required. Beginning on day seven (7), three (3) hours of treatment are required each week.

(B) In Acute II and PRTFs, by day five (5), one (1) hour of treatment is required. Beginning on day seven (7), two (2) hours of treatment are required each week.

(g) When an individual is determined to be too ill to participate in treatment, as determined by medical/nursing staff [registered nurse (RN)/licensed practical nurse (LPN)], documentation must be in the record clearly indicating the reason, limitations, and timeframe for those services to be excused without penalty.

317:30-5-95.37. Medical, psychiatric and social evaluations for inpatient services for children

The member's medical record must contain complete medical, psychiatric, and social evaluations.

(1) These evaluations are considered critical documents to the integrity of care and treatment and must be completed as follows:

(A) History and physical evaluation must be completed within twenty-four (24) hours of admission by a licensed independent practitioner (M.D., D.O., A.P.N., or P.A.) in Acute, Acute II, and PRTFs~~, excluding CBTs, and within seven (7) calendar days of admission in a CBT~~.

(B) Psychiatric evaluation must be completed within sixty (60) hours of admission by an allopathic or osteopathic physician with a current license and a board certification/eligible in psychiatry in Acute, Acute II, and PRTFs~~, excluding CBTs, and within seven (7) calendar days of admission in a CBT~~.

(C) Psychosocial evaluation must be completed within seventy-two (72) hours of an Acute admission, and within seven (7) calendar days of admission to Acute II and PRTFs~~, including CBTs,~~ by a licensed independent practitioner (M.D., D.O., A.P.N., or P.A.), LBHP, or licensure candidate.

(2) Each of the evaluations must be clearly identified as such and must be signed and dated by the evaluators.

(3) Each of the evaluations must be completed when the member changes levels of care if the existing evaluation is more than thirty (30) calendar days from admission. For continued stays at the same level of care, evaluations remain current for twelve (12) months from the date of admission and must be updated annually within seven (7) calendar days of that anniversary date.

(4) Existing evaluations of thirty (30) days or less may be used when a member changes provider or level of care. The evaluation(s) must be reviewed, updated as necessary, and signed and dated by the appropriate level of professional as defined by the type of evaluation.

317:30-5-95.38. Nursing services for children

Each facility must have a qualified director of psychiatric nursing. In addition to the director of nursing, there must be adequate numbers of registered nurses (RNs), licensed practical nurses (LPNs), and mental health workers to provide nursing care necessary under the active treatment program and to maintain progress notes on each member. ~~In a CBT, an RN must be on site at least one (1) hour each day and be available twenty-four (24) hours a day when not on site. An RN must document member progress at least weekly, except in a CBT where the requirement will be twice a month.~~ The progress note must contain recommendations for revisions in the individual plan of care (IPC), as needed, as well as an assessment of the member's progress as it relates to the IPC goals and objectives.

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 4. EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) PROGRAM/CHILD-HEALTH SERVICES

317:30-3-65.12. Applied behavior analysis (ABA) services

~~(a) **Purpose and general provisions.** The purpose of this Section is to establish guidelines for the provision of ABA services under the EPSDT benefit.~~

~~(1) ABA focuses on the analysis, design, implementation, and evaluation of instructional and other environmental modifications to produce meaningful changes in human behavior. ABA services include the use of direct observation, measurement, and functional analysis of the relations between the environment and behavior. Common ABA-based techniques include, but are not limited to; discrete trial training (DTT); naturalistic developmental behavioral intervention (NDBI); and verbal behavioral intervention.~~

~~(2) ABA may be provided in a variety of settings, including home, community, or a clinical setting. It involves development of an individualized treatment plan that includes transition and aftercare planning, and family/caregiver involvement.~~

~~(3) At an initial assessment, target symptoms are identified. A treatment plan is developed to identify core deficits and aberrant behaviors, and includes designated interventions intended to address these deficits and behaviors and that are functional, meaningful and connected to the member's daily activities routines.~~

~~(4) ABA services require prior authorization [refer to Oklahoma Administrative Code (OAC) 317:30-3-31 and 317:30-3-65.12(c)].~~

~~(b) **Functional behavior assessment (FBA) and treatment plan components**~~

~~(1) The FBA serves as a critical component of the treatment plan and is conducted by a board certified behavior analyst (BCBA) to identify the specific behavioral needs of the member. The FBA consists of:~~

~~(A) Description of the problematic behavior (topography, onset/offset, cycle, intensity, severity);~~

~~(B) History of the problematic behavior (long-term and recent);~~

~~(C) Antecedent analysis (setting, people, time of day, events);~~

~~(D) Consequence analysis; and~~

(E) Impression and analysis of the function of the problematic behavior.

(2) The treatment plan is developed by a BCBA or a licensed psychologist from the FBA. The treatment plan shall:

(A) Be person-centered and individualized;

(B) Delineate the baseline levels of target behaviors;

(C) Specify long and short term objectives that are defined in observable, measureable behavioral terms;

(D) Specify criteria that will be used to determine achievement of objectives;

(E) Include assessment and treatment protocols for addressing each of the target behaviors;

(F) Clearly identify the schedule of services planned and the individuals responsible for delivering the services, including frequent review of data on target behaviors and adjustments in the treatment plan and/or protocols by the BCBA or licensed psychologist as needed;

(G) Include training and supervision to enable board certified assistant behavior analysts (BCaBAs) and registered behavior technicians (RBTs) to implement assessment and treatment protocols;

(H) Include training and support to enable parents and other caregivers to participate in treatment planning and successfully reinforce the established treatment plan;

(I) Include care coordination involving the parents or caregiver(s), school, state disability programs, and others as applicable; and

(J) Ensure that services are consistent with applicable professional standards and guidelines relating to the practice of applied behavior analysis as well as state Medicaid laws and regulations.

(c) **Eligible providers.** Eligible ABA provider types include:

(1) Board certified behavior analyst7 (BCBA7) **B** A master's or doctoral level independent practitioner who is certified by the national-accrediting Behavior Analyst Certification Board, Inc.7 (BACB7) and licensed by the Oklahoma Department of Human Services' (OKDHS) Developmental Disabilities Services Division (DDS) to provide behavior analysis services. A BCBA may supervise the work of board certified assistant behavior analysts and registered behavior technicians implementing behavior analytic interventions;

(2) Board certified assistant behavior analyst7 (BCaBA7) **B** A bachelor's level practitioner who is certified by the national-accrediting BACB and certified by OKDHS DDS to provide behavior analysis services under the supervision of a BCBA;

(3) Registered behavior technician™ (RBT7) **B** A high school level

or higher paraprofessional who is certified by the national-accrediting BACB and practices under the close and ongoing supervision of a BCBA. The RBT works under the license number of a BCBA and is primarily responsible for the direct implementation of BCBA designed and prescribed behavior-analytic services;

(4) Licensed psychologist **B** An individual who is licensed and in good standing with the Oklahoma State Board of Examiners of Psychologists and has professional experience in the use of ABA therapy may render behavior analysis services. Refer to OAC 317:30-5-275; and

(5) Human services professional - A practitioner who is licensed by the State of Oklahoma pursuant to (A) - (H), and certified by the national-accrediting BACB, and who is working within the scope of his or her practice, to include:

(A) A licensed physical therapist;

(B) A licensed occupational therapist;

(C) A licensed clinical social worker or social worker candidate under the supervision of a licensed clinical social worker;

(D) A licensed speech-language pathologist or licensed audiologist;

(E) A licensed professional counselor or professional counselor candidate under the supervision of a licensed professional counselor;

(F) A licensed marital and family therapist or marital and family therapist candidate under the supervision of a licensed marital and family therapist; or

(G) A licensed behavioral practitioner or behavioral practitioner candidate under the supervision of a licensed behavioral practitioner.

(d) **Provider criteria.** To direct, supervise, and/or render ABA services, the following conditions shall be met.

(1) A BCBA shall:

(A) Be currently licensed by OKDHS DDS as a BCBA;

(B) Have no sanctions or disciplinary actions by OKDHS DDS or the BACB;

(C) Have no current overpayment(s) due to SoonerCare, and no Medicare or Medicaid sanctions or exclusions from participation in federally funded programs; and

(D) Be fully contracted with SoonerCare as a provider.

(2) A BCaBA shall:

(A) Be currently certified by OKDHS DDS as a BCaBA;

(B) Work under the supervision of a SoonerCare-contracted BCBA provider;

(C) Have no current overpayment(s) due to SoonerCare, and no

Medicare or Medicaid sanctions or exclusions from participation in federally funded programs; and

(D) Be fully contracted with SoonerCare as a provider.

(3) An RBT shall:

(A) Be currently certified by the national-accrediting BACB as an RBT;

(B) Work under the supervision of a SoonerCare-contracted BCBA provider;

(C) Have no current overpayment(s) due to SoonerCare, and no Medicare or Medicaid sanctions or exclusions from participation in federally funded programs; and

(D) Be fully contracted with SoonerCare as a provider.

(4) A human services professional shall:

(A) Be currently licensed or certified by the State of Oklahoma, in accordance with Section 1928 of Title 59 of the Oklahoma Statutes;

(B) Be currently certified by the national-accrediting BACB;

(C) Have no sanctions or disciplinary actions by the applicable state licensing board or the BACB;

(D) If working under supervision within the scope of his or her practice, have a documented relationship with a fully-licensed human service professional working in a supervisory capacity;

(E) Have no current overpayment(s) due to SoonerCare, and no Medicare or Medicaid sanctions or exclusions from participation in federally funded programs; and

(F) Be fully contracted with SoonerCare as a provider.

(c) **Medical necessity criteria for members under twenty-one (21) years of age.** ABA services are considered medically necessary when all of the following conditions are met:

(1) The member is under twenty-one (21) years of age with a definitive diagnosis of an Autism Spectrum Disorder (ASD) from the following providers:

(A) Pediatric neurologist or neurologist;

(B) Developmental pediatrician;

(C) Licensed psychologist;

(D) Psychiatrist or neuropsychiatrist; or

(E) Other licensed physician experienced in the diagnosis and treatment of ASD.

(2) A comprehensive diagnostic evaluation completed by one (1) of the above identified professionals must:

(A) Be completed within the last two (2) years;

(B) Include a complete pertinent medical and social history, including pre-and perinatal, medical, developmental, family, and social elements; and

(C) Be based on criteria outlined in the Diagnostic and

Statistical Manual of Mental Disorders (DSM-V) or the most current version of the DSM for ASD and/or may also include scores from the use of formal diagnostic tests such as the Autism Diagnostic Interview-Revised (ADI-R), Autism Diagnostic Observation Schedule-2 (ADOS-2), Childhood Autism Rating Scale (CARS) or other tools with acceptable psychometric properties. Screening scales are not sufficient to make a diagnosis and will not be accepted as the only formal scale.

(3) There must be a reasonable expectation that the member will benefit from ABA. The member must exhibit:

(A) The ability/capacity to learn and develop generalized skills to assist with his or her independence; and

(B) The ability to develop generalized skills to assist in addressing maladaptive behaviors associated with ASD.

(4) The member is medically stable and does not require twenty-four (24) hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for individuals with intellectual disabilities (ICF/IID).

(5) The member exhibits atypical or disruptive behavior within the most recent thirty (30) calendar days that significantly interferes with daily functioning and activities. Such atypical or disruptive behavior may include, but is not limited to:

(A) Impulsive aggression toward others;

(B) Self-injury behaviors;

(C) Intentional property destruction; or

(D) Severe disruption in daily functioning (e.g. the individual's inability to maintain in school, child care settings, social settings, etc.) due to changes in routine activities that have not been helped by other treatments such as occupational, speech therapy, additional psychotherapy and/or school/ daycare interventions.

(6) The focus of treatment is not custodial in nature (which is defined as care provided when the member "has reached maximum level of physical or mental function and such person is not likely to make further significant improvement" or "any type of care where the primary purpose of the type of care provided is to attend to the member's daily living activities which do not entail or require the continuing attention of trained medical or paramedical personnel.") Interventions are intended to strengthen the individual's/parent's/legal guardian's capacity for self care and self sufficiency to decrease interventions in the home by those other than the parent(s)/legal guardian(s).

(7) It has been determined that there is no less intensive or more appropriate level of service which can be safely and effectively provided.

(f) **Prior authorization.** Eligible providers must submit an initial prior authorization request to the Oklahoma Health Care Authority (OHCA) or its designated agent. Prior authorization requests shall be granted up to six (6) months of ABA treatment services at one (1) time unless a longer duration of treatment is clinically indicated. The number of hours authorized may differ from the hours requested on the prior authorization request based on the review by an OHCA reviewer and/or physician. If the member's condition necessitates a change in the treatment plan, the provider must request a new prior authorization. The prior authorization request must meet the following SoonerCare criteria for ABA services.

(1) The criteria includes a comprehensive behavioral and FBA outlining the maladaptive behaviors consistent with the diagnosis of ASD and its associated comorbidities. In addition to completing the initial request form, providers will be required to submit documentation that will consist of the following:

(A) Information about relevant medical status, prior assessment results, response to prior treatment, and other relevant information gathered from review of records and past assessments.

(B) Information gathered from interview of family and/or caregivers, rating scales, and social validity measures to assess perceptions of the client's skill deficits and behavioral excesses, and the extent to which these deficits impede the daily life of the member and the family.

(C) Direct assessment and observation, including any data related to the identified problem behavior. The analysis of such data serves as the primary basis for identifying pretreatment levels of functioning, developing and adapting treatment protocols, and evaluating response to treatment and progress towards goals.

(D) Functional assessment of problem behavior that includes antecedent factors, skill deficits, and consequences contributing to the problem behavior. The treatment plan should address all three (3) areas, including antecedent interventions, teaching replacement skills, and modification of consequences.

(2) The prior authorization for ABA treatment will be time limited for up to thirty (30) hours per week unless other hours are deemed medically necessary and authorized through a prior authorization request and must:

(A) Be a one-on-one encounter (face to face between the member and ABA provider) except in the case of family adaptive treatment guidance;

(B) Be child-centered and based upon individualized goals

~~that are strengths-specific, family focused, and community based;~~
~~(C) Be culturally competent and the least intrusive as possible;~~
~~(D) Clearly define in measurable and objective terms the intervention plan so it can address specific target behaviors. The intervention plan should be clearly linked to the function of the maladaptive behavior and include antecedent interventions, replacement skills to be taught, and modification of consequences. Additional goals may be identified that are related to the core deficits of ASD and are prioritized based on current research and social significance for the individual.~~
~~(E) Record the frequency, rate, symptom intensity/duration, or other objective measures of baseline levels;~~
~~(F) Set quantifiable criteria for progress;~~
~~(G) Establish and record behavioral intervention techniques that are appropriate to target behaviors. The detailed treatment plan utilizes reinforcement and other behavioral principles and excludes the use of methods or techniques that lack consensus about their effectiveness based on evidence in peer-reviewed publications;~~
~~(H) Specify strategies for generalization of learned skills beyond the clinical settings such as in the home or other community settings;~~
~~(I) Document planning for transition through the continuum of interventions, services, and settings, as well as discharge criteria. Treatment (behavioral training) will be individualized and documentation will support the identified atypical or disruptive behavior.~~
~~(J) Include parent(s)/legal guardian(s) in behavioral training techniques so that they can practice additional hours of intervention on their own. The treatment plan is expected to achieve the parent(s)/legal guardian(s) ability to successfully reinforce the established plan of care and support generalization of skills in the home and community settings. Frequency of parental involvement will be determined by the treatment provider and listed on the treatment plan;~~
~~(K) Document parent(s)/legal guardian(s) participation in the training of behavioral techniques in the member's medical record. Parent(s)/legal guardian(s)' participation is critical to the generalization of treatment goals to the member's environment; and~~
~~(L) Ensure that recommended ABA services do not duplicate or replicate services received in a member's primary academic education setting, or provided within an Individualized~~

Education Plan (IEP), Individualized Service Plan (ISP), or any other individual plan of care. Documentation may be requested by the OHCA to support coordination of services with other providers and to prevent overlap and duplication of services including those in school settings.

(g) **ABA extension requests.** Extension requests for ABA services must be submitted to the OHCA or its designated agent. Extension requests must contain the appropriate documentation validating the need for continued treatment and establish the following:

(1) Eligibility criteria in OAC 317:30-3-65.12(d) 1-6;

(2) The frequency of the target behavior has diminished since last review, or if not, there has been modification of the treatment or additional assessments have been conducted;

(3) A functional analysis shall be completed by the provider when no measurable progress has occurred, or it may be requested by the OHCA. The functional analysis should record the member's serious maladaptive target behavioral symptom(s) and precipitants, and document the modifications of the current treatment plan to address progress, as well as make a determination of the function a particular maladaptive behavior serves for the member in the environmental context;

(4) Appropriate consultations from other staff or experts have occurred (to optimize psychiatric medications and medical treatments to include but not limited to psychiatric consults, pediatric evaluation for other conditions, etc.) and interventions have been changed, including the number of hours per week of service or setting (higher level of care);

(5) The OHCA may suggest appropriate consultation from other staff or experts during the process of prior authorization;

(6) Parent(s)/legal guardian(s) have received re-training on these changed approaches; and

(7) The treatment plan documents a gradual tapering of higher intensities of intervention and transitioning to supports from other sources (i.e., schools) as progress allows.

(h) **Reimburement methodology.** SoonerCare shall provide reimbursement for ABA services in accordance with the Medicaid State Plan.

(1) Payment shall only be made to SoonerCare-contracted groups or qualified individual providers who are currently licensed and in good standing. Payment is not made to under supervision ABA practitioners/paraprofessionals, including but not limited to, BCaBAs and RBTs.

(2) Reimbursement for ABA services is only made on a fee-for-services basis. The maximum allowable fee for a unit of service has been determined by OHCA to be a reasonable fee, consistent with efficiency, economy, and quality of care. Payment for

~~covered services is the lower of the provider's actual billed charges, consistent with the provider's usual and customary charge to the general public for the service, or the maximum allowable per unit of service.~~

~~(3) Reimbursement shall only be made for services that have been prior-authorized by OHCA or its designee; and performed on an individualized basis and not in a group setting except for family adaptive behavior treatment guidance by a qualified ABA provider [OAC 317:30-3-65.12(b)].~~

~~(4) Reimbursement for ABA services shall not be made to or for services rendered by a parent, legal guardian, or other legally responsible person.~~

ABA services are provided under the EPSDT benefit. Refer to OAC 317:30-5-310 through 317:30-5-316 for coverage, provider and program requirements, and reimbursement methodology.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 30. APPLIED BEHAVIOR ANALYSIS (ABA) SERVICES

317:30-5-310. Purpose

The purpose of this Section is to establish guidelines for the provision of ABA services under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit.

(1) ABA focuses on the analysis, design, implementation, and evaluation of instructional and other environmental modifications to produce meaningful changes in human behavior. ABA services include the use of direct observation, measurement, and functional analysis of the relations between the environment and behavior. Common ABA-based techniques include but are not limited to; discrete trial training (DTT); naturalistic developmental behavioral intervention (NDBI); and verbal behavioral intervention.

(2) ABA may be provided in a variety of settings, including home, community, or clinical. It involves development of an individualized treatment plan that includes transition and aftercare planning, and family/caregiver involvement.

(3) At an initial assessment, target symptoms are identified. A treatment plan is developed to identify core deficits and aberrant behaviors, and includes designated interventions intended to address these deficits and behaviors and that are functional, meaningful, and connected to the member's daily activities routines.

(4) ABA services require prior authorization [refer to Oklahoma Administrative Code (OAC) 317:30-3-31 and 317:30-5-314].

317:30-5-311. Eligible providers and requirements

(a) Eligible ABA provider types include:

(1) Board certified behavior analyst® (BCBA®) – A master's or doctoral level independent practitioner who is certified by the national-accrediting Behavior Analyst Certification Board, Inc.® (BACB®) and licensed by the Oklahoma Department of Human Services' (OKDHS) Developmental Disabilities Services Division (DDS) to provide behavior analysis services. A BCBA may supervise the work of board-certified assistant behavior analysts and registered behavior technicians implementing behavior analytic interventions;

(2) Board-certified assistant behavior analyst® (BCaBA®) – A bachelor's level practitioner who is certified by the national-accrediting BACB and certified by OKDHS DDS to provide behavior analysis services under the supervision of a BCBA;

(3) Registered behavior technician™ (RBT®) – A high school level or higher paraprofessional who is certified by the national-accrediting BACB and practices under the close and ongoing supervision of a BCBA. The RBT works under the license number of a BCBA and is primarily responsible for the direct implementation of BCBA designed and prescribed behavior-analytic services;

(4) Licensed psychologist – An individual who is licensed and in good standing with the Oklahoma State Board of Examiners of Psychologists and has professional experience in the use of ABA therapy may render behavior analysis services. Refer to OAC 317:30-5-275; and

(5) Human services professional - A practitioner who is licensed by the State of Oklahoma pursuant to (A) - (G), and certified by the national-accrediting BACB, and who is working within the scope of his or her practice, to include:

(A) A licensed physical therapist;

(B) A licensed occupational therapist;

(C) A licensed clinical social worker or social worker candidate under the supervision of a licensed clinical social worker;

(D) A licensed speech-language pathologist or licensed audiologist;

(E) A licensed professional counselor or professional counselor candidate under the supervision of a licensed professional counselor;

(F) A licensed marital and family therapist or marital and family therapist candidate under the supervision of a licensed marital and family therapist; or

(G) A licensed behavioral practitioner or behavioral practitioner candidate under the supervision of a licensed behavioral practitioner.

(b) **Provider criteria.** To direct, supervise, and/or render ABA

services, the following conditions shall be met.

(1) A BCBA shall:

(A) Be currently licensed by OKDHS DDS as a BCBA;

(B) Have no sanctions or disciplinary actions by OKDHS DDS or the BACB;

(C) Have no current overpayment(s) due to SoonerCare, and no Medicare or Medicaid sanctions or exclusions from participation in federally funded programs; and

(D) Be fully contracted with SoonerCare as a provider.

(2) A BCaBA shall:

(A) Be currently certified by OKDHS DDS as a BCaBA;

(B) Work under the supervision of a SoonerCare-contracted BCBA provider;

(C) Have no current overpayment(s) due to SoonerCare, and no Medicare or Medicaid sanctions or exclusions from participation in federally funded programs; and

(D) Be fully contracted with SoonerCare as a provider.

(3) An RBT shall:

(A) Be currently certified by the national-accrediting BACB as an RBT;

(B) Work under the supervision of a SoonerCare-contracted BCBA provider;

(C) Have no current overpayment(s) due to SoonerCare, and no Medicare or Medicaid sanctions or exclusions from participation in federally funded programs; and

(D) Be fully contracted with SoonerCare as a provider.

(4) A human services professional shall:

(A) Be currently licensed or certified by the State of Oklahoma, in accordance with Section 1928 of Title 59 of the Oklahoma Statutes;

(B) Be currently certified by the national-accrediting BACB;

(C) Have no sanctions or disciplinary actions by the applicable state licensing board or the BACB;

(D) If working under supervision within the scope of his or her practice, have a documented relationship with a fully-licensed human service professional working in a supervisory capacity;

(E) Have no current overpayment(s) due to SoonerCare, and no Medicare or Medicaid sanctions or exclusions from participation in federally funded programs; and

(F) Be fully contracted with SoonerCare as a provider.

317:30-5-312. Treatment plan components and documentation requirements

(a) **Functional behavior assessment (FBA).** The FBA serves as a critical component of the treatment plan and is conducted by a

board-certified behavior analyst (BCBA) to identify the specific behavioral needs of the member. The FBA consists of:

(1) Description of the problematic behavior (topography, onset/offset, cycle, intensity, severity);

(2) History of the problematic behavior (long-term and recent);

(3) Antecedent analysis (setting, people, time of day, events);

(4) Consequence analysis; and

(5) Impression and analysis of the function of the problematic behavior.

(b) **Treatment plan.** The treatment plan is developed by a BCBA or a licensed psychologist from the FBA. The treatment plan shall:

(1) Be person-centered and individualized;

(2) Delineate the baseline levels of target behaviors;

(3) Specify long-term and short-term objectives that are defined in observable, measurable behavioral terms;

(4) Specify criteria that will be used to determine achievement of objectives;

(5) Include assessment and treatment protocols for addressing each of the target behaviors such as include antecedent and consequence interventions, and teaching of replacement skills specific to the function of the identified maladaptive behaviors;

(6) Clearly identify the schedule of services planned and the individuals responsible for delivering the services, including frequent review of data on target behaviors and adjustments in the treatment plan and/or protocols by the BCBA or licensed psychologist as needed;

(7) Include training and supervision to enable board certified assistant behavior analysts (BCaBAs) and registered behavior technicians (RBTs) to implement assessment and treatment protocols;

(8) Include training and support to enable parents and other caregivers to participate in treatment planning and successfully reinforce the established treatment plan in the home and community settings;

(9) Include care coordination involving the parents or caregiver(s), school, state disability programs, and others as applicable; and

(10) Ensure that services are consistent with applicable professional standards and guidelines relating to the practice of applied behavior analysis as well as state Medicaid laws and regulations.

(c) **Documentation requirements.** All ABA services must be documented in the member's record. All assessment and treatment services must include the following:

(1) Date;

(2) Start and stop time for each session/unit billed and

physical location where service was provided;
(3) Signature of the provider;
(4) Credentials of provider;
(5) Specific problem(s), goals and/or objectives addressed;
(6) Methods used to address problem(s), goals and objectives;
(7) Progress made toward goals and objectives;
(8) Patient response to the session or intervention; and
(9) Any new problem(s), goals and/or objectives identified during the session.
(10) Treatment plans are not valid until all signatures are present [signatures are required from the member, if fourteen (14) or over (unless the member who by reason of a physical or mental incapacity cannot give consent as defined by state law)], the parent/guardian [if younger than eighteen (18) or otherwise applicable] and the supervising BCBA or licensed psychologist. The signatures may be included in a signature page applicable to both the assessment and treatment plan if the signature page clearly indicates that the signatories consent and approve of both.

317:30-5-313. Medical necessity criteria for members under twenty-one (21) years of age.

ABA services are considered medically necessary when all the following conditions are met:

(1) The member is under twenty-one (21) years of age with a definitive diagnosis of an Autism Spectrum Disorder (ASD) from the following providers:

(A) Pediatric neurologist or neurologist;
(B) Developmental pediatrician;
(C) Licensed psychologist;
(D) Psychiatrist or neuropsychiatrist; or
(E) Other licensed physician experienced in the diagnosis and treatment of ASD.

(2) A comprehensive diagnostic evaluation or thorough clinical assessment completed by one (1) of the above identified professionals must:

(A) Be completed within the most recent treatment plan; however, the OHCA may request an updated psychological evaluation to be completed prior to the next extension period;
(B) Include a complete pertinent medical and social history, including pre-and perinatal, medical, developmental, family, and social elements; and
(C) Be based on criteria outlined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) or the most current version of the DSM for ASD and/or may also include

scores from the use of formal diagnostic tests such as the Autism Diagnostic Interview-Revised (ADI-R), Autism Diagnostic Observation Schedule-2 (ADOS-2), Childhood Autism Rating Scale (CARS) or other tools with acceptable psychometric properties. Screening scales are not sufficient to make a diagnosis and will not be accepted as the only formal scale.

(3) There must be a reasonable expectation that the member will benefit from ABA. The member must exhibit:

(A) The ability/capacity to learn and develop generalized skills to assist with his or her independence; and

(B) The ability to develop generalized skills to assist in addressing maladaptive behaviors associated with ASD.

(4) The member is medically stable and does not require twenty-four (24) hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for individuals with intellectual disabilities (ICF/IID).

(5) The member exhibits atypical or disruptive behavior within the most recent thirty (30) calendar days that significantly interferes with daily functioning and activities. Such atypical or disruptive behavior may include, but is not limited to:

(A) Impulsive aggression toward others;

(B) Self-injury behaviors;

(C) Intentional property destruction; or

(D) Severe disruption in daily functioning (e.g., the individual's inability to maintain in school, child care settings, social settings, etc.) due to changes in routine activities that have not been helped by other treatments such as occupational therapy, speech therapy, additional psychotherapy and/or school/ daycare interventions.

(6) The focus of treatment is not custodial in nature (which is defined as care provided when the member "has reached maximum level of physical or mental function and such person is not likely to make further significant improvement" or "any type of care where the primary purpose of the type of care provided is to attend to the member's daily living activities which do not entail or require the continuing attention of trained medical or paramedical personnel.") Interventions are intended to strengthen the individual's/parent's/legal guardian's capacity for self care and self sufficiency to decrease interventions in the home by those other than the parent(s)/legal guardian(s).

(7) It has been determined that there is no less intensive or more appropriate level of service which can be safely and effectively provided.

317:30-5-314. Prior authorization

Eligible providers must submit an initial prior authorization request to the Oklahoma Health Care Authority (OHCA) or its designated agent. Prior authorization requests shall be granted up to six (6) months of ABA treatment services at one (1) time unless a longer duration of treatment is clinically indicated. The number of hours authorized may differ from the hours requested on the prior authorization request based on the review by an OHCA reviewer and/or physician. If the member's condition necessitates a change in the treatment plan, the provider must request a new prior authorization. The prior authorization request must meet the following SoonerCare criteria for ABA services.

(1) The criteria include a comprehensive behavioral and FBA outlining the maladaptive behaviors consistent with the diagnosis of ASD and its associated comorbidities. In addition to completing the initial request form, providers will be required to submit documentation that will consist of the following:

(A) Information about relevant medical status, prior assessment results, response to prior treatment, and other relevant information gathered from review of records and past assessments.

(B) Information gathered from interview of family and/or caregivers, rating scales, and social validity measures to assess perceptions of the client's skill deficits and behavioral excesses, and the extent to which these deficits impede the daily life of the member and the family.

(C) Direct assessment and observation, including any data related to the identified problem behavior. The analysis of such data serves as the primary basis for identifying pretreatment levels of functioning, developing, and adapting treatment protocols, and evaluating response to treatment and progress towards goals.

(D) Functional assessment of problem behavior that includes antecedent factors, skill deficits, and consequences contributing to the problem behavior. The treatment plan should address all three (3) areas, including antecedent interventions, teaching replacement skills, and modification of consequences.

(2) The prior authorization for ABA treatment will be time limited for up to thirty (30) hours per week unless other hours are deemed medically necessary and authorized through a prior authorization request and must:

(A) Be a one-on-one encounter (face to face between the member and ABA provider) except in the case of family adaptive treatment guidance;

(B) Be child-centered and based upon individualized goals that are strengths-specific, family focused, and community

based;
(C) Be culturally competent and the least intrusive as possible;
(D) Clearly define in measurable and objective terms the intervention plan so it can address specific target behaviors. The intervention plan should be clearly linked to the function of the maladaptive behavior and include antecedent interventions, replacement skills to be taught, and modification of consequences. Additional goals may be identified that are related to the core deficits of ASD and are prioritized based on current research and social significance for the individual.
(E) Record the frequency, rate, symptom intensity/duration, or other objective measures of baseline levels;
(F) Set quantifiable criteria for progress;
(G) Establish and record behavioral intervention techniques that are appropriate to target behaviors. The detailed treatment plan utilizes reinforcement and other behavioral principles and excludes the use of methods or techniques that lack consensus about their effectiveness based on evidence in peer-reviewed publications;
(H) Specify strategies for generalization of learned skills beyond the clinical settings such as in the home or other community settings;
(I) Document planning for transition through the continuum of interventions, services, and settings, as well as discharge criteria. Treatment (behavioral training) will be individualized, and documentation will support the identified atypical or disruptive behavior.
(J) Include parent(s)/legal guardian(s) in behavioral training techniques so that they can practice additional hours of intervention on their own. The treatment plan is expected to achieve the parent(s)/legal guardian(s) ability to successfully reinforce the established plan of care and support generalization of skills in the home and community settings. Frequency of parental involvement will be determined by the treatment provider and listed on the treatment plan;
(K) Document parent(s)/legal guardian(s) participation in the training of behavioral techniques in the member's medical record. Parent(s)/legal guardian(s)' participation is critical to the generalization of treatment goals to the member's environment; and
(L) Ensure that recommended ABA services do not duplicate, or replicate services received in a member's primary academic education setting or provided within an Individualized Education Plan (IEP), Individualized Service Plan (ISP), or

any other individual plan of care. Documentation may be requested by the OHCA to support coordination of services with other providers and to prevent overlap and duplication of services including those in school settings.

317:30-5-315. ABA extension requests

Extension requests for ABA services must be submitted to the OHCA or its designated agent. Extension requests must contain the appropriate documentation validating the need for continued treatment and establish the following:

(1) Eligibility criteria in OAC 317:30-5-313;

(2) The frequency of the target behavior has diminished since last review, or if not, there has been modification of the treatment or additional assessments have been conducted;

(3) A functional analysis shall be completed by the provider when no measurable progress has occurred, or it may be requested by the OHCA. The functional analysis should record the member's serious maladaptive target behavioral symptom(s) and precipitants, and document the modifications of the current treatment plan to address progress, as well as make a determination of the function a particular maladaptive behavior serves for the member in the environmental context;

(4) Appropriate consultations from other staff or experts have occurred (to optimize psychiatric medications and medical treatments to include but not limited to psychiatric consults, pediatric evaluation for other conditions, etc.) and interventions have been changed, including the number of hours per week of service or setting (higher level of care);

(5) The OHCA may suggest appropriate consultation from other staff or experts during the process of prior authorization;

(6) Parent(s)/legal guardian(s) have received re-training on these changed approaches; and

(7) The treatment plan documents a gradual tapering of higher intensities of intervention and transitioning to supports from other sources (i.e., schools) as progress allows.

317:30-5-316. Reimbursement methodology

SoonerCare shall provide reimbursement for ABA services in accordance with the Medicaid State Plan.

(1) Payment shall only be made to SoonerCare-contracted groups or qualified individual providers who are currently licensed and in good standing. Payment is not made to under supervision ABA practitioners/paraprofessionals, including but not limited to, BCaBAs and RBTs.

(2) Reimbursement for ABA services is only made on a fee-for-services basis. The maximum allowable fee for a unit of service has been determined by OHCA to be a reasonable fee, consistent

with efficiency, economy, and quality of care. Payment for covered services is the lower of the provider's actual billed charges, consistent with the provider's usual and customary charge to the general public for the service, or the maximum allowable per unit of service.

(3) Reimbursement shall only be made for services that have been prior authorized by OHCA or its designee; and performed on an individualized basis and not in a group setting except for family adaptive behavior treatment guidance by a qualified ABA provider (OAC 317:30-5-311).

(4) Providers may only concurrently bill current Procedural Terminology (CPT) codes when they outline in the prior authorization the following criteria:

(A) The BCBA or licensed psychologist meet with the member and/or parent/guardian and are directing the RBT through one (1) or more of the following:

(i) Selection of treatment targets;

(ii) Collaboration with family members and other stakeholders;

(iii) Training RBTs;

(iv) Creating materials, gathering materials; and/or

(v) Reviewing data.

(B) The BCBA or licensed psychologist used behavior training in session. Behavioral skills training consists of instructions, modeling, rehearsal, and feedback between provider and member.

(5) Reimbursement for ABA services shall not be made to or for services rendered by a parent, legal guardian, or other legally responsible person.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 5. PHARMACIES

317:30-5-87. 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 340B Ceiling Price from the amount reimbursed and multiplying the difference by the quantity submitted. All drugs shall be adjusted by the 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 340B Ceiling Price applicable to the quarter in which the claim is 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.~~

(a) The 340B Drug Discount Program is a drug-pricing program established under section 256b of Title 42 of the United States Code (U.S.C) under which a manufacturer of covered outpatient drugs agrees that it will not charge a 340B covered entity more than the 340B price for a 340B covered outpatient drug.

(b) Covered entities participating in the 340B Drug Discount Program will adhere to the following provisions outlined in this

Section and as defined in 42 U.S.C. §256b. Covered entities must:

(1) Notify the OHCA Pharmacy Department in writing within thirty (30) days of any changes in 340B Program participation, as well as any changes in name, address, National Provider Identification (NPI) number, etc.

(2) Maintain their status on the Health Resources & Services Administration (HRSA) Medicaid Exclusion File (MEF) and report any changes to the OHCA within thirty (30) days.

(3) Execute a contract addendum with the OHCA in addition to their provider contract.

(c) To prevent a duplicate discount, quarterly adjustments will be made to all pharmacy or medical claims for drugs submitted by covered entities when billed using the registered SoonerCare NPI number on the MEF.

(1) All pharmacy claims submitted by covered entities shall be adjusted by the 340B ceiling price whether purchased through the 340B Program or otherwise.

(2) Medical claims submitted by covered entities with procedure code modifiers indicating the use of the 340B purchased drugs shall be adjusted by the 340B ceiling price. OHCA will adjust each claim by subtracting the 340B ceiling price from the amount reimbursed and multiplying the difference by the quantity submitted. OHCA will use the 340B ceiling price applicable to the quarter in which the claim is paid. Medical claims submitted by covered entities with a procedure code modifier indicating the use of non 340B purchased drugs will not be adjusted by the 340B ceiling price and will be submitted for federal rebates as required by CMS. Covered entities are required to use an appropriate procedure code modifier on all physician administered drug lines when submitting medical claims.

(d) 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 the OHCA, the contract pharmacy, and the covered entity. These pharmacies will be subject to the recovery process stated in this Section.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 21. OUTPATIENT BEHAVIORAL HEALTH SERVICES

317:30-5-240.1. Definitions

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

"Accrediting body" means one (1) of the following:

(A) Accreditation Association for Ambulatory Health Care (AAAHC);

(B) American Osteopathic Association (AOA);

(C) Commission on Accreditation of Rehabilitation Facilities (CARF);

(D) Council on Accreditation of Services for Families and Children, Inc. (COA);

(E) The Joint Commission (TJC) formerly known as Joint Commission on Accreditation of Healthcare Organizations;

(F) Accreditation Commission for Health Care (ACHC); or

(G) ~~other~~Other OHCA approved accreditation.

"Adult" means an individual twenty-one (21) and over, unless otherwise specified.

"AOD" means ~~Alcohol~~alcohol and ~~Other Drug~~other drug.

"AODTP" means ~~Alcohol and Other Drug Treatment Professional~~alcohol and other drug treatment professional.

"ASAM" means the American Society of Addiction Medicine.

"ASAM ~~Patient Placement Criteria~~patient placement criteria (ASAM PPC)" means the most current edition of the American Society of Addiction Medicine's published criteria for admission to treatment, continued services, and discharge.

"Behavioral ~~Health (BH) Services~~health (BH) services" means a wide range of diagnostic, therapeutic, and rehabilitative services used in the treatment of mental illness, substance abuse, and co-occurring disorders.

"BHAs" means ~~Behavioral Health Aides~~behavioral health aides.

"Certifying ~~Agency~~agency" means the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS).

"C.F.R." means Code of Federal Regulations.

"Child" means an individual younger than twenty-one (21), unless otherwise specified.

"Client Assessment Record (CAR)" means the ~~use of~~ standardized tool recognized by OHCA and ODMHSAS to evaluate the functioning of the member as per the OHCA prior authorization manual on the OHCA'S

website at www.oklahoma.gov/ohca.

"CM" means case management.

"Cultural competency" means the ability to recognize, respect, and address the unique needs, worth, thoughts, communications, actions, customs, beliefs and values that reflect an individual's racial, ethnic, age group, religious, sexual orientation, and/or social group.

"DSM" means the most current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

"EBP" means an ~~Evidence Based Practice~~evidence-based practice per the Substance Abuse & Mental Health Services Administration (SAMHSA).

"EPSDT" means the ~~Medicaid~~ Early and Periodic Screening, Diagnostic and Treatment benefit for children. In addition to screening services, EPSDT also covers the diagnostic and treatment services necessary to ameliorate acute and chronic physical and mental health conditions.

"FBCS" means ~~Facility Based Crisis Stabilization~~facility-based crisis stabilization.

"FSPs" means ~~Family Support Providers~~family support providers.

"ICF/IID" means ~~Intermediate Care Facility for Individuals with Intellectual Disabilities~~intermediate care facility for individuals with intellectual disabilities.

"Institution" means an inpatient hospital facility or ~~Institution for Mental Disease~~institution for mental disease (IMD).

"IMD" means ~~Institution for Mental Disease~~institution for mental disease as per 42 C.F.R. § 435.1009 as a hospital, nursing facility, or other institution of more than sixteen (16) beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care and related services. The regulations indicate that an institution is an IMD if its overall character is that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases. Title XIX of the Social Security Act provides that, except for individuals under age twenty-one (21) receiving inpatient psychiatric care, Medicaid (Title XIX) does not cover services to IMD patients under sixty-five (65) years of age [Section 1905(a)(24)(B) of the Social Security Act].

"Level of ~~Functioning Rating~~functioning rating" means a standardized mechanism to determine the intensity or level of services needed based upon the severity of the member's condition. The CAR level of function rating scale is the tool that links the clinical assessment to the appropriate level of Mental Health treatment. Either the Addiction Severity Index (ASI) or the Teen

Addiction Severity Index (TASI), based on age, is the tool that links the clinical assessment to the appropriate level of Substance Abuse (SA) treatment.

"LBHP" means a licensed behavioral health professional.

"MST" means the EBP Multi-Systemic Therapy.

"OAC" means ~~Oklahoma Administrative Code,~~ the publication authorized by 75 Oklahoma Statutes, Sec. 256 known as The Oklahoma Administrative Code, or, prior to its publication, the compilation of codified rules authorized by 75 O.S. § 256(A)(1)(a) and maintained in the Office of Administrative Rules.

"Objectives" means a specific statement of planned accomplishments or results that are specific, measurable, attainable, realistic, and ~~time-limited~~time limited.

"ODMHSAS" means the Oklahoma Department of Mental Health and Substance Abuse Services.

"ODMHSAS contracted facilities" means those providers that have a contract with the ODMHSAS to provide mental health or substance use disorder treatment services, and ~~also~~ contract directly with the Oklahoma Health Care Authority to provide ~~Outpatient Behavioral Health Services~~outpatient behavioral health services.

"OHCA" means the Oklahoma Health Care Authority.

"OJA" means the Office of Juvenile Affairs.

"O.S." means Oklahoma Statutes.

"RBMS" means ~~Residential Behavioral Management Services~~residential behavioral management services within a group home or therapeutic foster home.

"Recovery" means an ongoing process of discovery and/or rediscovery that must be self defined, individualized and may contain some, if not all, of the ten fundamental components of recovery as outlined by SAMHSA.

"PRSS" means ~~Peer Recovery Support Specialist~~peer recovery support specialist.

"SAMHSA" means the Substance Abuse and Mental Health Services Administration.

"Serious ~~Emotional Disturbance~~emotional disturbance (SED)" means a condition experienced by persons from birth to eighteen (18) that show evidence of points of (A), (B) and (C) below:

(A) The disability must have persisted for six (6) months and be expected to persist for a year or longer.

(B) A condition or serious emotional disturbance as defined by the most recently published version of the DSM or the International Classification of Disease (ICD) equivalent with the exception of DSM "V" codes, substance abuse, and developmental disorders which are excluded, unless they co-occur with another diagnosable serious emotional disturbance.

(C) The child must exhibit either (i) or (ii) below:

(i) Psychotic symptoms of a serious mental illness (e.g., Schizophrenia characterized by defective or lost contact with reality, often hallucinations or delusions); or

(ii) Experience difficulties that substantially interfere with or limit a child or adolescent from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills. There is functional impairment in at least two (2) of the following capacities (compared with expected developmental level):

(I) Impairment in self-care manifested by a person's consistent inability to take care of personal grooming, hygiene, clothes and meeting of nutritional needs.

(II) Impairment in community function manifested by a consistent lack of ~~age appropriate~~age-appropriate behavioral controls, decision-making, judgment and value systems which result in potential involvement or involvement with the juvenile justice system.

(III) Impairment of social relationships manifested by the consistent inability to develop and maintain satisfactory relationships with peers and adults.

(IV) Impairment in family function manifested by a pattern of disruptive behavior exemplified by repeated and/or unprovoked violence to siblings and/or parents, disregard for safety and welfare or self or others (e.g., fire setting, serious and chronic destructiveness, inability to conform to reasonable limitations and expectations which may result in removal from the family or its equivalent).

(V) Impairment in functioning at school manifested by the inability to pursue educational goals in a normal time frame (e.g., consistently failing grades, repeated truancy, expulsion, property damage or violence toward others).

"Serious ~~Mental Illness~~mental illness (SMI)" means a condition experienced by persons age eighteen (18) and over that show evidence of points of (A), (B) and (C) below:

(A) The disability must have persisted for six (6) months and be expected to persist for a year or longer.

(B) A condition or serious mental illness as defined by the most recently published version of the DSM or the International Classification of Disease (ICD) equivalent with the exception of DSM "V" codes, substance abuse, and developmental disorders which are excluded, unless they co-occur with another diagnosable serious mental illness.

(C) The adult must exhibit either (i) or (ii) below:

(i) Psychotic symptoms of a serious mental illness (e.g., Schizophrenia characterized by defective or lost contact with reality, often hallucinations or delusions); or
(ii) Experience difficulties that substantially interfere with or limit an adult from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills. There is functional impairment in at least two (2) of the following capacities (compared with expected developmental level):
(I) Impairment in self-care manifested by a person's consistent inability to take care of personal grooming, hygiene, clothes and meeting of nutritional needs.
(II) Impairment in community function manifested by a consistent lack of appropriate behavioral controls, decision-making, judgment and value systems which result in potential involvement or involvement with the criminal justice system.
(III) Impairment of social relationships manifested by the consistent inability to develop and maintain satisfactory relationships with peers.
(IV) Impairment in family function manifested by a pattern of disruptive behavior exemplified by repeated and/or unprovoked violence, disregard for safety and welfare of self or others (e.g., fire setting, serious and chronic destructiveness, inability to conform to reasonable limitations and expectations).
(V) Impairment in functioning at school or work manifested by the inability to pursue educational or career goals.

"Trauma informed" means the recognition and responsiveness to the presence of the effects of past and current traumatic experiences in the lives of members.

PART 24. CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS

317:30-5-266. Covered services

CCBHCs provide a comprehensive array of services that create access, stabilize people in crisis, and provide the needed treatment and recovery support services for those with the most serious and complex mental health and substance use disorders. CCBHCs integrate additional services to ensure an approach to health care that emphasizes recovery, wellness, trauma-informed care, and physical-behavioral health integration. Initial screening, assessment, and diagnosis must be completed in order to receive a covered service. Services must be medically necessary and recommended by an LBHP or licensure candidate (see OAC 317:30-

5-263). Services are covered when provided in accordance with a person-centered and family-centered service plan. Coverage includes the following services:

(1) **Crisis assessment and intervention services.**

(A) **Service requirements.** This service is an immediately available service designed to meet the psychological, physiological, and environmental needs of individuals who are experiencing mental health and/or substance use disorder crises. Services include the following:

(i) Twenty-four (24) hours mobile crisis teams [see OAC 317:30-5-241.4(a) for service definition]. Reimbursement is triggered by the LBHP/licensure candidate crisis assessment;

(ii) Emergency crisis intervention service [see OAC 317:30-5-241.4(a) for service definition]; ~~and~~

(iii) Facility-based crisis stabilization [see OAC 317:30-5-241.4(b) for service definition], provided directly by the CCBHC or by a State-sanctioned alternative~~.~~; and

(iv) Urgent recovery clinic (URC) services provided in accordance with OAC 450:23-3-20 through 450:23-3-24.

(B) **Qualified professionals.** Twenty-four (24) hours mobile crisis intervention is provided by either a team consisting of an LBHP/licensure candidate and a CM II or CADC, or just an LBHP/licensure candidate. Emergency crisis intervention is provided by an LBHP/licensure candidate. Facility-based crisis stabilization is provided by a team, directed by a physician, and consisting of an LBHP/licensure candidate, licensed nurses, CM II or CADC, and PRSS staff. URC services are provided by an LBHP/licensure candidate with supervision from a physician or APRN with prescribing authority.

(2) **Behavioral health integrated (BHI) services.**

(A) **Service requirements.** This service includes activities provided that have the purpose of coordinating and managing the care and services furnished to each member, assuring a fixed point of responsibility for providing treatment, rehabilitation, and support services. This service includes, but is not limited to:

(i) Care coordination for primary health care, specialty health care, and transitional care from emergency departments, hospitals, and PRTFs;

(ii) Ensuring integration and compatibility of mental health and physical health activities;

(iii) Providing on-going service coordination and linking members to resources;

(iv) Tracking completion of mental and physical health goals in member's comprehensive care plan;

(v) Coordinating with all team members to ensure all objectives of the comprehensive care plan are progressing;
(vi) Appointment scheduling;
(vii) Conducting referrals and follow-up monitoring;
(viii) Participating in hospital discharge processes; and
(ix) Communicating with other providers and members/family.

(B) **Qualified professionals.** This service is performed by an LBHP/licensure candidate, nurse, CM II or CADC, and/or PRSS staff.

(3) **Person-centered and family-centered treatment planning.**

(A) **Service requirements.** This service is a process in which the information obtained in the initial screenings and assessments are used to develop a treatment plan that has individualized goals, objectives, activities, and services that will enable the member to improve. For children assessed as SED with significant behavioral needs, treatment planning is a wraparound process consistent with System of Care values. A wraparound planning process supports children and youth in returning to or remaining in the community.

(B) **Qualified professionals.** This service is conducted by LBHPs/licensure candidates, nurses, CM II or CADC, and/or PRSS staff. Treatment planning must include the member and involved practitioners.

(4) **Psychotherapy (individual / group / family).**

(A) **Service requirements.** See OAC 317:30-5-241.2 for service definitions and requirements. Fee-for-service billing limitations do not apply.

(B) **Qualified professionals.** This service is conducted by an LBHP/licensure candidate.

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

(A) **Service requirements.** This service includes:
(i) A review and educational session focused on the member's response to medication and compliance with the medication regimen and/or medication administration;
(ii) Prescription administration and ordering of medication by appropriate medical staff;
(iii) Assisting the member in accessing medications;
(iv) Monitoring medication response and side effects; and
(v) Assisting members with developing the ability to take medications with greater independence.

(B) **Qualified professionals.** This service is performed by an RN, APRN, or a physician assistant (PA) as a direct service under the supervision of a physician.

(6) **Psychosocial rehabilitation services (PSR).**

(A) **Service requirements.**

(i) Adult. PSR services are face-to-face behavioral health rehabilitation (BHR) services which are necessary to improve the member's ability to function in the community. They are performed to improve the skills and abilities of members to live independently in the community, improve self-care and social skills, and promote lifestyle change and recovery practices. Rehabilitation services may be provided individually or in group sessions through the format of curriculum-based education and skills training. This service is generally performed with only the member and the qualified provider, but may include a member and the member's family/support system when providing educational services from a curriculum that focuses on the member's diagnosis, symptom management, and recovery. A member who, at the time of service, is not able to cognitively benefit from the treatment due to active hallucinations, substance abuse, or other impairments, is not suitable for this service. Family involvement is allowed for support of the member and education regarding his/her recovery but does not constitute family therapy, which requires a licensed provider. Eligibility requirements and billing limits found in OAC 317:30-5-241.3 do not apply.

(ii) Children. PSR services are an array of services that are provided in the child's home, in the location where behavioral challenges are most likely to occur such as school, or in community settings for all children, youth, and young adults ages zero (0) to twenty (20). PSR services must be provided in a context that is child-centered, family-focused, strength-based, culturally competent, and responsive to each child's psychosocial, developmental, and treatment care needs. PSR service array includes:

(I) Intensive in-home services;

(II) Therapeutic behavioral services;

(III) Intensive family intervention; and

(IV) Intensive outpatient substance abuse rehabilitation.

(B) **Qualified professionals.** This service is solely restorative in nature and may be performed by a behavioral health CM II, CADC, LBHP, or licensure candidate, following development of a service plan and treatment curriculum approved by an LBHP or licensure candidate. ~~The behavioral health CM II and CADC~~For children, services are typically provided by a team that can offer a combination of therapy from a LBHP or licensure candidate and skills training and support from a paraprofessional [CM II, behavioral health

aide (BHA)]. The behavioral health CM II, CADC, and BHA must have immediate access to an LBHP who can provide clinical oversight and collaborate with the qualified PSR provider in the provision of services.

(7) **Psychoeducation and counseling.**

(A) **Service requirements.** This service is designed to restore, rehabilitate, and support the individual's overall health and wellness. Services are intended for members to provide purposeful and ongoing psychoeducation and counseling that are specified in the individual's person-centered, individualized plan of care. For children and their families, treatment services are an array of therapeutic strategies and services designed to ameliorate or reduce the risk of social, emotional, and behavioral disorders and disruptions in the relationship between an infant and parent/caregiver. Such disorders and disruptions may be due to infant/toddler and/or parent/caregiver vulnerabilities and/or negative environmental factors that are significantly impacting the infant and/or parent/caregiver-infant relationship. Treatment services are grounded in attachment theory and are relationship focused. Components include:

(i) Delivery of manualized wellness management interventions via group and individual work such as WRAP or IMR/WMR; and

(ii) Emotional support, education, resources during periods of crisis, and problem-solving skills.

(B) **Qualified professionals.** For children, zero (0) to five (5) years old, this service is provided by an LBHP or licensure candidate. For all other ages, this service is provided by a licensed nurse, licensed nutritionist, or CM II or CADC within the scope of their licensure, certification, and/or training.

(8) **Peer recovery support services.**

(A) **Service requirements.** See OAC 317:30-5-241.5(d) for service requirements.

(B) **Qualified professionals.** PRSS must be certified through ODMHSAS pursuant to OAC 450:53.

(9) **Family support and training.**

(A) **Service requirements.** See OAC 317:30-5-241.5(c) for service requirements.

(B) **Qualified professionals.** Family support providers must be trained/credentialed through ODMHSAS.

(10) **Screening, assessment, and service planning.**

(A) **Service requirements.** See OAC 317:30-5-241.1 for service requirements. Service billing limitations found in OAC 317:30-5-241.1 do not apply.

(B) **Qualified professionals.** Screenings can be performed by any qualified team member as listed in OAC 317:30-5-265(b). Assessment and service planning can only be performed by an LBHP or licensure candidate.

(11) **Occupational therapy.**

(A) **Service requirements.** This service includes the therapeutic use of everyday life activities (occupations) with an individual or groups for the purpose of participation in roles and situations in home, school, workplace, community, and other settings for the purpose of promoting health and wellness. Occupational therapy services are provided to those who have developed an illness, injury, disease, disorder, condition, impairment, disability, activity limitation, or participation restrictions. Occupational therapy addresses the physical, cognitive, psychosocial, sensory, and other aspects of performance in a variety of contexts to support engagement in everyday life activities that affect health, well-being, and quality of life.

(B) **Qualified professionals.** This service is solely restorative in nature and provided by a qualified occupational therapist who is contracted with the OHCA or an occupational therapist assistant who is working under the supervision of a licensed occupational therapist (see OAC 317:30-5-295).

(C) **Coverage limitations.** In order to be eligible for SoonerCare reimbursement, occupational therapy services must be prior authorized and/or prescribed by a physician or other licensed practitioner of the healing arts, in accordance with State and federal law, including, but not limited to, OAC 317:30-5-296, OAC 317:30-5-1020, and 42 C.F.R. § 440.110.

(12) Behavioral health targeted case management.

(A) Service requirements. See OAC 317:30-5-241.6 for service requirements.

(B) Qualified professionals. This service is provided by a CM II certified in accordance with OAC 450:50.

(C) Coverage limitations. Services are provided to individuals of all ages who meet medical necessity criteria.

(13) Outpatient substance abuse prevention counseling.

(A) Service requirements. This service provides counseling to enable individuals to successfully resist social and other pressures to engage in destructive activities.

(B) Qualified professionals. This service must be recommended by a physician or licensed practitioner and provided by LBHP/licensure candidate.

(C) Coverage limitations. Services are provided to individuals under age twenty-one (21) who meet medical necessity criteria.

317:30-5-267. Reimbursement

(a) In order to be eligible for payment, CCBHCs must have an approved provider agreement on file with the OHCA. Through this agreement, the CCBHC assures that OHCA's requirements are met and assures compliance with all applicable federal and state Medicaid law, including, but not limited to, OHCA administrative rules, ODMHSAS administrative rules, the Code of Federal Regulations, and the Oklahoma State Medicaid Plan. These agreements are renewed annually with each provider.

(b) Reimbursement is made using a provider-specific prospective payment system (PPS) rate developed based on provider-specific cost report data. The PPS rate varies by category and level of service intensity and is paid when a CCBH program delivers at least one (1) CCBHC covered service, and when a valid individual procedure code is reported for the calendar month. ~~Care coordination services do not trigger a PPS payment when billed alone in a calendar month.~~ For reimbursement purposes, members are categorized as follows, and are assigned to special populations by the State:

(1) Standard population;

(2) Special population 1. This population includes individuals eighteen (18) years of age and over with SMI and complex needs including those with co-occurring substance use disorder (SUD). Individuals between eighteen (18) and twenty-one (21) years of age can be served in either special population 1 or 2 depending on the member's individualized needs; and

(3) Special population 2. This population includes children and youth [ages six (6) through twenty-one (21)] with SED and complex needs, including those with co-occurring mental health and SUD.

~~(c) Payments for services provided to non-established clients will be separately billable. Non-established CCBH clients are those who receive crisis services directly from the CCBHC without receiving a preliminary screening and risk assessment by the CCBHC and those referred to the CCBHC directly from other outpatient behavioral health agencies for pharmacologic management.~~

~~(d) Additional reimbursement may be made to the CCBHC once in the same calendar month as the PPS payment for care coordination provided by CCBHC staff to members who are involved in a drug court or other specialty court program. Physician services provided to these members by the CCBHC are reimbursable using the SoonerCare fee schedule.~~

~~(e) Reimbursement rates will be reviewed bi-annually and updated~~

~~as necessary by the Medicare Economic Index (MEI).~~

(c) Preliminary screening, risk assessment, and care coordination services are required activities to establish CCBHC members but do not trigger a PPS payment. An additional, qualifying service must be provided in the calendar month for the CCBHC to receive the PPS payment.

(d) Payments for services provided to non-established CCBHC members will be separately billable. Non-established CCBHC members are those who receive crisis services directly from the CCBHC without receiving a preliminary screening and risk assessment by the CCBHC and who are not established at another CCBHC, and those referred to the CCBHC directly from other outpatient behavioral health agencies for pharmacologic management.

(e) Additional reimbursement may be made to the CCBHC once in the same calendar month as the PPS payment for care coordination provided by CCBHC staff to members who are involved in a drug court or other specialty court program. Physician services provided to these members by the CCBHC are reimbursable using the SoonerCare fee schedule.

(f) Initial provider-specific rates are rebased after one (1) year based on actual cost and visit data. All other provider-specific rates are rebased once every two (2) years. Provider-specific rates are updated between rebasing periods based on the Medicare Economic Index (MEI).

(g) Providers may receive a provider-specific rate adjustment for changes in scope expected to change payment rates by two point five percent (2.5%) or more, once per year, subject to State approval in accordance with the Oklahoma Medicaid State Plan.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 25. PSYCHOLOGISTS

317:30-5-275. Eligible providers

(a) Licensed Psychologist must be licensed to practice in the state in which services are provided. Payment is made for compensable services to psychologists licensed in the state in which ~~face to face~~face-to-face services are delivered.

(b) Psychologists employed in State and Federal ~~Agencies~~agencies, who are not permitted to engage in private practice, cannot be reimbursed for services as an individually contracted provider.

(c) Services provided by practitioners, who have completed education requirements to begin an internship or a post-doctoral fellowship in an accredited clinical psychology academic training program and are under current board approved supervision toward licensure, are eligible for reimbursement. Each supervising psychologist must have a current contract with the Oklahoma Health Care Authority (OHCA).

(d) For those licensure candidates who are actively and regularly receiving board approved supervision, or extended supervision by a fully licensed clinician and if the board's supervision requirement is met but the individual is not yet licensed, each supervising psychologist must have a current contract with the Oklahoma Health Care Authority (OHCA).

(e) In order for services provided by clinical psychology interns completing required internships, post-doctoral fellows completing required supervision for licensure to be reimbursed, the following conditions must be met:

(1) The licensed practitioner billing SoonerCare must have a letter on file covering the dates of services of the internship or ~~post-doctoral~~post-doctoral fellowship;

(2) The psychology intern or post-doctoral fellow must be under the direct supervision of the licensed psychologist who is responsible for the member's care;

(3) The licensed psychologist responsible for the member's care must:

(A) ~~staff~~Staff the member's case with the intern or fellow,

(B) ~~actively~~Actively direct the services~~,~~;

(C) ~~be~~Be available to the intern or fellow for in-person consultation while they are providing services~~,~~;

(D) ~~agree~~Agree with the current plan for the member~~,~~; and

(E) ~~confirm~~Confirm that the service provided by the intern or fellow was appropriate~~; and~~.

(4) The member's medical record must show that the requirements for reimbursement were met and the licensed psychologist responsible for the member's care has reviewed, countersigned, and dated the notes in the medical record at least every week so that it is documented that the licensed psychologist is responsible for the member's care.

317:30-5-276. Coverage by category

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

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

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

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

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

~~(1) The interview and assessment is defined as a face-to-face interaction with the member. Assessment includes a history, mental status, full bio-psycho-social evaluation, a disposition, communications with family or other sources,~~

~~review of laboratory or other pertinent medical information, and medical/clinical consultations as necessary. The pre-op evaluation should aim to assess the member's psychological well-being, ability to make informed decisions, and willingness to participate actively in postoperative treatment.~~

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

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

(1) Bio-Psycho-Social Assessments. Psychiatric Diagnostic Interview Examination (PDIE) initial assessment or Level of Care Assessment. The interview and assessment is defined as a face-to-face interaction with the member. Psychiatric diagnostic interview examination includes a history, mental status, and a disposition, and may include communication with family or other sources, ordering and medical interpretation of laboratory or other medical diagnostic studies. Only one (1) PDIE is allowable per provider per member. If there has been a break in service over a six (6) month period, then an additional unit of PDIE can be prior authorized by OHCA, or their designated agent.

(2) Psychotherapy in an outpatient setting including an office, clinic, or other confidential setting. The services may be performed at the residence of the member if it is demonstrated that it is clinically beneficial, or if the member is unable to go to a clinic or office. Psychotherapy is defined as a one to one treatment using a widely accepted modality or treatment framework suited to the individual's age, developmental abilities and diagnosis. It may include specialized techniques such as biofeedback or hypnosis. Psychotherapy is considered to involve "interactive complexity" when there are communication factors during a visit that complicate delivery of the psychotherapy by the psychologist. Sessions typically involve members who have other individuals legally responsible for their care (i.e. minors or adults with guardians); members who request others to be involved in their care during the session (i.e. adults accompanied by one or more participating family members or interpreter or language translator); or members that require involvement of other third parties (i.e. child welfare, juvenile justice, parole/probation officers, schools, etc.). Psychotherapy should only be reported as involving interactive

complexity when at least one (1) of the following communication factors is present:

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

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

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

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

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

(4) Group and/or Interactive Group psychotherapy in an outpatient setting must be performed in the psychologist's office, clinic, or other confidential setting. Group therapy is a face to face interaction between a therapist and two or more unrelated patients (though there may be siblings in the same group, just not siblings only) to facilitate emotional, psychological, or behavioral changes. All group therapy records must indicate group size. Maximum total group size is six (6) patients for children four years of age up to the age of 18. Groups ~~18-20 year olds~~ can include up to eight (8) individuals for members 18-20 years of age. Group therapy must be provided for the benefit of ~~a SoonerCare eligible child~~the member four years of age or older as a specifically identified component of an individual treatment plan. Multi-family group therapy size is limited to eight family units.

(5) Assessment/Evaluation and testing is provided by a psychological technician of a psychologist or a LBHP utilizing tests selected from currently accepted assessment test batteries. For assessments conducted in a school setting, the Oklahoma State Department of Education requires that a licensed supervisor sign the assessment. Eight hours/units of testing

per patient (over the age of three), per provider is allowed every 12 months. There may be instances when further testing is appropriate based on established medical necessity criteria found in the Prior Authorization Manual. Test results must be reflected in the service plan or medical record. The service must clearly document the need for the testing and what the testing is expected to achieve. Testing for a child younger than three must be medically necessary and meet established criteria as set forth in the Prior Authorization Manual. Justification for additional testing beyond allowed amount as specified in this section must be clearly explained and documented in the medical record. Testing units must be billed on the date the testing, interpretation, scoring, and/or reporting was performed and supported by documentation.

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

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

(8) Payment for therapy services provided by a psychologist to any one member is limited to eight sessions/units per month. A maximum of twelve (12) ~~12~~ sessions/units of therapy and testing services per day per provider are allowed. A maximum of ~~35~~thirty five (35) hours of therapy per week per provider are allowed. The weekly service hour limitation will be calculated using a rolling four (4) week average. ~~Case Management services are considered an integral component of the behavioral health services listed above.~~

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

(9) A child may receive psychological testing and evaluation services as separately reimbursable services.

(10) A child receiving Residential Behavioral Management in a foster home, also known as therapeutic foster care, or a child receiving Residential Behavioral Management in a group home, also known as therapeutic group home, may not receive individual, group or family counseling or ~~psychological testing~~unless allowed by the OHCA or its designated agent.

(c) **Adults.** Coverage for adults is the same as for children. For group therapy, groups can include up to eight individuals for adult members 18 years of age and older.

(d) **Home and Community Based Waiver Services for the Intellectually Disabled.** All providers participating in the Home and Community Based Waiver Services ~~for the intellectually disabled program~~program for people with intellectual and developmental disabilities must have a separate contract with this Authority to provide services under this program. All services are specified in

the individual's plan of care.
(e) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the Medicaid allowable for comparable services.
(f) **Nursing Facilities.** Services provided to members residing in nursing facilities may not be billed to SoonerCare.